



# California Health Benefit Exchange

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## Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability

### Options and Final Recommendations

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This document is a compilation of final recommendations on major issues the California Health Benefit Exchange needs to consider regarding the establishment of the structure for Qualified Health Plans (QHP) to participate in the Exchange. The options and final recommendations reflect work of Exchange staff, supported by PricewaterhouseCoopers.

The options, recommendations and background material reflect input that has been received over the past several months by the Exchange and a deep review of the relevant literature. They were developed with consideration both of the Exchange's overall mission and values, as well as a set of policy guidelines considered by the Board. An updated set of those guidelines are included in this document. The areas that follow include recommendations supported by a summary of the issue, background, options and reference material. In many cases, final recommendations are made with the understanding that they will be further refined as part of the process of developing a formal QHP solicitation process or may need to be modified in the future, either due to new federal rules or state law.

## Table of Contents

1. Executive Summary.....	1
2. The California & Affordable Care Act Context .....	23
3. Guidelines for Selection and Oversight of Qualified Health Plans and the Development of the Small Employer Health Options Program.....	33
4. Core Minimum Qualified Health Plan Certification Requirements and Regulator Partnerships .....	37
5. Plan and Network Design Issues .....	39
A. Active Purchaser: Number and Mix of Exchange Plans .....	39
B. Rating Issues: Family Tiers, Age, Geography, Tobacco and Wellness .....	59
C. Plan Design Standardization .....	79
D. Premium Subsidies and Cost Sharing Reductions.....	105
E. Provider Network Access: Adequacy Standards.....	113
F. Provider Network Access: Essential Community Providers Standards.....	127
6. Assuring Quality and Affordability.....	152
A. Strategies to Promote Better Quality and More Affordable Care.....	152
B. Accreditation Standards and Reporting for Qualified Health Plans .....	200
C. Promoting Wellness and Prevention .....	220
D. Administrative Simplification.....	237
7. Other .....	243
A. Aligning the Exchange with Medi-Cal, other State Funded Health Programs and Commercial Plans.....	243
B. Supplemental Health Benefits: Dental and Vision.....	249
C. Multi-State Plans.....	264
D. Consumer Operated and Oriented Plans (CO-OPs) .....	270
E. Partnering with Health Plan Issuers to Promote Enrollment .....	275

## Executive Summary

The California Health Benefit Exchange is establishing Individual and Small Business Health Options (SHOP) exchanges. The Individual and SHOP exchanges will offer a competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value. The staff of the California Health Benefit Exchange, with support from PricewaterhouseCoopers, has prepared this report to inform the Exchange Board of the issues pertaining to the certification and selection of Qualified Health Plans that will be offered on the exchanges.

The issues addressed and final recommendations outlined in this document reflect substantial input from a wide range of stakeholders. In addition, they were developed with consideration both of the Exchange's overall mission and values, as well as a set of policy guidelines that were shared in draft form with the Board in April and an updated version is included in this Report (See Section 3).

There are sixteen Board briefs concerning Qualified Health Plan selection and certification contained in this report addressing the wide range of issues and policy options for the Board's consideration regarding plan and network design issues, assuring quality and affordability and other related policy areas. They are as follows:

- Core Minimum QHP Certification Requirements and Regulator Partnerships
- Plan and Network Design Issues
  - 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 Provider Standards: Definition, Network Sufficiency, and Payment
- Assuring Quality and Affordability
  - Strategies to Promote Better Quality and More Affordable Care
  - Accreditation and QHP Quality Reporting
  - Promoting Wellness and Prevention
  - Administrative Simplification
- Other
  - Alignment with Medi-Cal Plans, other State Funded Health Plans and Commercial Plans
  - Supplemental Benefits: Dental and Vision and Pediatric Essential Health Benefits

- Multistate Plans
- Co-Ops
- Partnering with Health Plan Issuers to Promote Enrollment

In most areas, staff have previously presented the Board with initial recommended policy options. These recommendations are final and were informed by both public input to the Board, discussions by the Board, but also additional comments from small employers, consumers, health plan providers, agents and others.

## Plan and Network Design Issues

### 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.

#### Issue 1: The Exchange as an Active Purchaser

The California Affordable Care Act permits but does not require the Exchange to be an active purchaser. As an alternative, the Exchange could accept all health plan issuers that meet minimum criteria such as network adequacy. Staff recommends that the Exchange be an active purchaser and has structured all other recommendations based on this approach. As an active purchaser, staff recommend that selection of Qualified Health Plans in particular regions would seek to assure broad choice of offerings (e.g. four or five different issuers), but would not require the Exchange to accept all issuers.

#### Issue 2: Metal Level Tiers of Qualified Health Plan Bids

There are a range of options related to the metal levels of Qualified Health Plan bids for a health plan issuer in each geographic area.

The following options are offered for metal levels for Qualified Health Plans:

- **Option A.** Require all metal tiers per Qualified Health Plan bid: Requires 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.
- **Option B.** Require only select metal tiers per Qualified Health Plan bid: Requires issuers to propose a Qualified Health Plan product for specified metal level tier(s) in each geographic region in which it bids. The full metal tier and catastrophic requirement of the California Affordable Care Act may be met by proposing the other metal tier Qualified Health Plan products in at least one other geographic region.

*Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers*

Staff recommends that Qualified Health Plan bidders meet all actuarial value metal tiers within a geographic region (Option A). This option facilitates the Exchange's ability to meet its statutory obligation to ensure every metal level choice in every part of California. It also stimulates competition.

### Issue 3: Number of Qualified Health Plan Product Bids per Issuer

The number of Exchange plan products that a health plan may bid for each geographic area will determine the starting pool of options for consumers. Allowing multiple submissions for each health plan will maximize the Exchange opportunity to selectively contract based on the combination of choice, value, quality, and service. It is also expected that some health plan Exchange products may not meet minimum certification criteria and will be eliminated from consideration. At the same time, allowing too many products from each plan could be confusing to consumers, yet distinguishing product factors are necessary to create the "meaningful" choice sought by consumers. Therefore, the Exchange may want to be in the position of receiving a sufficient number of Qualified Health Plan proposals to be able to apply active purchaser principles across all regions of the state.

There are a range of options related to the permitted number and mix of Qualified Health Plan product bids per health plan issuer in each geographic area.

The following options are offered for number of issuer bids per geographic region:

- **Option A.** Allow one Qualified Health Plan bid: Limits the issuer bids to one Qualified Health Plan per geographic area. Must conform to standardized benefit design if a standardized benefit design option is adopted as policy.
- **Option B.** Limit number of Qualified Health Plan product bids per issuer to a small number, e.g. two or three per issuer per geographic region. This would permit plan bids with variation in provider networks, new or alternative benefit designs that allow for design innovation.
- **Option C.** Allow unlimited number of Qualified Health Plan product bids per issuer per geographic area: Permits any number and mix of bids across geographic area.

Staff recommends that issuers be allowed to propose 2-3 plan products per geographic region per issuer (Option B).

### Issue 4: Geographic Coverage by Health Plans

There are a range of options regarding requirements for geographic coverage across regions:

- **Option A:** Require each issuer to submit Qualified Health Plan bids for all service areas for which the product is licensed throughout the state.

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- **Option B:** An issuer submitting a bid for an Exchange plan may bid for a subset of the geographic regions in which it is licensed, but must have at least one product that fully covers the service areas within the region for which the issuer is licensed.
- **Option C:** Each issuer may submit bids only for service areas where it can demonstrate coverage of an entire defined geographic area, with the minimum geography set based on the state's legal definition of a region.

Staff recommends that an issuer be allowed to bid for subset regions but also require a full coverage plan for their licensed region (Option B).

#### Issue 5: Multi-Year Contracts with Qualified Health Plans

Given that the Exchange anticipates entering into multi-year contracts as part of the initial solicitation process, the options to consider are:

- **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 and timing.

Staff recommends the Exchange adopts specific multi-year contract criteria with health plans and is open to revisions and negotiation of additional terms and timing. (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 within 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.

#### Issue 1: Standardization of Family Structure Rating Factors

It is possible that federal rules may standardize both family tiers and tier ratios across the market. If this is the case, the Exchange may not need any options related to this issue. Barring any decision to that effect, the Exchange is considering three options with respect to the rating factors used by issuers to adjust for family structure in developing premium rates.

The following options are offered for standardization of family structure rating factors:

- **Option A.** No standardization: Allows issuers to use any family tier structure allowed by the regulations and to determine the premium relationships between the tiers (tier ratios).

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- **Option B.** Standardize family tier structure, but allow issuers to determine tier ratios: Standardizes the family tier structures used by all issuers participating in the Exchange, but allows issuers to determine the premium relationships between the tiers (tier ratios).
- **Option C.** Standardize family tier structure and tier ratios: Standardizes the family tier structures used by all issuers participating in the Exchange and standardizes the premium relationships between the tiers (tier ratios).

Staff believe that these types of rating factors are set on a marketwide basis, and would be best addressed with standards that apply to Exchange and non-Exchange products. If that doesn't occur in time for the Exchange's solicitation and selection of QHPs, staff recommends the Exchange standardize the family tiers but not the tier ratios (Option B) for the following reasons:

- It allows the health plans to perform the complicated calculations required to establish and update tier ratios and removes the Exchange from that process
- It reduces variation relative to not standardizing family structure
- It reduces the potential for discriminatory or selective pricing in the Exchange relative to not standardizing family structure.
- It recognizes that plans may react more quickly and nimbly to market changes, utilization patterns and actual costs than the Exchange.

#### Issue 2: Standardization of Age Factors

The Affordable Care Act requires Health and Human Services (HHS) to develop standard age bands to be used by issuers in the Individual and Small Group markets. However, they are not expected to standardize the factors used to determine premiums beyond the Affordable Care Act restriction of a 3 to 1 maximum ratio for adult. The Exchange is considering two options with respect to the rating factors used by issuers to adjust for age in developing premium rates. They are :

- **Option A:** Do not standardize age factors.
- **Option B:** Standardize age factors to be used by all issuers.

Staff recommends the Exchange not standardize the age factors used by Exchange issuers (Option A) for the following reasons:

- It allows the health plans to perform the complicated calculations required to establish and update age factors and removes the Exchange from that process
- Given the 3 to 1 limit on age-based rate variation, potential variation of age factors across issuers is significantly reduced

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### Issue 3: Requirement that Issuers Cover Entire Geographic Regions

The California legislature is pursuing the establishment of standardized geographic rating regions for the Individual and Small Group markets. However, staff recommend the Exchange consider allowing plans that serve an entire rating region also be allowed to bid to serve less than a full region with a different product. If issuers are allowed to serve only part of a geographic region, it may place issuers serving the entire region at a competitive disadvantage. Though some issuers may not be able to cover an entire region, it is reasonable to expect that issuers will cover the portion of the region for which they are licensed to offer coverage in the Individual and Small Group markets.

The Exchange considered three major options with respect to the geographic service areas for issuers in the Exchange.

- **Option A:** Do not require issuers to cover the entire region in order to offer coverage through the Exchange.
- **Option B:** Require issuers to cover the entire region in order to offer coverage through the Exchange
- **Option C:** Require issuers to cover the entire region for which they are licensed in order to offer coverage through the Exchange but allow regional or statewide plans to offer sub-regional products.

Staff recommends Option C: that the Exchange requires issuers to cover entire licensed region and allow statewide/region-wide plans to also offer sub-regional plans if they choose for the following reasons:

- This approach reduces the potential for unfair pricing advantages by a plan offering coverage through the Exchange only in lower cost areas.
- The approach encourages issuer participation in the Exchange by minimizing issuer provider network development costs associated with offering coverage through the Exchange.
- It also allows local initiatives to offer coverage through the Exchange to the extent contracting with them supports the Exchanges objectives. By allowing plans licensed to serve an entire region to also offer a sub-regional product, the Exchange achieves its obligation to ensure statewide coverage but also stimulates competition and levels the playing field for statewide/regional plans. However, if a plan is licensed to serve an entire region, it must first offer its QHPs on a regionwide basis since the Exchange is obligated to ensure that QHPs are available statewide. This requirement will ensure that the Exchange meets its statutory obligation to provide statewide coverage.

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#### Issue 4: Allowable Rate Adjustment for Tobacco Use

Tobacco use is one of the major preventable causes of disease and premature death that is touching the lives of millions of Californians. Tobacco use can also dramatically increase health care costs, especially over the long term. Providing incentives to smokers to stop using tobacco and to reduce the costs passed on to non-users is a policy worth exploration. However, the maximum allowable tobacco rating adjustment under the Affordable Care Act may raise premiums to an unaffordable level for some participants which would jeopardize the primary goal of increasing coverage. Further, since premium tax credits are calculated before tobacco rating factors are applied, the full cost of the tobacco use surcharge is passed on to the individual, resulting in a disproportionate premium increase for individuals receiving premium subsidies.

The Exchange considered three major options with respect to the tobacco use rating factors.

- **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 allowed by the Affordable Care Act
- **Option C:** 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.

Staff recognizes that any allowable tobacco rating should be applied marketwide and not solely within the Exchange which would cause adverse selection in the Exchange. At this point in time, market-wide rules regarding tobacco rating are not in place. Given the uncertainty of the extent to which smoking would be decreased and the risks of reducing enrollment, staff recommend prohibiting the application of tobacco rating to promote smoking cessation (Option A). Staff is concerned that permitting tobacco rating at this time, could have the effect of reducing enrollment of some individuals who can benefit most from the coverage of smoking cessation benefits in the Exchange maximizing enrollment. The Exchange should regularly reassess the best ways to promote smoking cessation.

#### Issue 5: Wellness Program Incentives

The promotion of improved health as well as personal responsibility support the goals of the Exchange, and these concepts are at the core of wellness programs. However, wellness programs also have the potential to negatively impact vulnerable populations or facilitate discrimination based on health status, and these programs should be monitored to assess their impact on health status improvement and affordability. The Affordable Care Act expressly allows wellness programs in the small group market. It calls for a 10 state demonstration project for wellness programs in the individual market.

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With respect to wellness programs in the small group market, the following options are presented for consideration:

- **Option A:** Prohibit wellness program incentives
- **Option B:** Allow wellness program incentives

Staff recommends the Exchange allow wellness program incentives (Option B) for the following reasons:

- It increases incentives related to personal responsibility for healthy living and health improvements
- It provides new opportunities to employees and employer for improved health outcomes.

The Exchange should also ensure that wellness program incentives allowable in the Exchange are consistent with those allowed by the rules governing the rest of the market, or in the absence of such rules, we recommend that allowable wellness program incentives be relatively modest.

### 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 certain level of equivalent coverage, they allow for a wide range of potential variation in plan designs.

#### Issue 1: Standardization of Cost Sharing Provisions of a Plan

Cost sharing components, such as annual deductibles, copayments, coinsurance, and out-of-pocket cost limits serve as the predominant determinants of actuarial value, which is the measure that will be used to categorize benefit plans to be offered to consumers. These components, along with premiums, allow consumers to compare how much various benefit plans will cost them under expected and adverse health event scenarios.

The Exchange is considering three options with respect to the cost sharing provisions used in benefit plans offered through the Exchange.

- **Option A.** No standardization: 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.
- **Option B.** Standardize major cost-sharing components of benefit plans and allow limited customization: Issuers would be required to offer standardized major cost-

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sharing components, such as deductibles, co-pays, coinsurance, and out-of-pocket limits. Value-based insurance design features and other innovations, such as varied provider networks as well as limited variation of ancillary benefits would be allowed subject to approval by the Exchange. In addition, issuers would be allowed to propose non-standardized designs.

- **Option C.** Strict standardization of all possible cost-sharing components of benefit plans: Standardizes all possible cost-sharing components. Value-based insurance design features or other changes to benefits would not be allowed.

Staff recommends the Exchange standardize the major cost-sharing components while allow limited customization (Option B) for the following reasons:

- Standardization simplifies comparison and promotes competition among health plans based on price, quality and customer service.
- Standardization reduces opportunities for risk selection through plan design.
- In allowing issuers to propose non-standardized designs that still meet required actuarial value standards, the Exchange would reserve the right to reject designs that appeared to be crafted to foster risk selection.

## Issue 2: Standardization of Benefit Exclusions and Limits

Due to the Essential Health Benefit requirements, much of the possible variation in covered services from plan to plan has been removed. Similarly, service limits, such as visit or day limits, which are allowed under the Affordable Care Act, are expected to be largely standardized by the legislature in California. However, it is unclear how precisely issuers must match the coverage and limits defined by the benchmark plan, and to what extent substitutions or additions may be permissible.

The Exchange is considering three options with respect to benefit exclusions and limits used in benefit plans offered through the Exchange.

- **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.

Staff recommends the Exchange standardize major benefit limits and exclusions (Option B) for the following reasons:

- Standardization simplifies comparison and promotes competition among health plans based on price, quality and customer service.

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- Standardization reduces opportunities for risk selection through plan design. Customization of less significant benefit areas may provide the opportunity to better meet the needs of some consumers.
- In allowing issuers to propose non-standardized designs that still meet required actuarial value standards, the Exchange would reserve the right to reject designs that appeared to be crafted to foster risk selection.

### Issue 3: Standardization of Drug Formularies

Drug formularies are determined by each health plan based on analyses of drug costs, safety, and efficacy in conjunction with discounts and rebates negotiated with manufacturers and prescription benefit managers (PBMs). Therefore, it is unlikely that drug formularies themselves can be standardized across health plans. Each issuer offering coverage through the Exchange will be required to meet minimum formulary standards. The Affordable Care Act requires that formularies cover at least one drug per therapeutic class or category, but the Exchange could require broader coverage, such as the requirement that Medicare Part D sponsors cover at least two chemically distinct drugs per category or class.

The Exchange is considering two options with respect to standardization of drug formularies in benefit plans offered through the Exchange.

- **Option A:** Require formularies in benefit plans offered in the Exchange to meet the Affordable Care Act minimum standard of at least one drug per class or category
- **Option B:** Require formularies in benefit plans offered in the Exchange to meet at least the Medicare Part D minimum standard of at least two drugs per class or category

Staff recommends the Exchange requires formularies to include at least one drug per class or category (Option A) for the following reasons:

- California health plans regulated by the Department of Managed Health Care must meet a medical necessity requirement for coverage of prescription drugs, and plans regulated by the Department of Insurance are expected to have the same requirement for Essential Health Benefits, through pending legislation. Consequently, a broader range of covered drugs is not necessary and may unnecessarily increase costs.

### Issue 4: Value-Based Benefit Designs in the Context of Benefit Standardization

Value-based benefit design has been adopted by many large employers and public purchasers to provide financial incentives (such as reduced cost sharing) to encourage enrollees to use high value services, adopt healthy lifestyles, use high performance providers and promote high value medical services. By providing appropriate incentives, the likelihood that patients will comply with treatment plans and engage in healthy activities is increased with the expectation that these behaviors will ultimately lower health care costs.

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Value-based benefit design is often but not always linked to the cost sharing provisions of the benefit plan. Strict standardization of cost-sharing could result in prohibiting the use of value-based incentives that lead to use of high-value services. This could lead to overuse of lower value services and underuse of higher value services.

Value-based insurance designs should be capable of changing to adapt to clinical nuance based on emerging evidence regarding effectiveness of treatment as well as plan design to encourage use of high-value care and providers. Value-based insurance design is an area where innovation is expected and the Exchange should leave enough room for plans to pursue value-based insurance design that will benefit consumers and assist in compliance with proven paths to better health outcomes.

The Exchange is considering two options with respect to value-based benefit designs in benefit plans offered through the Exchange.

- **Option A:** Prohibit value-based benefit designs
- **Option B:** Allow value-based benefit designs that may lower patient out-of-pocket costs or provide financial rewards or improved clinical support for avoidance or management of chronic disease.

Staff recommends the Exchange allows value-based benefit designs that may lower patient out-of-pocket costs or provide financial rewards (Option B) for the following reasons:

- It encourages the provision of health care services at lower cost to consumers, encourages healthy behaviors and patient compliance, promotes access to high value services, and enables the integration of new clinical evidence into care by providing appropriate incentives.

#### Issue 5: Standardization of Minimum Out-of-Network Benefits

While out-of-network benefits are clearly a secondary consideration for most consumers and typically apply only to Preferred Provider Option plans, staff believe it is reasonable to specify how they provide a minimum level of coverage. For example, given that the minimum in-network coverage level is Bronze with an actuarial value of 60%, a minimum out-of-network actuarial value might be 50%. However, the methodology for calculating the actuarial value for out-of-network benefits would need to be developed and agreed upon.

A related issue is the maximum fee that an issuer will pay for out-of-network care. Unless well understood, a member can be faced with very large balance billing liabilities (the difference between the provider's charge and the health plan's fee schedule).

The Exchange is considering two options with respect to out-of-network benefits in benefit plans offered through the Exchange

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- **Option A:** Do not standardize minimum out-of-network benefits
- **Option B:** Standardize minimum out-of-network benefits by setting out of network plan reimbursement at the 50<sup>th</sup> percentile of the Fair Health database and require plans to inform its members prior to use of non-emergent care of the amount the plan will pay. Require plans to require network providers to disclose the cost and use of non-network providers to members in advance of a member's decision to use out of network services.

Staff recommends the Exchange standardizes out-of-network benefits (Option B) through the requirement on issuers to use the FAIR Health database to establish the out of network benefit payable at 50<sup>th</sup> percentile of the Fair Health database amount as the minimum level of reimbursement to out-of-network providers, and require Issuers to inform members of their potential liability for the difference between the out-of-network plan payment amount and the out of network provider's charges so they will know their out of pocket liability in advance. This recommendation is made for the following reasons:

- It establishes the basis for standardizing out-of-network reimbursement
- It provides consumers the information they need to make informed choices about their out of network benefits
- It requires network providers to inform members about potential use of out of network facilities and other services for which members will bear a higher cost.

### 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).

#### Issue 1: Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification

The Exchange is considering three major options regarding its provider network access standard which could be a condition of Qualified Health Plan certification.

- **Option A:** Adopt regulatory requirements of the Qualified Health Plan's current regulator (e.g., PPOs regulated by CDI would comply with the Insurance Code and HMOs/PPOs regulated by DMHC would comply with the Health and Safety Code)
- **Option B:** Adopt regulatory requirements of DMHC for all Qualified Health Plan certification, and

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- **Option C:** Adopt additional Exchange-specific standards for Qualified Health Plan certification above and beyond the regulator's respective provider network adequacy standards

#### Issue 2: Approaches to Evaluating Provider Network Adequacy for QHP Certification

There are several approaches for measuring provider network adequacy or deficits and improvements in access to care and using such measurements for certification purposes. They may be adopted as minimum criteria for provider network adequacy or warrant higher scoring or other preferential consideration in the Qualified Health Plan selection process.

- **Option A:** The regulator - DMHC or CDI - certifies a Qualified Health Plan bidder's network complies with the applicable regulatory 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

The Exchange staff recommends the Exchange relies on the regulators' certification that the QHPs meet regulatory network adequacy standards (Option A) and will solicit comments from health plans, providers, consumer advocates, and others on the mechanism the Exchange might deploy to efficiently monitor and assess plans' compliance with the network adequacy standard.

#### Essential Community Provider Standards: Definition, Network Sufficiency, and Payment

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 mechanisms for Federally Qualified Health Centers.

#### Issue 1. Definition of Essential Community Providers

- **Option A:** Exchange defines Essential Community Providers as the minimum standard limited to the list of 340B and 1927 providers
- **Option B:** Exchange incorporates 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

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Regarding the definition of essential community providers Staff recommends that the Exchange adopt a broad definition of Essential Community providers to recognize the value of private practice physicians, physician groups, Medicaid Disproportionate Share Hospital and other clinics that have historically served the uninsured, low-income and medically underserved populations (Option B).

### Issue 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

Staff recommends that Qualified Health Plan bidders be required to demonstrate that its Essential Community Provider network overlaps with the low income population in its service area to demonstrate both sufficiency and geographic distribution (Option B).

### Issue 3. Payment rates to Federally Qualified Health Centers

The Exchange has an opportunity to support delivery of services by Essential Community Providers through the policies it adopts regarding Qualified Health Plan requirements regarding their contracting with and payment rates for Federally Qualified Health Center and considers the following options:

- **Option A:** Require Qualified Health Plans to contract with all FQHCs and mandate payment under terms of section 1902(bb) of the Act- at the PPS rate
- **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
- **Option D:** During the Qualified Health Plan evaluation process, assign greater weight to Qualified Health Plan networks that include in-network FQHCs

For contracting and payment of FQHC's, staff recommends inclusion of FQHCs in QHP networks and payment at fair compensation by the QHP defined as rates no less than the generally applicable rates of the issuer (Option C). As with the contracting for all Essential Community Providers, the Exchange should encourage innovative contracting and payment arrangements with the FQHCs.

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## 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.

Staff has made the following 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 using eValue8 as the tool.
- C. **Require certain health plan practices that promote better care** 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** (further detailed in a separate Board Recommendation Brief).

Staff recommends that the Exchange continue to work with key stakeholders to seek input and refinement of the proposed Qualified Health Plan Quality Value Promotion, including:

- Confer with the California Department of Health Care Services to affirm the adequacy of its HEDIS and CAHPS reporting requirements for the Exchange population.
- Confer with health plans and other stakeholders on the extent to which eValue8 should be used in parts or in its entirety.
- Seek expert input with respect to methodologies to stratify analysis of quality, patient experience and utilization experience among Exchange-based populations.
- Seek expert input with respect to Quality Measurement and Reporting information that can be incorporated into consumer education materials and/or decision support tools.
- Develop strategies to collect race and ethnicity information to support assessment and reduction of disparities in care.

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- Monitor progress in other states that are considering similar issues with respect to reporting of Quality Improvement Strategies.

### Accreditation Standards and QHP Reporting

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.

The following options address the issues related to establishing Qualified Health Plan Accreditation standards for consideration by the Board for the initial years of operation (2014-2016).

- **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

Staff recommends the Exchange require interim NCQA Accreditation and reporting of CAHPS and HEDIS measures required by Medi-Cal Managed Care (Option B). Option B establishes a minimum level of quality reporting and transparency and raises a higher bar than current proposed federal requirements, while also specifying a transitional glide path for newly organized plans and regional carriers to meet requirements. Option B thereby addresses the needs of new entrants or issuers accredited in categories other than the commercial market and demands commendable standing at minimum for all issuers by the second year of Qualified Health Plan operations.

Option B is recommended as the accreditation standard for the first two to three years of the Exchange. It is anticipated that the Exchange will consider more rigorous accreditation standards as it becomes established in the market. Higher accreditation standards could include Exchange specification for HEDIS and CAHPS Reporting, such as 1) threshold levels of performance in CAHPS and HEDIS results, 2) development of measures for the Qualified Health Plan enrolled population, or 3) oversampling of target populations on measures that differentiate performance and can be used to evaluate efforts to reduce health disparities. Higher accreditation standards could include required certification in selected areas of plan performance, such as NCQA Physician Hospital Quality Certification. At the same time, the

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Exchange may also raise the overall certification standards, such as requiring participation and submission of information to an All Payer Claims data base.

### Promoting Wellness and Prevention

The vision, mission and values adopted by the California Health Benefit Exchange, the California legislation to establish the 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.

#### Issue 1: Use of a Health Risk Assessment Tool or Other Plan based Wellness Promotion Initiatives

The following options are presented for consideration:

- **Option A:** The Exchange requires completion of a health risk assessment as part of the enrollment process.
- **Option B:** The Exchange requires completion of a health plan health risk assessment as part of the enrollment process.
- **Option C:** Health plans are required to provide an optional health risk assessment tool.

Staff recommends that the Exchange require health plans to provide an optional health risk assessment tool (Option C), which minimizes the complexity of the enrollment process and allows the plans to provide this as an opportunity. While Option C (making the health risk assessment optional) will certainly result in a lower rate of member participation in a health risk assessment process, it would minimize the administrative burden on the Exchange and avoid creating perceived barriers to using the Exchange. In the future, the Exchange may require common data elements be included in each QHPs Health Risk Assessment tool. The Exchange will require that QHPs share results from the use of HRAs as part of its ongoing evaluation of QHPs impacts on health and wellness.

#### Issue 2: Provision of a Wellness Program by the Exchange

Options for requirements on health plans for wellness programs and/or the provision of a wellness program by the Exchange include:

- **Option A:** The Exchange selects an additional vendor to augment issuer-based programs.
- **Option B:** The Exchange promotes use of wellness programs offered by issuers.
- **Option C:** The Exchange establishes requirements for the wellness programs that are offered by issuers and promotes those programs.

Staff recommends that the Exchange establish requirements for the wellness programs that are offered by health plans (**Option C**).

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### Issue 3: Use of Financial Incentives by Plans to Promote Wellness

With respect to the use of financial incentives as part of benefit design, the following options are presented in the context of being offered and administered by the issuer rather than the employer (note that the use of tobacco status as a rating factor is addressed in the Board Recommendation Brief on Rating Issues):

- **Option A:** The Exchange allows health plan issuers to use incentives as an optional program.
- **Option B:** The Exchange requires health plan issuers to use a common set of incentives.
- **Option C:** The Exchange prohibits issuers from using incentives.

Staff recommends that the Exchange allow health plans to offer wellness program incentives (Option A). Staff recommends wellness incentives now for small group and to seek to participate in the 10 state demonstration project to test wellness incentives in the individual market.

### Issue 4: Role of the Exchange in Addressing Community and Public Health

With respect to the role of the Exchange in addressing community and public health issues, the following options are presented for consideration

- **Option A:** The Exchange engages directly with public and community health efforts in conjunction with its outreach and marketing campaign.
- **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.

Staff recommends either that the Exchange engage in public and community health issues (Option A) or that the Exchange encourage health plans to address public health issues (Option B).

### Supplemental Benefits: Dental and Vision

The Affordable Care Act defines ten broad categories of Essential Health Benefits. The health plans must offer benefit packages to individuals and small employers both in and out of the exchanges that include a range of services from all ten categories, but are not obligated to provide any services beyond those stipulated in the EHB package. While pediatric dental and vision services are part of the Essential Health Benefits, adult coverage for those services is not.

The following options are offered regarding essential health benefits for pediatric dental and vision services:

- **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

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- **Option C:** Review bids from stand-alone dental plans and comprehensive bids from medical plans which cover all other essential health benefits including pediatric vision care.

Staff recommends reviewing bids from both stand-alone dental plans and medical plans which cover all essential health benefits including pediatric vision care. (Option C).

The following options are offered regarding supplemental benefits:

- **Option A. Offer supplemental benefits in both the Individual and SHOP Exchanges:** Offers supplemental benefits (expanded pediatric dental and vision and adult dental and vision) in both Individual and SHOP Exchanges.
- **Option B. Offer supplemental benefits only in SHOP Exchange:** Offers supplemental benefits (expanded pediatric dental and vision and adult dental and vision) only in SHOP Exchange.
- **Option C. Do not offer supplemental benefits:** Do not offer supplemental benefits (expanded pediatric dental and vision and adult dental and vision).

Staff recommends that supplemental benefits be offered solely in the SHOP Exchange in year one (Option B).

The following options are available for structuring individual health plan offerings:

- **Option A. Combined with medical:** Offers dental and vision coverage as part of medical QHP plans.
- **Option B. Stand-alone plans:** Consider offering stand-alone dental and medical plans to cover pediatric essential health benefits.
- **Option C. Hybrid:** Offers a combination of (a) stand-alone dental, vision, and medical plans; and (b) medical plans with embedded dental and vision benefits.

Subject to its active purchaser role, staff recommends considering stand-alone dental plans and medical plans (Option B). This does not preclude the Exchange from accepting bids from Qualified Health Plans that cover the full complement of Essential Health Benefits. However, allowing stand-alone dental plans to be considered in the Exchange is required by the Affordable Care Act. It will readily allow the Exchange to offer both "Child only" plans that cover the required pediatric dental services and adult and family plans that cover the broader scope of services commonly offered through employer group plans. If the decision is to offer the supplemental coverage only through the SHOP Exchange, Option B does not change the current environment for small group employer decision-making. Even with separate vendors for these supplemental services the employer will receive a single invoice through the Exchange, so issues related to administrative complexity that may arise in the external market with multiple providers will not apply.

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## Board Background Briefs

### 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. Staff recommend that all plan options be available to Exchange members regardless of income, but that clear and understandable information be provided to individuals eligible for cost sharing subsidies regarding the financial risk of choosing a benefit design other than a Silver plan.

### Core Minimum Qualified Health Plan Certification Requirements and Regulator Partnerships

The Affordable Care Act requires any issuer proposing a Qualified Health Plan (QHP) for certification by the California Health Benefit Exchange (Exchange) be found to be "licensed and in good standing". This finding must be made by the state, which means it could be made by either the state's regulators or by the Exchange. In this Background Brief, the respective roles of the Exchange and the State's regulators - the California Department of Insurance (CDI) and the California Department of Managed Health Care (DMHC) are discussed with respect to the application of statutorily based QHP certification criteria and making the important prerequisite finding of "licensed and in good standing". The components of making a finding of "licensed and in good standing" are listed.

### Administrative Simplification

There are numerous opportunities to improve efficiency and lower costs through administrative simplification and standardization in the clinical health care delivery system, in health plan administrative processes, and in the management of the California Health Benefit Exchange. Various research studies and estimates suggest that the average physician spends nearly three weeks a year on health plan and insurance administrative interactions. Overall private physicians and hospitals spend as much as 20 percent of revenue on administration and insurance billing and related functions. Health plan issuers spend 8% to 12% on pure administration (excluding profit but including agent commissions.) This level of administrative spending far exceeds international standards. Reducing these administrative expenses and the burden on providers would free up needed resources for healthcare and preventive efforts. The California Health Benefit Exchange is considering the opportunities for administrative simplification as part of its goal to promote ways to assure that more of the health care dollar goes to health care services and less to administrative and other costs.

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### Alignment with Medi-Cal and Commercial Plans

Beginning in 2014, the California Health Benefit Exchange will offer Qualified Health Plans (QHPs) to California residents. Many low-income Californians will qualify for either premium subsidies or reduced-cost-sharing or both to help purchase health care coverage in the Exchange. Others will qualify for Medi-Cal, California's Medicaid program, or the Children's Health Insurance Program (Healthy Families). This "Program Alignment" Board Background Brief discusses the issue of how coverage offered through the Exchange should be coordinated with Medi-Cal, and other state health care programs that serve low income Californians.

In addition, the brief highlights the importance of also aligning with commercial plans as many Exchange enrollees will migrate in and out of commercial coverage and/or may have family members with Medi-Cal or commercial coverage.

### Multi-State Plans

As part of its evaluation of qualified health plan (QHP) certification standards, the California Health Benefit Exchange (Exchange) must account for proposals to offer Exchange Plans from two unique entities created under the Affordable Care Act: Multi-State Health Plans and Consumer Operated and Oriented Plans. This brief describes the former, multi-state plans and highlights the implications of such plans for the Exchange.

### Co-Ops

As part of its qualified health plan (QHP or Exchange Plan) certification standards analysis, the California Health Benefit Exchange (Exchange) must account for proposals to offer Exchange Plans from two unique entities created under the Affordable Care Act: Multi-State Health Plans and Consumer Operated and Oriented Plans (CO-OPs). This brief describes the latter, CO-OPs, and attempts to raise the implications of such plans for the Exchange.

### Partnering with Health Plan Issuers to Promote Enrollment

Plan issuers must be integral partners of the Exchange; no other partner is more critical to the success of the Exchange. As the Exchange begins enrollment activities starting in 2013 and into its first year of operations in 2014, the investment health plan issuers devote to retention and their marketing and outreach activities will play a critical role in creating consumer awareness of health plans offered by plan issuers both within and outside of the Exchange. Plan issuers and the Exchange share a common interest in the success of these activities since they will drive enrollment in all plans -- both those offered inside and those outside the Exchange. Increased enrollment in turn helps fulfill the Exchange's goal of increasing overall the number of Californians with affordable health care coverage. Partnering with health plan issuers relative to their retention, marketing and outreach activities is also consistent with Exchange values of partnership and being a catalyst for change in California's health care system by using its

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market role to stimulate new strategies for providing high quality, affordable health care to all Californians. Accordingly, the Exchange must consider options and incentives to reward health plan issuers for affirmatively engaging in retention, and marketing activities that help promote enrollment such as helping existing insureds access credits in the Exchange, co-branding their plans with the Exchange and developing marketing messages emphasizing plan issuer's partnership with the Exchange.

## **Conclusion**

As the first state to enact a law establishing a Health Benefit Exchange under the federal Affordable Care Act, California took the lead in the nation and, due to our size and great diversity, on a grand scale. Moreover, by statute, California gave the Exchange the ability to be an "active purchaser" rather than a passive operation. In attempt to craft the right combination of policy options and analyses to help the Board adopt an approach to selection and certification of the Qualified Health Plans to be offered in 2014, the Exchange staff has covered a broad landscape and has relied heavily on input from stakeholders in striking a delicate, often difficult balance, on many policy issues. Certainly some issues may have been missed. We rely on the wisdom of our Board, the commitment of our stakeholders and many others to react to the ideas and approaches offered in these recommendations and anticipate and embrace robust public debate and discussion on an ongoing basis as the Exchange seeks to continually learn and improve.



## The California & Affordable Care Act Context

### Introduction

The California Health Benefit Exchange board has adopted a vision and mission that frame the strategies and tactics described in this document, those are:

The vision of the California Health Benefit Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care.

**The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.**

The California Health Benefit Exchange is guided by the following values:

- **Consumer-focused:** At the center of the Exchange's efforts are the people it serves, including patients and their families, and small business owners and their employees. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those we serve.
- **Affordability:** The Exchange will provide affordable health insurance while assuring quality and access.
- **Catalyst:** The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.
- **Integrity:** The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
- **Partnership:** The Exchange welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners, and other stakeholders. Results: The impact of the Exchange will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians.

The Affordable Care Act calls upon the Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The California Health Benefit Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and range of insurance market reforms that are in the process of being implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to one that will

reward better care, affordability and prevention. The Exchange needs to address those issues for the millions of Californians who will enroll through it to get coverage, but also must be part of broader efforts to improve care and control health care costs.

California has many of the infrastructure elements that will allow the Exchange to work with health plans, clinicians, hospitals, consumer groups, purchasers and others as partners to support the changes needed to achieve the three-part aim of better care, better health, and improved affordability. These include the state's history of multispecialty and organized medical groups, the presence of statewide and regional managed care health maintenance and preferred provider organizations, public reporting of health care information and delivery system performance, and active efforts by public and private sector payers to test new and innovative models of care delivery and payment reform.

### Challenges of the Health Care System

These elements must be harnessed to address the many challenges facing the health care system. The strategies and tactics described in this document detail some of the ways the Exchange can be part of addressing issues of high cost and affordability, inconsistent quality of health care delivery, and the complexity and lack of transparency about what people are buying when they select a health care plan. The Exchange's efforts must be part of the broader efforts already underway.

### High Cost and Affordability

Health care costs and the rate of increase in those costs is not sustainable. Even though the rate of increase during the recession has slowed, the United States spends more on health care, both per capita and as a share of GDP, than any other country in the world. Recent analyses of 2009 data for California highlight<sup>1</sup>:

- Health spending in California reached \$230 billion, triple 1991 levels.
- California's per capita spending of \$6,238 was the ninth lowest in the nation. By comparison, US spending per capita was \$6,815.
- Hospital and physician services continued to account for the majority of spending, totaling 63%.
- Medicare and Medicaid accounted for nearly 40% of California health spending, up from 27% in 1991.

Over the last decade, the cost for individual and family coverage has more than doubled, far exceeding the Consumer Price Index, and even the Medical Consumer Price Index. The rate of health care inflation has outpaced wage increases for a number of years.

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<sup>1</sup> Health Care Costs 101, California HealthCare Foundation, May 2012. Accessed at: <http://www.chcf.org/publications/2012/05/health-care-costs-101>

- Between 1999 and 2011, average annual premium for single and family coverage have increased approximately 250%. Although employers absorbed some of the increase, employee contributions to premium increased by 168%. Workers' wages increased less than one-third of that amount, by 50%.
- The impact has been felt most dramatically in the individual and small group markets, which have seen a significant shift towards products with greater cost-sharing. From 2006 to 2011, there was a more than four-fold increase in the proportion of covered workers in small employer firms (3-199 employees) enrolled in PPO and account-based plans with a deductible of \$2,000 or more, from 6% up to 28%.<sup>2</sup>

The Affordable Care Act provides many of the tools needed to begin bring health care costs under control and to make health insurance both understandable and affordable for most Americans. The Exchange is a key element of that effort by providing tax credits to help make care affordable for millions of Californians. The Exchange will create a marketplace that will be focused on affordability, but if the underlying costs of delivering care are not addressed then families, small and large businesses and governments will see health care costs as a major impediment to growth the ability to invest in education, security and other personal and social goals.

### Inconsistent Quality of Health Care Delivery

California has some of the best doctors, nurses and other health care professionals; and the state is fortunate to have among the world's best centers that are delivering care that attracts patients from around the world. We are the home to cutting-edge research and are creating the health care of tomorrow. At the same time the health care of today is challenged. Despite California's leadership in integrated delivery systems and history of managed care, research shows us that health care quality varies, is often unsafe, and that we are spending far too much on inappropriate and unnecessary care:

- Quality of care varies dramatically between doctors and hospitals, but those differences are invisible to patients.
- Payments reward quantity over quality and fixing problems over prevention.

Critical to the success of the Exchange is its ability to improve the affordability of health care for individuals and small businesses. But to address the affordability for those who enroll in the Exchange, the Exchange needs to look more broadly at affordability and the drivers of health care costs and cost increases. There is huge variation in the quality of health care and in the cost of care for services provided. In addition to the variation in quality, we also know that people of color, limited English speakers and low income people often receive lower quality health care, even when they have the same health care coverage as other populations.

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<sup>2</sup> 2011 Employer Health Benefits Survey, Kaiser Family Foundation/Health Research & Educational Trust, September 2011. Accessed at <http://ehbs.kff.org/>

- *People do not receive recommended care.* In a landmark study, Elizabeth McGlynn and her colleagues used patient surveys and review of medical records to evaluate quality performance indicators for 30 acute and chronic conditions, as well as preventive care. They found that little more than half of the adult patients received recommended care.<sup>3</sup> Similar findings have been reported for pediatric care, where overall, children received recommended care less than half of the time. Although children received indicated care for acute medical conditions more than two thirds of the time, they received recommended preventive care only 40% of the time.<sup>4</sup>
- *There is little correlation between cost and quality.* Higher cost does not mean the quality of care is better and lower cost does not mean it is worse. An analysis of charges for 12 common elective surgical procedures report found that hospitals in the highest priced regions charge 2.7 times as much for a surgery as hospitals in the lowest price regions.<sup>5</sup> Research has demonstrated for individual clinicians, medical groups, and hospitals that on a global level the variation clearly means that we cannot “pay our way” to better quality. The Integrated Healthcare Association (IHA) analysis of Appropriate Resource Use among California medical groups shows significant cost and quality variation even where payments are typically capitated in the aggregate for professional services and where there are often full risk or shared risk arrangements for hospital services.
- *There is substantial geographic variation in care.* Contributing to care variation are geographic differences, which are driven by different physician practice patterns and potentially by the supply of hospital beds, physicians and clinics. Research by John Wennberg and Dartmouth colleagues reinforce the disparate effect of supply on the volume of services. For example, repair of hip fractures does not vary with hospital bed supply but cardiac surgery varies significantly. Similar research conducted by Laurence Baker in California identified significant variation in cardiac care, joint replacement surgeries, as well as in general surgical services such as gall bladder removal.

### Lack of Transparency and Public Quality Performance Reporting

The Affordable Care Act supports the efforts in California and across the nation to provide consumers and clinicians with better information about health care benefits and the performance of health plans and their provider networks. However, today:

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<sup>3</sup> McGlynn, E., Asch, S. et al. The Quality of Health Care Delivered to Adults in the United States. The New England Journal of Medicine, v. 348, no. 26, June 26, 2003, p. 2635-2645

<sup>4</sup> Mangione-Smith, R., Alison H. DeCristofaro, A et al. The Quality of Health Care Delivered to Children in the United States. The New England Journal of Medicine, OCTOBER 11, 2007; 357:1515-1523

<sup>5</sup> CALPIRG Education Fund. Your Price May Vary. Geographic Variation in Hospital Charges in California. Summer 2012. <http://www.calpirg.org/sites/pirg/files/reports/Your%20Price%20May%20Vary%20web.pdf>

- Lack of standardized performance measures makes it hard to know which providers are doing a good job, and which are not.
- Consumers lack information to make the choices that are right for them.

The shortage of standardized performance measures for health outcomes can make it difficult to know which providers are doing a good job, and which are not. Health care is an information-dependent industry that, all too often, has failed to keep up with the revolution in knowledge and information processing that has transformed the global economy. Patients, clinicians, and policymakers need reliable, real-time information to make sound decisions – whether about individual patient care or the allocation of societal resources.

Nationally, the Center for Medicare and Medicaid Services has become a leader in making available information to help improve care and inform consumer choice. For example, Medicare Compare provides ratings of health plans offered in Medicare; Hospital Compare has information on the quality of care and patients' perspectives on thousands of hospitals across the country; and, Physician Compare and the Physicians Quality Reporting System is beginning the process of collecting standardized performance information about clinicians. California has important foundational elements, such as standardized public reporting of quality measures through the state's Office of the Patient Advocate, and existing collaboration through the Integrated Health Association Pay for Performance Program. Additional provider engagement strategies exist through Collaborative Alliance for Nursing Outcomes (CaNOC) and the California Quality Collaborative, which has sponsored learning networks to spread best practices and support implementation of quality improvement activities.

Yet, even with this growing amount of information, consumers often lack information and tools to help them make the choices that are right for them. Too often, health care consumers cannot compare the quality or cost of care offered by medical practitioners, clinics and hospitals or the various treatment options available to them to make good choices. Californians need tools to help them make good health care decisions. Consumers also want information on demand – where they need it, when they need it.

The Affordable Care Act requires the Exchange to use a Quality Rating System, based on Federal guidance still to be issued, that will allow comparison of Qualified Health Plans on benefits, costs, and "value" which is expected to take into consideration such measures as customer service and overall member satisfaction. A plan "calculator" will permit people to compare major benefit features to help them understand coverage exclusions, out of pocket costs and implications of using in-network and out-of network providers. The Exchange portal will link to the provider directories, allowing enrollees to look for doctors and hospitals that they may already use or wish to confirm is in the network.

## The Affordable Care Act and the California Health Benefit Exchange

The Affordable Care Act created the state based Health Benefit Exchanges and the Small Business Health Options Program (SHOP), a new marketplace for individuals and small businesses with up to 100 employees (50 in California) to purchase "Qualified Health Plans."

Each state that elects to operate their own Exchange, such as California, will operate within the federal standards in law and regulation. Beyond what is framed by the federal standards, state legislatures are permitted to shape the standards and define how the new marketplace for individual and small group health insurance will operate in ways specific to their context. And, the Exchange has the latitude in the context of the minimum Federal criteria and standards used to "certify" the Qualified Health Plans that will be offered in the Exchange.

The State of California was the first state in the nation to pass legislation after the passage of the Affordable Care Act to establish as state-based exchange – that would be designed and built specifically to meet the needs of California. The California Health Benefit Exchange was established with the ability to be an "active purchaser" to "selectively contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service." and to establish and use a competitive process to select the participating health plan issuers.<sup>6</sup>

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. With a goal of enrolling 2.8 million Californians by 2014,<sup>7</sup> the Exchange must focus on affordability and strategies to leverage its market power with public and private sector payers that share similar a similar vision of health care delivery system improvement.

Important issues include how much to standardize the individual and small group market rating rules and the benefits and member cost-sharing for the Exchange plans, how many and what type of products are offered, what reporting and quality standards the plans must meet, and how to build upon and encourage innovation in both health care delivery and payment mechanisms. Many of these policy issues are addressed in Qualified Health Plan Board Recommendation Briefs and Board Background Briefs.

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<sup>6</sup> California Government Code §§100503(c) (AB 1602 §7), and 100505 (AB 1602 §9).

<sup>7</sup> Marketing, Outreach & Education and Assistants Program for the California Health Benefits Marketplace. California Health Benefit Exchange. June 26, 2012. Accessed at [http://www.healthexchange.ca.gov/Stakeholders/Documents/CHBE,DHCS,MRMIB\\_ComprehensiveMarketingandOutreachWorkPlan\\_6-26-12.pdf](http://www.healthexchange.ca.gov/Stakeholders/Documents/CHBE,DHCS,MRMIB_ComprehensiveMarketingandOutreachWorkPlan_6-26-12.pdf)

## Provisions Affecting the Entire Individual and Small Group Health Insurance Markets

There are major changes in health insurance market and rating rules which will apply to all individual and small group plans, both inside and outside the Exchange. Most of these market rules are effective beginning in January 2014.

- *Coverage of the ten Essential Health Benefits service categories.* The ten categories of Essential health benefits provide comprehensive coverage of hospitalization, ambulatory care, maternity, prescription drug, preventive care and other benefits. The specific benefits and possible benefit limitations will be established in reference to a "benchmark plan". This will bring some standardization of benefits and allow consumers to compare their plan options. The proposed benchmark plan for California is a Kaiser small group HMO product.
- *Minimum Medical Loss (Benefit) Ratio.* Individual and small group health plans, except those that are "grandfathered" plans, must spend at least 80% of the plan premium on medical care benefits and quality improvements or return the excess to the individual or employer in the form of a rebate. The first round of rebates applies to the 2011 plan year and must be distributed by August 1, 2012.
- *Guaranteed Issue and renewability.* Health plans will no longer be able to deny health insurance coverage because of a person's health status or pre-existing conditions.
- *Limits on rating factors used in pricing.* Identifies age, family size, geography and tobacco use as permissible factors to use to vary premium. It eliminates gender and health status as factors that can be used to raise or lower premium. States are also required to establish the geographic rating region(s) and may establish additional rating factor requirements. California is considering legislation to establish rating regions and may also consider standardization of other factors, such as age bands or the definition of family size tiers.
- *Benefit "Metal Level" tiers to meet actuarial value criteria.* The law requires health issuers to provide plan coverage at four metal levels: bronze, silver, gold or platinum. Each plan must meet an actuarial value, in a range of 60% to 90%, which is a measure of the expected proportion of the cost of the benefits that the plan will cover. For each benefit tier offered by an issuer, it must also develop the same level of coverage in a plan specifically designed for those who are under 21. Although the Federal law requires only that an issuer develop plan products at the silver and gold level to participate in the Exchange, California law requires the issuer to develop plans at each of the four metal levels, plus a catastrophic plan that will be available to those under 30 or those who are exempt from the individual mandate.
- *Removal of annual and lifetime maximum payment limits.* The law raises the minimum allowable dollar limit on coverage benefits, and, for plans issued or renewed beginning January 1, 2014, prohibits annual limits on essential health benefits.



- *Limits on annual out-of-pocket member cost sharing.* A health plan that provides essential health benefits cannot impose member cost sharing that is greater than the limits that apply to plans that meet IRS standards for Health Savings Account qualified High Deductible Health Plans. For 2012, these are \$6,050 for an individual and \$12,100 for a family. Small group health plans may not impose a deductible greater than \$2,000 per individual, or \$4,000 for other coverage (adjusted annually). Deductibles may not be applied to preventive health services. Already in place is a list of preventive health services for children and adults which must be covered without having to pay a copayment or deductible. Additional preventive services for women, including pregnant women, which must be available without cost sharing, will become effective August 2012. Beyond that, the Exchange may determine the specific cost sharing provisions permitted in each metal level tier benefit package, further standardizing products and allowing consumers to compare Qualified Health Plan products on other measures of access, service and quality.

Plans that are offered inside the Exchange may also be offered outside the Exchange, but must be available at the same price. The California law requires any issuer that offers plans on the Exchange to offer at least one plan at each metal level outside the Exchange. Health plan issuers that do not have a plan on the Exchange, must offer a standardized qualified health plan if the Exchange standardizes benefits and may not offer a catastrophic plan.

### Provisions Affecting Qualified Health Plans Offered on the Exchange

Qualified Health Plans offered inside the Exchange must be "certified" and meet additional requirements of the Affordable Care Act. Also, the Act provides for premium subsidies in the form of refundable tax credits and reduced point-of-service cost sharing for lower income individuals when they purchase health insurance through the state exchanges. These provisions use federal funds to reduce the cost for subsidy-eligible individuals and will provide a strong incentive for this population to buy insurance through the Exchange.

Exchange plans must be licensed by the state and in good standing in order provide coverage through the Exchange and must meet additional criteria, which include:<sup>8</sup>

- *Accreditation.* The plan must be accredited by an entity recognized by the federal government or obtain such accreditation within a timeframe established by the Exchange.
- *Provider Network Adequacy.* The plan must offer a choice of providers and provide information on the availability of in-network and out-of network providers.
- *Contracting with "sufficient" essential community providers.* Include in the provider network sufficient providers that serve a predominantly low-income, medically underserved population. This is required to support continuity of care for the newly

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<sup>8</sup> ACA 1311(c)(1)



insured and those who may move between private Exchange and public Medi-Cal coverage due to changes in income and circumstance. This is not a requirement for plans offered outside the Exchange.

- *Implement a quality improvement strategy.* The Affordable Care Act explicitly requires Exchange plans to establish quality initiatives to improve patient care. These should advance the Triple Aim and may include specific delivery changes such as pilots for medical homes. To the extent that these strategies improve care and/or lower cost, it will demonstrate the value of the Exchange and spur wider adoption.
- *Marketing requirements.* Meet marketing requirements and not use marketing practices or benefit designs that may discourage enrollment by persons with greater health care needs.
- *Reporting and transparency requirements.* Adopt standard tools and formats for such tasks as member enrollment, presentation of the health benefits options, enrollee satisfaction and quality reporting. These include a number of consumer decision support tools with information about prices, quality and physician and hospital networks. Robust and up-to-date consumer decision support tools can be a major market differentiator for the Exchange and drive membership growth. At the same time, it can sharpen health plan competition, not only based on premium, but based on other features consumers value.

### Premium Tax Credits and Cost Sharing Subsidies for Plans Offered on the Exchange

Premium tax credits and cost sharing subsidies will make coverage more affordable for the lower income individuals and families between 100% and 400% of the Federal Poverty Level (FPL) who purchase insurance through the Exchange. In addition, to be eligible for premium subsidies or cost sharing reductions, individuals must be US citizens or legal residents, and a resident of the state; not be offered affordable premiums through an employer; and not be eligible for other essential coverage, such as Medicare, Medicaid, or the Children's Health Insurance Program

The tax credit funds are paid directly to the health plan issuer, and the individual pays the balance of the premium due. The amount of the premium tax credit an individual can receive is a sliding percentage based on family income and the cost of the premium for the second lowest cost silver plan (actuarial value of 70%) offered by the Exchange in the individual's geographic coverage area.

The premium tax credit is intended to reduce the premium cost for a silver plan to an "affordable" percentage of the individual's income. For example, for those 133% to 150% of the FPL, the premium tax credit will reduce the monthly cost of the silver plan to 3% to 4% of income. At the higher 300% to 400% of FPL, the premium tax credit will reduce the monthly cost of that silver plan to 9.5% of income. However, the tax credit-eligible individual is not limited to purchasing the second lowest cost silver plan; it is simply the basis for determining

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the premium subsidy amount. The individual may buy a more expensive silver plan or a gold or platinum plan, but would have to pay a higher premium.

In addition to the premium subsidies/tax credits, the Affordable Care Act directs health plans to reduce point-of-service cost sharing for individuals in families with incomes between 100% and 400% of FPL who purchase silver level coverage through the Exchange. Although cost-sharing reductions were originally proposed for all subsidy levels, they are now proposed for individuals with income between 100 to 250% of FPL. The cost sharing reductions are only available to those who purchase at the silver level. They are not available to individuals who opt either for the less rich bronze, or the richer gold or platinum coverage. For the lowest income groups, those 100% to 200% of the FPL, the cost sharing subsidy is expected to reduce the point of service out of pocket expenditures by two thirds, raising the actuarial value of a silver level plan from 70% to a range of 87% to 93%.

## Guidelines for Selection and Oversight of Qualified Health Plans and the Development of the Small Employer Health Options Program

The policies, procedures and criteria for the California Health Benefit Exchange's selection and oversight of Qualified Health Plans (QHP) and the Small Employer Health Options Program (SHOP) should be specifically guided by the Exchange's vision, mission and values. The Guidelines that follow reflect core issues that should be considered for each policy/decision made by the Exchange in the development and implementation of coverage offerings. Where possible, the positive or negative impact on each of the following considerations should be quantified or framed by clearly articulated rationales for the basis of the assumptions used.

There will be "trade-offs" among competing goals and interests, but Exchange policies should consider those trade-offs and the implications of alternative policies.

Policy guidelines (with detailed examples on following pages):

- 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 of 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

- I. **Promote affordability for the consumer and small employer – both in terms of premium and at point of care**
  - a. Offer health plans, plan designs and networks that are affordable to consumers in terms of premiums and at the point of care, while fostering competition and stable premiums.
  - b. Offer health plans, plan designs and networks that will attract maximum enrollment as part of the Exchange’s effort to lower costs by spreading risk as broadly as possible.
  - c. Assure Qualified Health Plans are not disadvantaged compared to the price or products offered outside of the Exchange.
  - d. Offer benefit plan designs and contribution strategies that encourage small employers to make available robust coverage and support effective employer contribution levels.
  - e. Link plan selection and designs to the Exchange’s outreach and enrollment practices geared at maximizing enrollment of subsidy-eligible individuals and tax-credit eligible small businesses, as well as unsubsidized individuals and businesses.
  - f. Rely on existing standards, measures or processes for selecting and monitoring health plans and provider performance, building toward more robust standards and outcome measures over time to minimize burden and costs.
  - g. Evaluate all Exchange policies, marketing and oversight in context of the potential impact on premiums
- II. **Assure access to quality care for individuals with varying health statuses and conditions**
  - a. Require robust performance measures in order to ensure that consumers receive high quality care. Exchange measurement strategies should include:
    1. Align with standard measures, such as those adopted by the National Quality Forum and as reflected in the National Quality Strategy, the National Prevention and Health Promotion Strategy and the Medicare Strategic Framework for Multiple Chronic Conditions.
    2. Build on established quality, performance and patient experience measures currently in use.
    3. Support the expansion of measures that focus on health outcomes, patient-reported health status and cost of care.
  - b. Ensure that plan design, provider network and access standards promote access to care based on patients’ needs, health status and individual characteristics, including but not limited to sexual orientation, including the desire to promote continuity of care for individuals that may move between coverage types (e.g., Medi-Cal, Healthy Families, Individual and Employer) or have family members with different coverage. Evaluate options in consideration of the following:
    1. Meaningful access and timeliness standards;
    2. Language and culturally appropriate care to Exchange enrollees;
    3. Access to primary care and reduction of health risks;
    4. Effective management of chronic conditions;

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5. Specialty care, including addressing rare and complex conditions; mental health and substance abuse care needs.
  6. Effective inclusion of safety net community health centers; academic, children's, rural and public hospitals; a mix of trained health professionals.
- c. Consider how access to needed care is promoted and how Exchange policies can expand primary care access over the medium to long term, including through innovations in care delivery such as use of telemedicine and person-centered care that meets the needs of each individual.
  - d. Consider how Exchange policies can support improvement in health outcomes, patient safety and reduce avoidable readmissions.

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

- a. Because "health care is local", health plan choice should be anchored in local options for consumers and employers, while assuring the Exchange offers statewide coverage.
- b. Foster a high level of plan participation that will permit meaningful choice for individuals and small employers.
- c. Contracted plans should provide Exchange enrollees with tools to understand the implications of their coverage selection on provider and treatment choices and tools to choose their providers.
- d. Participate in and support efforts to efficiently collect and appropriately report information that can inform consumers' choice of coverage, providers and treatment options including information on QHP and provider quality, cost and consumer experience.

**IV. Promote wellness and prevention**

- a. Offer health plans, plan designs and networks that will promote enrollees' maintaining good health and preventing disease.
- b. Identify opportunities to align with community health and wellness initiatives.

**V. Reduce health disparities and foster health equity for all Exchange members, taking special circumstances into account in evaluating health disparities**

- a. Consider and evaluate on an ongoing basis the extent to which Exchange policies promote health equity and the reduction of health disparities.
- b. Exchange policies shall assure that QHPs offer a sufficient number of providers with linguistic and cultural competence to serve diverse enrollment.

**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**

- a. Align Exchange strategies to foster improvements in care delivery with other National and state payment and delivery system redesign efforts to maximize impact on the

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delivery system, including Centers for Medicare and Medicaid Services, Medi-Cal, CalPERS and private sector purchaser initiatives.

- b. Adopt policies that encourage and measure provider payment, provider contracting and measurement processes that foster the Exchange's values.
- c. Promote consistent evidence-based care while allowing for innovation and person-centered care that meets the individual's needs.
- d. Support effective use of health information technology to expand access and foster electronic information exchange.
- e. Support making care affordable for individuals inside and outside of the Exchange and be mindful of impacts of Exchange policies on care systems that provide care to the uninsured.
- f. Promote innovations and changes in the administrative processes that reduce the burden on plans, providers and consumers.

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

- a. Consider the administrative capacity of the Exchange and the need to phase in some programs over time.
- b. In adopting standards, consider the practical capabilities of impacted parties to meet the standards, which may include the need to phase in some standards over time and to modify some standards as data capacity, the delivery system and markets evolve.
- c. Continue to learn and mature our approach based on input from our national partners, California stakeholders, on-going research, evaluation and measurement of quality of care and measurement of impacts of Exchange policies on achieving the goals of better care, improved health and lower costs.

## Core Minimum Qualified Health Plan Certification Requirements and Regulator Partnerships

### Summary

The Affordable Care Act requires any issuer proposing a Qualified Health Plan (QHP) for certification by the California Health Benefit Exchange (the Exchange) be found to be “licensed and in good standing.” This finding must be made by the state, which means it could be made by either the state’s regulators or by the Exchange. In this Background Brief, the respective roles of the Exchange and the State’s regulators – the California Department of Insurance (CDI) and the California Department of Managed Health Care (DMHC) – are discussed with respect to the application of statutorily based QHP certification criteria and making the important prerequisite finding of “licensed and in good standing.”

### Background and Discussion

The Affordable Care Act requires the Exchange to certify only Qualified Health Plans (QHP) offered by issuers that are “licensed and in good standing” to offer health insurance/coverage in California.<sup>9</sup> Federal rules further elaborate that “good standing” means that an issuer faces no outstanding sanctions imposed by the state. In California, the state means either the California Department of Managed Health Care or the California Department of Insurance. Federal rules also provide the Exchange with latitude to more specifically define what constitutes “in good standing.” While the regulator will make the finding of whether or not a proposed QHP issuer is “licensed and in good standing”, the Exchange has been working in tandem with the State’s regulators to more specifically define exactly what standards are required before a regulator would make a finding that a proposed QHP issuer “in good standing.”

### Exchange Operating Principles

The Exchange is committed to operating as efficiently and effectively as possible. As part of this commitment, it seeks to avoid “reinventing the wheel” and avoid duplication whenever possible without sacrificing commitment to its mission, values and principles. Moreover, the Exchange is sensitive to minimizing administrative burden on plans unless additional requirements are essential to a priority Exchange goal. Consistent with these operating principles, the Exchange is working with state regulators to share the application of certain QHP certification standards to avoid redundancy in submission by plans and review by both regulators and the Exchange; specifically the Exchange proposes that the state and federal statutory and regulatory requirements that apply to all plans to be offered market wide, not only to QHPs offered through the Exchange, be applied by the regulators as a prerequisite to consideration of a QHP bid from an issuer.

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<sup>9</sup> The Affordable Care Act Section 1301(a)(1)(C)

### Definition of “In Good Standing”

In collaboration with California regulators, the Exchange has compiled a list of requirements which an issuer must meet in order to be declared as “in good standing” under the Affordable Care Act. The regulator makes this finding as a prerequisite to consideration of an issuer for QHP certification. These include:

- Issuer possesses a valid license for the applicable geographic service area.
- Benefit plan design requirements are met for state mandates, essential health benefits, basic health care services, no cost sharing for Indians/Alaska Natives and other Affordable Care Act requirements including federal mental health parity.
- Provider network adequacy and accessibility requirements are met.
- Evidence of Coverage/Benefit disclosure is compliant.
- Issuer is compliant with statutory requirements concerning claims payment practices, utilization review policies and procedures, enrollee grievance/complaint and appeal policies, independent medical review requirements, marketing and advertising and medical loss ratio.
- No regulator concerns with financial solvency and reserves.
- Sufficient administrative and organizational capacity exists.

Further, the regulator will verify that the QHP bid has met specified core requirements such as:

- Verify that the issuer’s underwriting complies with allowable rating factors and that prohibited rating factors are not utilized.
- Verify the reported actuarial value is accurate and within the permitted “de minimis” allowance or otherwise determine actuarial value of a proposed QHP.
- Complete premium rate review and make finding of reasonableness.
- Assure segregation of funds for coverage of abortion services for which federal funding is prohibited.

The Exchange in collaboration with regulators is considering inclusion of a finding by the regulator that the proposed QHP issuer does not have any “material or grievous statutory or regulatory violations,” including penalties levied, in the past two years” of any of the statutes or regulations tied to the specifically identified “in good standing” criteria listed above. This finding would not necessarily bar the regulator from making a finding of “in good standing” but it would serve as an important communication vehicle between regulators and the Exchange about an issuer’s historical track record with its regulator. This type of information could be important to the Exchange as it applies its certification criteria.



## Plan and Network Design Issues

### Active Purchaser: Number and Mix of Exchange Plans

#### Summary

The California Health Benefit Exchange (the Exchange) is considering the options related to the requirements for the number of products that each health plan issuer may propose for the Exchange. The selected options will also guide the decision rules when the Exchange selects the final Qualified Health Plan products from among the certified Exchange plans. This "Active Purchaser Plan Benefit Design" Board Recommendations Brief provides background on the issues, a summary of the options available to the Exchange, and includes final recommendations for the Board's consideration.

These final recommendations must be considered in conjunction with Exchange Plan selection considerations relating to affordability and quality in administrative and clinical operations as well as benefit and pricing requirements under the Federal Affordable Care Act. These are discussed in briefs on the options for other decisions presented to the Board, specifically Plan Design Standardization, Rating Factors, and Individual and SHOP Alignment. Each of these options will also require further description and clarification as part of the development of the health plan solicitation process and support documents.

#### Background

The Federal Affordable Care Act and its implementing regulations require a state health benefit exchange to make Exchange Plan coverage available state-wide.<sup>10</sup> The State Legislation that authorized the California Health Benefit Exchange empowered the Exchange to serve as an "active purchaser" to "selectively contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service" and to establish and use a competitive process to select the participating health plan issuers.<sup>11</sup>

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.

The ability of the Exchange to engage as an active purchaser depends on the market conditions, environmental factors, and the policy climate. A broad definition of an active purchaser allows the Exchange to use a wide range of criteria to credential and select Exchange plans. A number

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<sup>10</sup> Affordable Care Act section 1311(d)(1)(2)(A) An Exchange shall make available qualified health plans to qualified individuals and qualified employers.

<sup>11</sup> California Government Code §§100503(c) (AB 1602 §7), and 100505 (AB 1602 §9).

of these factors are addressed in separate Board Recommendation Briefs and Board Background Briefs. Active purchasers can develop policies to:

- Establish Qualified Health Plan certification criteria that reflect the Exchange's goals for quality, affordability and prevention;
- Encourage quality and delivery system improvements to improve care coordination and efficiency;
- Develop and leverage consumer information and decision support tools that promote transparency;
- Align with other large purchasers in the state and nationally to reinforce purchasing priorities to health plan issuers and providers; and
- Define Qualified Health Plan products based upon the benchmark plan essential health benefits and standardized cost sharing features.

The market and purchasing environment must be taken into consideration in order to effectively execute a competitive selective contracting strategy to achieve that "optimal" value. Market factors that must be considered include:

- Expected size of the Exchange population. The California Exchange has a goal of enrolling 2.8 million Californians by 2014 in the Exchange, Medi-Cal and Healthy Families.<sup>12</sup> It will be the exclusive source of coverage for that portion of the population that receives premium and cost-sharing subsidies. Statewide, this potential enrollment is expected to encourage existing health plan expansion and new health plan entrants. Within a given geographic area, the enrollment projections will vary substantially. In areas with smaller population, it may be necessary to establish different guidelines to attract the desired number and quality of health plan bids. In areas with high expected new enrollment, many plans may bid and the Exchange must establish parameters to encourage affordable health care coverage offerings and robust competition, while also determining what number of plans and products may be "too many."
- Rules for individual and small group products outside of the Exchange. Individual and small group health insurance products will be available outside of the Exchange. The Exchange health plan bid and selection rules will influence their interest in participating in the Exchange. To the extent Exchange policies create different market requirements compared to the outside market, they have the potential to segment risk and produce adverse selection against plans in the Exchange. The Affordable Care Act creates temporary risk corridor and reinsurance programs, and a permanent risk adjustment

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<sup>12</sup> Marketing, Outreach & Education and Assistants Program for the California Health Benefits Marketplace. Final Recommendations and Board Action. California Health Benefits Exchange. June 26, 2012.

program are designed to mitigate this concern, but will not be in place until after the change plans are initially selected and people enroll.

- Competition and use of selective contracting to negotiate desirable contract terms. A selective contracting process may involve two steps. A first step to certify the Qualified Health Plan and a second step to negotiate and finalize price and contract terms. Price negotiation may be challenging because the Exchange will not be the sole source of coverage and the Affordable Care Act requires that prices for the same Exchange products be the same inside and outside of the Exchange. Other contract terms, such as multi-year arrangements with a limited number of issuers, may increase carrier interest and promote year over year stability, but would limit the Exchange's flexibility.
- Promoting Affordability. There are many changes to market rules both inside and outside of the Exchange that take effect in 2014 that may affect premium rates in the individual market. These include: guaranteed issue (no denials due to pre-existing conditions) which may result in a more expensive risk pool than the current market; the requirement that age based premium rates may not vary by more than 3:1 is expected to raise rates for younger age groups and lower rates for those approaching Medicare eligibility; the Essential Health Benefits package requires coverage of maternity services which recently became mandated coverage as of July 1, 2012 which will increase average rates; and reinsurance which will lower rates for the first three years starting with 2014. New policies must also provide coverage for certain preventive services without member cost sharing, although that change is already in effect.

The state has begun to address some of the competitive market features through the enabling legislation. Some of these include:

- While the Federal Affordable Care Act requires a carrier to offer at least one Qualified Health Plan at the Silver level and one Qualified Health Plan at the Gold level in each Exchange, the California Affordable Care Act goes further. The California law requires the Exchange to offer a choice of Qualified Health Plans at each of the five federally specified benefit tiers within each region. (The four metal levels defined by actuarial value; Bronze 60%, Silver 70%, Gold 80% and Platinum 90%, and the fifth product being a catastrophic plan). The Federal Affordable Care Act does not go as far and requires a carrier to offer at least one QHP at the Silver level and one QHP at the Gold level in each Exchange. The second lowest cost silver plan available to the consumer is the benchmark for premium subsidies and cost sharing reductions for qualified consumers.
- Each participating Exchange Plan issuer must offer at least one plan in each of the five levels. Further clarification of this requirement may be forthcoming from the federal government and the Exchange will need to set parameters on how a health plan meets this requirement.

- As of January 1, 2014, the date the Exchange becomes operational, health plan issuers may only sell products that conform to the federally specified levels outside the Exchange.
- If a carrier does not participate in the Exchange and the Exchange standardizes plan designs, every carrier who sells products outside the Exchange must offer at least one Exchange designated standardized plan at each of the four metal levels and it cannot sell products at the catastrophic level.
- If an issuer does not sell any commercial products outside the Exchange, it is permitted to sell its Qualified Health Plans solely through the Exchange.

Additional legislation has been introduced in California that could further clarify market-wide individual and small group health plan Qualified Health Plan product requirements. The Exchange staff fully expects the Legislature to enact bills that establish both the Essential Health Benefits and the geographic rating regions.<sup>13</sup>

### Individual and Small Group Health Insurance Markets in California

Based on survey data and a review of plan reports submitted to the DMHC and the CDI, approximately 15% of the California population has health coverage through commercial individual and small group health insurance plans. Anthem Blue Cross, Blue Shield of California, and Kaiser are the dominant health plans in both markets, with these three plans representing approximately 75% of the enrollment in individual market in 2009. It is important to note however, that there is substantial regional variation. In some areas, there are regional plans with substantial enrollment and, in many of the rural areas of the state, Kaiser does not have a delivery system.

The Exchange collected a snapshot of enrollment and benefit information on the individual and small group insurance markets from five major insurers in California for the year ended 2011. Those responses were consistent with the earlier 2009 survey data published by California Health Care Foundation for the individual market and showed that consumers have a choice of at least three health plan issuers in all counties, with the most limited choice in the Northern and Sierra region counties.

For the small group market, employers have a choice of at least two plans in each county, with competition more limited in the Northern and Sierra counties. Some of the Medi-Cal managed care plans, such as LA Care Health Plan, Inland Empire (Riverside-San Bernadino ), CalOPTIMA (Orange), and Central California Alliance for Health (Monterey, Santa Cruz, Merced), have significant enrollment in their respective counties, but have not traditionally offered commercial insurance products. And there are some regional plans that may have significant market share when just their licensed service area is considered.

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<sup>13</sup> As of late May, AB1453/SB951, which designates a Kaiser small group HMO plan as the Essential Health Benefits benchmark plan, has passed the Assembly Committee on Health and has been referred the State Senate Committee on Health.

This high level overview suggests that, in order to generate substantive choice and competition in all regions, the Exchange may need to look to regional health plans and attract new entrants into the market.<sup>14</sup>

### **Metal Level Tier of Qualified Health Plan Bids**

California law requires the Exchange to offer a choice of Qualified Health Plans at each of the five federally specified benefit tiers. This raises issues for both 1) the structure of bids from potential health plan participants and 2) for the Exchange process for selecting the certified Qualified Health Plan that are offered in the Exchange. While the legislation specifies that plans must offer all metal tiers, it is not specific as to how health plans or the Exchange are to meet that requirement. A policy decision by the Exchange will likely require the Exchange to exercise its authority to incorporate contractual language between the Exchange and the health plan issuers to assure that their Qualified Health Plan products offered inside the Exchange are consistent with products offered and sold outside of the Exchange.

There are a number of issues that must be addressed, including:

- Will a health plan be required to bid/offer a Qualified Health at all five levels in each geographic area or can it meet the requirement by offering a product at each metal level in at least one geographic area of the state?
- If a health plan is not required to offer all five metal levels in each geographic area, is there a minimum number of metal tiers that must be bid in an area? For example, would the minimum be the Affordable Care Act requirement of silver and gold?
- Under federal rules, the second lowest cost silver plan will serve as the benchmark for premium subsidies and cost sharing reductions. The CMS Actuarial Value and Cost Sharing Reductions Bulletin issued in February 2012 indicates that they intend to direct the Exchange to require that each Qualified Health Plan issuer submit, in addition to a silver plan, three variations of that silver plan to match the statute's three levels of cost-sharing reductions for low income enrollees.
- At what level will the Exchange select plans for certification as an Exchange plan? Will Qualified Health Plan bids be by geographic area? Can the Qualified Health Plan product offerings vary across regions? Will the Exchange select a health plan bid across all metal level tiers? Or can it select at the metal level? Selection of Qualified Health Plans at the metal level could result in health plan X's A and B products at the Silver level and health plan Y's C and D products at the Gold level within a given geographic area.
- If a health plan submits an Exchange plan bid that includes proposals for products at all of the required levels, but the Exchange does not select all of the offered products, is the health plan considered to have met the five level product requirement for their products that are offered on the Exchange?

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<sup>14</sup> Exchange staff note these issues are subject to continued legal review and will be updated and are subject to change as additional regulations are issued.

Many of these issues are addressed in the Issues and recommendations that follow, and others are likely to be the subject of further clarification in the federal regulatory process.

### **Number and Type of Qualified Health Plan Products**

The current individual and small group market products are a mixture of Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) products and all of the major plans offer both HMO and PPO products in their portfolios. This mixture varies by health plan and by geography. In particular, we would expect counties with Kaiser hospitals and physician groups to have a higher proportion of HMO membership.

Over time, the plan benefit design and cost sharing structure of HMO and PPO products has become more similar, with both using deductibles and copayments and decreasing their use of coinsurance, other than in the high deductible plans. A more complete description of benefit designs is provided in the Benefit Standardization Board Recommendation Brief. The main differences between what is called an HMO and a PPO are the size of provider networks and the rules to access care. HMO products generally continue to use primary care physician assignment or a medical group home and often require physician referral to specialists, while PPOs allow members to self-refer to both primary care and specialists. In responses to the Exchanges' data request, none of the plans reported "narrow network" products among current offerings or bestselling products in the individuals and small group markets, but informal conversations with health plan stakeholders indicate that some are considering such an option for Exchange plan products.<sup>15</sup>

This indicates that the Exchange must take network type variation into account, including whether an issuer is offering an HMO or PPO product, and whether a narrow network design is among the offerings when establishing guidelines for the number of health plan Qualified Health Plan bids and the Exchange Plan selection.

### **Geographic Coverage by Health Plans**

The HMO and PPO products offered by health plans are licensed by the Department of Managed Health Care or the Department of Insurance to serve specified geographic areas, usually defined at a zip code level. One result is that health plan service areas may not match common governmental boundary lines, such as counties.

Most state insurance laws, including those in California, permit some form of geographic rating in the individual and small group health insurance markets. Often the state also defines the number and boundaries of the geographic rating areas used by health insurers. However,

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<sup>15</sup> Narrow network product designs can substantially limit the size of the physician and hospital networks and provide substantial financial incentives in the form of reduced cost sharing for members who restrict their health care use to a predetermined set of providers within a health plan's broader contracted network. Typically plans sponsoring these networks assert that their selected providers have earned high ratings for a combination of lower cost and/or higher quality. Under any circumstance, all networks will be required to meet the same provider adequacy standards.

under current law in California the geographic service areas are defined by the health plan, not the regulators.

In a change to take effect in 2014, the Affordable Care Act requires that the State specify geographic regions for rating purposes but does not specify the number or configuration of those regions, and legislation or regulation is needed to meet this Affordable Care Act requirement. The regional definition is subject to review by the Secretary of the Department of Health and Human Services; if a state does not establish the rating areas, the Secretary may do so.

Although legislation has been introduced, it is still undecided whether and how geographic regions may be standardized for the California individual and small group market. It remains to be seen whether the creation of rating regions will prompt alignment of plan and insurer licensed service areas with those regions, or at least service areas that cover full counties.

Depending on how geographic regions are defined in law, there is concern that variation in the definition of health plan service areas is associated with differences in standard costs (for example, if the law allows regions to be defined narrowly). It is generally true that plans can obtain lower contracted rates in areas with a greater number of competitor providers and hospitals. In areas with fewer providers or sole community hospitals, the providers have greater negotiating leverage and the health plan may be a price taker. To the extent that these are higher cost providers, it will be reflected in the premium cost of the product. Unless there are offsetting factors, this puts a health plan that develops a broad geographic provider network at a pricing disadvantage relative to a plan that contracts only with providers in the more competitive markets. A more complete description of options related to geographic rating is included in the Rating Issues: Family Tiers, Age, Geography, Tobacco, and Wellness Board Recommendations Brief.

### **Exchange Selection of Qualified Health Plans**

Based upon the recent market scan of major health plans, even the smaller counties have a choice of at least two health plan issuers. There are also regional health plans, including provider sponsored plans and Medi-Cal managed care plans that are available in many parts of the state to increase the possible offerings. However, two Exchange plans may be perceived as a limited choice by consumers and the currently available plans may not meet all Exchange desired certification criteria for quality, provider access and customer service. Other geographic areas may be served by more than a dozen health plans and products and the challenge is for consumers to easily compare the offerings. These different circumstances suggest that different preferred contracting arrangements may need to be considered for different geographic areas.

In less populated areas, fewer health plan issuers could increase the probability that Exchange plans achieve adequate enrollment and the market size to justify contracting efforts and the



operational investment. The Exchange may consider asking health plan issuers to offer a wider range of product designs to provide for choice for consumers in those areas. For example, two selected carriers may each offer three products, providing consumer choice of six Qualified Health Plans. In contrast, more competitive urban areas may offer the Exchange greater opportunity to engage as an Active Purchaser.

### Stakeholder Perspectives

Overall, stakeholders expressed concern about the Exchange offering too much choice that might impair the ability of consumers to evaluate plan attributes efficiently and effectively. They also underscored the importance of meaningful choice. Meaningful choice was articulated as options that would permit comparison on provider network, quality, and member support, as well as cost. There was specific mention that many plans use the same provider networks and there should be an effort to avoid "look-alike" plans, and that consumers should have access to high quality information to inform their plan choice. They also commented on the importance of monitoring plans and selecting those likely to succeed over the longer time period. A more limited selection of health plans should allow the Exchange to focus resources more effectively on those tasks. However, while most comments supported the Exchange offering "selected" but "meaningful" choice of plans, some thought the Exchange should be a marketplace for all plans that met the minimum requirements. Some stakeholders suggested that multi-year contracts would encourage health plan participation in the first year of the Exchange and could be a mechanism to encourage better price offerings in the first year, but the contracting process should recognize the unique requirements being placed on Local Initiative Health Plans that must simultaneously prepare for the large infusion of new Medi-Cal enrollees in 2014.

Stakeholders generally supported the idea of requiring health plans offer their full licensed coverage area, but offered different points of view regarding how that broad coverage should be achieved. Some commented that issuers should have flexibility to offer sub-regional products, while others commented that such sub-regional contracting should be allowed only after broad coverage is achieved.

### Issues and Recommendations

There are two issues to be considered when assessing the appropriate number and mix of plans to offer on the Exchange:

1. How a health plan may structure the Qualified Health Plan bids and the number of Qualified Health Plan products it may propose for the Exchange.
2. The number and mix of Qualified Health Plan products that the Exchange will select and offer to the consumer in each geographic region.

It is assumed that both health plan issuer bids and the selection of health plans will occur at a geographic or regional level. The establishment of regions has yet to be determined by the California Legislature as of the date of this brief.

This brief presents the issues related to determining the number, mix and geographic coverage area of Exchange Plans and are presented as separate options and recommendations. However, the final recommendations should consider all of these factors as a package. Together with the decisions identified in the briefs – Plan Design Standardization, Rating Issuers and Premium Subsidies and Cost-Sharing Reduction – they will influence health plan interest in participating in the Exchange, their strategic thinking regarding the geographic regions to enter, and their product design.

### **Issue 1: The Exchange as an Active Purchaser**

The California Affordable Care Act permits but does not require that the Exchange be an active purchaser, and selectively contract with health plans. Alternatively, the Exchange could establish participation rules related to cost, quality and access, and accept all qualifying health plans. Staff recommends the Exchange be an active purchaser, and has structured all other recommendations based on this approach. As an active purchaser, staff recommend that selection of Qualified Health Plans in particular regions would seek to assure broad choice of offerings (e.g. four or five different issuers), but would not require the Exchange to accept all issuers.

### **Issue 2: Metal Level Tiers of Qualified Health Plan Bids:**

There are a range of options related to the metal levels of Qualified Health Plan bids for a health plan issuer in each geographic area (see Table 1 for detail):

- **Option A:** 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.
- **Option B:** Require only select metal tiers per Qualified Health Plan bid: Requires issuers to propose a Qualified Health Plan product for specified metal level tier(s) in each geographic region in which it bids. The full metal tier and catastrophic requirement of the California Affordable Care Act may be met by proposing the other metal tier Qualified Health Plan products in at least one other geographic region.

If an issuer is not required to submit Qualified Health Plan bids that offer a product at all tiers within each region, the Exchange may consider a minimum requirement to bid for a region. If this is the case, the recommendation would be to require a silver plan and a gold plan per regional bid. This would meet the minimum requirements for a Qualified Health Plan as specified in the Affordable Care Act.

Another option was identified and reflects the uncertainty regarding how health plan issuers might meet the five tier requirement. It would allow health plan issuers to propose a Qualified

Health Plan product for each metal level tier and catastrophic based on the plan assessment of its strategic advantage and subject to the requirement that it offers at least one Qualified Health Plan product in each tier in at least one geographic region of the state. This was rejected because it was considered to not meet the intent of either the Federal or State legislation and was therefore not subject to further analysis.

Staff recommends that the Exchange Qualified Health Plan bidders meet all actuarial value metal tiers within a geographic region (**Option A**). This recommendation assumes that a bidder will propose a "family" or suite of products across the metal tiers that includes the same covered benefits, product type and provider network, but varies primarily on cost sharing features. The suite would also include a child-only plan at each tier and the catastrophic plan option. A suite of products offered by a given health plan will allow the consumer to more easily evaluate the value of a plan and understand the trade-offs between the monthly premium cost and out of pocket costs at the time of service. Presenting a suite of products will also make it easier for the consumer to compare Qualified Health Plan products within the metal level tiers. The primary disadvantage is that this option requires the greatest amount of resources to evaluate and certify health plan products because there will be at least five products per bidder per region.

### **Issue 3: Number of Qualified Health Plan Product Bids per Issuer**

The number of Exchange plan products that an issuer may bid for each geographic area will determine the starting pool of options for consumers. Allowing multiple submissions for each health plan will maximize the Exchange opportunity to selectively contract based on the combination of choice, value, quality, and service. It is also expected that some health plan Exchange products may not meet minimum certification criteria and will be eliminated from consideration. At the same time, allowing too many products from each plan could be confusing to consumers, yet distinguishing product factors are necessary to create the "meaningful" choice sought by consumers. Therefore, the Exchange may want to be in the position of receiving a sufficient number of Qualified Health Plan proposals to be able to apply active purchaser principles across all regions of the state.

There are a range of options related to the permitted number and mix of Qualified Health Plan product bids per health plan issuer in each geographic area (see Table 2 for detail):

- **Option A:** Allow one Qualified Health Plan product bid per health plan per geographic area. This must conform to standardized benefit design if a standardized benefit design option is adopted as policy.
- **Option B:** Limit number of Qualified Health Plan product bids per issuer to a small number, e.g., two or three per issuer per geographic area. This would permit plan bids with variation in provider networks, new or alternative benefit plan designs that allow for variation.

- **Option C:** Allow unlimited number of Qualified Health Plan product bids per health plan per geographic area.

Staff recommends that issuers be allowed to propose 2-3 Qualified Health Plan products per geographic region (**Option B**). This increases competition among the health plans and increases the probability that there will be a sufficient number of health plan proposals that meet certification requirements and will result in a desirable level of product differentiation and consumer choice. This recommendation does not establish the number of Issuers that will be accepted for each region; that decision will be made when issuer proposals have been submitted and reviewed.

Limiting the number of bids to one Qualified Health Plan product per geography increases the probability that elimination of a bidder results in too little consumer choice in some areas, while allowing health plans to submit an unlimited number of bids per geographic region increases administrative burden and the possibility that issuers will present plans with only small differences in benefit design and provider network, thereby adding complexity without increases true choice. Limiting the number of Qualified Health Plan products an issuer may also encourage the issuer to consider the best value benefit design to offer to Exchange members to increase its enrollment. In addition, the Exchange is recommending that each issuer be permitted to offer one non-standard bid per geographic region. ( See Standardization of Plan Design discussed later).

This option increases the administrative burden to evaluate and certify Qualified Health Plan products compared to only accepting only one product. However, allowing for multiple offerings per issuer is expected to encourage innovation. The Exchange will have the option of selecting some or all of the offered products for each issuer.

The recommendation to limit the number to two or three plan products per issuer depends on other policy decisions made by the Exchange, such as the extent of standardization of benefit design. At minimum, a health plan issuer would be required to bid the standardized benefit design(s) developed for each metal tier.

The Exchange could offer a contingent opportunity to submit additional bids. For example, a health plan may submit more than one bid if they represent different types of products, such as an HMO and a PPO product, or if the Qualified Health Plan is offered as both a broad network and a narrow network plan. It may be necessary to offer such an option if there is concern that there may not be a sufficient number of bids to evaluate for an area. In such a case, in order to provide sufficient choice to the members, the Exchange may select fewer health plan issuers but require each to offer more than one Qualified Health Plan product.

Any Qualified Health Plan product bids by an issuer in addition to the standardized benefit design(s) must meet the requirements of the Essential Health Benefits and build upon the structure of the standardized Exchange benefit plan design. Specifically, the Exchange wants

any additional bids to add value relative to the standardized benefit design(s) and to allow the opportunity for some design innovation

#### Issue 4: Geographic Coverage by Health Plans

There are a range of options regarding requirements for geographic coverage across regions (see Table 3 for detail):

- **Option A:** Require each issuer to submit Qualified Health Plan bids for all service areas for which the product is licensed throughout the state
- **Option B:** An issuer submitting a bid for an Exchange plan may bid for a subset of the geographic regions in which it is licensed, but must have at least one product that fully covers the service areas within the region for which the issuer is licensed.
- **Option C:** Each issuer may submit bids only for service areas where it can demonstrate coverage of an entire defined geographic area, with the minimum geography set based on the state's legal definition of a region.

Staff recommends that an issuer be allowed to bid for a subset of the geographic region but also require a full coverage plan for their licensed region (Option B). This would mean that a plan licensed to operate in all four counties of a rating region must submit a bid to cover all counties. (Consideration of a corollary, that a carrier or plan submitting a bid for full region coverage may also bid to offer a sub-regional plan alongside of its region-wide product is discussed as Issue 3, Option C in the Rating Issue Board Recommendation Brief and is recommended to the Board.) This option recognizes market dynamics and the need to attract participation from both regional plans and those that serve a broader geographic area. This option allows a health plan to identify regions where it believes it can position itself for strategic advantage and lowers the risk of the absence of bids sufficient to cover the whole state. For the larger health plans, this option does not force an all-or-nothing participation decision. If this option is adopted, the Exchange may want to consider incentives and scoring criteria that reward plans that propose in multiple geographic areas. This option requires that regional plans or plan service areas that partially cover a region, submit a bid that presents the entire service area for which the product is licensed, to guard against selective offerings.

If all of these recommendations are adopted, there could easily be more than 500 total Qualified Health Plan products offered on the Exchange statewide and approximately 60 Qualified Health Plan options per region (assuming 3 health plans, five metal tiers, 4 products within each plan per tier, and nine or more geographic regions). A standardized benefit design could reduce this to 300 Qualified Health Plan products statewide and approximately 30 Qualified Health Plans per region, based on the assumption that a corollary decision rule is a health plan Qualified Health Plan alternative design would only be offered if that health plan standardized benefit design was a certified offering.

### Issue 5: Multi-Year Contracts with Qualified Health Plans

Although the Exchange will not require multi-year contracts with Qualified Health Plan issuers in the first years of Exchange operation, it wants to encourage the development of Exchange and health plan long term partnerships and desires to engage some plans in multi-year contracts beginning the first year of Exchange operation on January 1, 2014. The rationale for pursuing this active purchaser goal is to change short term incentives and risks for participating health plans. If plans are contracted for multiple years, there is the opportunity for the Exchange to work with the issuers to 1) create mechanisms to reduce health plan risk and therefore to offer lower premium rates, especially in year one and 2) develop better and more stable provider networks and/or strategies to address health delivery reform that take multiple years to implement, evaluate and refine.

The willingness of a health plan issuer to enter into a multiple year contract could be fostered by an Exchange commitment to limit new competition in a region. In general, the Exchange would not intend to allow new plans to enter a region during the three year term, with the possible exception of qualified new and existing Medi-Cal managed care plans that submit applications for 2015, in recognition of their role in the expansion of Medi-Cal eligibility under health reform. This exception recognizes the significant resources Medi-Cal Managed Care plans must commit to the coverage expansions. A multi-year partnership could also include agreement on mechanisms to adjust prices in years 2 and 3 depending on actual cost experience in year one resulting in either an upward or downward price for years 2 and 3.

Under such conditions, multi-year contracts are likely to be an important means of attracting plans in year 1 and most importantly, increasing affordability in year one.

An indication that a health plan issuer is willing to enter into a multi-year contract will likely be an important consideration in the review of Qualified Health Plan bids for 2014.

Given that the Exchange anticipates entering into multi-year contracts as part of the initial solicitation process, the options to consider are:

- **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 and timing.

Staff recommends the Exchange adopts specific multi-year contract criteria with health plans and is open to revisions and negotiation of additional terms and timing. (Option B) Details for the options can be found in Table 4.

While specific terms of the multi-year contract may be open to negotiation during the solicitation process between the Exchange and the participating health plans, the general terms would be expected to include such features as:

- Initial three year term. However, QHP issuer would be subject to sanction or decertification for "cause" or failure to meet Exchange standards or to violate terms of the agreement.
- Pre-determined process for rate adjustments in years two and three of the contract.
- Pre-determined process for risk-sharing adjustments and roll-forward consideration of gains or losses.

The current consideration for the rating agreement would include a strong commitment to pricing and results transparency. This may include an agreement to a fixed or shared administrative percent, an upper limit on the percent of profit, and a verifiable process to confirm financial results. Premium rates for years two and three of the contract would be adjusted by changes in the cost of medical care and potentially utilization although this factor should be adjusted for through federal reinsurance and risk adjustment programs. Determination of the cost of care change would be based upon an independent actuarial review, at the QHP issuer's expense, by a firm selected by the Exchange from a list of mutually approved and agreed upon vendors.

The parameters for risk sharing must recognize the uncertainty of start-up enrollment and other factors in the initial years of operation. The general proposed approach would project a "cost of care" range within which gains and losses are absorbed by the Qualified Health Plan issuer and within which there is no carry-forward consideration. If actual costs of care are above the range, the Exchange would agree to have some or all of the overage added into the plan rates for the subsequent year. If costs are below the range, the Qualified Health Plan issuer would agree to have some or all of the gains credited to reduce the plan rates for the subsequent year. While there may be significant issues related to timing in the first year of the Exchange, such as the potential for limited data at the time that rates must be established for year 2 and not knowing the impact of federal reinsurance, it is expected that such details can be worked out and any reinsurance and risk sharing transfers reconciled for Exchange operations in year 3. The reconciliation will need to take into account federal risk mitigation programs that will be operational beginning in 2014, including risk corridors, reinsurance for high cost claimants and risk assessment/risk adjustment. The timing of payment calculations and transfers associated with these programs will need to be built into the planning for multi-year contracts.

The following tables present an outline of the issues and the pros and cons of these options.



Table 1: Issue 2 Metal Level Tiers of Qualified Health Plan Bids	
Option A: Require All Metal Tiers Per Qualified Health Plan Bid	Option B: Require Selected Metal Tiers Per Qualified Health Plan Bid
<p><b>SUMMARY</b> The Exchange would require the health plan to submit a Qualified Health Plan bid that includes all metal tiers for each geographic region. This must conform to standardized benefit design if a standardized benefit design option is adopted as policy. If there is not a standardized benefit design, the Qualified Health Plan would be a consistent suite of products that vary in cost sharing across metal tiers.</p>	<p><b>SUMMARY</b> The Exchange would require select metal tiers for Qualified Health Plan bids for each geographic region. These must conform to a standardized benefit design if a standardized benefit design option is adopted as policy. Requirement for all metal tiers would be met by offering other metal levels in at least one geographic region.</p>
<p><b>PURPOSE</b> Assures that all selected Qualified Health Plans meet CA metal level offering requirements. Provides a level competitive market for carriers. If standardized, it allows for consumer ease of comparison of Qualified Health Plan products across other features: price, network, quality.</p>	<p><b>PURPOSE</b> Increases consumer choice and allows for carrier benefit design innovation. If standardized, it allows consumer ease of comparison of Qualified Health Plan products across other features: price, network, quality. May increase consumer understanding of trade-offs of benefit design, price, network and quality.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Maximizes the options available to consumers.</li> <li>▪ Simplifies consumer comparison of Qualified Health Plans across and within metal levels. Promotes competition among health plans on basis of price, network, quality and other features</li> <li>▪ Simplifies calculation and validation of benefit plan actuarial values</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Attempts to balance Exchange and health plan stakeholder preferences</li> <li>▪ Because it may result in fewer distinct Qualified Health Plan bids it should reduce resources needed for calculation and validation of benefit plan actuarial values.</li> <li>▪ Reduce potential risk selection across metal tiers</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Offering all tiers per health plan in each region Increases the potential risk selection across metal tiers</li> <li>▪ Results in a large number of options for consumers, which will require strong decision support tools for plan comparison</li> <li>▪ Requires a high level of administrative support for the bid evaluation process</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Qualified Health Plan choice may not meet consumer needs</li> <li>▪ May not receive desired number of Qualified Health Plan bids to allow active purchaser in all geographic areas</li> </ul>

Table 2: Issue 3 Number of Issuer Qualified Health Plan Bids		
Option A: Allow 1 Qualified Health Plan Bid	Option B: Limited Number of Qualified Health Plan Product Per Issuer	Option C: Allow any number of Qualified Health Plan Bids
<p><b>SUMMARY</b>                      The Exchange would limit the carrier bids to one Qualified Health Plans per geographic area. This must conform to standardized benefit design if a standardized benefit design option is adopted as policy.</p>	<p><b>SUMMARY</b>                      The Exchange would limit the carrier bids to a small number (2-3) of Qualified Health Plan products per issuer for each geographic area.</p>	<p><b>SUMMARY</b>                      The Exchange would permit any number and mix of bids across geographic area.</p>
<p><b>PURPOSE</b>                      Provides a level competitive market for carriers. If there is a standardized benefit design, it allows for consumer ease of comparison of Qualified Health Plan products across other features: price, network, quality</p>	<p><b>PURPOSE</b>                      Increases consumer choice and allows for carrier benefit design innovation. Allows consumer ease of comparison of Qualified Health Plan products across other features: price, network, quality. May increase consumer understanding of trade-offs of benefit design, price, network and quality.</p>	<p><b>PURPOSE</b>                      Provides greatest flexibility for carrier benefit design innovation</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Simplifies calculation and validation of benefit plan actuarial values</li> <li>▪ Promotes competition among health plans on basis of price, network, quality and other features</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Attempts to balance opportunity for consumer choice and administrative burden on Exchange and health plans</li> <li>▪ Promotes competition among health plans on basis of price, network, quality and other features.</li> <li>▪ Increases probability of sufficient number of bid submissions across all geographies</li> <li>▪ Encourages health plan issuer to identify the benefit design that is expected to be most desirable to Exchange participants</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Increases opportunity for health plan innovation</li> <li>▪ Increases options for consumers.</li> <li>▪ Allows health plan issuers to sell any certified Qualified Health Plan that they believe positions them most favorably</li> </ul>

Table 2: Issue 3 Number of Issuer Qualified Health Plan Bids		
Option A: Allow 1 Qualified Health Plan Bid	Option B: Limited Number of Qualified Health Plan Product Per Issuer	Option C: Allow any number of Qualified Health Plan Bids
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Reduces the options available to consumers</li> <li>▪ Qualified Health Plans may not meet consumer needs</li> <li>▪ May not receive desired number of Qualified Health Plan bids to allow active purchaser in all geographic areas</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Increase in regulator and/or Exchange administration and oversight to calculate and validate certified Qualified Health Plan actuarial values and other standards</li> <li>▪ May require a greater degree of communication to consumers to explain plan differences</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ If a large number of options are selected, it is more difficult for consumers to compare plan features</li> <li>▪ Opportunity for health plan issuer to drive risk selection through benefit design</li> <li>▪ Increase in regulator and/or Exchange administration and oversight to calculate and validate certified Qualified Health Plan actuarial values and other standards.</li> </ul>

Table 3: Issue 4 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
<p><b>SUMMARY</b> The Exchange would require a health plan to submit QHP bids for all geographic regions for which it is licensed. Full service area within a region must be offered.</p>	<p><b>SUMMARY</b> The Exchange would allow the health plan to select geographic subset(s) of licensed service area for QHP bid(s) but would require complete service area coverage for any plan licensed in proposed region.</p>	<p><b>SUMMARY</b> Health plans would be required to be licensed to serve minimum defined service area to submit QHP bid.</p>
<p><b>PURPOSE</b> May help to assure QHP bids in all geographic regions of the state</p>	<p><b>PURPOSE</b> This approach is consistent with current market practice for market expansions.</p>	<p><b>PURPOSE</b> A common service area should neutralize pricing factors associated with geographic variation.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ May help to assure QHP bids in all geographic regions of the state</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Attempts to balance opportunity for consumer choice and administrative burden on Exchange and health plans.</li> <li>▪ Less effort for larger and statewide plans to submit QHP bids</li> <li>▪ Most likely to match issuer QHP plans offered outside the Exchange</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Increases competition and access for population in the services area</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Increased effort for larger and statewide plans to submit QHP bids</li> <li>▪ Level of effort may dissuade some desired plans from submitting a bid</li> <li>▪ Service area definitions will differ across health plan issuers</li> <li>▪ Possible "gaming" of service areas if QHP products are developed that require new license</li> <li>▪ May not match issuer QHP products offered outside the Exchange</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ May need to develop QHP solicitation and contract incentives to encourage larger and statewide plans to submit bids to serve broadest licensed service areas.</li> <li>▪ Service area definitions will differ across health plan issuers</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Increased effort for plans with service areas that do not match defined service area</li> <li>▪ Depending on how regions are defined, may exclude smaller plans from participating and may constrain boundaries of larger plans that serve portions of the defined service area</li> <li>▪ Opportunity for health plan issuer to drive risk selection through benefit design and choice of coverage area</li> <li>▪ Unless defined in new legislation, geographic rating regions cannot be enforced in market outside the Exchange</li> </ul>

Table 4: Issue 5 Multi-Year Contracts with Qualified Health Plans	
Option A: The Exchange establishes broad parameters for multi-year contracting	Option B: The Exchange establishes criteria for multi-year contracting and negotiates revisions
<p><b>SUMMARY</b>                      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.</p>	<p><b>SUMMARY</b>                      The Exchange adopts specific multi-year contract criteria with health plans and is open to revisions and negotiation of additional terms and timing</p>
<p><b>PURPOSE</b>                      Allows for multi-year contracting, but provides for broad flexibility in structuring the contracts</p>	<p><b>PURPOSE</b>                      Establishes standards for multi-year contracting, but retains flexibility through negotiation process</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Multiyear contracting provides a level of stability to the Exchange</li> <li>▪ Providing greater flexibility in establishing multi-year arrangements may encourage creative approaches that would not otherwise emerge Encourages health plan participation early in the Exchange's operations</li> <li>▪ Multi-year contracting should increase affordability and limit plan risk</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Multiyear contracting provides a level of stability to the Exchange</li> <li>▪ Establishing standards in advance provides Issuers with a framework for considering a multi-year arrangement and reduces variation in contract terms</li> <li>▪ Encourages health plan participation early in the Exchange's operations</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ May limit the ability of new plans to enter the market</li> <li>▪ Some new options will not be available to Exchange members</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ May limit the ability of new plans to enter the market</li> <li>▪ Some new options will not be available to Exchange members</li> <li>▪ May make Exchange less competitive with outside offerings</li> </ul>

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

### Summary

The California Health Benefit Exchange is considering the options it has related to issues affecting pricing of Individual and Small Group premiums for qualified health plans (QHPs). This “Rating Issues: Family Tiers, Age, Geography, Tobacco, and Wellness” Board Recommendation Brief provides background on the issues and a summary of the options available to the Exchange, and includes final recommendations for the Board's consideration.

Proposed legislation that would require use of fixed geographic rating regions is being considered by the California Legislature. Geographic rating regions set by this legislation would apply market-wide in California for individual and small group markets. 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 within the 3:1 maximum allowable premium variation required by the Affordable Care Act. In addition, pending state legislative proposals would disallow the use of tobacco as a premium rating factor. In light of the impact that proposed state legislation and federal rules would have on the Exchange regarding allowable rating factors, the Exchange should be mindful that some of the recommendations in this Brief may be impacted by state or federal action in the next few months.

The importance of ensuring a level playing field for the health insurance market in California so as to not disadvantage the sale of Qualified Health Plans through the Exchange cannot be overstated. Given the prohibition on medical underwriting beginning in January 1, 2014, the rating factors analyzed in this brief will be critical ones in premium-setting. The Exchange, working closely with California's regulators and legislators, must prioritize the need for the same rating rules to apply to Qualified Health Plans sold through the Exchange and to all other health plans sold outside the Exchange, especially products that are non-qualified health plans. Failure to establish rating rules that apply to all plans both inside and outside of the Exchange leaves the Exchange plans vulnerable to adverse selection. The California legislature is currently developing legislation related to health insurance market rules, and it is expected that decisions will be made by the time the legislature breaks at the end of August 2012.

Allowing plans to set their own age bands (e.g. use ages 30-35 vs. 30-39) would distort premium- setting and confuse consumers. It could allow plans to engage in risk selection practices that could disadvantage Exchange plans. For example, if a plan outside the market was allowed to sell a lower cost plan to persons between ages 30-35 and this type of plan was

not offered through the Exchange, potentially healthier younger age 30-35 members would be pulled away from the Exchange.

If federal rules and state laws do not equalize these rating factors for health insurance market-wide, the Exchange should work closely with state regulators to establish regulations which will accomplish a level playing field in health insurance in California so essential to the success of the Exchange and to broader coverage market wide.

**Background**

The Affordable Care Act implements a number of insurance market reforms that have already gone into effect or are scheduled to go into effect in January 2014. Among these reforms are restrictions on factors that can be used to adjust premium rates offered to individuals and small employers (in California, those with 2 - 50 employees) based on their characteristics, as well as restrictions on how much premiums can vary due to these factors. Specifically, effective January 1, 2014, the allowable rating factors and associated restrictions are shown in Table 5 below:

<b>Table 5: Allowable Rating Factors and Variation</b>	
<b>Allowable Rating Factor</b>	<b>Allowable Variation</b>
Family structure	Family composition
Age	3 to 1 maximum age-based variation for adults
Geographic region	State-defined areas
Tobacco use	1.5 to 1 variation for tobacco users vs. non-users
Wellness programs (SHOP)	Incentives worth up to 30% to 50% of premiums for employees of small employers who meet certain health-related goals

Other rating factors that have traditionally been used in the individual and small employer markets, such as health status and gender, will not be allowed.

The Affordable Care Act expressly requires QHPs to offer rating for a child-only non-catastrophic plan for individuals who have not yet attained age 21 by the beginning of the benefit year. Federal rules have interpreted this requirement to mean that QHPs may satisfy this requirement by offering the same level of coverage on a child-only basis as proposed for other enrollees. The Exchange intends to satisfy this requirement by requiring QHP bidders to submit rating for child-only coverage for each of the same plan designs submitted for all other enrollees in every metal tier for each region the QHP proposes to serve. Coupling this requirement with the requirement that QHP bidders submit bids for every metal tier in



geographic areas proposed to be served will result in a broad range of choice of child-only plans throughout the state.

The following provides some discussion of the issues associated with each of the allowable rating factors.

### **Family Structure**

Under the Affordable Care Act one of the allowable factors on which the premium rate charged by a health insurance issuer for coverage offered in the individual or small group market may vary is "whether such plan or coverage covers an individual or family." In its strictest interpretation, the language appears to limit the premium tier structure to two tiers -- Individual and Family. However, a broader interpretation would allow the premium tier structure to take into account differences in family composition, so as to reflect whether a dependent was a spouse or a child and/or to reflect the number of individuals covered under the family tier. In its proposed rule on the establishment of exchanges and qualified health plans, the U.S. Department of Health and Human Services (HHS) proposed that issuers be allowed to "vary premiums among no more than four different types of family composition that are commonly used among health insurance issuers currently: individual; two adults; adult plus child or children; and a catch-all "family" category for two-adult families with a child or children and other family compositions that do not fit in." Issuers would be allowed to combine categories to result in fewer rate tiers. In the current market, four-tier rate structures such as that proposed by HHS, are among the most common, but other tier structures exist. Some issuers currently adjust the premium for every additional child, essentially producing an unlimited number of tiers. This type of variation is unlikely to continue in 2014.

Under the assumption that HHS adopts a final rule with provisions similar to the proposed rule, the following issues will need to be addressed by the state:

- **Number and composition of premium rate tiers.** The proposed rule suggests four family tiers, but allows issuers to combine tiers. The state will need to determine whether it will allow issuers to combine tiers and if so, whether it will place any restrictions on doing so.
- **Tier ratios.** The ratio of the premiums for each tier to the Single tier premium is the tier ratio. The tier ratio generally reflects the average costs of those covered in each tier, but may vary from those relationships for competitive reasons. The state will need to determine whether it will standardize those ratios or place other restrictions on them.

If allowed, differences between the tier structures and tier ratios used by various issuers can have a significant impact on the relative attractiveness of premium rates offered to certain

population cohorts. Unless restricted, issuers may be able to adjust the tier structure or tier ratios to increase the appeal of its products to certain individuals or groups while decreasing the appeal of others. Ideally issuers will use the same tier structure and tier ratios inside and outside the Exchange, to eliminate this as a mechanism for health plan selection and this may well be set by federal rule in the near future. Though the Exchange may be able to dictate the tier structure and tier ratios for Qualified Health Plans and as a matter of contract for non-QHP products offered by issues in the Exchange, if issuers not participating in the Exchange are allowed to use different tier structures and ratios than issuers in the Exchange, it increases the potential risk of adverse selection against Exchange issuers by allowing an unlevel playing field in the market. To force non-Exchange issuers to use the same tier structure and tier ratios as Qualified Health Plans requires either a law or regulation that establishes that requirement. In the absence of federal rules or state law to fix family tier structures and premium ratios, the Exchange would to approach regulators to discuss how to ensure a level playing field among California health insurers come 2014.

### **Age Bands**

The Affordable Care Act establishes that age-based premiums in the individual and small group markets may not vary more than 3 to 1 for adults. That is, the most expensive premium based on age cannot be more than 3 times the least expensive premium based on age. This is significantly less than the 5 to 1 actuarially based age ratios that exist in the market today. Reducing the ratio introduces a significant reduction in premiums for older participants through premium increases on younger participants. The Exchange has been working with the health plans to analyze the impact of the 3 to 1 maximum age-based rate variation, and it is clear that the immediate implementation of this rating restriction will have a large impact on premiums. Of particular concern is the increase in rates for younger individuals whose participation is critical to the stability of the market.

Age bands, which set a range of ages which are treated the same for premium-setting purposes, are in wide use in today's market, though the age bands used by issuers differ considerably. For example, 5- and 10-year age bands (e.g., ages 31 to 35 or ages 31 to 40, respectively) are relatively common, though other groupings are used, and some use single-year ages for determination of premium rates. The Affordable Care Act requires HHS, in consultation with the National Association of Insurance Commissioners (NAIC), to define the permissible age bands for rating purposes.

While age factors (the relationships between the premiums at each age band) should generally reflect the relative costs between age bands, similar to the family tier structure, they provide a potential mechanism for issuers to attract certain cohorts and discourage others. Age bands

and factors vary widely in the current market, and though variation will be reduced by the 3 to 1 maximum age ratio, the potential remains for variation that may influence plan selection. The Exchange will need to consider whether the age factors and age bands should also be standardized so that all issuers use the same age factors and age bands, and if so, enlist regulators to develop these factors to ensure that non-Exchange issuers do not have an unfair competitive advantage. If non-Exchange issuers are allowed to customize age factors but Exchange issuers must use standardized age factors, Exchange issuers face an increased risk of adverse selection. If the age factors and age bands are to be standardized, it would be appropriate to consider whether they should differ by metal tier and/or benefit plan. Legislative or regulatory action would be needed to establish market-wide age factors.

### **Geographic Rating Regions**

In the current market, geographic region definitions used by issuers for rating vary widely based on licensed service areas, provider contracts, and other strategic considerations. Per the Affordable Care Act, effective January 1, 2014 "Each State shall establish 1 or more rating areas" for health insurance coverage offered in the individual and small group markets, subject to approval by HHS.

Premium rates within an issuer's geographic rating region reflect the average costs within the region, and to the extent that region definitions used by issuers differ, it may create an advantage for one of the issuers. For example, in a scenario where there are two issuers, if issuer A uses a regional definition that combines a low cost area and a high cost area, but issuer B uses a regional definition that splits the low cost and high cost areas, issuer B will have a competitive advantage in the low cost area due solely to differences in the region definitions. In the high cost area, Issuer A will have offered premium rates that reflect an average of low and high cost areas and be financially disadvantaged if they attract a disproportionate share of members from the high cost area. A similar situation can occur when issuers are allowed to serve only a portion of a region. In that instance, if the issuer serving the sub-region is operating in lower cost areas it will have a competitive advantage against an issuer serving the entire region.

The California legislature is pursuing the establishment of standardized geographic rating regions for the individual and small group markets. Even if the state fixes geographic regions market wide for use by all insurers in 2014, the plan which is licensed to serve a sub-region that includes the lower cost areas could put region-wide plans at a competitive disadvantage if the regions are not well structured. The Exchange must plan for submissions by plans serving sub-regions and balance this against the Exchange's obligation under the Affordable Care Act to ensure coverage statewide.

It is generally desirable for issuers to cover entire geographic rating regions to provide adequate choice for consumers and to minimize potential unfair pricing advantages for issuers serving only part of a region. There are a number of reasons it may not be feasible for a health plan to cover an entire region. These include:

- The difficulty of developing provider networks in rural areas, which precludes HMO and other narrow network plans in certain areas due to provider access requirements
- The reliance of some health plans on plan-owned facilities, where it may not be economically feasible to develop new facilities or contract with external providers to satisfy access requirements across the entire region
- The potential participation of local initiative plans, which operate within localized geographies and would not be able to cover an entire region

Recognizing that it may not be feasible for issuers to cover an entire region, it is reasonable to expect that, at a minimum, issuers will cover the full portion of the region for which they are licensed to offer coverage in the Individual and Small Group markets. To a large extent, the issue can be managed through the Exchange's Qualified Health Plan selection process where preference could be given to issuers that cover entire or substantial percentages of a region or that cover specific areas within a region. The Exchange should consult with regulators to determine whether pricing adjustments, within the bounds of the geographic rating region and risk adjustment regulations, may be allowable in a situation where regional coverage differences may create significant unfair advantages for an issuer. The Exchange should consider allowing a plan which serves an entire region to also offer a sub-regional plan which competes with other sub-regional plans. This would allow the Exchange to meet its statutory obligation to ensure statewide coverage while allowing region-wide plans to compete directly with sub-regional plans. This option would need to be considered in the context of the requirement that issuers offer the same plan design at the same price inside and outside of the Exchange.

### **Tobacco Use**

Tobacco use is an established risk factor used by issuers and plan sponsors to evaluate health risk. In the current California Individual market, health plans consider tobacco use when deciding whether to offer coverage and the rate at which it will be offered. The Affordable Care Act permits a maximum 1.5 adjustment for individuals and employees of small groups who use tobacco. States can choose a lower maximum adjustment or choose to eliminate tobacco rating. Currently legislation (SB 961) is under consideration which would prohibit the use of tobacco use as a premium rating factor market wide in California. Absent enactment of this

legislation, the Exchange could require a tobacco use rating factor of any percentage up to 50% for smokers as allowed by the Affordable Care Act.

Arguments supporting the tobacco rating factor include:

- Similar to a tobacco tax, higher premiums for tobacco users provide an additional incentive to stop;
- Tobacco use increases an individual's expected health care costs that are borne by all enrollees;
- In the absence of an adjustment for tobacco use those who don't use tobacco subsidize the higher health care costs of those who do; and
- In the absence of legislation establishing standards or eliminating rating variation, the Exchange would be at risk of adverse selection if plans outside of the Exchange imposed rating factors and the Exchange did not.
- Reduce harm to people caused by tobacco use by helping people stop smoking.

Arguments against a tobacco rating factor include:

- The premium tax credit (available to Individuals with income between 100% and 400% of the Federal Poverty Level who purchase insurance through the Exchange) is calculated based on premiums before any tobacco use adjustments are applied. This means that tobacco users must pay the entire cost of any tobacco use surcharges, regardless of their income. Since premiums are subsidized based on income, low income tobacco users will bear a disproportionate burden of the higher premiums, and depending on the size of the tobacco rating factor premiums could be unaffordable, reducing potential Exchange enrollment.
- In addition to the disproportionately high impact on premium for low income tobacco users, a higher than average percentage of low income individuals use tobacco and would be required to pay the surcharge.
- The maximum 50% surcharge may be more than the increase in expected health care costs associated with tobacco use, and health plans may use the tobacco use rating factor as a proxy for health status rate adjustments.
- Tobacco is addictive, and it is not clear that a premium surcharge would be an effective incentive to stop using tobacco.
- The UCLA Center for Health Policy Research and the UC Berkeley Labor Center modeled the changes in enrollment as a response to changes in premium (price elasticity). Specifically, they estimated that enrollment would decrease 0.08% if premiums increase \$50, enrollment would decrease 0.16% if premiums increase \$100, and enrollment would decrease 0.29% if premiums increase \$200. Based on these elasticity estimates,

the table below provides the estimated decrease in Exchange enrollment based on various tobacco use loads.

Table 6: Estimated Enrollment Impact Due to Various Tobacco Use Loads (Assumed Average Monthly Premium = \$400, Baseline Enrollment = 3,000,000)		
Tobacco Use Load	Increase in Premium	Decrease in Enrollment
10%	\$40	2,400
25%	\$100	4,800
50%	\$200	8,700

In the event there is not a legislative prohibition of a tobacco rate-up factor, the Exchange needs to be concerned that plans or products outside of the Exchange may impose rating factors for smokers that could make the Exchange particularly attractive for smokers.

**Wellness Programs**

The Affordable Care Act increased the incentives that may be offered to employees who join wellness programs and meet health-related targets. While under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), wellness program incentives were limited to 20% of the cost of employee-only coverage, the Affordable Care Act raises that adjustment to 30% in 2014, and it could be increased to 50% if the Secretaries of Health and Human Services, Labor, and the Treasury all approve. Incentives can include premium discounts, waiver of premium surcharges, waivers of cost sharing requirements, or benefits not otherwise covered, such as gym memberships.

An important feature of the Affordable Care Act's wellness incentives provision is that it allows the incentives to be financed through penalties or surcharges on those who do not participate in the wellness program or who do not meet the health-related targets. This potential shift in costs from individuals who participate in wellness programs or are healthier to less healthy individuals who do not participate or are less healthy is an exception to other Affordable Care Act provisions that prevent rating based on health status, and could increase premiums for some individuals. However, the law allows individuals to request a waiver from the wellness program based on a medical condition that makes it unreasonable or inadvisable, which eliminates any premium surcharges or penalties.

The Exchange should consider whether to allow QHPs to use wellness incentives, and if so, the amount of adjustment that should be allowed. The Exchange will also need to work with regulators to ensure that Exchange and non-Exchange issuers are subject to similar rules to minimize adverse selection between the markets. The Exchange would also need to be designated by HHS as one of the national pilot regions in which wellness incentives could be offered for individual plan products.

It should be noted that numerous studies cite the importance of financial incentives in member engagement in wellness programs. However, Exchange staff should closely monitor the use of financial incentives in consideration of potential unintended consequences. Other success factors among wellness programs include<sup>16</sup>:

- Clear approach to a needs assessment and prioritization of key intervention opportunities such as smoking cessation, weight management, promotion of healthy eating and exercise;
- Use of validated health risk assessment and measurement tools;
- Alignment with other community and workplace initiatives. The Exchange should coordinate its efforts with the Let's Get Healthy California Task Force, organized under the auspices of the California Health & Human Services Agency (<http://www.chhs.ca.gov/Pages/HealthCalTaskforce.aspx>);
- Provision of tailored communications and risk reduction strategies that are culturally sensitive and reflect the targeted audiences;
- Support self-care and self-management strategies with a view towards sustained behavior change;
- Address multiple risk factors simultaneously to optimize the impact of the intervention and facilitate a member's engagement through many entry points and adaptable based on their readiness to change;
- Offer a variety of engagement modalities, including but not limited to telephonic, Web-based interactions, social media, and/or smart phone apps, and
- Assure ease of access to programs for everyone

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<sup>16</sup> Adapted from Goetzel RZ and Ozminkowski RJ, "The Health and Cost Benefits of Work Site Health-Promotion Programs," *Annu. Rev. Public Health* 2008. 29:303–23. Accessed at [http://staff.washington.edu/ostergrn/CommuterProfiles/health%20promotion/Health\\_CostBenefits\\_WorksiteHealthPromotions.pdf](http://staff.washington.edu/ostergrn/CommuterProfiles/health%20promotion/Health_CostBenefits_WorksiteHealthPromotions.pdf)



## Stakeholder Perspectives

Stakeholders generally support the notion of standardizing rating characteristics such as the definition of family size and age groupings. There was less consensus on the notion of standardizing rating factors (i.e., the relationship in cost between age bands or family sizes.) Some stakeholders commented that complete standardization would be preferred, while others commented that true variation in health care cost should determine the relative cost factors.

With regard to tobacco rating, some stakeholders commented that use of rate adjustments for tobacco use would discourage enrollment of tobacco users and may not achieve the desired goal of reducing smoking. Other stakeholders commented that incentives should be in place to reduce smoking and that smokers should have a stake in their added cost of health care services. There was strong support for encouraging participation in wellness programs, although some stakeholders commented that requiring active participation in a wellness program to receive lower premium rates would disadvantage some families with complex medical and social situations.

With regard to geographic region offerings, stakeholders want to ensure there is broad coverage available.

## Issues

There are a number of issues associated with the rating factors described in previous sections. Many of these issues may be resolved in whole or in part by federal regulation or are being considered currently by the state legislature, and the options may change once rules are finalized and/or legislative actions are taken. The following issues are presented for consideration:

1. Should the rating factors used by issuers to adjust for differences in Family Structure (number of rate tiers, composition of rate tiers, or tier ratios) be standardized? And if yes, how?
2. Though the Age Bands used by issuers may be standardized by HHS, should the Age Factors used by issuers to adjust rates also be standardized?
3. The state is required to designate the geographic rating regions used by issuers in the Individual and Small Group markets. Should the Exchange require issuers to cover the entire region in order to offer coverage through the Exchange?
4. Should issuers be allowed to apply the full amount of the tobacco use rating factors allowed by the Affordable Care Act, a reduced amount, or not at all?
5. Should wellness program incentives allowed by the Affordable Care Act be permitted in the Exchange?

### Issue 1: Standardization of Family Structure Rating Factors

It is possible that federal rules may standardize both family tiers and tier ratios across the market. If this is the case, the Exchange may not need any options related to this issue. Barring any decision to that effect, the Exchange is considering three options with respect to the rating factors used by issuers to adjust for family structure in developing premium rates. They are (see Table 7 for detail):

- **Option A:** Do not standardize the number of rate tiers, composition of rate tiers, or tier ratios
- **Option B:** Standardize allowable rate tiers and composition to be used by all issuers, but allow issuers to choose tier ratios
- **Option C:** Standardize allowable rate tiers, tier composition, and tier ratios to be used by all issuers

Staff recommends the Exchange standardize the family tiers but not the tier ratios (Option B) for the following reasons:

- It allows the health plans to perform the complicated calculations required to establish and update tier ratios and removes the Exchange from that process
- It reduces variation relative to not standardizing family structure
- It reduces the potential for discriminatory or selective pricing in the Exchange relative to not standardizing family structure

While Option B is preferable in terms of balancing standardization and flexibility while promoting price competition and reducing gaming for consumers inside of the Exchange, it could place Exchange issuers at an unfair disadvantage to issuers operating outside the Exchange if all California issuers are not required to set premiums using the same structure and tier ratios. The Exchange should work with the regulators to determine to what extent standardized tiers should apply to the entire market. If standardized rate tiers cannot be achieved through regulation, the Exchange will actively monitor the impact and may recommend changes in future years.

### Issue 2: Standardization of Age Factors

The Affordable Care Act requires HHS to develop standard age bands to be used by issuers in the Individual and Small Group markets. However, they are not expected to standardize the factors used to determine premiums beyond the Affordable Care Act restriction of a 3 to 1 maximum ratio for adult. The Exchange is considering two options with respect to the rating factors used by issuers to adjust for age in developing premium rates. They are (See Table 8 for detail):

- **Option A:** Do not standardize age factors.
- **Option B:** Standardize age factors to be used by all issuers

Staff recommends the Exchange not standardize the age factors used by Exchange issuers (Option A) for the following reasons:

- It allows the health plans to perform the complicated calculations required to establish and update age factors and removes the Exchange from that process
- Given the 3 to 1 limit on age-based rate variation, potential variation of age factors across issuers is significantly reduced

The Exchange will actively monitor the impact of non-standardized age factors and may recommend changes in future years.

### **Issue 3: Requirement that Issuers Cover Entire Geographic Regions**

The California legislature is pursuing the establishment of standardized geographic rating regions for the Individual and Small Group markets. However, if issuers are allowed to serve only part of a geographic region, it may place issuers serving the entire region at a competitive disadvantage. Though some issuers may not be able to cover an entire region, it is reasonable to expect that issuers will cover the portion of the region for which they are licensed to offer coverage in the Individual and Small Group markets. The Exchange considered three major options with respect to the geographic service areas for issuers in the Exchange. They are (see Table 9 for details):

- **Option A:** Do not require issuers to cover the entire region in order to offer coverage through the Exchange
- **Option B:** Require issuers to cover the entire region in order to offer coverage through the Exchange
- **Option C:** Require issuers to cover the entire region for which they are licensed in order to offer coverage through the Exchange but allow regional or statewide plans to offer sub-regional products.

Staff recommends the Exchange require issuers to cover entire licensed region and allow statewide/region-wide plans to also offer sub-regional plans if they choose (Option C) for the following reasons:

- This approach reduces the potential for unfair pricing advantages by a plan offering coverage through the Exchange only in lower cost areas.

- The approach encourages issuer participation in the Exchange by minimizing issuer provider network development costs associated with offering coverage through the Exchange.
- It also allows local initiatives to offer coverage through the Exchange to the extent contracting with them supports the Exchanges objectives. By allowing plans licensed to serve an entire region to also offer a sub-regional plan, the Exchange achieves its obligation to ensure statewide coverage but also stimulates competition and levels the playing field for statewide/regional plans. However, if a plan is licensed to serve an entire region, it must first offer its QHPs on a region wide basis since the Exchange is obligated to ensure that QHPs are available statewide. This requirement will ensure that the Exchange meets its statutory obligation to provide statewide coverage.

#### **Issue 4: Allowable Rate Adjustment for Tobacco Use**

Tobacco use can dramatically increase health care costs, and requiring tobacco users to be responsible for some of these increased costs as an incentive to stop using tobacco and to reduce the costs passed on to non-users makes sense from a policy perspective. It is also consistent with efforts to encourage reduced tobacco use. However, a tobacco use rating adjustment, which is allowed under the Affordable Care Act may raise premiums to an unaffordable level for some participants and jeopardize the primary goal of increasing coverage. Further, since premium tax credits are calculated before tobacco rating factors are applied, the full cost of the tobacco use surcharge is passed on to the individual, resulting in a disproportionate premium increase for individuals receiving premium subsidies.

The Exchange is considering three major options with respect to the tobacco use rating factors. They are (see Table 10 for detail):

- **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 allowed by the Affordable Care Act
- **Option C:** 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.

Staff recommends that the Exchange prohibit the application of a tobacco use rate up (Option A) for the following reasons:

- It eliminates the impact on affordability for tobacco users
- It avoids a penalty with unproven effectiveness in changing behavior
- It maximizes potential enrollment in the Exchange

Staff recognizes that any allowable tobacco rating should be applied marketwide and not solely within the Exchange which would cause adverse selection in the Exchange. At this point in time, market-wide rules regarding tobacco rating are not in place. Given the uncertainty of the extent to which smoking would be decreased and the risks of reducing enrollment, staff recommend prohibiting the application of tobacco rating to promote smoking cessation (Option A). Staff is concerned that permitting tobacco rating at this time, could have the effect of reducing enrollment of some individuals who can benefit most from the coverage of smoking cessation benefits in the Exchange maximizing enrollment. The Exchange should regularly reassess the best ways to promote smoking cessation.

### **Issue 5: Wellness Program Incentives**

The research supporting the efficacy of wellness program incentives in improving patient compliance with treatment regimens and improving other healthy behaviors is somewhat limited but generally convincing, though the evidence that these programs produce a positive return on investment is less robust. The promotion of improved health as well as personal responsibility support the goals of the Exchange, and these concepts are at the core of wellness programs. However, wellness programs also have the potential to negatively impact vulnerable populations or facilitate discrimination based on health status, and these programs should be monitored to assess their impact on health status improvement and affordability. The Affordable Care Act expressly allows wellness programs in the small group market. It calls for a 10 state demonstration project for wellness programs in the individual market.

With respect to wellness programs in the small group market, the following options are presented for consideration (see Table 11 for detail):

- **Option A:** Prohibit wellness program incentives
- **Option B:** Allow wellness program incentives

Staff recommends the Exchange allow wellness program incentives (Option B) for the following reasons:

- It increases incentives related to personal responsibility for healthy living and health improvements
- It provides new opportunities to employees and employers for improved health outcomes.

The types of wellness programs recommended by the Exchange are outlined in the Promoting Wellness and Prevention brief. The Exchange should also ensure that wellness program incentives allowable in the Exchange are consistent with those allowed by the rules governing the rest of the market, or in the absence of such rules, we recommend that allowable wellness program incentives be relatively modest. The Exchange recommends the use of wellness incentives in the SHOP initially as expressly permitted by the Affordable Care Act.

Table 7. Issue 1: Standardization of Family Structure Rating Factors		
Option A: Allow issuers to determine family tier structure and tier ratios	Option B: Standardize family tier structure, but allow issuers to determine tier ratios	Option C: Standardize family tier structure and tier ratios
<p><b>SUMMARY</b>                      This option allows issuers to use any family tier structure allowed by the regulations and to determine the premium relationships between the tiers (tier ratios).</p>	<p><b>SUMMARY</b>                      This option standardizes the family tier structures used by all issuers participating in the Exchange, but allows issuers to determine the premium relationships between the tiers (tier ratios).</p>	<p><b>SUMMARY</b>                      This option standardizes the family tier structures used by all issuers participating in the Exchange and standardizes the premium relationships between the tiers (tier ratios).</p>
<p><b>PURPOSE</b>                      This option permits issuers to use the family tier structure and tier ratios they believe position them to most favorably compete for certain populations so long as they comply with regulations.</p>	<p><b>PURPOSE</b>                      This option reduces variation by requiring all issuers to use the same family tier structure, but provides an opportunity for issuers to apply tier ratios they believe position them to most favorably compete for certain populations.</p>	<p><b>PURPOSE</b>                      This option minimizes variation and maximizes price competition by requiring all issuers to use the same family tier structure and tier ratios.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Reduces issuer administrative burden if they can retain existing family tier structure and tier ratios</li> <li>▪ May increase health plan participation in the Exchange</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Reduces variation relative to Option A</li> <li>▪ Reduces potential for discriminatory or selective pricing in the Exchange relative to Option A</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Maximizes premium comparability for consumers relative to Options A &amp; B</li> <li>▪ Minimizes potential for discriminatory or selective pricing in the Exchange</li> <li>▪ Minimizes variation relative to Options A &amp; B</li> <li>▪ Maximizes price competition relative to Options A &amp; B</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Maximizes potential for consumer confusion relative to Options B &amp; C</li> <li>▪ Maximizes potential for discriminatory or selective pricing relative to Options B &amp; C</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Increases potential for discriminatory or selective pricing relative to Option C</li> <li>▪ Increases variation relative to Option C</li> <li>▪ Standardized tiers may be difficult for some health plans to administer</li> <li>▪ May increase issuer administrative burden if new tier ratios need to be developed to fit standardized family tier structure</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ May reduce health plan participation in the Exchange</li> <li>▪ Standardized tiers may be difficult for some health plans to administer</li> <li>▪ May put Exchange issuers at an unfair disadvantage to issuers operating outside the Exchange</li> </ul>

Table 8. Issue 2: Standardization of Age Factors	
Option A: Allow issuers to use any age factors (subject to ACA limits)	Option B: Standardize age factors
<p><b>SUMMARY</b>                      This option allows issuers to use any age factors for premium rate development, subject to the 3 to 1 maximum age-based premium variation for adults.</p>	<p><b>SUMMARY</b>                      This option standardizes the age factors for premium rate development by all issuers participating in the Exchange.</p>
<p><b>PURPOSE</b>                      Standard age bands are to be developed by HHS and the NAIC for use by all issuers in the Individual and Small Group markets. This option permits issuers to use the age factors for the standardized age bands that they believe position them to most favorably compete for certain populations.</p>	<p><b>PURPOSE</b>                      Standard age bands are to be developed by HHS and the NAIC for use by all issuers in the Individual and Small Group markets. This option minimizes variation and maximizes price competition by requiring all issuers to use the same age factors and age bands.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ May increase health plan participation in the Exchange</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Maximizes price competition</li> <li>▪ Reduces potential for discriminatory or selective pricing</li> <li>▪ Reduces variation and potential for consumer confusion</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Increases potential for discriminatory or selective pricing</li> <li>▪ Increases potential for consumer confusion</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ May reduce health plan participation in the Exchange</li> <li>▪ May put Exchange issuers at an unfair disadvantage to issuers operating outside the Exchange</li> </ul>

Table 9: 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 but allow them to offer sub-regional products
<p><b>SUMMARY</b>                      This option allows issuers to select which portions of a region it will offer for coverage through the Exchange.</p>	<p><b>SUMMARY</b>                      This option requires issuers to cover an entire region in order to offer coverage through the Exchange.</p>	<p><b>SUMMARY</b>                      This option requires issuers to offer coverage through the Exchange for the entire region in which they are licensed to offer coverage in the Individual and Small Group markets but permits them to offer a sub-regional product.</p>
<p><b>PURPOSE</b>                      Premium rates must be the same across a region, and therefore reflect the average costs across the region. This option allows issuers to select which parts of a region it will offer for coverage, which may create unfair advantages to plans serving lower cost areas relative to plans covering an entire region.</p>	<p><b>PURPOSE</b>                      Premium rates must be the same across a region, and therefore reflect the average costs across the region. This option requires issuers to cover the entire region in order to offer coverage within the region. This may create barriers to entry for some issuers, and may bar certain types of network plans (for example, some HMO or narrow network plans).</p>	<p><b>PURPOSE</b>                      Premium rates must be the same across a region, and therefore reflect the average costs across the region. This option requires issuers to cover the entire region for which they are licensed to offer coverage in the Individual and Small Group markets.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ May increase health plan participation in the Exchange for certain plans</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Reduces potential for anti-competitive pricing due to selective coverage areas</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Reduces potential for anti-competitive pricing due to selective coverage areas, with respect to coverage offered through the Exchange</li> <li>▪ Minimizes issuer network development costs associated with offering coverage through the Exchange</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Increases potential for anti-competitive pricing due to selective coverage areas</li> <li>▪ Increases potential that certain areas will have insufficient selection of health plans</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Likely to decrease health plan participation in the Exchange</li> <li>▪ May preclude certain network plan types from being offered through the Exchange</li> <li>▪ May be economically unfeasible for some health plans</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Certain areas may be faced with inadequate choice of health plans</li> </ul>



Table 10. Issue 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: Reduce the magnitude of allowable tobacco use rating factors to a value below that permitted by the ACA
<p><b>SUMMARY</b>                      This option prohibits issuers from applying tobacco use rating factors to determine premiums.</p>	<p><b>SUMMARY</b>                      This option allows issuers to apply the full tobacco use rating adjustment to determine premiums, up to the 1.5 factor allowed under the Affordable Care Act.</p>	<p><b>SUMMARY</b>                      This option allows issuers to apply tobacco use rating factors to determine premiums, but reduces the maximum adjustment to an amount below the allowed adjustment of 1.5.</p>
<p><b>PURPOSE</b>                      Premium rates cannot be adjusted based on tobacco use. This option spreads the increased health care cost associated with tobacco users across the entire population, raising premiums for non-users.</p>	<p><b>PURPOSE</b>                      Premium rates can be adjusted based on tobacco use. This option charges the increased health care cost associated with tobacco users across to tobacco users up to the amount allowed by the ACA.</p>	<p><b>PURPOSE</b>                      Premium rates can be adjusted based on tobacco use. This option charges increased health care cost associated with tobacco users across to tobacco users, but at an amount below that allowed by the ACA.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Eliminates a premium adjustment that could make premiums unaffordable, reducing adverse selection risk</li> <li>▪ Removes a barrier to enrollment for tobacco users</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ May create an incentive to stop using tobacco</li> <li>▪ Can pass some costs of lifestyle choice to individuals</li> <li>▪ Reduces the amount that non-users have to subsidize tobacco users</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Reduces the impact on affordability for tobacco users</li> <li>▪ Maintains an incentive to stop using tobacco</li> <li>▪ Can pass some costs of lifestyle choice to individuals</li> <li>▪ If applied after premium subsidies, it eliminates the disproportionate impact on individuals receiving premium subsidies</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Eliminates the tobacco use factor as an incentive to stop using tobacco</li> <li>▪ Spreads increased health care costs associated with tobacco users across the entire population, raising premiums for non-users</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Likely to make premiums unaffordable, particularly for those in the lower income brackets, increasing adverse selection risk</li> <li>▪ The full 1.5 rating adjustment may overstate the additional health care costs associated with tobacco use</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ May still result in unaffordable premiums, particularly for those in the lower income brackets</li> <li>▪ Increases health care costs associated with tobacco users that are passed on to non-users, raising their premiums</li> </ul>

Table 11. Issue 5: Wellness Program Incentives	
Option A: Prohibit wellness program incentives	Option B: Allow wellness program incentives
<p><b>SUMMARY</b>                      This option prohibits QHPs from implementing wellness program incentives.</p>	<p><b>SUMMARY</b>                      This option allows QHPs to implement wellness program incentives.</p>
<p><b>PURPOSE</b>                      Under the Affordable Care Act, plans are allowed to implement wellness incentive programs to encourage participation and achievement of health-related targets. However, it also increases the potential for discrimination or premium variations based on health status. This option eliminates that risk.</p>	<p><b>PURPOSE</b>                      Under the Affordable Care Act, plans are allowed to implement wellness incentive programs to encourage participation and achievement of health-related targets. This option permits the operation of these incentive programs.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ The potential for discrimination or premium variations based on health status would be eliminated</li> <li>▪ Removes affordability barriers if wellness program incentives are financed through surcharges to non-participants or those who don't meet health targets</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Increases incentives related to personal responsibility for healthy living and health improvements</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Reduces incentives related to personal responsibility for healthy living and health improvements</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Increases potential for discrimination or premium variations based on health status</li> <li>▪ Increases affordability barriers if wellness program incentives are financed through surcharges to non-participants or those who don't meet health targets</li> </ul>

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## Plan Design Standardization

### Summary

The California Health Benefit Exchange is considering the options related to the degree to which the benefits offered in Qualified Health Plans are standardized versus allowing some variation among plans or products. This “Plan Design Standardization” Board Recommendation Brief provides background on the issues and a summary of the options available to the Exchange, and includes preliminary recommendations for the Board's consideration.

### Background

Effective 2014, under the Affordable Care Act, all health benefit plans offered, including those offered through the Exchange 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. The Affordable Care Act removed the ability of health plans to risk select through medical underwriting, pre-existing condition exclusions, or health-related premium adjustments. However, there remains the concern that through strategic plan design a plan can attract its preferred customers and deter less desirable, more risky ones. While the risk assessment and risk adjustment process will lessen the impact of these practices, there is still a concern that plans may seek to "cherry pick" through their benefit design. Standardization can limit the ability of health plans to structure benefit plan designs to drive certain populations into or away from their plans. Standardization can also reduce consumer confusion and frustration, but it does so at the expense of limiting consumer choice. If the Exchange decides to standardize cost-sharing features of its offerings, close attention must be given to market preferences so that adjustments can be made quickly because there will be variation outside of the Exchange that will require the Exchange to respond accordingly.

The following sections provide additional information related to the standardization of plan designs.

### **Essential Health Benefits Define What's Covered in 2014 Plans Market-wide**

Effective January 1, 2014, all health plans offered in the individual and small group markets, both inside and outside of the Exchange, must provide coverage of the following ten Essential Health Benefit categories:

- d. Ambulatory patient services,
- e. Emergency services,

- f. Hospitalization,
- g. Maternity and newborn care,
- h. Mental health and substance use disorder services, including behavioral health treatment,
- i. Prescription drugs,
- j. Rehabilitative and habilitative services and devices,
- k. Laboratory services,
- l. Preventive and wellness services and chronic disease management, and
- m. Pediatric services, including oral and vision care

While in many states the decisions pertaining to the Essential Health Benefits requirement, which are market-wide and not Exchange-specific, are being made by regulation, in California there is bill pending which is expected to more finely define the Essential Health Benefits. Therefore, this brief does not address issues relating to the Essential Health Benefits.

The Legislature is expected to leave decisions regarding the enrollee’s share of cost in health plans in 2014 to the Exchange (for Exchange plans) or the market (for out-of-Exchange plans). (Note: all plans offered through the Exchange must also be offered outside of the Exchange at the same price and on the same terms.)

**"Metal Tiers" Determine OVERALL Share of Costs between Plan and Enrollee**

Under the Affordable Care Act, benefit plans offered inside and outside the Exchange by all plans must fall into one of the metal tiers defined as follows in Table 12:

Metal Tier	Actuarial Value
Platinum	90%
Gold	80%
Silver	70%
Bronze	60%
Catastrophic <sup>17</sup>	100% in-network coverage after deductible is met. Deductible and maximum out-of-pocket expenses equal to out-of-pocket limit for HSA-qualified high deductible health plan. Deductible waived for at least 3 primary care visits.

Actuarial value is defined as the *overall average* percentage of Essential Health Benefit costs covered by the plan, though the actual percentage of costs covered by the plan for each individual in any given year will vary based on the individual’s actual utilization of health care

<sup>17</sup> The Affordable Care Act restricts catastrophic plans to the individual market, and they can be offered only to those under age 30 or exempt from the coverage mandate due to lack of affordable coverage or a hardship exemption. The Affordable Care Act does not restrict who may sell "catastrophic" coverage, however the California Affordable Care Act only allows catastrophic coverage to be sold only by carriers who participate in the Exchange.

services, whether the provider is out-of-network, negotiated provider fees, and other reasons. HHS released a proposal under which it will develop a calculation model to calculate actuarial values on a consistent basis. States may develop their own actuarial value models, but they must be approved by HHS<sup>18</sup>. The HHS proposal includes an allowable *de minimis* variation for the actuarial value of a benefit plan under which the plan is considered to satisfy a particular metal tier if its actuarial value is within +/-2% of the tier's specified actuarial value.

**Benefit Plan Design Parameters**

A range of benefit design cost-sharing parameters are used by health plans to define the coverage and payment obligations of each benefit plan offered to consumers. Table 13 describes the most common.

Table 13: Common Benefit Design Parameters			
Parameter		Definition	Example
Cost-sharing	Deductibles	The amount of expenses that must be paid out of pocket before the plan will pay any expenses. Calendar year or benefit year accumulation period.	Insured pays \$1000 annual deductible before plan pays anything
	Copays	The fee to be paid by the insured each time a medical service is accessed.	Insured pays \$30 copay per primary care office visit
	Coinsurance	The percentage share of expenses between the plan and the insured, typically applied after a deductible is met.	Insured pays 30% of cost after deductible is met
	Out-of-Pocket Maximums	The maximum total amount an insured can be required to pay toward the cost of covered health care expenses during the calendar or benefit year. Typically excludes balance billing payments for out-of-network services and payments for non-covered services.	Maximum out-of-pocket expenses of \$6,000 includes deductibles, copays, and coinsurance
Benefit Limits/ Exclusions	Service/Benefit Limits	Limits, in the form of dollar, visit, day or other units of service, which when reached, benefit coverage ends.	Coverage limited to 50 physical therapy visits per year
	Benefit Exclusions	Services that are specifically excluded from coverage. The Essential Health Benefits will determine the minimum set of services that must be covered.	Chiropractic services are not covered

<sup>18</sup> The Exchange is unaware of any interest in California to develop its own actuarial value calculator and believes that California will rely on the consistency offered by the HHS calculator.

Table 13: Common Benefit Design Parameters		
Parameter	Definition	Example
<b>Drug Formularies</b>	A list of prescription drugs covered or preferred by a particular benefit plan. Insureds generally pay lower amounts for drugs that are on formulary, and may vary amounts by drug "tier", which defines the insured's share of costs. For drugs that are not on formulary, insureds must pay a larger share of the drug cost, sometimes the full cost. Formularies vary between carriers and sometimes benefit plans, differing in the numbers of drugs and the specific drugs that are covered.	Insured pays:  \$30 copay for Preferred (formulary) Brand drug,  \$50 copay for non-Preferred (non-formulary) Brand drug
<b>Tiered/Narrow Networks and Out-of-Network Benefits</b>	Some products stratify health care providers into tiered or narrow networks based on cost of care, quality of care, and other measures. Patient cost-sharing in these products is determined by the benefit plan provisions and the network tier to which the provider performing services belongs. Depending on plan design, services performed by out-of-network providers may subject the patient to significant balanced billing liabilities (the difference between the provider's charges and the health plan's maximum allowable charges) and may not be covered by the plan at all.	Insured pays:  \$500 deductible plus 20% coinsurance for services at In-Network providers  \$1000 deductible plus 40% coinsurance (plus balance billing) for services at non-Network providers

**Cost-Sharing**

Annual deductibles, copayments, coinsurance, and out-of-pocket expense limits are the most typical mechanisms used to define the individual's share of the costs for covered services. In general, as the first three of these mechanisms increase in value, premiums go down; however, premiums decrease as out-of-pocket expense limits increase. Under the Affordable Care Act, all preventive services are exempt from cost sharing. In some benefit plans, annual deductibles are waived for certain services (such as, the first three or four office visits or for generic drugs), which may make higher deductible plans more palatable for consumers, albeit for a tradeoff of somewhat higher premiums.

Effective January 2014, the Affordable Care Act caps out-of-pocket maximums at the out-of-pocket limits for health plans with qualified Health Savings Accounts and limits Small Group deductibles at \$2,000 per Individual (\$4,000 Family). Lifetime and annual dollar limits have long been applied to benefit plans as a mechanism for limiting health plan exposure to high cost cases. However, the Affordable Care Act eliminated lifetime benefit limits in all health benefit plans for policies issued or renewed on or after September 23, 2010, restricted annual dollar limits beginning September 23, 2010, and eliminates annual dollar limits completely by January 1, 2014.

### ***Limits and Exclusions***

Specific coverage exclusions, pre-authorization requirements, and other coverage provisions used to reduce inappropriate care are generally still permitted by the Affordable Care Act (subject to coverage under the Essential Health Benefit benchmark plan). Service limits, such as visit or day limits, are still allowed under the Affordable Care Act, but the Essential Health Benefit legislation will define which services can have limits and what those limits can be. It is always permissible for an issuer to provide greater coverage for any given service should they choose to do so.

### ***Drug Formularies***

Drug formularies (lists of approved or preferred medications) are another benefit design component that may significantly impact an individual's cost share as well as premium costs. Formularies are often not as transparent to consumers as the more typical cost-sharing components, and often a health plan's coverage of specific medications must be researched by the consumer. Drug formularies and tiered prescription drug benefits provide other mechanisms for health plans to manage utilization and cost of services. These benefit components are determined by each health plan based on analyses of drug costs, safety, and efficacy in conjunction with discounts and rebates negotiated with manufacturers and prescription benefit managers (PBMs). In general, the more restrictive or limited a formulary is, the lower the premium will be. However, cost sharing works in conjunction with formulary design and manufacturer and PBM discounts and rebates to determine the ultimate impact on premiums.

### ***Value-Based Benefit Design***

Health services research provides support for the use of financial incentives to influence healthy behaviors. Further, it is known that health care costs, including costs related to benefit plan cost sharing provisions, impact the utilization of services and compliance with treatment and drug regimens. "Value-based benefit design" is a concept adopted by many large employers and public purchasers that primarily uses financial incentives (such as reduced cost sharing) to encourage enrollees to use high value services, adopt healthy lifestyles, and use high performance providers. By providing appropriate incentives, value-based benefit designs can increase the likelihood that patients will comply with treatment plans and engage in healthy behaviors that will ultimately result in lower health care costs. These programs can be designed to target specific individuals (such as individuals with a specific diagnosis or users of a specific drug) or to provide incentives more broadly.

### ***Tiered/Narrow Networks and Out-of-Network Benefits***

Table 14 provides a summary of common provider network strategies used by health plans in the current market:



Table 14: Common Provider Network Strategies

Typical Plan Type	Description
<b>HMO/EPO Plans</b>	Limit coverage of health care services exclusively to those provided by contracted or "network" providers, except in emergencies
<b>PPO/POS Plans</b>	Provide reduced cost-sharing as well as protection from "balance billing" when services are provided by in-network providers who agree to the health plan's fee schedule as payment in full
<b>Narrow Network Plans</b>	A small or select set of providers within a larger network of providers. Patients are only allowed to see providers within the narrow network.
<b>Tiered Network Plans</b>	Providers are assigned to "tiers" based on measures of cost, efficiency, and other factors. Cost-based incentives are used to steer patients to providers in the preferred tiers.

With respect to the potential plan offerings through the Exchange, all Qualified Health Plan products will be required to satisfy minimum provider access standards regardless of the provider network strategy used. For example, there has been increased interest in narrow network plans as a means of reducing premiums, and narrow network offerings will need to demonstrate minimum access before they will be certified for sale through the Exchange.

Benefit plans are typically designed around the cost sharing for in-network services, which is also how consumers shop for plans. In general, it is presumed that provider networks meet industry standard access requirements, and therefore, in-network benefits provide the basis for comparisons between benefit plans. Though HHS has not released its final rules, it is expected that the calculations to determine a plan's actuarial value will be limited to in-network benefits. Out-of-network benefits (or benefits for providers under non-preferred tiers in tiered network plans) only come into play if access to network providers is inadequate or specific providers are desired. If a provider network provides sufficient choice, non-network providers will be infrequently used largely due to the higher cost sharing and potential for balance billing. The Exchange has proposed using the FAIR Health database to determine appropriate reimbursement amounts for out-of-network services. FAIR Health is a national, independent not-for-profit corporation that provides a transparent source for current healthcare charge information which many plans currently use. This database establishes a common fee for each type of service, and is designed to establish a benchmark for out-of-network costs. The information on the amount payable for out-of-network benefits would be made available to the Exchange member through their health plan, thereby providing the member the opportunity to discuss the costs with their provider and make an informed decision regarding the choice of obtaining care outside of the network.

The Affordable Care Act requires that health plans cover emergency services without regard to network participation. That is, the member cannot be charged higher cost sharing amounts. While the Affordable Care Act does not prohibit balance billing when emergency services are obtained out-of-network, California state law bars balance billing for emergency services. The Affordable Care Act does set standards to ensure adequate payment to providers reducing potential balance bill amounts. Specifically, the health plan must pay emergency services providers the maximum of 1) the amount the health plan pays to in-network providers, 2) the amount the health plan would pay using the same methods it uses to pay other out-of-network providers, and 3) the amount Medicare would pay.

**Standardization of Benefit Plans**

There are a number of arguments for and against standardizing components of benefit plans offered through the Exchange. Table 15 that follows lists some examples:

Table 15: Advantages and Disadvantages of Benefit Standardization	
Standardization of Benefit Plans	
<b>Advantages</b>	<ul style="list-style-type: none"> <li>✓ Simplifies comparison of competing offerings by consumers</li> <li>✓ Simplifies calculation and validation of benefit plan actuarial values</li> <li>✓ Reduces opportunities for risk selection by health plans through plan design</li> <li>✓ Promotes competition among health plans based on price, quality and customer service</li> </ul>
<b>Disadvantages</b>	<ul style="list-style-type: none"> <li>✓ Reduces the options available to consumers</li> <li>✓ Standardized plans may not meet the needs of every consumer</li> <li>✓ May stifle innovation if standardization is overly restrictive</li> <li>✓ Standard plans will need to be regularly updated to reflect consumer preferences, market changes, and healthcare inflation</li> </ul>

Through the standardization of benefit plans offered by the Exchange (that is, specifying the cost sharing and some other attributes of the benefit plan) the task of comparing plans becomes much simpler and the likelihood increases that consumers will choose a plan that meet their needs. Similarly, since the actuarial value of benefit plans will need to be certified<sup>19</sup>, standardized plan designs reduce the number of plans that need to be analyzed, streamlining administrative processes for regulators and the Exchange.

In today's market, health plans often use strategic plan design to attract or deter consumers with certain healthcare needs. This method of risk selection, while still permissible under the

<sup>19</sup> The Exchange is recommending that the regulators certify actuarial value since this is a market-wide regulatory requirement and not an Exchange-specific function. See Regulator Partner QHP Certification Criteria brief.

Affordable Care Act, is contrary to the objectives of health reform whereby health plans are expected to compete on price, quality, and service rather than risk avoidance. Standardization of benefit plans limits the ability of health plans to manipulate risk selection through plan design. To the extent that standardized plan designs are offered through the Exchange, all health plans offering coverage through the Exchange will be required to offer all standardized plans. Moreover, issuers who are not selling through the Exchange will also be required to offer at least one standardized plan outside of the Exchange.

The Essential Health Benefits and metal tier actuarial value requirements standardize benefits by ensuring all benefit plans provide the same broad coverage of services and grouping of plans into relatively narrowly defined benefit value ranges. However, there are nearly infinite combinations of deductibles, coinsurance, and out-of-pocket expense limits that can be selected to produce a given actuarial value, and the proposed +/-2% *de minimis* allowable variation permits even more plan variations to satisfy the actuarial value requirements of a given metal tier. Thus, while consumers have increased ability to understand plan designs, the Affordable Care Act permits wide variation in cost-sharing features of benefit plans offered through exchanges.

Studies have shown that when people are faced with too many choices, it increases the likelihood that they will make poor decisions. For example, in a recent study of Medicare Part D, the majority of participants did not purchase the most cost effective prescription drug plans, often buying plans that provided less coverage at a higher total cost than more appropriate plans for their circumstances. Similarly, in the Medicare Advantage (MA) program, CMS recently stated that “the large number of MA plan options that have been offered in many areas has made it difficult and confusing for beneficiaries to distinguish between these plans and to choose the best option to meet their needs.”

However, standardization of plan designs must be done carefully. Otherwise the Exchange may end up with product offerings that do not match well with consumer preferences. Standard plan designs will need to be updated regularly to reflect changes in the market, consumer preferences, and changes in healthcare costs. Additionally, if requirements are too restrictive, standardization could stifle the innovation in plan design and service delivery that lead to improvements in value. For example, if value-based benefit design (under which incentives such as reduced or waived cost sharing for use of high value services or high performing providers) is considered desirable innovation, the standardized benefit designs and related rules will need to be structured in a way that permits the health plans to make such modifications to the plan design.

Given the pros and cons of standardized plans, staff is recommending that the Board permit every QHP issuer to offer one non-standard benefit plan design (at each metal level) for each geographic rating region in which it is selected to offer a QHP. The Exchange will be on guard for non-standard plans that attempt to use plan design as a surrogate for risk selection and will

not permit such designs. However, to encourage even more innovation in plan design that the Exchange encourages in conjunction with standardization of major cost-sharing provisions, staff believes it is wise to permit QHPs to have full rein to innovate by permitting one non-standard benefit plan design per issuer per region where that issuer is also offering a QHP.

### Stakeholder Perspectives

Stakeholder comments indicate there is broad support for some standardization of benefit plan offerings to enable consumers to make informed choices. However, stakeholders appear more concerned about offering too many choices consumers and the resulting confusion and frustration. Standardizing plans would reduce the number of benefit options in the Exchange and facilitate more direct and meaningful plan comparisons based on price and quality, which should empower consumers to make appropriate coverage decisions. However, plan choices available to consumers will also depend on the number of unique health plans and products offered through the Exchange, which is a topic addressed in a separate Board Recommendation Brief.

Stakeholders broadly commented that access to prescription drugs is covered under current Department of Managed Health Care regulations, which require that medically necessary drugs be available, and that requiring multiple drugs within each drug class would increase costs.

Stakeholders expressed concern that too much standardization of out-of-network benefits would have the unintended consequence of discouraging providers from contracting with health plans, and that any action with regard to out-of-network benefits should be approached with caution, but agreed that consumers should have access to information on their costs of obtaining services out of network.

There was strong support among stakeholders for encouraging innovation and value-based benefit designs.

### Issues and Recommendations

There are a number of issues associated with benefit plan standardization described in previous sections. The following issues are presented for consideration:

1. Should the cost-sharing provisions in benefit plans offered by Exchange issuers be standardized?
2. Should the benefit exclusions and limitations in benefit plans offered by Exchange issuers be standardized?
3. Should drug formularies and/or drug tiers in benefit plans offered by Exchange issuers be standardized?
4. Should value-based benefit design be allowed in benefit plans offered by Exchange issuers be standardized?

5. Should out-of-network benefits in benefit plans offered by Exchange issuers, if applicable, be standardized?

The California Affordable Care Act requires issuers who sell outside the Exchange to offer at least one standardized Exchange plan if the Board elects to standardize Exchange benefit plans. The sum total of the following set of recommendations to standardize various parts of Exchange benefit plans results in fully standardized Exchange benefit plans which will trigger this legal requirement for issuers outside the Exchange.

### **Issue 1: Standardization of Cost Sharing Provisions**

The cost sharing components, such as annual deductibles, copayments, coinsurance, and out-of-pocket cost limits are expected to serve as the predominant determinants of actuarial value, which is the measure that will be used to categorize benefit plans to be offered to consumers. These components, along with premiums, allow consumers to compare how much various benefit plans will cost them under expected and adverse health event scenarios.

The Exchange is considering three options with respect to the cost sharing provisions used in benefit plans offered through the Exchange. They are (see Table 16 for detail):

- **Option A.** No standardization: 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.
- **Option B.** Standardize major cost-sharing components of benefit plans and allow limited customization: Issuers would be required to offer standardized major cost-sharing components, such as deductibles, co-pays, coinsurance, and out-of-pocket limits. Value-based insurance design features and other innovations, such as varied provider networks as well as limited variation of ancillary benefits would be allowed subject to approval by the Exchange. In addition, issuers would be allowed to propose non-standardized designs.
- **Option C.** Strict standardization of all possible cost-sharing components of benefit plans: Standardizes all possible cost-sharing components. Value-based insurance design features or other changes to benefits would not be allowed.

Staff recommends the Exchange standardize the major cost-sharing components while allowing limited customization (Option B) for the following reasons:

- By recommending standardization, California consumers will benefit by having the ability to compare product choices on price for issuers not in the Exchange because the California Affordable Care Act requires issuers outside the Exchange to offer at least one of the Exchange's standardized benefit plans to purchasers outside the Exchange.

- Standardization simplifies comparison and promotes competition among health plans based on price, quality and customer service. Further, it reduces opportunities for risk selection through plan design.
- Though standardization of the cost sharing components reduces the options available to consumers, cost sharing is not an area of particular innovation. Standardized cost sharing values will need to be regularly updated to reflect consumer preferences, market changes, and healthcare inflation. The reason some flexibility is recommended is that it can be difficult to define some services or provider types specifically enough to ensure health plans will administer them in a uniform manner. Further, they may have information technology limitations or organizational aspects that make uniformity difficult to achieve in the early stages of implementation. Therefore, some limited flexibility should be allowed.
- Since covered services will be virtually identical from plan to plan due to the Essential Health Benefit requirements, consumers will be keenly interested in better understanding what their share of cost will be in addition to their premium when choosing a plan. When the most important cost sharing components, such as deductibles and copays, are standardized, the potential for consumer confusion is significantly reduced. This should dramatically increase the opportunity for consumers to select a plan that best meets their individual needs.

High level illustrative plan designs for consideration as standardized benefit plans to be offered through by Exchange issuers are presented in the Plan Design Standardization Appendix A for the Board's consideration and public comment. These proposed cost-sharing designs may be modified and/or others added following further discussions with stakeholders and during the solicitation process. Further, these recommendations are based on actuarial modeling performed by PricewaterhouseCoopers using their internal pricing tool. The HHS actuarial model, which has yet to be released, will ultimately be used to determine the actuarial values of plan designs, which may lead to further modifications.

## **Issue 2: Standardization of Benefit Exclusions and Limits**

Due to the Essential Health Benefit requirements, much of the possible variation in covered services from plan to plan has been removed. Similarly, service limits, such as visit or day limits, which are allowed under the Affordable Care Act, are expected to be largely standardized by the legislature in California. However, it is unclear how precisely issuers must match the coverage and limits defined by the benchmark plan, and to what extent substitutions or additions may be permissible.

The Exchange is considering three options with respect to benefit exclusions and limits used in benefit plans offered through the Exchange. They are (see Table 17 for detail):

- **Option A:** No standardization of benefit limits and exclusions in benefit plans offered in the Exchange

*Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers*

- **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.

Staff recommends the Exchange standardizes major benefit limits and exclusions and allow limited customization (Option B) for the following reasons:

- Covered services will be virtually identical from plan to plan due to the Essential Health Benefit requirements.
- Standardization reduces opportunities for risk selection through plan design.
- Some flexibility is recommended in that it can be difficult to define some services or provider types specifically enough to ensure health plans will administer them in a uniform manner. Further, they may have information technology limitations or organizational aspects that make strict uniformity difficult to achieve. Therefore, some limited flexibility should be allowed.
- Standardizing Exchange benefit plans will trigger the requirement that issuers outside of the Exchange sell at least one standardized Exchange plan design.

### **Issue 3: Standardization of Drug Formularies**

Drug formularies are determined by each health plan based on analyses of drug costs, safety, and efficacy in conjunction with discounts and rebates negotiated with manufacturers and prescription benefit managers (PBMs). Therefore, it is unlikely that drug formularies themselves can be standardized across health plans. Each issuer offering coverage through the Exchange will be required to meet minimum formulary standards. The Affordable Care Act requires that formularies cover at least one drug per therapeutic class or category, but the Exchange could require broader coverage, such as the requirement that Medicare Part D sponsors cover at least two chemically distinct drugs per category or class. Under the current Department of Managed Health Care Health and Safety Code, a medical necessity clause exists that allows prescribing providers to obtain authorization for a medically necessary non-formulary prescription drug. A similar clause is expected to be included in California legislation establishing the benchmark plan for Essential Health Benefits that will apply to all health plans irrespective of state regulator.

The Affordable Care Act requires Medicare plan sponsors to include all covered part D drugs in the classes identified by CMS as classes of clinical concern, i.e. protected classes. CMS required a plan sponsor to cover all or substantially all covered Part D drugs in protected classes. Furthermore, the law requires that protection must be maintained for the following classes of drugs, which are already protected under existing CMS guidance: anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants for the treatment of transplant rejection. An exception process is in place that allows a plan



sponsor to exclude from its formulary a particular drug in a protected class or limit coverage for such a drug.

The Exchange is considering two options with respect to standardization of drug formularies in benefit plans offered through the Exchange. They are (see Table 18 for detail):

- **Option A:** Require formularies in benefit plans offered in the Exchange to meet the Affordable Care Act minimum standard of at least one drug per class or category
- **Option B:** Require formularies in benefit plans offered in the Exchange to meet at least the Medicare Part D minimum standard of at least two drugs per class or category

Staff recommends the Exchange requires formularies to include at least one drug per class or category (Option A) for the following reasons:

- Requiring at least one drug in each therapeutic class or category are covered under the formulary is consistent with the Affordable Care Act's minimum standards
- Requiring at least one drug in each therapeutic class or category are covered under the formulary allows issuers to expand formulary coverage
- Other drugs could still be made available under medical necessity rules if the drug in the formulary did not work for an individual.
- Standardizing Exchange benefit plans will trigger the requirement that issuers outside of the Exchange sell at least one standardized Exchange plan design

#### **Issue 4: Value-Based Benefit Designs in the Context of Benefit Standardization**

Value-based benefit design has been adopted by many large employers and public purchasers to provide financial incentives (one example is reduced cost sharing) to encourage enrollees to use high value services, adopt healthy lifestyles, and use high performance providers. By providing appropriate incentives, the likelihood that patients will comply with treatment plans and engage in healthy activities is increased with the expectation that these behaviors will ultimately lower health care costs.

Value-based benefit design is often, but not always, linked to the cost sharing provisions of the benefit plan. Strict standardization of cost-sharing could prohibit the use of value-based incentives that reduce cost-sharing. Primarily for this reason, the Exchange is recommending that QHP bidders be encouraged to deviate from the proposed plan design standardization through the use of value-based benefit design. Allowing plans to customize their own approach to value-based benefit plan design should stimulate innovation in this area and should ultimately be beneficial to consumers and lower costs. For the first few years, the Exchange staff is recommending that value-based benefit plan designs used by Qualified Health Plans be largely of a positive nature (“carrots”) to incent compliance with beneficial treatment plans.

To the extent that value-based benefit design incentives are not standardized, it may cause consumer confusion due to variations among issuers. However, value-based benefit design is



an area where innovation is expected. Incentives can be altered and refined as new clinical evidence is obtained. As a result, strict standardization of value-based benefit designs is not appropriate. However, guidelines could be implemented in their development, such as a requirement that value-based benefit designs lower cost sharing relative to the main plan design to which it is attached. The Exchange should encourage QHP issuers to submit bids that incorporate value-based benefit design features, such as reduced outpatient pharmacy cost sharing for members with diabetes and hypertension or other chronic conditions. There has been some question about the impact of value-based benefit design on the actuarial value of a plan and whether this innovation must be contained within the +/- 2% de minimis allowed variation. Federal rules are expected to encourage value-based insurance design irrespective of its potential impact on actuarial value. The Exchange is considering two options with respect to value-based benefit designs in benefit plans offered through the Exchange. They are (see Table 19 for detail):

- **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 or improved clinical support for chronic disease management.

Staff recommends the Exchange allows value-based benefit designs that lower patient out-of-pocket costs or provide financial or non-financial rewards (Option B) because it encourages the following:

- Promotes access to high value services,
- Encourages provision of health care services at lower cost to consumers,
- Encourages healthy behaviors and patient compliance,
- Enables the integration of new clinical evidence into care by providing appropriate incentives.
- Standardizing Exchange benefit plans will trigger the requirement that issuers outside of the Exchange sell at least one standardized Exchange plan design

### **Issue 5: Standardization of Minimum Out-of-Network Benefits**

While out-of-network benefits are clearly a secondary consideration for most consumers and typically only apply to PPO plans, it may be reasonable to specify that they provide a minimum level of coverage. For example, given that the minimum in-network coverage level is Bronze with an actuarial value of 60%, a minimum out-of-network actuarial value might be 50%. However, the methodology for calculating the actuarial value for out-of-network benefits would need to be developed and agreed upon.

A persistent problem among consumers in PPO plans exists with respect to unknown liability for non-emergent out of network services. The Exchange is seeking ways to address this problem which negatively affects both plans and consumers by creating unpredictable costs. Balance billing by out of network providers who can charge any amount may catch members by surprise

if they choose out of network services. It is not practical at this time to consider a cap on provider's charges.

The Exchange is considering two options with respect to out-of-network benefits in benefit plans offered through the Exchange. They are (see Table 20 for detail):

- **Option A:** Do not standardize minimum out-of-network benefits
- **Option B:** Standardize minimum out-of-network benefits by setting out of network plan reimbursement at the 50<sup>th</sup> percentile of the Fair Health database and require plans to inform its members prior to use of non-emergent care of the amount the plan will pay. Require plans to require network providers to disclose the cost and use of non-network providers to members in advance of a member's decision to use out of network services.

Staff recommends the Exchange standardizes out-of-network benefits (Option B) through the requirement on issuers to use the FAIR Health database to establish the minimum level of reimbursement to out-of-network providers, and require Issuers to inform members of their potential liability for the difference between the out-of-network plan payment amount and the out of network provider's charges so they will know their out of pocket liability in advance. Staff recommends that out of network reimbursement be set at the 50<sup>th</sup> percentile for the service using the Fair Health database. This recommendation is made for the following reasons:

- It establishes the basis for standard out-of-network reimbursement
- It provides consumers the information they need to make informed choices about their out of network benefits
- It ensures a minimum level of out-of-network coverage that may be higher than Affordable Care Act requirements.
- It may significantly reduce consumer out-of-network cost liabilities.
- It may reduce consumer confusion.
- Standardizing Exchange benefit plans will trigger the requirement that issuers outside of the Exchange sell at least one standardized Exchange plan design

Staff further intends to use its contracting process with QHPs to make information available to Exchange members regarding the amount that the plan will pay for out-of-network non-emergent services, so the member can make an informed choice when using those services.

Table 16: 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
<p><b>SUMMARY</b> This option allows health plans 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. Health plans may be limited in the number of plans they can offer within each tier.</p>	<p><b>SUMMARY</b> This option standardizes the major cost-sharing components, such as deductibles, copays, 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.</p>	<p><b>SUMMARY</b> This option standardizes all possible cost-sharing components s. Value-based plan modifications or other changes to benefits would not be allowed.</p>
<p><b>PURPOSE</b> This option permits health plans to sell any Affordable Care Act-compliant plan design they believe positions them most favorably as long as it has been approved by the regulator. It maximizes variations in benefit plan designs.</p>	<p><b>PURPOSE</b> This option significantly reduces the variations in plan designs, forcing health plans to compete on price, quality, and customer service while still allowing for innovation.</p>	<p><b>PURPOSE</b> This option eliminates nearly all variation in benefit coverage between health plans and forces them to compete on price and quality.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Increases potential for innovation relative to Option C</li> <li>▪ Increases number of plan options for consumers</li> <li>▪ May increase health plan participation in the Exchange</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Reduces potential for consumer confusion relative to Option A</li> <li>▪ Allows health plans to explore innovative plan designs</li> <li>▪ Reduces issues related to validation of actuarial values</li> <li>▪ Promotes value-based benefit design</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Easier for consumers to compare plans</li> <li>▪ Increases price competition</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ More difficult for consumers to compare plans</li> <li>▪ Increases potential for discriminatory or selective plan designs</li> <li>▪ Increases difficulty of validating actuarial values</li> <li>▪ Price competition is reduced</li> <li>▪ Increases the likelihood of many “me-too” plans</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Potential for health plans to violate intent of option unless allowable modifications are clearly defined</li> <li>▪ Standardized plan designs may be difficult for some health plans to administer</li> <li>▪ Standardized designs may not suit consumer preferences</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Innovation is stifled</li> <li>▪ Standardized plan designs may be difficult for some health plans to administer</li> <li>▪ Drug formularies will still be different and present opportunities for health plans to drive risk</li> </ul>

Table 17: 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: Standardization of major benefit limits and exclusions in benefit plans and allow limited customization	Option C: Standardization of all possible benefit limits and exclusions
<p><b>SUMMARY</b> This option allows health plans to apply benefit limits and exclusions in plan designs for sale in the Exchange as long as Essential Health Benefits coverage is satisfied.</p>	<p><b>SUMMARY</b> This option standardizes the major benefit limits and exclusions, but allows for limited customization.</p>	<p><b>SUMMARY</b> This option standardizes all possible benefit limits and exclusions, and allows the health plan to make no changes.</p>
<p><b>PURPOSE</b> This option permits health plans to sell any Affordable Care Act-compliant plan design they believe positions them most favorably as long as it has been approved by the regulator. It maximizes variations in benefit plan designs, though the Essential Health Benefits coverage requirements limit the amount of variation.</p>	<p><b>PURPOSE</b> This option significantly reduces the variations in plan designs, forcing health plans to compete on price, quality, and customer service while still allowing for innovation. Some flexibility would help accommodate difficult to define services or provider types. Further, information technology limitations or organizational aspects that make uniformity difficult to achieve.</p>	<p><b>PURPOSE</b> This option eliminates nearly all variation in benefit coverage between health plans and forces them to compete on price and quality. Covered services will be virtually identical from plan to plan due to the Essential Health Benefit requirements. Standardization reduces opportunities for risk selection by health plans through plan design.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Increases potential for innovation relative to Option B</li> <li>▪ Increases number of plan options for consumers</li> <li>▪ May increase health plan participation in the Exchange</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Reduces potential for consumer confusion relative to Option A</li> <li>▪ Allows health plans to accommodate difficult to define services or provider types and information technology limitations or organizational aspects that make uniformity difficult to achieve.</li> <li>▪ Reduces issues related to validation of actuarial values</li> <li>▪ Avoids “gotcha” situations for consumers who believe they are using covered benefits</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Easier for consumers to compare plans</li> <li>▪ Increases price competition</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ More difficult for consumers to compare plans</li> <li>▪ Increases potential for discriminatory or selective plan designs</li> <li>▪ Increases difficulty of validating actuarial values</li> <li>▪ Price competition is reduced</li> <li>▪ Increases the likelihood of many “me-too” plans</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Potential for health plans to violate intent of option unless allowable modifications are clearly defined</li> <li>▪ Standardized plan designs may be difficult for some health plans to administer</li> <li>▪ Standardized designs may not suit consumer preferences</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Innovation is stifled</li> <li>▪ Standardized plan designs may be difficult for some health plans to administer</li> <li>▪ Drug formularies will still be different and present opportunities for health plans to drive risk</li> </ul>

Table 18: 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
<p><b>SUMMARY</b> This option 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.</p>	<p><b>SUMMARY</b> This option requires that issuers in the Exchange exceed the Affordable Care Act minimum requirement that drug formularies by covering at least two drugs per class or category.</p>
<p><b>PURPOSE</b> This option requires that issuers only meet the minimum standard of one drug per class or category in drug formularies. Issuers are free to include more drugs per class.</p>	<p><b>PURPOSE</b> This option expands the Affordable Care Act's minimum drug formulary requirement to provide additional lower cost drug options for patients.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Consistent with the Affordable Care Act's minimum standards</li> <li>▪ Allows issuers to expand formulary coverage</li> <li>▪ Enhances affordability without sacrificing access to drugs that are medically necessary</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Requiring at least two drugs in each therapeutic class or category are covered under the formulary ensures that patients and their physicians have some less costly drug options when deciding on a treatment</li> <li>▪ Requiring at least two drugs in each therapeutic class or category are covered under the formulary is already a requirement in other healthcare programs, including Medicare</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ The minimum standard may not provide sufficient lower cost drug options for patients.</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ May result in an increase in drug-related premiums relative to the Affordable Care Act's minimum requirements</li> <li>▪ Creates wasteful choices by allowing selection of brand drugs when not necessary.</li> </ul>

Table 19: 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
<p><b>SUMMARY</b> This option prohibits issuers from including value-based benefit designs in benefit plans offered through the Exchange.</p>	<p><b>SUMMARY</b> This option allows issuers to offer value-based benefit designs that lower patient out-of-pocket costs or provide financial rewards</p>
<p><b>PURPOSE</b> This option presumes that value-based benefit design does not bring sufficient improvements in value to offset the potential consumer confusion and the costs of reviewing and certifying the designs.</p>	<p><b>PURPOSE</b> This option positions value-based benefit design as an important element of the Exchange's strategy to control costs and improve quality and access. Any additional consumer confusion is assumed to be offset by increased value.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Reduces potential for consumer confusion</li> <li>▪ May simplify the QHP certification process</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Encourages the provision of health care services at lower cost to consumers, encourages healthy behaviors and patient compliance, promotes access to high value services, and enables the integration of new clinical evidence into care by providing appropriate incentives.</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ May result in higher costs, less healthy behaviors, and reduced access to high value services</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ May increase consumer confusion</li> </ul>

Table 20: Issue 5: Standardization of Minimum Out-of-Network Benefits

<p><b>Option A: Do not standardize minimum out-of-network benefits</b></p>	<ul style="list-style-type: none"> <li>• <b>Option B: Standardize minimum out-of-network benefits by setting out of network plan reimbursement at the 50<sup>th</sup> percentile of the Fair Health database and require plans to inform its members prior to use of non-emergent care of the amount the plan will pay. Require plans to require network providers to disclose the cost and use of non-network providers to members in advance of a member’s decision to use out of network services.</b></li> </ul>
<p><b>SUMMARY</b> This option does not standardize the minimum out-of-network benefits and allows issuers to customize the out-of-network benefits included in benefit plans offered through the Exchange.</p>	<p><b>SUMMARY</b> This option standardizes minimum out-of-network benefits included in benefit plans offered through the Exchange.</p>
<p><b>PURPOSE</b> This option allows issuers the freedom to design out-of-network benefits as long as they meet the requirements of the Affordable Care Act.</p>	<p><b>PURPOSE</b> This option standardizes the minimum out-of-network benefits in benefit plans offered through the Exchange by requiring the use of the FAIR Health database to determine appropriate reimbursement amounts for out-of-network services and to limit balance billing liabilities.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Out-of-network benefits will at least meet Affordable Care Act requirements</li> <li>▪ Keeps plan out of network benefits very low.</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Ensures a minimum level of out-of-network coverage that may be higher than Affordable Care Act requirements</li> <li>▪ May significantly reduce consumer out-of-network cost liabilities</li> <li>▪ May reduce consumer confusion</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Out-of-network coverage may be inadequate, leaving consumers with large, unanticipated out-of-pocket expenses</li> <li>▪ May increase consumer confusion to the extent there is significant variation among issuers</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ May increase premium costs though OON services are not a big line item for issuers.</li> </ul>

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## Plan Design Standardization Appendix A

Staff is recommending that cost-sharing amounts be standardized for each metal tier for the major service categories. Staff is providing the current templates for standardized plan designs in the tables below as models for the Board and the public's consideration and reaction. The plan designs are intended to be illustrative of the types of plans and the level of cost sharing that are expected to satisfy the actuarial values that determine into which metal tier a benefit plan is categorized. In the development of the current templates for standardized plan designs, the following principles guided the process:

- Actuarial values must fall within the allowable  $\pm 2\%$  *de minimis* variation around the metal tier actuarial values;
- Standardized plan designs did consider the designs that are selling in the current market with modifications as necessary to reflect coverage of Essential Health Benefits;
- Standardized plan designs within a metal tier reflect material differences in cost sharing;
- Access to primary care office visits should not be impaired by high deductibles, so the deductible is waived for the first two primary care office visits plus an annual preventive care visit;
- Consumers generally dislike coinsurance due to uncertainty about costs, so where possible coinsurance provisions should be minimized;
- Copayments should apply to high volume services, particularly those that are discretionary;
- Member copayments and coinsurance cannot exceed 50% of the cost of a service;
- It is impractical to apply copayments to every service or item provided during a visit or encounter, so only core services are assigned copays.

Actuarial value estimates were developed by PricewaterhouseCoopers using a proprietary actuarial pricing model. A range of assumptions were applied, and the analysis found that modeled actuarial values can vary several percentage points due to variations in cost and utilization caused by geography and other factors. In general, factors that increase aggregate costs drive an increase in the actuarial value since deductibles and maximum out-of-pocket expense limits will be reached sooner after which the plan's share of cost increases. The illustrative plan designs were developed based on review of plans currently sold in the market, the anticipated Essential Health Benefits for California, and general direction provided by the Exchange, with adjustments to achieve actuarial values within the allowable  $\pm 2\%$  *de minimis* variation around each metal tier.

HHS is developing a model to facilitate the calculation of actuarial values on a consistent basis. States may develop their own actuarial value models, but they must be approved by HHS. California is expected to rely on the HHS calculator when it develops its final standardized benefit plans or when it evaluates benefit plans proposed by issuers pursuing certification as

qualified health plans. It can be expected that the results will differ from those developed by PricewaterhouseCoopers when run through the HHS model when finally released, and therefore, the illustrative designs should be reviewed for general design and approximate levels of cost sharing.

Table 21: Appendix A: Illustrative Standardized Benefit Plan Descriptions – Platinum and Gold				
	Platinum		Gold	
	Plan 1	Plan 2	Plan 1	Plan 2
Annual Deductible	\$0	\$250	\$0	\$500
Out-of-Pocket Max	\$6,350	\$2,000	\$6,350	\$3,500
Inpatient Hospital	\$100 per day	10% coinsurance	\$400 per day	\$250 per day
Outpatient Hospital	\$100-\$200 copays	10% coinsurance	\$200-\$400 copays	20% coinsurance
Emergency Room	\$100 copay	\$150 copay	\$150 copay	\$150 copay
Preventive Care	No cost share	No cost share	No cost share	No cost share
Primary Care Visit (for deductible plans, the first 2 PCP visits are exempt from the deductible)	\$20 copay	10% coinsurance	\$30 copay	\$20 copay
Specialty Care Visit	\$30 copay	10% coinsurance	\$40 copay	20% coinsurance
Imaging-Advanced and X-ray	OP Hosp: \$50 copay, Prof: \$10-\$30 copay	10% coinsurance	OP Hosp: \$50 copay, Prof: \$10-\$40 copay	20% coinsurance
Lab tests	\$10 copay	10% coinsurance	\$10 copay	20% coinsurance
PT/OT/ST	\$30 copay	10% coinsurance	\$40 copay	20% coinsurance
Mental Health/Substance Abuse - Inpatient	\$100 per day	10% coinsurance	\$400 per day	\$250 per day
Mental Health/Substance Abuse - Outpatient	\$20 copay	10% coinsurance	\$30 copay	20% coinsurance
Prescription Drugs	\$0 deductible	\$0 deductible	\$250 brand deductible	\$0 deductible
Generic	\$5 copay	\$5 copay	\$15 copay	\$10 copay
Brand-Preferred	\$15 copay	\$15 copay	\$30 copay	\$25 copay
Brand-non-Preferred	\$25 copay	\$25 copay	\$40 copay	\$35 copay

Table 22: Appendix A: Illustrative Standardized Benefit Plan Descriptions - Silver			
	Silver		
	Plan 1	Plan 2	Plan 3
Annual Deductible	\$500	\$1,000	\$2,000
Out-of-Pocket Max	\$6,350	\$6,350	\$5,000
Inpatient Hospital	30% coinsurance	\$400 per day	\$400 per day
Outpatient Hospital	30% coinsurance	20% coinsurance	25% coinsurance
Emergency Room	\$150 copay	\$150 copay	\$150 copay
Preventive Care	No cost share	No cost share	No cost share
Primary Care Visit (for deductible plans, the first 2 PCP visits are exempt from the deductible)	\$30 copay	\$30 copay	\$30 copay
Specialty Care Visit	\$30 copay	20% coinsurance	25% coinsurance
Imaging-Advanced and X-ray	30% coinsurance	20% coinsurance	25% coinsurance
Lab tests	30% coinsurance	20% coinsurance	25% coinsurance
PT/OT/ST	30% coinsurance	20% coinsurance	25% coinsurance
Mental Health/Substance Abuse - Inpatient	30% coinsurance	\$400 per day	\$400 per day
Mental Health/Substance Abuse - Outpatient	\$30 copay	\$30 copay	25% coinsurance
Prescription Drugs	\$150 brand deductible	\$250 brand deductible	250 brand deductible
Generic	\$10 copay	\$10 copay	\$10 copay
Brand-Preferred	\$30 copay	\$25 copay	\$25 copay
Brand-non-Preferred	\$50 copay	\$35 copay	\$35 copay

Table 23: Appendix A: Illustrative Standardized Benefit Plan Descriptions – Bronze and Catastrophic			
	Bronze*		Catastrophic
	Plan 1	Plan 2	
Annual Deductible	\$2,000	\$3,000	\$6,350
Out-of-Pocket Max	\$6,350	\$5,000	\$6,350
Inpatient Hospital	\$500 per day	30% coinsurance	0% coinsurance
Outpatient Hospital	30% coinsurance	30% coinsurance	0% coinsurance
Emergency Room	30% coinsurance	30% coinsurance	0% coinsurance
Preventive Care	No cost share	No cost share	No cost share
Primary Care Visit (for deductible plans, the first 4 PCP visits are exempt from the deductible)	\$50 copay	\$50 copay	0% coinsurance
Specialty Care Visit	30% coinsurance	30% coinsurance	0% coinsurance
Imaging-Advanced and X-ray	30% coinsurance	30% coinsurance	0% coinsurance
Lab tests	30% coinsurance	30% coinsurance	0% coinsurance
PT/OT/ST	30% coinsurance	30% coinsurance	0% coinsurance
Mental Health/Substance Abuse - Inpatient	\$500 per day	30% coinsurance	0% coinsurance
Mental Health/Substance Abuse - Outpatient	\$50 copay	\$50 copay	0% coinsurance
Prescription Drugs	\$500 brand deductible	\$500 brand deductible	N/A
Generic	\$15 copay	\$15 copay	0% coinsurance
Brand-Preferred	\$40 copay	\$40 copay	0% coinsurance
Brand-non-Preferred	\$50 copay	\$50 copay	0% coinsurance

\*Note that the Affordable Care Act limits deductibles for small employer plans to \$2,000; plans with higher deductibles would be available only in the individual market.

## Premium Subsidies and Cost Sharing Reductions

### Summary

The California Health Benefit Exchange is considering the options related to how to structure premium and cost sharing subsidies provided to lower income participants who purchase health insurance through the Exchange. 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. This "Premium Subsidies and Cost Sharing Reductions" Board Recommendation Brief provides background on the issues, a summary of the options available to the Exchange, and final recommendations for the Board's consideration.

### Background

Beginning in 2014, the Affordable Care Act provides for premium subsidies in the form of refundable tax credits and reduced point-of-service cost sharing for lower income individuals when they purchase health insurance through the state exchanges. These provisions reduce costs for subsidy-eligible individuals using federal funds and will provide a strong incentive for this population to buy insurance through the Exchange.

To be eligible for premium subsidies or cost sharing reductions, individuals must:

- Be US citizens or legal residents and a resident of the state;
- To be eligible for the premium tax credits, individuals must be in families with incomes from 100% to 400% of FPL, though those with income below 133% FPL (138% FPL after 5% income disregard) will generally be eligible for Medi-Cal coverage.<sup>20</sup> Not be offered affordable premiums (affordability provision is satisfied if an individual's share of premium is less than 9.5% of income) for a health plan that provides an actuarial value at least 60% (bronze coverage) through an employer; and
- Not be eligible for other essential coverage, including Medicare, Medicaid, Children's Health Insurance Program, coverage related to military service, a grandfathered plan, or other coverage recognized by the Secretary of the U.S. Department of Health and Human Services (HHS).

The premium subsidies and cost-sharing reductions are explained below, including the range of subsidies provided at various income levels.

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<sup>20</sup> Premium subsidies are available for people between 100% to 133% of FPL who are not eligible for full benefit or benchmark plan Medicaid (Medi-Cal) and those covered in a non-Medicaid state funded program

***Premium Subsidies (Tax Credits)***

To reduce cost barriers to obtaining coverage, the Affordable Care Act created refundable (meaning it is available even if the individual has no tax liability) and advanceable (meaning the individual can choose to receive the benefit in the form of advanced payments to their insurer each month to reduce their premium) federal premium tax credits towards purchase of health insurance through exchanges. The tax credit funds are paid directly to the issuer, and the individual pays the balance of the premium due. To be eligible for the premium tax credits, individuals must be in families with incomes from 100% to 400% of FPL, though those with income below 133% FPL (138% FPL after 5% income disregard) will generally be eligible for Medi-Cal coverage.

The amount of the premium tax credit an individual can receive is a sliding percentage based on family income and the cost of the premium for the second lowest cost silver plan (actuarial value of 70%) offered by the Exchange in the individual's geographic coverage area. The premium tax credit is intended to reduce the premium cost for a silver plan to an "affordable" percentage of the individual's income. Since the amount of the tax credit is tied to premium, older individuals and families will receive larger tax credits due to higher premiums.

Under the Affordable Care Act, the tax credit-eligible individual is not limited to purchasing the second lowest cost silver plan; it is simply the basis for determining the premium subsidy amount. The individual may buy a more expensive silver plan or a gold or platinum plan, but would have to pay a higher premium -- the difference in premium cost for the more expensive plan and the second lowest cost silver plan. An individual may also buy down to a bronze plan or a cheaper silver plan, which would reduce the individual's premium cost, but the tax credit (subsidy) cannot be any higher than the premium for the purchased plan so the premium cannot be a negative amount. Exchanges may choose to limit the choice of plans for subsidy-eligible individuals, for example by restricting their ability to purchase higher cost gold or platinum plans when eligible for both premium subsidies and cost-sharing reductions.

Table 24 shows the percentage of income and the monthly amount an individual or family would pay towards the premium for the second lowest cost silver plan after application of the tax credit.

Table 24: Premium Cost Net of Tax Credit for Subsidy Eligible Individuals				
Income (percent of Federal Poverty Level)	Family Size	Annual Income (based on 2012 FPL)	Premium Cost Net of Tax Credit for the Second Lowest Cost Silver Plan	
			Percent of Income	Monthly Amount (based on 2012 FPL)
Below 133%	Single	below \$14,856	2.0%	\$25
	Family of 4	below \$30,657		\$51
133%-150%	Single	\$14,856 - \$16,755	3.0% - 4.0%	\$37 - \$56
	Family of 4	\$30,657 - \$34,575		\$77 - \$115
150%-200%	Single	\$16,755 - \$22,340	4.0% - 6.3%	\$56 - \$117
	Family of 4	\$34,575 - \$46,100		\$115 - \$242
200%-250%	Single	\$22,340 - \$27,925	6.3% - 8.05%	\$117 - \$187
	Family of 4	\$46,100 - \$57,625		\$242 - \$387
250%-300%	Single	\$27,925 - \$33,510	8.05% - 9.5%	\$187 - \$265
	Family of 4	\$57,625 - \$69,150		\$387 - \$547
300%-400%	Single	\$33,510 - \$44,680	9.5%	\$265 - \$354
	Family of 4	\$69,150 - \$92,200		\$547 - \$730

**Cost Sharing Reductions**

In addition to the premium subsidies/tax credits, the Affordable Care Act directs health plans to reduce point-of-service cost sharing for individuals in families with incomes between 100% and 400% of FPL who purchase silver level (70% actuarial value) coverage through the Exchange. (Although cost-sharing reductions were originally proposed for all subsidy levels, they are now available for individuals with income between 100-250% of FPL). The cost sharing reductions are *not available* to individuals who opt either for the less rich bronze (60%) or the richer gold (80%) or platinum (90%) coverage. In other words, cost-sharing reductions are *only* available to individuals with income between 100% -250% of FPL who purchase a Silver level plan. The Affordable Care Act directs the cost sharing reductions to be achieved by reducing maximum out-of-pocket limits to the extent possible without causing the actuarial values (the average percentage of costs paid by the plan) to exceed certain levels, and then by reductions in other cost sharing components, such as deductibles, copays, and coinsurance. Table 22 shows the out-of-pocket reductions and increases in plan actuarial values for eligible individuals by % of FPL income choosing a silver tier plan.



**Table 25: Reductions in Maximum Out-of-Pocket Limits and Actuarial Value Requirements for Silver Level Coverage**

Income (percent of Federal Poverty Level)	Reduction in Maximum OOP Limit**	Required Actuarial Value of Benefit Plan
100%-150%	2/3	94%
150%-200%	2/3	87%
200%-250%	½	73%
250%-300%	1/2*	70%
300%-400%	1/3*	70%

\*HHS HAS PROPOSED TO ELIMINATE THE OOP MAXIMUM REDUCTION FOR INCOMES BETWEEN 250% AND 400% OF FPL

BECAUSE THE ACTUARIAL VALUE IS ALREADY EQUIVALENT TO THAT OF THE SILVER PLAN.

\*\*THE OOP LIMIT IS TO BE REDUCED FIRST TO MEET THE ACTUARIAL VALUE GOAL. IF THAT REDUCTION IS INSUFFICIENT, OTHER CHANGES IN COST SHARING MUST BE MADE.

Payments for the value of the cost sharing reductions will be made by HHS to the health plan issuing coverage to the individual whose cost sharing was reduced once the plan notifies HHS. Though final federal rules have yet to be released, the February 2012 bulletin released by the Center for Consumer Information & Insurance Oversight (CCIIO) describes a federal approach for implementing cost sharing reductions and making payments to qualified health plan (QHP) issuers to offset the cost of these reductions.

HHS has indicated its intent to require the Exchange or health plans to make available three variations of each standard silver plan to correspond with the out-of-pocket and actuarial value requirements shown in Table 24. Thus, an individual with income of 175% FPL will be offered a modified silver plan with a richer average benefit value (87% actuarial value compared to 70% for the regular silver plan), by limiting their out-of-pocket expenses to one-third the amount of the regular silver plan as required by the reduced cost-sharing rules.

One component of the proposal made by HHS is to eliminate the reduction in the maximum out-of-pocket limit for individuals in families with income between 250% and 400% of FPL. Their reasoning is that a reduction in the out-of-pocket maximum will increase the actuarial value above 70% unless other changes in cost sharing are made, such as increasing deductibles or copays. Since most enrolled individuals will not reach the out-of-pocket maximums even at the reduced levels, they are likely to pay higher cost sharing than they would have if the benefits had not been modified. For this reason, and so as not to introduce additional administrative burden, HHS has proposed not to reduce the out-of-pocket cost sharing for individuals in families with income of 250%-400% of FPL.

As previously noticed, if an individual purchases a plan other than a silver plan, he or she will not receive the benefit of the cost sharing reductions shown in. As a result, decision support to individuals in the 100-250% FPL group as they make benefit plan selection will be especially important. While buying up to a gold or platinum coverage may be appealing in concept, the additional premium cost may not make financial sense given that an individual with income in the 150%-200% of FPL range already is eligible for benefits from reduced cost sharing that translates to nearly platinum level coverage (87% actuarial value) if a silver plan is purchased. Similarly, an individual with income in the 100%-150% of FPL range is provided with better than platinum coverage (94% actuarial value) for a silver plan purchase. For individuals within the 100-250% FPL group, purchase of a bronze plan will reduce premium costs, and the premium subsidy may result in a zero premium. However, these consumers will be exposed to a much greater cost-sharing risk since bronze plans, on average, expect consumers to pay 40% of average plan costs out-of-pocket, and they will have foregone the cost-sharing reductions they would be entitled to with purchase of a silver plan. The Exchange must develop information and decision support tools to assist consumers in evaluating their expected costs under the various tier and plan options, and to clearly demonstrate the value of the cost sharing reductions to those that are eligible.

### Examples

Table 26 presents some examples of the impact on benefit tier selection on total participant costs under a range of income and healthcare utilization scenarios. The table presents two potential Exchange members, Joe who has an income of 150% of FPL (annual income of \$16,755) and Maria who has an income of 200% of FPL (annual income of \$22,340). Though the premium tax credits are available to Joe and Maria regardless of their plan choice, cost sharing reductions are only provided if Joe and Maria purchase silver plans, which substantially impacts total expected costs for an individual.

Three scenarios are presented for Joe and Maria:

- In Scenario 1, Joe and Maria are assumed to be average healthcare users. In the examples, the estimated annual cost sharing expense is calculated by assuming that Joe and Maria are responsible for the average percentage of health care costs not covered by the plan, or 100% minus the actuarial value. This amount is further reduced to reflect the percentage of premiums not attributed to claim costs (e.g., administrative expenses and profit).
- In Scenario 2, Joe and Maria are assumed to be high healthcare users. In the examples, the estimated annual cost sharing expense is assumed to equal the maximum out-of-pocket expense under the plan.
- In Scenario 3, Joe and Maria are assumed not to use any healthcare services, other than preventive care. Therefore, they have no out-of-pocket expense.

Table 26: Comparison of Total Costs for an Exchange Member based on Choice of Benefit Plans

Member Name	Joe				Maria			
Income	150% of Federal Poverty Level				200% of Federal Poverty Level			
<b>Illustrative Benefit Plan Information and Cost Sharing Reductions</b>								
Benefit Tier	Platinum	Gold	Silver	Bronze	Platinum	Gold	Silver	Bronze
Actuarial Value <u>After Cost Sharing Reductions</u>	90%	80%	<b>94%</b>	60%	90%	80%	<b>87%</b>	60%
Max Out-of-Pocket Expense <u>After Cost Sharing Reductions</u>	\$2,000	\$3,500	<b>\$1,667</b>	\$6,000	\$2,000	\$3,500	<b>\$1,667</b>	\$6,000
<b>Premiums and Tax Credits</b>								
Illustrative Monthly Premium	\$579	\$514	\$450	\$386	\$579	\$514	\$450	\$386
Monthly Premium <u>After Tax Credit</u>	\$185	\$120	\$56	\$0	\$246	\$181	\$117	\$53
<b>Examples</b>								
<b>Scenario 1: Joe &amp; Maria have average healthcare use and expenses</b>								
Annual Premium After Tax Credit	\$2,220	\$1,440	\$672	\$0	\$2,952	\$2,172	\$1,404	\$636
Annual cost sharing expense	<u>\$556</u>	<u>\$987</u>	<u>\$259</u>	<u>\$1,482</u>	<u>\$556</u>	<u>\$987</u>	<u>\$562</u>	<u>\$1,482</u>
Total Annual Cost	<b>\$2,776</b>	<b>\$2,427</b>	<b>\$931</b>	<b>\$1,482</b>	<b>\$3,508</b>	<b>\$3,159</b>	<b>\$1,966</b>	<b>\$2,118</b>
<b>Scenario 2: Joe &amp; Maria have high healthcare use and expenses</b>								
Annual Premium After Tax Credit	\$2,220	\$1,440	\$672	\$0	\$2,952	\$2,172	\$1,404	\$636
Annual cost sharing expense	<u>\$2,000</u>	<u>\$3,500</u>	<u>\$1,667</u>	<u>\$6,000</u>	<u>\$2,000</u>	<u>\$3,500</u>	<u>\$1,667</u>	<u>\$6,000</u>
Total Annual Cost	<b>\$4,220</b>	<b>\$4,940</b>	<b>\$2,339</b>	<b>\$6,000</b>	<b>\$4,952</b>	<b>\$5,672</b>	<b>\$3,071</b>	<b>\$6,636</b>
<b>Scenario 3: Joe &amp; Maria have no healthcare use or expenses (except Preventive Services)</b>								
Annual Premium After Tax Credit	\$2,220	\$1,440	\$672	\$0	\$2,952	\$2,172	\$1,404	\$636
Annual cost sharing expense	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>
Total Annual Cost	<b>\$2,220</b>	<b>\$1,440</b>	<b>\$672</b>	<b>\$0</b>	<b>\$2,952</b>	<b>\$2,172</b>	<b>\$1,404</b>	<b>\$636</b>

Premium tax credits reduce premium costs for members eligible for these subsidies. These tables show:

- Each is responsible for any premium cost in excess of the tax credit, which is determined based on the second lowest cost silver plan.
- If Joe and Maria purchased the second lowest cost silver plan, premium tax credits would reduce Joe's monthly premium to 4.0% of monthly income or \$56 per month, and Maria's premium to 6.3% of monthly income or \$117 per month.
- If Joe or Maria purchased the lowest cost silver plan or a bronze plan, the tax credit would further reduce premium costs, potentially resulting in a \$0 premium.

In addition to the premium tax credits, cost sharing reductions would apply if Joe and Maria purchased a silver plan. As shown in Tables 25 and 26:

- Joe would receive a benefit plan with a 94% actuarial value (richer than platinum coverage) with a maximum out-of-pocket expense that is 2/3 less than the silver plan, which in this example is \$1,667 compared to the \$5,000 maximum out-of-pocket under the illustrative silver plan. Maria would receive a plan with an 87% actuarial value (nearly as rich as a platinum plan) with maximum out-of-pocket expenses also reduced by 2/3.
- If Joe or Maria purchased a platinum, gold, or bronze plan, the benefit plans are not modified and he or she would be ineligible for cost sharing reductions.

As the examples in Table 25 show:

- Under the average or high healthcare use scenarios, the premium cost subsidies and reduced cost sharing mean that a member is better off financially if he or she purchases a silver plan, with lower total expenditures for premiums and out-of-pocket expenses.
- In none of the scenarios is the member better off financially through purchase of platinum or gold coverage.
- It is only in a low healthcare use scenario where the member may be better off financially by purchasing a bronze plan, though their risk of high out-of-pocket expenses is much higher with a bronze plan.

Members with higher incomes receive smaller premium tax credits and smaller or no cost sharing reductions; therefore, the financial advantage of purchase of a silver plan is likely to be smaller in magnitude or nonexistent.

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## Provider Network Access: Adequacy Standards

### Summary

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). This Brief provides background on the issues, a summary of the options available to the Exchange, and includes final recommendations for the Board's consideration.

### Background

DMHC and CDI each have regulatory requirements for provider network adequacy standards.<sup>21</sup> The information, presented in Table 27 below, indicates that in general, California's regulators impose very similar standards for network adequacy. Some view DMHC's standards as more rigorous due to (1) more detailed timely access standards and reporting requirements, and (2) the addition of requirements for timely appointments. For both regulators, new provider networks are required to file Geo-access style reports demonstrating that the geographic time and distance standards have been met. It should be noted that plans regulated by DMHC are largely closed panel health maintenance organization (HMO) plans, whereas plans regulated by CDI are preferred provider organization (PPO) plans and indemnity products characterized by both very large provider networks and more flexibility receiving services from out-of-network providers.<sup>22</sup> Because of this, network access analysis is quite different for PPOs compared to HMOs.

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<sup>21</sup> California Health & Safety Code §1367, 1367.03, California Insurance Code §10133.5, and California Code of Regulations §§2240.1 et seq, 1300.51, 1300.67.2, 1300.67.2.1, and 1300.67.2.2.

<sup>22</sup> Closed panel network is used to refer to provider network design where, except for emergencies, benefits are covered by the plan only when the member seeks services provided by contracted in-network providers. In contrast, in "open-panel" PPO plans, benefits are covered by the plan when the member seeks services both from in-network and out-of-network providers, although use of out-of-network providers are reimbursed at lower rates by the plan and the member is subject to higher cost sharing and possibly balance billing.

Table 27: Summary of Regulatory Network Adequacy Requirements	
DMHC Knox-Keene Act	CDI Insurance Code and Regulations
<b>Geographic Access</b>	
<p><b>Primary Care Physicians</b></p> <ul style="list-style-type: none"> <li>15 miles/30 minutes</li> </ul> <p><b>Facilities Providing Primary Care Services</b></p> <ul style="list-style-type: none"> <li>Reasonable proximity</li> <li>Distance may not be unreasonable barrier</li> </ul> <p><b>Specialists</b></p> <ul style="list-style-type: none"> <li>Reasonable proximity</li> </ul> <p><b>Network Hospitals</b></p> <ul style="list-style-type: none"> <li>15 miles/30 minutes</li> </ul> <p><b>Ancillary</b></p> <ul style="list-style-type: none"> <li>Reasonable distance from primary care provider</li> </ul>	<p><b>Primary Care Physicians</b></p> <ul style="list-style-type: none"> <li>15 miles/30 minutes</li> </ul> <p><b>Facilities Providing Primary Care Services</b></p> <ul style="list-style-type: none"> <li>Reasonable proximity</li> </ul> <p><b>Specialists</b></p> <ul style="list-style-type: none"> <li>30 miles/60 minutes</li> </ul> <p><b>Network Hospitals</b></p> <ul style="list-style-type: none"> <li>15 miles/30 minutes</li> </ul> <p><b>Mental Health Professionals</b></p> <ul style="list-style-type: none"> <li>15 miles/30 minutes</li> </ul>
<b>Availability of Providers</b>	
<p><b>Primary Care Physicians (full-time or equivalents)</b></p> <ul style="list-style-type: none"> <li>1:2,000</li> </ul> <p><b>Physicians (full-time or equivalents)</b></p> <ul style="list-style-type: none"> <li>1: 1,200</li> </ul> <p><b>All Services</b></p> <ul style="list-style-type: none"> <li>Readily accessible</li> </ul>	<p><b>Primary Care Physicians (full-time or equivalents)</b></p> <ul style="list-style-type: none"> <li>1:2,000</li> </ul> <p><b>Physicians (full-time or equivalents)</b></p> <ul style="list-style-type: none"> <li>1: 1,200</li> </ul> <p><b>Basic Health Care Services (non-emergency)</b></p> <ul style="list-style-type: none"> <li>Available at least 40 hrs/week</li> <li>Until 10p.m. at least one day/week or for at least four hrs/each Saturday</li> </ul> <p><b>Facilities Used By Providers</b></p> <ul style="list-style-type: none"> <li>Reasonably accessible by public transportation and to the physically handicapped</li> </ul>
<b>Timely Access</b>	
<p>Sets standards for appointments (urgent and non-urgent), interpreter services, triage, and customer service day and hour wait and availability standards</p> <ul style="list-style-type: none"> <li>Prompt rescheduling of appointments</li> <li>Interpreter services coordinated with scheduled appointments</li> <li>Enrollees appointments to meet time standards (following date of request):                             <ul style="list-style-type: none"> <li>Urgent care, no prior authorization: 48 hours</li> <li>Urgent care, prior authorization: 96 hours</li> <li>Non-urgent care, primary care: 10 business days</li> <li>Non-urgent care, specialists: 15 business days</li> <li>Non-urgent care, non-physician mental health provider: 10 business days</li> <li>Non-urgent care, ancillary services: 15 business days</li> </ul> </li> </ul>	<p>Monitoring of waiting times for appointments part of insurer written procedures for monitoring and evaluating accessibility</p> <p>Required reporting of complaints regarding delay in obtaining appointments or finding care</p>
<b>Provider Types</b>	
<p>Physician, hospital, specialist, ancillary, home health, emergency, mental health. Reserves the right to seek access information on any type of provider (e.g. dialysis clinics, autism providers)</p>	<p>Same</p>
<b>Monitoring and Reporting</b>	
<p>Actively monitor accessibility and have a system designed for correcting problems if they develop</p>	<p>Monitoring of waiting times for appointments must be part of insurer written procedures</p> <p>Insurers must file a copy of the written procedures and data on insured complaints</p>

The DMHC Knox Keene timely access standards took effect in January 2010 and implement AB497, passed in 2002 in response to consumer complaints about the difficulty or inability to

obtain health care appointments within a reasonable amount of time. These are the first in the nation time-elapsed standards to establish limits on maximum acceptable delays to appointments. Previously, health plans could set their own standards and the written requirements were included in filings and approved by the regulators. The 2002 law directed the DMHC to establish the standards, which were developed by the department using an Advisory Committee to the Department and after a series of public hearings.

The adopted standards are consistent with standards that had been adopted by many of the health plans, but which had not been enforced. Another component of the 2002 legislation was compliance monitoring and DMHC procedures for review. Plans must also survey providers and enrollees to assure compliance with the regulation. For PPOs, this includes monitoring and reporting on the number of physicians under contract, member grievance and appeals, and overall rates of compliance. The first annual reports required under the law were submitted to DMHC in early 2012.

### **Impact on Composition of QHP Provider Networks due to Essential Health Benefit Requirements**

By the end of August, the California Legislature is expected to enact legislation bringing California's 2014 plans into compliance with the Essential Health Benefits (EHBs) requirement of the Affordable Care Act. One of the ten categories of EHBs that all California issuers, including QHPs, will be required to cover as of January 1, 2014 and provide is pediatric oral care and pediatric vision care. Pediatric oral care is typically provided by dentists and pediatric vision care is typically provided by optometrists and ophthalmologists. QHPs intending to provide the full set of EHBs in a single plan will be required to demonstrate an adequate provider network that includes a sufficient number and geographic distribution of dentists. All QHPs will be required to demonstrate an adequate network which includes a sufficient number and geographic distribution of ophthalmologists and optometrists. Network ophthalmologists and optometrists will subject to the specialist network adequacy standards. Generally, licensed dental plans in California currently strive to meet the 15 minutes or within 30 miles standard geographic access standard even though there is not a dentist-specific network access standard set by either regulator

The pediatric oral care benefit may be provided either by a medical QHP which includes dentists to provide the required EHBs or by a medical QHP in combination with a standalone dental plan. The Exchange expects to receive bids from standalone dental plans seeking to provide the pediatric essential oral care benefit.

The pediatric vision benefit includes a comprehensive eye evaluation, and if medically indicated, dilation and refraction for prescription glasses as well as other medically indicated vision services. This type of eye care is primarily provided by optometrists. As a result,



optometrists must be included in QHP networks in order to meet the requirement to provide pediatric vision care.

### ***Stakeholder Perspectives***

Stakeholder comments recognized the necessary balancing of provider network access with other criteria that support choice, quality and affordability. In general, they recommended reliance on existing DMHC and CDI standards for network adequacy and timely access, with some suggesting that DMHC standards, which they view as more stringent, be applied to all Qualified Health Plans. Stakeholders expressed concern about potential problems of incorrect information about a network provider participation (e.g. outdated directories) or circumstances where network providers were not taking any new patients. They also expressed concern that contracted provider networks should demonstrate cultural and linguistic competency and familiarity with the special needs populations expected to enroll in the Exchange.

While supporting the existing standards, stakeholders recommended that the Exchange commit to benchmarking, monitoring and reporting access and consumer issues and complaints to assure that provider network adequacy requirements are met.

### **Issues and Recommendations**

There are two sets of issues to consider related to the Provider Network Adequacy standards. These are:

1. What regulatory or other standards should be applied to demonstrate provider network adequacy?
2. What evaluation and monitoring should be established to assure that provider network adequacy requirements are met?

### **Issue 1: Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification**

The Exchange is considering three major options regarding its provider network access standard which could be a condition of Qualified Health Plan certification. They are (see Table 28 for detail):

- **Option A:** Adopt regulatory requirements of the Qualified Health Plan's current regulator (e.g., PPOs regulated by CDI would comply with the Insurance Code and HMOs/PPOs regulated by DMHC would comply with the Health and Safety Code)
- **Option B:** Adopt regulatory requirements of DMHC for all Qualified Health Plan certification, and
- **Option C:** Adopt additional Exchange-specific standards for Qualified Health Plan certification above and beyond the regulator's respective provider network adequacy standards

Staff recommends the Exchange applies the current regulatory requirements for provider network adequacy (Option A) because:

- It minimizes new administrative and operational requirements for health plan products. Additional provider network access requirements could mean that health plans would be required to expand provider networks, revise or renegotiate provider contracts and implement new monitoring and compliance activities in advance or concurrent with efforts to evaluate plan options and to develop new products to be offered on the Exchange. Requiring expansion of provider networks while plans are changing to adapt to a wide range of new market rules in 2013 and 2014 may be particularly difficult and add significant cost to their current operations, and may discourage issuers from submitting bids.
- Differences in provider network access standards reflect differences in the plans and products regulated by the two agencies. Appointment waiting time issues may be less of a concern for PPO products, which typically feature a broader network of providers than HMO plans and do not require selection of or referral by a PCP or medical group as a prerequisite to accessing specialty care.
- Assessing network adequacy is an existing statutory responsibility of the regulatory agencies and relies on the Exchange's regulator partner agencies to fulfill the important role of verification and enforcement that issuers have met current regulatory provider network adequacy standards.
- It allows the Exchange to monitor whether or not substantial problems exist with current provider network adequacy standards (if it's not broke, don't fix it.) and it does not preclude establishing additional reporting or monitoring requirements on provider network adequacy to monitor health plan performance using existing standards.
- It does not preclude establishing different or additional standards in the future, which can be informed by data on the experience of Exchange members. It does not preclude the ability of the Exchange to require that QHPs demonstrate network adequacy or directory adequacy.

Because it has not been decided whether and how the Exchange may establish criteria in addition to the current regulatory requirements, this Brief does not address the detailed pros and cons for specific examples of additional Exchange-specific criteria that might be adopted regarding provider network adequacy or how a Qualified Health Plan bidder may be evaluated and scored on this factor in the Qualified Health Plan solicitation. A separate Essential Community Provider Board Brief addresses network sufficiency for Essential Community Providers.

While Option B, adopt DMHC regulations for all Qualified Health Plans, would ensure common network adequacy criteria across all issuers and would add specific timely appointment requirements for Exchange plans licensed under CDI standards, imposing these common

criteria at the start of the Exchange's operations would likely create unnecessary challenges for some plans including the plans with the majority of current individual market products.

There are possible disadvantages to tightening or increasing provider network adequacy standards that would apply to CDI plans under Option B and all plans under Option C. These include:

- It may be more difficult to apply DMHC access requirements to PPO networks where members have a broader choice of providers and are not required to select a PCP.
- It may be unnecessary to impose timely appointment requirements in a PPO context when members could select another network provider who could accommodate them more quickly.
- This option would increase health plan issuer administrative and operational requirements. These could include negotiation and revisions to provider contracts and increased compliance monitoring and reporting. It could require information system changes to track appointment waiting times for network providers that does not currently exist.
- This option would increase Exchange resources for administration and oversight.
- New requirements would add to the complexity of the discussion and negotiation of authority and responsibilities under Exchange and partner inter-agency agreements.
- This option would require additional coordination across Exchange and partner-agencies for Qualified Health Plan certification.
- Additional Exchange requirements may not be applicable to Qualified Health Plans outside the Exchange unless the state legislature or regulators modify the current laws and regulations.
- If the Exchange establishes different and more stringent standards, it would add health plan issuer costs that could translate into higher premiums.

While the Exchange staff recommends that network adequacy standards align with the current regulatory guidance, the Exchange adequacy criteria will also incorporate support for and efforts to promote team based primary care which develops practices that include nurse practitioner, physician assistant, social worker, and other licensed and trained personnel who can assist in the diagnosis, management, and appropriate care coordination of health plan members. To the extent that these providers are included in a health plan network, individual and team listings would be included in the network provider directories.

## **Issue 2: Approaches to Evaluating Provider Network Adequacy for QHP Certification**

There are several approaches for measuring provider network adequacy or deficits and improvements in access to care and using such measurements for certification purposes. They may be adopted as minimum criteria for provider network adequacy or warrant higher scoring

or other preferential consideration in the Qualified Health Plan selection process (see Table 29 for detail).

- **Option A:** The regulator - DMHC or CDI - certifies a Qualified Health Plan bidder's network complies with the applicable regulatory 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

Additional discussion of each option is as follows:

- **Option A:** The Exchange relies solely on regulators' application of its respective provider network adequacy standards and requests supplemental regulator review if and when it has cause to believe there are problems of inadequate or untimely access to a particular provider type for a covered service. The regulator would certify that a Qualified Health Plan bidder's network has complied with the applicable regulatory network access standard.
- **Option B:** The Exchange requires periodic additional provider network surveys or analysis for all Qualified Health Plans to benchmark or to monitor potential areas of concern. This could focus on selected services, such as behavioral and mental health, or targeted enrolled members, such as those in rural geographies, those with special medical needs, or members of population groups, such as non-English speakers, who may be at risk for under service. Other metrics, such as outreach to new members, length of time between enrollment and first preventive care visit, and frequency and timeliness of referral appointments may be appropriate reporting requirements. Such compliance reports may be incorporated into the QHP solicitation and procurement process, or be developed as part of an overall performance measurement program.
- **Option C:** The Exchange requires an increase in frequency and detail in geo-access reporting. Qualified Health Plans may be required to affirmatively demonstrate network adequacy by more frequent or more detailed reporting of contracted provider networks and measures of access to care. For example, plans may be required to file complete geo-access reports, similar to those required for initial health plan licensure, when contracts are re-bid or renewed. Again, these may be general or specific to a provider type or member subgroup within a geographic region.

In addition, the Exchange is expected to require the use of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for measuring and reporting on the experiences of members with their QHPs. A requirement to use CAHPS or its equivalent is consistent with standards described in the Accreditation Brief.

Staff recommends the Exchange relies on the regulators' certification that the QHPs meet regulatory network adequacy standards (Option A) and will solicit comments from health plans,

providers, consumer advocates, and others on the mechanism the Exchange might deploy to efficiently monitor and assess plans' compliance with the network adequacy standard.

The primary advantages are similar to the reasons already outlined in the discussion of the recommendation to use the existing regulatory standards of DMHC and CDI related to provider network adequacy.

- It minimizes duplication and addition of new administrative and operational requirements for health plans.
- Differences in provider network access monitoring reflect differences in the plans and products regulated by the two agencies.
- Evaluation and monitoring network adequacy is an existing responsibility of the regulatory agencies and the Exchange is committed to not “reinventing the wheel”.
- It does not preclude establishing additional reporting or monitoring requirements on provider network adequacy to benchmark and monitor health plan performance using existing standards if standard reporting identifies areas of concern.
- It does not preclude establishing different or additional standards in the future, which can be informed by data on the experience of Exchange members.
- Measures for areas of concern, such as health disparities, can be captured through other mechanisms, such as CAPHS survey, that will be required under other standards and criteria for QHPs.

Options B and C require more frequent reporting and monitoring. These may be important in selected specific circumstances. For example, there may be provider types or geographic area that are areas of concern and are determined to require regular monitoring. For example, because the Essential Health Benefits include pediatric vision care, networks will be required to include optometrists. Additionally, with regard to Option B, there may be new metrics which supplement existing information or are considered better indicators of how a network is meeting member needs. Option C may be appropriate where current requirements to report changes in provider networks are considered insufficient to monitor network adequacy over time.

Overall, there are possible disadvantages to increasing the number or frequency of provider network adequacy monitoring and reporting that would occur under Options B and C. Again these are similar to the considerations for the options for regulatory standards and include:

- This would increase health plan issuer administrative and operational requirements. It could require information system changes to track information that does not currently exist.
- This option would increase Exchange and regulator resource needs for administration and oversight.

- New requirements would add to the complexity of the discussion and negotiation of authority and responsibilities under Exchange and partner inter-agency agreements.
- This option would require additional coordination across Exchange and partner-agencies for Qualified Health Plan certification.
- Additional Exchange requirements may not be applicable to Qualified Health Plans outside the Exchange unless the state legislature or regulators modify the current laws and regulations.
- If the Exchange establishes different and more stringent monitoring standards, it would add health plan issuer costs that could translate into higher premiums.

### Recommended Approach

Staff recommends that, for the first solicitation and the first two years of operation of the Exchange, the provider network adequacy standards conform to the Qualified Health Plan bidder's respective regulator, either DMHC or CDI (Option A). It also recommends, for at least the same time period, that evaluation and monitoring of provider network adequacy is done by the relevant regulatory agency (Option A). However, these options permit the Exchange to request supplemental reporting or benchmarking of network access by Qualified Health Plans during the first two years. It also permits the Exchange and Qualified Health Plans to monitor enrollee complaints regarding network access over time to ascertain if there are areas of valid concern, where those might be and in which provider types they may exist. The Exchange may undertake additional steps to monitor network adequacy, including but not limited to: 1) oversampling with the CAHPS patient experience survey, 2) California Health Interview Survey, 3) geographic access analysis, or 4) "Secret Shopper" sample surveys for appointment availability. Such analyses should be stratified based on income, race and ethnicity, and languages spoken, these approaches should also take into consideration the ethnic and language diversity of providers available to serve the Exchange membership. Finally, the Exchange, through cooperation with regulators, can work with Qualified Health Plans and their regulators to identify and address any provider network adequacy problems that might arise.

These options and respective pros/cons are detailed in the following tables.

Table 28: Issue 1: Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification		
Option A: Adopt Regulatory Requirements of QHP Bidder's Current Regulatory Agency	Option B Adopt Regulatory Requirements of DMHC for All QHP Bidders	Option C: Adopt Exchange-Specific Standards for all QHPs in Addition to Existing Regulatory Provider Network Access Requirements
<p><b>SUMMARY</b>                      The Exchange would adopt the provider network adequacy standards applicable to the existing license of the health plan issuer for the QHP</p>	<p><b>SUMMARY</b>                      The Exchange would adopt the DMHC Knox Keene standards for all QHPs offered in the Exchange</p>	<p><b>SUMMARY</b>                      The Exchange would develop Exchange-specific standards above and beyond the DMHC Health and Safety Code and CDI Insurance Code standards for all QHP offered in the Exchange</p>
<p><b>PURPOSE</b>                      Continues current regulatory requirements</p>	<p><b>PURPOSE</b>                      Establishes more rigorous provider network adequacy and access standard for QHPs licensed under CDI</p>	<p><b>PURPOSE</b>                      Establishes more rigorous provider network adequacy and access standard for all QHPs and promotes Exchange mission and values</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ No significant new health plan issuer administrative burden</li> <li>▪ Non-duplicative</li> <li>▪ Differences in provider network access standards reflect differences in the plans and products regulated by the two agencies</li> <li>▪ Relies on the regulator partner-agencies for verification and enforcement</li> <li>▪ Allows Exchange to monitor existing standards for problems</li> <li>▪ Does not preclude increasing health plan monitoring and reporting requirements if issues are identified</li> <li>▪ Does not preclude increasing regulator or Exchange review and reporting over time</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Raises provider network adequacy requirements for QHP licensed under CDI standards</li> <li>▪ Standardizes network adequacy requirements across all QHPs</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Raises provider network adequacy requirements for QHP licensed under CDI standards and</li> <li>▪ Standardizes network adequacy requirements across all QHPs</li> <li>▪ Promotes Exchange vision and values</li> </ul>

Table 28: Issue 1: Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification		
Option A: Adopt Regulatory Requirements of QHP Bidder's Current Regulatory Agency	Option B Adopt Regulatory Requirements of DMHC for All QHP Bidders	Option C: Adopt Exchange-Specific Standards for all QHPs in Addition to Existing Regulatory Provider Network Access Requirements
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>Does not raise provider network adequacy requirements for QHPs licensed under CDI</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>More difficult to apply DMHC access requirements to PPO networks where members have a broader choice of providers and are not required to select a PCP</li> <li>May be unnecessary to impose timely appointment requirements in a PPO context</li> <li>Adds new health plan issuer administrative requirements for QHP regulated under CDI</li> <li>Increase in regulator and/or Exchange resources for administration and oversight</li> <li>Requires additional negotiation of authority and responsibilities under Exchange and partner inter-agency agreements</li> <li>Requires additional coordination across Exchange and partner-agency for QHP certification</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>Adds new health plan issuer administrative requirements for all QHPs</li> <li>Increase in regulator and/or Exchange resources for administration and oversight</li> <li>Requires additional negotiation of authority and responsibilities under Exchange and partner inter-agency agreements</li> <li>Requires additional coordination across Exchange and partner-agency for QHP certification</li> </ul>



Table 29. Issue 2: Approaches to Evaluating Provider Network Adequacy for QHP Certification		
Option A: The applicable regulator would certify compliance with network access standard	Option B: The Exchange requires regular additional provider network surveys or analysis	Option C: The Exchange requires increased frequency and detail in geo-access reporting
<p><b>SUMMARY</b>                      The Exchange would adopt the provider network adequacy monitoring requirements applicable to the existing license of the health plan issuer for the QHP</p>	<p><b>SUMMARY</b>                      The Exchange would adopt the additional provider network adequacy monitoring requirements applicable to the existing license of the health plan issuer for the QHP. This may be by type of specialty, by region or by other provider characteristics. It may also include new metrics.</p>	<p><b>SUMMARY</b>                      The Exchange would adopt more frequent provider network adequacy monitoring requirements applicable to the existing license of the health plan issuer for the QHP. This may be by type of specialty, by region or by other provider characteristics.</p>
<p><b>PURPOSE</b>                      Continues current regulatory requirements</p>	<p><b>PURPOSE</b>                      Establish more rigorous provider network adequacy and access monitoring requirements for QHP and promote Exchange mission and values</p>	<p><b>PURPOSE</b>                      Establish more frequent provider network adequacy and access monitoring requirements for QHPs and promote Exchange mission and values</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ No significant new health plan issuer administrative burden</li> <li>▪ Relies on the regulator partner-agencies for verification and enforcement</li> <li>▪ Allows Exchange to monitor existing standards for problems</li> <li>▪ Does not preclude increasing health plan monitoring and reporting requirements if issues are identified</li> <li>▪ Does not preclude increasing regulator or Exchange review and reporting over time</li> <li>▪ Some measures of interest, can be captured through other mechanisms, such as CAPHS survey,</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Can target provider types or geographic area that are areas of concern and are determined to require regular monitoring</li> <li>▪ Can add new metrics which supplement existing information or are considered better indicators of whether a network is meeting member needs</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ There may be provider types that are areas of concern and are determined to require more frequent monitoring</li> <li>▪ Current requirements to report changes in provider networks are considered insufficient to monitor network adequacy over time</li> </ul>

Table 29. Issue 2: Approaches to Evaluating Provider Network Adequacy for QHP Certification		
Option A: The applicable regulator would certify compliance with network access standard	Option B: The Exchange requires regular additional provider network surveys or analysis	Option C: The Exchange requires increased frequency and detail in geo-access reporting
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Relies on existing reporting requirements and consumer complaints to identify issues with member access</li> <li>▪ Current requirements may not be considered sufficient to capture changes in provider network over time</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Adds new health plan issuer administrative requirements for all QHP</li> <li>▪ Some measures of interest may be captured through other standards and criteria</li> <li>▪ Increase in regulator and/or Exchange resources for administration and oversight</li> <li>▪ Requires additional negotiation of authority and responsibilities under Exchange and partner inter-agency agreements</li> <li>▪ Requires additional coordination across Exchange and partner-agency for QHP certification</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Adds new health plan issuer administrative requirements for all QHP</li> <li>▪ Some measures of interest may be captured through other standards and criteria</li> <li>▪ Increase in regulator and/or Exchange resources for administration and oversight</li> <li>▪ Requires additional negotiation of authority and responsibilities under Exchange and partner inter-agency agreements</li> <li>▪ Requires additional coordination across Exchange and partner-agency for QHP certification</li> </ul>

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## Provider Network Access: Essential Community Providers Standards

### Summary

The California Health Benefit Exchange is considering the options related to the definition of essential community providers, "sufficient participation" of essential community providers as a component of provider network adequacy for plans offered through the Exchange and potential payment policies for Federally Qualified Health Centers. This "Provider Network Access: Essential Community Providers Standards" Board Recommendations Brief provides background on the issues, a summary of the options available to the Exchange, and recommendations to the Board.

### Background

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. These patient populations include the low income and uninsured, residents in medically underserved rural and urban areas, and often those with special care needs, such as children with serious illness, people with mental health and substance abuse disorders, the chronically ill, or target communities such as the homeless, persons with HIV/AIDS, and migrant workers.

Section 156.235 of the Affordable Care Act rules establish requirements related to essential community providers; this provision describes some aspects of the characteristics of essential community providers, but does not specify what will be considered "sufficient". :

- *(a)General requirement.* (1) A QHP issuer must have a **sufficient** number and **geographic distribution** of essential community providers...to ensure reasonable and timely access to **a broad range** of such providers **for low income, medically underserved individuals...** (emphasis added).
- *(b) Alternate standard.* A QHP issuer ...must have a sufficient number ... of **employed** providers and hospital facilities, or providers of its **contracted** medical group and hospital facilities..." (emphasis added).
- *(c)Definition.* Essential community providers are providers that **serve predominately low-income, medically underserved individuals, including...**providers defined in section 340B(a)(4)of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV)of the Social Security Act...(emphasis added).

### Identifying 340B and 1927(c) providers

Further federal regulatory guidance is expected. The requirement to include essential community providers in the provider network applies only to Qualified Health Plans sold in the

Exchange. However, the Federally Qualified Health Center payment rules apply to any plan that must meet Essential Health Benefit requirements, both inside and outside the Exchange.<sup>23</sup>

The federal minimum definition of essential community providers is those entities eligible for outpatient pharmacy discounts under Section 340B of the Public Health Service Act and in 1927 of the Social Security Act. This list includes over 1600 separately licensed sites throughout the state and approximately 600 corporate or government entities that may operate a single hospital or clinic, a network of clinics, or a combination of hospitals and clinics. See Exhibit 1 for a listing of 340B and 1927 providers counts in California as identified in the federal rules cited earlier.

Table 30 summarizes the location of the 340B eligible provider locations in California, based on distinct license and address, as of May 2012. This list includes the Medi-Cal Disproportionate Share Hospitals (DSH) as well as Medicare DSH facilities (about a third of the Medicaid DSH also qualify as Medicare DSH). Based on the license and address criteria, hospital counts may also include satellite outpatient departments and affiliated clinics and surgical centers.

The Medicare Disproportionate Share Hospital (DSH) designation identifies more hospitals (243) than the Medicaid DSH designation (140) maintained by the California Department of Health and Human Services. More than half of the short term community hospitals in the state meet the Medicare DSH criteria. About 50 of those also meet Medicaid DSH criteria. Although many of the Medicaid DSH hospitals do not have a 340B license, their separate outpatient departments and affiliated clinics have the pharmacy license.

Based on the federal minimum definition of 340B and 1927 providers, essential community providers include clinics such as Federally Qualified Health Centers (FQHCs), Tribal and Urban Indian health centers or clinics, certain specialty service clinics such Hemophilia, Tuberculosis, Ryan White (HIV/AIDS services), specified Medi-Cal and Medicare DSH facilities and their affiliated outpatient clinics, other hospitals such as Children's Hospitals, Critical Access Hospitals and Sole Community Hospitals. Some community clinics, Urban Indian clinics not yet designated FQHC, certain Disproportionate Share hospitals and individual providers serving low-income, medically underserved populations do not appear on the 340B listing. However, the 340B list is subject to change and may grow.

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<sup>23</sup> Sarah Rosenbaum. Essential Community Providers. HealthReformGPS. March 11, 2011.

Table 30: California 340(b) Eligible Providers, Number of Sites by Major Entity Type							
Region/Counties*	California 340B Entities and Sub-entities						
	CHC/ FQHC	Tribal	Other Clinic	Medicare DSH	Medicaid DSH	Other Hosp	Total
Northern and Sierra Counties	60	38	29	23	15	62	227
Greater Bay Area	133	3	91	62	14	17	320
Sacramento Area	18	4	27	14	3	1	67
San Joaquin Valley	113	5	56	43	20	2	239
Central Coast	79	4	44	27	9	0	163
Los Angeles	126	0	149	47	43	1	366
Other Southern CA	104	9	134	27	36	3	313
Grand Total	633	63	530	243	140	86	1,695

SOURCE: 340(b) HRSA OFFICE OF PHARMACY AFFAIRS (MAY 2012)

MEDICAID DSH: CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (2011-2012)

\* REGIONAL GROUPINGS ARE BASED ON THE DEFINITIONS USED TO REPORT THE RESULTS OF THE CALIFORNIA HEALTH INTERVIEW SURVEY (CHIS)

CHC/FQHC - CONSOLIDATED HEALTH CENTER PROGRAM / FEDERALLY QUALIFIED HEALTH CENTER

TRIBAL - TRIBAL CONTRACT/COMPACT WITH HIS AND URBAN INDIAN

DSH - DISPROPORTIONATE SHARE HOSPITAL; THERE IS AN OVERLAP OF APPROXIMATELY 50 HOSPITALS IN MEDICARE AND MEDICAID DSH

OTHER CLINIC - RYAN WHITE (PARTS A, B, AND C), FAMILY PLANNING, SEXUALLY TRANSMITTED DISEASES,

COMPREHENSIVE HEMOPHILIA TREATMENT CENTER, TUBERCULOSIS

OTHER HOSPITAL - CHILDREN'S HOSPITAL, CRITICAL ACCESS HOSPITAL, SOLE COMMUNITY HOSPITAL

### Alternate Standard for Essential Community Providers<sup>24</sup>

The final rule “alternate standard” for issuers using a contracted medical group or employed physicians requires a sufficient distribution of employed providers and hospitals, or contracted providers to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP’s service area in accordance with the Exchange’s network adequacy standards. Staff believes the Kaiser Health Plan will be subject to the alternate standard. It is unknown at this time if any other issuers in the State may also fall under this alternate standard.

One issue to consider is how the existing capacity of Kaiser and other alternative providers will be measured against the expected new enrollment as it is unlikely that the alternative standard

<sup>24</sup> Section 156.235(b) Alternate Standard. A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities OR providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP’s service area, in accordance with the Exchange’s network adequacy standards.

providers will be permitted to limit new enrollment relative to their distribution of employed providers and hospitals. If the alternative standard providers are permitted to limit enrollment, the Exchange will need to consider whether there is a minimum that they must accept, either as a total number or as a proportion of the expected population to be considered under this definition. Other details of how the requirement will be met may also be needed. This Brief assumes that any alternative providers must meet the overall network adequacy standards but does not further specify detailed requirements under the alternate standard.

### Defining Essential Community Providers Serving California's Low-Income, Medically Underserved Individuals<sup>25</sup>

The Federal government final rule grants states flexibility in defining who constitutes an essential community provider for purposes of Qualified Health Plan certification. The final rule allows the Exchange to identify and include these providers in its definition of essential community provider. In addition to the previously discussed "340B" providers, California has a wide range of provider types that serve its low-income population. This Brief considers what additional types of providers that serve the low-income population should be included in the Exchange's definition of essential community providers.

Other California programs, such as Medi-Cal Managed Care and the Healthy Families Program have developed program-specific definitions of "safety-net" providers or "traditional and safety-net providers". Such definitions may include 340B and 1927(c) providers as well as additional types of providers such as all California Medicaid Disproportionate Share Hospitals reported by the Department of Health Care Services, University teaching hospitals, children's hospitals, county-owned and operated general acute care hospitals, a broad list of clinics (e.g. "clinics exempt from licensure"), and physicians who provide Child Health and Disability Prevention (CHDP) services. For these programs, these "safety-net" providers are generally measured based on historical services provided to the Medi-Cal population. A major category of providers: private practice physicians, physician groups, non-340B clinics, health centers, retail clinics and other types of providers who are not on the 340B list may also serve the low-income population and could be considered for inclusion in the definition of essential community providers. Many of them qualify as Medi-Cal Managed Care or Healthy Families safety-net providers and currently treat the uninsured population, people eligible for/or enrolled in Medi-Cal, Healthy Families, and other government sponsored health programs. To the extent that these providers do not also meet the Essential Community Provider definition as 340B or 1927 provider, they could be considered to meet the federal requirements as providers who "serve predominately low-income, medically underserved individuals" by virtue of their office location and patient mix.

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<sup>25</sup> Other than the federal minimum of essential community providers who are on the 340B list.

***Medi-Cal and Healthy Families application of traditional and safety-net providers.***

Medi-Cal Managed Care identifies safety-net provider participation combined with health plan quality measures for the purpose of assigning “default” membership to participating plans. Default membership occurs when individuals are determined to be Medi-Cal eligible, fall into a mandatory Managed Care participation code, and the individual does not proactively select a health plan. Members are “assigned by default” into a plan based on an algorithm of plan quality and a safety-net provider participation formula (including percentage of patients discharged from a safety net hospital, percent of members assigned to a safety net provider, etc.) Once defaulted to a plan, a Medi-Cal managed care enrollee is entitled to select a new health plan monthly. Such default enrollment will not occur in the Exchange. Under the Exchange, each member’s enrollment is fully voluntary and each enrollee must actively select a QHP that meets their unique needs. The reason is obvious: if eligible for tax credits, the QHP enrollee is potentially on the hook to return the advanced tax credit if they experience an increase in income by end of the plan year. Additionally, Exchange enrollees will not be allowed to change plans monthly.

The Healthy Families Program offers the broadest definition of “traditional and safety net providers”, including a comprehensive list of clinics, hospitals and all physicians who provide CHDP services. Providing one CHDP visit qualifies a provider to be listed and weight is assigned based on the percentage of county children that received State-only funded CHDP services from the provider. Since the Healthy Families program is a child-only program, tracking CHDP providers is a means to identify practitioners who serve low-income children. Such lists are annually reviewed, revised and updated based on CHDP utilization, clinic and hospital ownership changes, and license or other business changes.

The Healthy Families Program traditional and safety net provider lists are used in an annual process to competitively designate a health plan as the “Community Provider Plan (CPP)”. The CPP plan demonstrates the highest proportion of contracts with such traditional and safety net providers. The CPP is offered to potential enrollees, county by county, at a discounted premium. Families are anticipated to select health plans based on price as well as provider networks that meet their needs. Like Medi-Cal Managed Care, Healthy Families enrollment occurs at the county level, with different plan offerings county by county. Unlike Medi-Cal Managed Care, Healthy Families enrollment tends to be more pro-active, families actively enroll children into a health plan and, prior to July 2012, were not allowed to change plans every month.

Applying a CPP- type of program under the Exchange has been considered. However, unlike Healthy Families, there is no source of funds to cover the costs of discounted premiums. Further, in the Exchange it is imperative that members voluntarily and completely select their



own QHP for enrollment. In the Exchange all premiums correlate to the metal tier of the offered plan. Creating a further discounted premium plan (such as a CPP) would affect actuarial value of the plan which is not allowed under ACA. The administration of such a program would be complex and unworkable.

***Other providers who serve the low-income, medically underserved population.***

To qualify for Medi-Cal, eligible individuals must be low-income. In the absence of another measure, Medi-Cal patient mix could serve as a proxy for serving the low-income population and providers who serve them are serving low income individuals.

A recent survey of California physicians who renewed their medical license in 2008 reported that more than two thirds, 68%, served some Medi-Cal patients. However, for the majority of physicians, Medi-Cal patients represent less than 20% of their practice.

In contrast, approximately 40% of primary care physicians and a quarter of specialists reported a panel with 30% or more Medi-Cal patients. Of primary care physicians, pediatricians reported a high of 51% Medi-Cal patients on their panels. Overall, although many physicians see some Medi-Cal patients in their practice, about 25% of physicians who see Medi-Cal patients care for 80% of the beneficiaries. A small proportion of physicians care for a large number of the low income population and could be considered essential community providers. However identifying such providers would be necessary for the Exchange to include them as essential community providers. Alternatively, the burden of identification of these high volume Medi-Cal physicians would fall to the QHPs.

Under the Health Information for Economic and Clinical Health (HI-TECH) legislation,<sup>26</sup> Medicare and Medicaid providers that meet federal criteria receive financial incentives to adopt and attain "meaningful use" of their patient electronic health records. This program includes a very useful definition of providers serving low-income individuals. Two programs are separately administered: Medicare Incentives are managed at the federal level while Medicaid Incentives are managed at the state level. Eligible Professionals (EPs) (physicians and other non-hospital providers as defined by the programs) may not participate in both programs. To qualify for the financial incentive, a provider must demonstrate their adoption of electronic medical records and that they serve Medicare, Medicaid and low income populations. The Medi-Cal Electronic Health Record Incentive Program managed through the California Department of Health Care Services began accepting applications in December of 2011. The provider application includes a detailed formula to calculate Medi-Cal patient encounter volume per provider and requires an attestation to the fact that the provider served the requisite proportion of Medi-Cal patients. As of August 2012, more than 10,000 California

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<sup>26</sup> This is the portion of the American Recovery and Reinvestment Act of 2009 that included \$19.2 billion of funding to increase the use of Electronic Health Records by physicians and hospitals. The majority of this, \$18 billion, is targeted through the Medicare and Medicaid reimbursement systems.

providers, including nearly 7,000 physicians, have been qualified to receive HI-TECH incentive payments. Other applicants include hospitals, nurse practitioners and physician assistants, dentists, and clinics. The Medi-Cal Electronic Health Record Incentive program has diligently created and maintained a list of specified Eligible Professionals (EPs) who have demonstrated and attested to meeting criteria for service to low-income populations. The Incentive Program staff reports they can easily provide a list of qualified providers by National Provider Identifier (NPI) and that the Exchange may access as a means to identify providers who have been proven to serve the low-income population. By adopting this list of EPs, the Exchange leverages the work of the HI-TECH program to rigorously qualify providers serving the low-income population, encourages additional providers to pursue such incentives and therefore adopt electronic medical records which will allow quality improvement through data collection, sharing and analysis. As importantly, by deploying this list, QHP bidders are relieved of the burden of identifying physicians who qualify as essential community providers; they can simply access this list for contracting purposes.

### **Federally Qualified Health Center Payment Rates**

Federally Qualified Health Centers (FQHCs) are a subset of Essential Community Providers. These clinics receive section 330 grant funding under the Public Health Service Act. Each also goes through an additional application and review process administered by the Bureau of Primary Health Care (in the Health Resources Service Administration, an agency of the Department of Health and Human Services) to receive the FQHC designation. These clinics provide comprehensive primary care medical and support services through physicians, nurse practitioners, physician assistants, social workers, nutritionists and other providers. FQHCs may also provide outpatient laboratory and pharmacy services (for which it likely has a 340B license), and in some cases, dental services. They are funded to serve a medically underserved and low income community, including uninsured and Medi-Cal populations. Some grantees receive funds to serve other target populations, including migrant and seasonal farm workers and their families, the homeless, and residents of public housing. An FQHC may operate a single or multiple sites under a single license.

Payment to Federally-Qualified Health Centers is specifically addressed in the Affordable Care Act and will apply to all plans, both inside and outside the Exchange, which must meet Essential Health Benefit requirements. Under the Act, plans are not required to contract with FQHCs, but for those that do contract, payment due to FQHCs is set at either a mutually agreed payment amount which must not be less than the Qualified Health Plan's generally applicable payment rate for similar services, or at the visit amount under section 1902(bb), also known as the Medicaid Prospective Payment System (PPS) rate.<sup>27</sup> The Medicaid PPS rate is an enhanced

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<sup>27</sup> There is also a Medicare FQHC PPS rate. It will differ from the Medicaid FQHC PPS rate because it is based upon a different set of covered services. Also, Medicare patients are subject to a 20% co-payment for physician and

payment rate that is initially based upon a per visit rate developed from reported costs and subsequently updated by an inflation factor. Determination of and payment of the Medicaid PPS rate is administered by the State Department of Health Care Services and takes into account the average cost of all services (professional, lab, radiology, etc.) provided to both insured and uninsured patients. The PPS rate is paid per visit of eligible Medi-Cal beneficiaries. Under the Federal Medicaid managed care regulations, participating managed care plans are permitted to pay FQHCs at a rate comparable to that paid to other primary care providers in their networks. Administratively, most commercial and some public health plans that participate in the Medi-Cal managed care or the Healthy Families programs pay FQHCs contract rates comparable with the local market and do not administer the additional payment up to PPS rates. Instead, California's DHCS administers supplemental PPS payments after adjudication against initial health plan payments to the FQHCs for services provided to those enrollees. Funding for such additional payments, commonly referred to as "wrap around" payment, is provided by state and federal funding. In addition, at all times statutory rules governing payment for covered and non-covered services apply.

### Stakeholder Perspectives

Stakeholder comments recognized the necessary balancing of provider network access and participation of essential community providers with other criteria that support choice, quality and affordability. To the extent that stakeholders expressed concern, they noted potential problems of incorrect information about provider participation in a network or circumstances where providers were not taking any new low-income patients. The other major concern was that contracted provider networks demonstrate cultural and linguistic competency and familiarity with the special needs populations expected to enroll in the Exchange. A range of views were presented regarding whether a narrow or broad definition of Essential Community Providers should be adopted, but there was broad consensus that the definition should be structured to provide for continuity of care of Exchange enrollees who have a history of obtaining health care services from safety net providers.

### Issues and Recommendations

There are two separate sets of issues related to the meeting the requirements of Federal Rule Section 156.235 which sets the Exchange requirements for Essential Community Providers: 1) definition of Essential Community Provider, and 2) requirements for demonstrating that a Qualified Health Plan's network has a "sufficient" number and "geographic distribution" of Essential Community Providers. Lastly, the Exchange addresses the question of payment to Federally Qualified Health Centers.

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related Medicare Part B services, which requires the FQHC to collect the patient cost sharing to meet the Medicare PPS rate. For Full Dual eligible, the cost share requirement is paid by the State Medicaid program.

*Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers*

## Issue 1. Definition of Essential Community Providers

- **Option A:** Exchange defines essential community providers as the minimum standard limited to the list of 340B and 1927 providers
- **Option B:** Exchange incorporates minimum standard above and broadens the definition of essential community providers to include physicians, clinics and hospitals which have demonstrated service to the Medi-Cal, low-income, and medically underserved population.

### Recommended Option

Staff recommends that the Exchange adopt a broader definition of Essential Community providers to recognize the value of private practice physicians, physician groups, Medicaid Disproportionate Share Hospitals and other clinics that have historically served the uninsured, low-income and medically underserved populations (Option B) and proposes that Essential Community Providers include the categories listed below.

The definition of essential community providers distinguishes between hospital facilities and the physician, clinics and other ambulatory based providers and is proposed as follows:

- Hospital providers:
  - Hospitals that are included in the list of 340B and 1927 providers and
  - Medi-Cal Disproportionate Share Hospitals designated annually by the California DHCS.
- Non-Hospital providers:
  - Covered entities on the list of 340B and 1927 providers; and
  - All providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program; and
  - Federally designated 638 Tribal Health Programs or Title V Urban Indian Health Programs; and
  - Community clinic or health centers licensed as either a “community clinic” or “free clinic”, by the State under California Health & Safety Code section 1204(a)(1) and (2), or is exempt from licensure under Section 1206.

## Issue 2. Definition of “sufficient” participation of Essential Community Providers”

- **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:** Qualified Health Plans must demonstrate sufficient geographic distribution of a broad range of providers reasonably distributed throughout the region with a balance of hospital and non-hospital providers by:

- Demonstrating contracts with at least 15% of 340B entities per geographic region proposed by a QHP bidder; and
- Include at least one essential community provider hospital per region; and
- Demonstrate a minimum proportion of QHP network overlap among Qualified Health Plan networks and essential community provider network as defined above.

Staff recommends that Qualified Health Plan bidders show that its Essential Community Provider network is reasonably distributed throughout the region where the low-income population is located with a balance of hospital and non-hospital providers and includes at least one hospital per region (Option B). Staff recommends that each QHP issuer be required that it has contracted with at least 15% of available 340B providers in each geographic region it proposes to serve and that those contracted 340B providers be reasonably distributed throughout the region and include at least one 340B hospital. The Exchange continues to seek comment on the specific measurement of "sufficient" as staff believes it is premature to quantify the degree of overlap between a QHP provider network and its Essential Community Provider network at this time. Table 32 describes the details of the options.

### Considerations for Defining a Sufficient Number and Geographic Distribution of Essential Community Providers

Federal requirements leave the determination of the "sufficient" number of essential community providers to the states, acknowledging that this determination is best left to the states to allow consideration of local health care marketplace circumstances.

A broader definition of essential community providers in the selection of Qualified Health Plans allows the Exchange to acknowledge and consideration local provider supply and distribution. Other considerations include the expected effort necessary for potential health plan issuers to comply with the essential community provider criteria in all geographies where they may propose a Qualified Health Plan balanced against the truth that contracting essential community providers is not required outside the Exchange.

Exchange staff has wrestled with the appropriate method to determine sufficient geographic distribution of essential community providers. Stakeholder input described strong agreement that QHPs should demonstrate the ability for Exchange enrollees to access providers and facilities that have traditionally served the low income population, a request for clarity on the methodology and the opportunity to be flexible in the first cycle of QHP bidding, given the urgent/protracted time-frame proposed for essential community provider network development.

Under Option A, a Qualified Health Plan bidder must show sufficient participation of essential community providers by demonstrating geographic access within the same time and distance criteria as that established for overall provider network adequacy. There are no objective

grounds for super-imposing a general network adequacy standard on essential community provider networks. This would require additional geo-access mapping and reporting for hospital and non-hospital providers in low income population areas. Additionally, a Qualified Health Plan bidder must show sufficient participation of essential community providers by demonstrating their availability as a ratio of providers to the target population. The target population could be defined as those individuals at or below 200% FPL, as identified on geographic maps potentially to be provided by the Exchange.

Under Option B, sufficient essential community provider participation may be demonstrated by showing a minimum overlap of the Qualified Health Plan bidder network and the essential community provider network. It also specifically requires contracting with at least 15% of the available 340B providers in the geographic region. Lastly, it allows some flexibility for a process that has shown to be complex and uncharted.

### Issue 3. Payment rates to Federally Qualified Health Centers

The Exchange has an opportunity to support delivery of services by essential community providers through the policies it adopts regarding Qualified Health Plan requirements regarding contracting and payment of Federally Qualified Health Centers, and considers the following options (see Table 33 for details):

- **Option A:** Require Qualified Health Plans to contract with all FQHCs and mandate payment under terms of section 1902(bb) of the Act- at the PPS rate
- **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
- **Option D:** During the Qualified Health Plan evaluation process, assign greater weight to Qualified Health Plan networks that include in-network FQHCs

For contracting and payment of FQHCs, staff recommends encouraging inclusion of FQHCs in QHP networks and payment at fair compensation by the QHP defined at rates no less than the generally applicable rates of the issuer (Option C). As with the contracting for all Essential Community Providers, the Exchange should encourage innovative contracting and payment arrangements with the FQHCs. Additionally, staff recommends assigning greater weight to QHP bids that include in-network FQHCs (Option D).

### Federally Qualified Health Center Payment Rates

Federal regulations regarding payment to Essential Community Providers is strictly limited to payment of Federally-Qualified Health Centers (FQHCs), a subset of Essential Community Providers and will apply to all plans, both inside and outside the Exchange that must meet Essential Health Benefit requirements. Payment due to FQHCs for covered services, in the



absence of a mutually agreed payment amount which must not be less than the Qualified Health Plan's generally applicable payment rate, is set at the amount under section 1902(bb), also known as the Medicaid Prospective Payment System (PPS) rate. Statutory rules governing payment for covered services and non-covered services apply.

Considerations in favor of Options A and B, requiring or encouraging FQHC as in-network providers and payment at the Medicaid PPS rate include:

- It will increase provider network overlap with Medi-Cal managed care and Healthy Families Program providers.
- It will increase revenue to FQHCs to the extent that current uninsured clients who generally self-pay on a sliding scale (not eligible for wrap around PPS funding) enroll in Exchange plans and continue to seek care at the FQHC which is then compensated at the PPS rate.
- It will support the continued and longer term financial viability of an important type of essential community provider.

Considerations that may lead to rejection of Options A and B, requiring or encouraging FQHC as in-network providers and payment at the Medicaid PPS rate include:

- Because the Medicaid PPS rate is usually higher than payment at rates no less than the generally applicable rates of the issuer, inclusion of FQHCs may increase premiums for members of those Exchange plans with high FQHC utilization.
- The Medicaid PPS rate may be "overpayment". The Medicaid PPS rate for an FQHC clinic is for a bundle of services, some of which are not included in the definition of Essential Health Benefits or are services that the Exchange plan may not wish to purchase from the FQHC.
- Because FQHCs are a subset of clinic providers, Qualified Health Plans may not need to contract with FQHCs to meet the "sufficient" standard for Essential Community Providers, and may be discouraged from doing so if the payment rate is high.
- The Exchange does not have a mechanism or the funds to administer supplemental PPS payments to FQHCs on behalf of Exchange members.

Considerations for Option C, to require payment at rates no less than the generally applicable rates of the issuer include:

- FQHCs are expected to continue to serve the Medi-Cal population and are expected to experience both patient population and revenue increases under the Medicaid expansion provisions of the Affordable Care Act. Therefore they anticipate increased Medi-Cal revenue which may be an offset against the shortfall in payment under generally applicable rates of the issuer. Payment at generally applicable rates affirms and reinforces Exchange support of FQHC participation in Qualified Health Plan networks as important Essential Community Providers, complies with Federal

regulations to ensure FQHC compensation at commercial market rates and encourages Qualified Health Plan issuers to contract with FQHCs.

- Payment under Option C may encourage innovative contracting strategies between FQHCs and Qualified Health Plan issuers, such as bundled payments for selected services and patient conditions or enhanced and incentive payments to FQHCs that participate in the Federal Advanced Primary Care Practice demonstration project.

Option D, to assign higher scoring in the solicitation to Qualified Health Plan networks that include, or that include a higher proportion of FQHCs, is not mutually exclusive of Options A to C and can be added to any of the three. The primary consideration is that it will serve to encourage Exchange plan bidders to increase the number of contracted in-network FQHC providers. Therefore, Option D is not included in the summary Table 33 that follows this discussion.

The pros and cons of each of the three issues are presented in the following tables.



Table 31: Issue 1: Definition of Essential Community Providers

Option A: Exchange defines Essential Community Providers as the minimum standard limited to the list of 340B and 1927 providers	Option B: Exchange broadens Essential Community Providers to include physicians, clinics and hospitals that have demonstrated service to the Medi-Cal or low-income, medically underserved population
<p><b>SUMMARY</b></p> <p>The Exchange would adopt the definition of Essential Community Provider used in the Federal Law and additional regulations to include Section 340B and 1927 providers.</p>	<p><b>SUMMARY</b></p> <p>The Exchange would expand the definition of Essential Community Provider beyond the ACA identified providers to include private practice physicians, clinics and hospital that have traditionally served Medi-Cal and other low-income populations. The Exchange would establish criteria to identify providers that meet the definition of Essential Community Provider.</p>
<p><b>PURPOSE</b></p> <p>Meets the requirements of the Affordable Care Act.</p>	<p><b>PURPOSE</b></p> <p>Increases pool of Essential Community Providers to meet "sufficient" participation criteria. Increases potential overlap in provider networks for members who may shift enrollment between Medicaid and the Exchange.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Meets requirements of the Affordable Care Act.</li> <li>▪ Definition of Essential Community Provider determined by Federal designation and definition</li> <li>▪ There are a sufficient number of providers to provide Qualified Health Plans the ability to meet Essential Community Provider "sufficient" participation standard</li> <li>▪ Supports Exchange mission and values for cultural competency and potential to reduce health disparities</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Expanded Essential Community Provider definition permitted by the Affordable Care Act.</li> <li>▪ It would increase the number of Essential Community Providers for Qualified Health Plans to meet Essential Community Provider "sufficient" standard</li> <li>▪ Expanded definition can more closely match definition of traditional and Safety Net providers that has been used in Medi-Cal managed care and Healthy Families</li> <li>▪ Allows Exchange to take local provider supply and other market characteristics into consideration in designating Essential Community Providers</li> <li>▪ Improved continuity of care by increased overlap with provider networks available through Medi-Cal FFS and managed care.</li> <li>▪ Encourage responses by health plan issuers that have previously demonstrated ability to work with Essential Community Provider through Medi-Cal managed care and Healthy Families programs</li> <li>▪ May encourage health plans that have not previously included Essential Community Provider in their provider networks</li> <li>▪ Supports Exchange mission and values for cultural competency and potential to reduce health disparities</li> </ul>

Table 31: Issue 1: Definition of Essential Community Providers

Option A: Exchange defines Essential Community Providers as the minimum standard limited to the list of 340B and 1927 providers	Option B: Exchange broadens Essential Community Providers to include physicians, clinics and hospitals that have demonstrated service to the Medi-Cal or low-income, medically underserved population
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Essential Community Provider participation is not required outside the Exchange</li> <li>▪ May attract higher risk members to plans inside the Exchange to the extent high risk patients disproportionately rely on these providers</li> <li>▪ May be insufficient number to support continuation and coordination of care objectives.</li> </ul> <p>Licensed 340B providers are not distributed proportionately across all geographic areas of the state.</p>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Essential Community Provider participation is not required outside the Exchange</li> <li>▪ Requires Exchange to clarify criteria and measures for definition of additional Essential Community Providers</li> <li>▪ Increase in health plan reporting and monitoring requirements related to non-standard entities</li> <li>▪ Requires ongoing monitoring of providers identified as DSH, Medi-Cal Incentive qualified, and other designated providers who are not 340B.</li> </ul> <p>Increase in Exchange administration and oversight related to non-standard entities</p>

**Table 32: Issue 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 network overlap among MCMC, HFP networks and/or PCP providers serving 30% Medi-Cal patients and specialists serving 20% Medi-Cal patients in their practices	Option C: Demonstrate provider contracts with at least 15% of 340B providers in each region and for each product for which a health plan submits a Qualified Health Plan bid.
<p><b>SUMMARY</b> The Exchange would adopt the existing geographic and availability regulatory framework for network adequacy and apply it with Essential Community Providers.</p>	<p><b>SUMMARY</b> The Exchange would broaden the network adequacy criteria that could be used to demonstrate sufficient participation of Essential Community Provider by expanding the definition of Essential Community Provider and accepting metrics that are not limited to regulatory criteria. .</p>	<p><b>SUMMARY</b> The Exchange would require health plans to demonstrate sufficient participation of Essential Community Provider by requiring contracts with 15% of the 340B providers in each region and for each product for which a health plan submits a Qualified Health Plan bid. The criteria would be applied separately for acute care hospital and ambulatory care providers.</p>
<p><b>PURPOSE</b> Maximum participation of FQHCs at preferred Medicaid PPS payment rates</p>	<p><b>PURPOSE</b> Recognizes autonomy of health plan to determine what Essential Community Provider it will contract with to meet sufficient Essential Community Provider participation requirement.</p>	<p><b>PURPOSE</b> Recognizes the federal standard for providers that serve predominately low-income, medically underserved individuals.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Meets requirements of the Affordable Care Act.</li> <li>▪ Measures and reporting requirements are understood by health plans and regulators.</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Meets requirements of the Affordable Care Act</li> <li>▪ It would increase the options for Qualified Health Plan to meet Essential Community Provider "sufficient" standard</li> <li>▪ Provide measure of continuity of care through documented overlap with provider networks available through Medi-Cal FFS, Medi-Cal managed care, and Healthy Families Program.</li> <li>▪ Encourage responses by health plan issuers that have previously demonstrated ability to work with Essential Community Provider through Medi-Cal managed care and Healthy Families programs</li> <li>▪ Could include metrics for cultural competency and potential to reduce health disparities</li> <li>▪ Permits consistent evaluation and scoring of Essential Community Provider criteria in Qualified Health Plan selection</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Meets requirements of the Affordable Care Act</li> <li>▪ Assures minimum level of participation of traditional safety net providers</li> <li>▪ Encourage responses by health plan issuers that have previously demonstrated ability to work with Essential Community Provider through Medi-Cal</li> <li>▪ Could include metrics for cultural competency and potential to reduce health disparities</li> <li>▪ Permits consistent evaluation and scoring of Essential Community Provider criteria in Qualified Health Plan selection</li> </ul>

Table 32: Issue 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 network overlap among MCMC, HFP networks and/or PCP providers serving 30% Medi-Cal patients and specialists serving 20% Medi-Cal patients in their practices	Option C: Demonstrate provider contracts with at least 15% of 340B providers in each region and for each product for which a health plan submits a Qualified Health Plan bid.
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Essential Community Provider "sufficient" participation not required outside the Exchange. A higher threshold may discourage health plan participation.</li> <li>▪ May be insufficient to support continuation and coordination of care objectives.</li> <li>▪ Does not include measures to support Exchange mission and values for cultural competency and potential to reduce health disparities</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Essential Community Provider "sufficient" participation not required outside the Exchange. A higher threshold may discourage health plan participation.</li> <li>▪ Data may not be available to develop and clarify definition or to report on desired new metrics</li> <li>▪ Increase in health plan reporting and monitoring requirements related to new metrics</li> <li>▪ Increase in regulator and/or Exchange administration and oversight related to non-standard entities new metrics</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Essential Community Provider "sufficient" participation not required outside the Exchange. A higher threshold may discourage health plan participation.</li> <li>▪ May be insufficient to support continuation and coordination of care objectives</li> </ul>

Table 33: Issue 3: Payment rates to Federally Qualified Health Centers

Option A: Require Qualified Health Plans to contract with all FQHCs and mandate payment at PPS rate	Option B: Encourage inclusion of FQHCs in Qualified Health Plan provider networks and require payment at PPS rate	Option C: Encourage inclusion of FQHCs in Qualified Health Plan networks and require payment at fair compensation by the Qualified Health Plan
<p><b>SUMMARY</b></p> <p>The Exchange would require Qualified Health Plans to contract with all FQHCs and mandate payment at Medicaid PPS rate.</p>	<p><b>SUMMARY</b></p> <p>The Exchange would encourage but not require inclusion of FQHCs in Qualified Health Plan provider networks and require payment at Medicaid PPS rate.</p>	<p><b>SUMMARY</b></p> <p>The Exchange would encourage inclusion of FQHCs in Qualified Health Plan networks and require Qualified Health Plan payment at fair compensation, rather than at Medicaid PPS rate.</p>
<p><b>PURPOSE</b></p> <p>Maximum participation of FQHCs at preferred Medicaid PPS payment rates</p>	<p><b>PURPOSE</b></p> <p>Recognizes autonomy of health plan to determine what Essential Community Provider it will contract with to meet sufficient Essential Community Provider participation requirement.</p>	<p><b>PURPOSE</b></p> <p>Recognizes autonomy of health plan to determine what Essential Community Provider it will contract with to meet sufficient Essential Community Provider participation requirement at payment rates that contributes to an affordable product.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Improved continuity of care through increased overlap with provider networks available through Medi-Cal FFS and managed care.</li> <li>▪ Supplemental value-added services will be available to members</li> <li>▪ Supports Exchange mission and values for cultural competency and potential to reduce health disparities</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Improved continuity of care through increased overlap with provider networks available through Medi-Cal FFS and managed care.</li> <li>▪ Supplemental value-added services may be available to members</li> <li>▪ Supports Exchange mission and values for cultural competency and potential to reduce health disparities</li> <li>▪ Health plans are not required to buy services they would not otherwise provide</li> <li>▪ Encourage responses by health plan issuers that have previously demonstrated ability to work with FQHC through Medi-Cal managed care and Healthy Families programs</li> <li>▪</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Affirms and reinforces Exchange support of FQHC participation in Qualified Health Plan networks as important Essential Community Providers</li> <li>▪ Complies with Federal regulations to ensure FQHC compensation at commercial market rates and encourages Qualified Health Plan issuers to contract with FQHCs</li> <li>▪ Improved continuity of care through increased overlap with provider networks available through Medi-Cal FFS and managed care.</li> <li>▪ Supplemental value-added services may be available to members</li> <li>▪ Supports Exchange mission and values for cultural competency and potential to reduce health disparities</li> <li>▪ Encourages responses by health plan issuers that have previously demonstrated ability to work with Essential Community Provider through Medi-Cal managed care and Healthy Families programs</li> <li>▪ Encourages health plan to contract with FQHC outside the Exchange</li> <li>▪ Aligns with key Exchange value of affordability</li> </ul>

Table 33: Issue 3: Payment rates to Federally Qualified Health Centers

Option A: Require Qualified Health Plans to contract with all FQHCs and mandate payment at PPS rate	Option B: Encourage inclusion of FQHCs in Qualified Health Plan provider networks and require payment at PPS rate	Option C: Encourage inclusion of FQHCs in Qualified Health Plan networks and require payment at fair compensation by the Qualified Health Plan
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Health plan required to fund full Medicaid PPS rate. Not feasible for the Exchange as it has no additional source of funds to administer supplemental payments on behalf of Exchange members.</li> <li>▪ Does not align with key Exchange value of affordability</li> <li>▪ Would drive up cost of Exchange plans since Medicaid PPS rates are in general higher than Medicaid FFS rate for individual physician for the same services and likely to be higher than commercial rate</li> <li>▪ Discourages health plan participation as some health plans may not want to be forced into buying services that they may not otherwise include</li> <li>▪ FQHCs contracting not required outside the Exchange and may not be able to enforce payment rate for FQHCs outside the Exchange</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ It would decrease the options for Qualified Health Plan to meet Essential Community Provider "sufficient" standard</li> <li>▪ Not feasible under the Exchange as it has no additional source of funds to administer supplemental payments on behalf of Exchange members.</li> <li>▪ Does not align with key Exchange value of affordability</li> <li>▪ Would drive up cost of plans inside Exchange since PPS rates are in general higher than Medicaid FFS rate for individual physician for the same services and likely to be higher than commercial rate</li> <li>▪ Discourages health plan participation as some health plans may not want to pay for services that they may not otherwise include</li> <li>▪ FQHCs contracting not required outside the Exchange and may not be able to enforce payment rate for FQHC outside the Exchange</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ It would decrease the options for Qualified Health Plan to meet Essential Community Provider "sufficient" standard</li> </ul>

**Exhibit 1: Summary of 340B Entities and Sub-entities Grouped by Entity Type and County**

**Data Source: HRSA Office of Pharmacy Affairs (May 2012) and California Department of Health Care Services (2011-2012)**

Region/ Counties*	340B Entities and Sub-entities							340B Entities						
	CHC/ FQHC	Tribal	Other Clinic	Medicare DSH	Medicaid DSH	Other Hospital	Total	CHC/FQHC	Tribal	Other Clinic	Medicare DSH	Medicaid DSH	Other Hospital	Total
<b>Northern and Sierra Counties</b>	<b>60</b>	<b>38</b>	<b>29</b>	<b>23</b>	<b>15</b>	<b>62</b>	<b>227</b>	<b>29</b>	<b>28</b>	<b>28</b>	<b>9</b>	<b>15</b>	<b>18</b>	<b>127</b>
Alpine	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Amador	0	1	1	0	0	0	2	0	1	1	0	0	0	2
Butte	4	2	5	11	4	2	28	1	2	5	2	4	1	15
Calaveras	0	2	0	0	0	4	6	0	2	0	0	0	1	3
Colusa	2	1	0	0	0	1	4	1	1	0	0	0	1	3
Del Norte	1	2	0	0	0	0	3	1	1	0	0	0	0	2
Glenn	2	1	0	0	0	0	3	1	1	0	0	0	0	2
Humboldt	9	4	3	2	3	1	22	2	2	3	1	3	1	12
Inyo	1	3	0	0	0	2	6	1	1	0	0	0	1	3
Lake	1	1	0	3	1	13	19	1	1	0	1	1	2	6
Lassen	4	1	0	0	0	1	6	2	1	0	0	0	1	4
Mariposa	0	1	0	0	1	4	6	0	1	0	0	1	1	3
Mendocino	8	3	3	1	1	2	18	5	2	3	1	1	2	14
Modoc	0	0	1	0	1	3	5	0	0	1	0	1	2	4
Mono	0	1	0	0	0	1	2	0	1	0	0	0	1	2
Nevada	2	1	3	0	0	1	7	2	1	2	0	0	1	6
Plumas	0	1	1	0	1	0	3	0	1	1	0	1	0	3
Shasta	11	2	3	1	1	1	19	4	1	3	1	1	1	11
Sierra	2	0	1	0	0	0	3	1	0	1	0	0	0	2
Siskiyou	4	1	1	0	0	3	9	2	1	1	0	0	1	5
Sutter	5	1	3	2	0	0	11	2	1	3	1	0	0	7
Tehama	0	4	1	1	0	0	6	0	3	1	1	0	0	5
Trinity	1	0	0	0	1	0	2	1	0	0	0	1	0	2
Tuolumne	0	5	1	0	0	23	29	0	3	1	0	0	1	5
Yuba	3	0	2	2	1	0	8	2	0	2	1	1	0	6

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California Health Benefit Exchange  
Essential Community Providers Standards

Board Recommendation Brief

Region/ Counties*	340B Entities and Sub-entities							340B Entities						
	CHC/ FQHC	Tribal	Other Clinic	Medicare DSH	Medicaid DSH	Other Hospital	Total	CHC/FQHC	Tribal	Other Clinic	Medicare DSH	Medicaid DSH	Other Hospital	Total
<b>Greater Bay Area</b>	<b>133</b>	<b>3</b>	<b>91</b>	<b>62</b>	<b>14</b>	<b>17</b>	<b>320</b>	<b>40</b>	<b>3</b>	<b>55</b>	<b>25</b>	<b>14</b>	<b>2</b>	<b>139</b>
Alameda	27	2	24	9	5	0	67	9	2	14	5	5	0	35
Contra Costa	6	0	16	13	2	0	37	3	0	5	3	2	0	13
Marin	8	0	3	0	0	0	11	3	0	3	0	0	0	6
Napa	4	0	2	15	0	0	21	1	0	2	1	0	0	4
San Francisco	26	0	9	12	2	0	49	3	0	9	7	2	0	21
San Mateo	11	0	2	2	1	0	16	3	0	2	2	1	0	8
Santa Clara	25	0	20	6	1	16	68	9	0	9	3	1	1	23
Solano	14	0	8	3	2	0	27	3	0	5	2	2	0	12
Sonoma	12	1	7	2	1	1	24	6	1	6	2	1	1	17
<b>Sacramento Area</b>	<b>18</b>	<b>4</b>	<b>27</b>	<b>14</b>	<b>3</b>	<b>1</b>	<b>67</b>	<b>7</b>	<b>4</b>	<b>21</b>	<b>8</b>	<b>3</b>	<b>1</b>	<b>44</b>
El Dorado	2	1	2	0	0	1	6	1	1	2	0	0	1	5
Placer	0	1	4	0	1	0	6	0	1	4	0	1	0	6
Sacramento	9	1	17	9	2	0	38	3	1	11	5	2	0	22
Yolo	7	1	4	5	0	0	17	3	1	4	3	0	0	11
<b>San Joaquin Valley</b>	<b>113</b>	<b>5</b>	<b>56</b>	<b>43</b>	<b>20</b>	<b>2</b>	<b>239</b>	<b>20</b>	<b>4</b>	<b>35</b>	<b>21</b>	<b>20</b>	<b>1</b>	<b>101</b>
Fresno	18	2	9	7	4	0	40	3	2	7	4	4	0	20
Kern	29	1	6	4	5	2	47	2	1	5	3	5	1	17
Kings	3	0	4	2	2	0	11	3	0	2	2	2	0	9
Madera	4	0	4	1	2	0	11	1	0	4	1	2	0	8
Merced	12	0	4	3	1	0	20	3	0	4	2	1	0	10
San Joaquin	9	0	12	5	1	0	27	1	0	5	4	1	0	11
Stanislaus	18	0	7	3	2	0	30	2	0	5	2	2	0	11
Tulare	20	2	10	18	3	0	53	5	1	3	3	3	0	15
<b>Central Coast</b>	<b>79</b>	<b>4</b>	<b>44</b>	<b>27</b>	<b>9</b>	<b>0</b>	<b>163</b>	<b>10</b>	<b>2</b>	<b>24</b>	<b>9</b>	<b>9</b>	<b>0</b>	<b>54</b>
Monterey	17	0	8	8	2	0	35	2	0	4	3	2	0	11
San Benito	1	0	3	1	1	0	6	1	0	3	1	1	0	6

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**California Health Benefit Exchange  
Essential Community Providers Standards**

**Board Recommendation Brief**

Region/ Counties*	340B Entities and Sub-entities							340B Entities						
	CHC/ FQHC	Tribal	Other Clinic	Medicare DSH	Medicaid DSH	Other Hospital	Total	CHC/FQHC	Tribal	Other Clinic	Medicare DSH	Medicaid DSH	Other Hospital	Total
San Luis Obispo	18	0	5	0	1	0	24	1	0	4	0	1	0	6
Santa Barbara	11	4	8	3	2	0	28	2	2	4	2	2	0	12
Santa Cruz	6	0	7	1	1	0	15	2	0	5	1	1	0	9
Ventura	26	0	13	14	2	0	55	2	0	4	2	2	0	10
<b>Los Angeles</b>	<b>126</b>	<b>0</b>	<b>149</b>	<b>47</b>	<b>43</b>	<b>1</b>	<b>366</b>	<b>39</b>	<b>0</b>	<b>55</b>	<b>30</b>	<b>43</b>	<b>1</b>	<b>168</b>
<b>Other Southern California</b>	<b>104</b>	<b>9</b>	<b>134</b>	<b>27</b>	<b>36</b>	<b>3</b>	<b>313</b>	<b>26</b>	<b>8</b>	<b>44</b>	<b>17</b>	<b>36</b>	<b>1</b>	<b>132</b>
Imperial	6	0	2	4	2	0	14	1	0	2	2	2	0	7
Orange	13	0	19	3	12	0	47	5	0	14	1	12	0	32
Riverside	18	2	44	4	5	0	73	5	2	7	2	5	0	21
San Bernardino	3	1	14	6	10	3	37	2	1	9	5	10	1	28
San Diego	64	6	55	10	7	0	142	13	5	12	7	7	0	44
<b>Grand Total</b>	<b>633</b>	<b>63</b>	<b>530</b>	<b>243</b>	<b>140</b>	<b>86</b>	<b>1,695</b>	<b>171</b>	<b>49</b>	<b>262</b>	<b>119</b>	<b>140</b>	<b>24</b>	<b>765</b>

\* Regional groupings are based on the definitions used to report the results of the California Health Interview Survey (CHIS)

CHC/FQHC - Consolidated Health Center Program / Federally Qualified Health Center

Tribal - Tribal contract/compact with HIS and Urban Indian

DSH - Disproportionate share hospital

Other Clinic - Ryan White (Parts A, B, and C), Family Planning, Sexually Transmitted Diseases, Comprehensive Hemophilia Treatment Center, Tuberculosis

Other Hospital - Children's Hospital, Critical Access Hospital, Sole Community Hospital

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**Exhibit 1.B: Analysis of 340B Medicaid DSH Entities and Sub-entities**

**Data Source: HRSA Office of Pharmacy Affairs (May 2012) and California Department of Health Care Services (2011-2012)**

Region/Counties*	340B Entities Overlap with Medicaid DSH						
	CHC/FQHC	Tribal	Other Clinic	Other Hospital	Medicare DSH	Medicaid DSH	Medicaid DSH Only
Mono	0	0	0	0	0	0	0
Nevada	0	0	0	0	0	0	0
Plumas	0	0	0	0	0	1	1
Shasta	0	0	0	1	0	1	0
Sierra	0	0	0	0	0	0	0
Siskiyou	0	0	0	0	0	0	0
Sutter	0	0	0	0	0	0	0
Tehama	0	0	0	0	0	0	0
Trinity	0	0	0	0	1	1	0
Tuolumne	0	0	0	0	0	0	0
Yuba	0	0	0	0	1	1	0
<b>Greater Bay Area</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>9</b>	<b>14</b>	<b>4</b>
Alameda	1	0	0	0	2	5	2
Contra Costa	0	0	0	0	1	2	1
Marin	0	0	0	0	0	0	0
Napa	0	0	0	0	0	0	0
San Francisco	0	0	0	0	2	2	0
San Mateo	0	0	0	0	1	1	0
Santa Clara	0	0	0	0	1	1	0
Solano	0	0	0	0	1	2	1
Sonoma	0	0	0	0	1	1	0
<b>Sacramento Area</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>3</b>	<b>1</b>
El Dorado	0	0	0	0	0	0	0
Placer	0	0	0	0	0	1	1
Sacramento	0	0	0	0	2	2	0
Yolo	0	0	0	0	0	0	0
<b>San Joaquin Valley</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>10</b>	<b>20</b>	<b>8</b>

*Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers*

Region/Counties*	340B Entities Overlap with Medicaid DSH						
	CHC/FQHC	Tribal	Other Clinic	Other Hospital	Medicare DSH	Medicaid DSH	Medicaid DSH Only
Fresno	0	0	0	0	1	4	3
Kern	0	0	0	1	2	5	2
Kings	0	0	0	0	1	2	1
Madera	0	0	1	0	1	2	0
Merced	0	0	0	0	1	1	0
San Joaquin	0	0	0	0	1	1	0
Stanislaus	0	0	0	0	1	2	1
Tulare	0	0	0	0	2	3	1
<b>Central Coast</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>4</b>	<b>9</b>	<b>4</b>
Monterey	0	0	0	0	1	2	1
San Benito	0	0	0	0	1	1	0
San Luis Obispo	0	0	1	0	0	1	0
Santa Barbara	0	0	0	0	1	2	1
Santa Cruz	0	0	0	0	0	1	1
Ventura	0	0	0	0	1	2	1
<b>Los Angeles</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>14</b>	<b>43</b>	<b>28</b>
<b>Other Southern California</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>10</b>	<b>36</b>	<b>26</b>
Imperial	0	0	0	0	2	2	0
Orange	0	0	0	0	1	12	11
Riverside	0	0	0	0	1	5	4
San Bernardino	0	0	0	0	3	10	7
San Diego	0	0	0	0	3	7	4
<b>Grand Total</b>	<b>1</b>	<b>0</b>	<b>3</b>	<b>6</b>	<b>55</b>	<b>140</b>	<b>75</b>

\*Regional groupings are based on the definitions used to report the results of the California Health Interview Survey (CHIS)

CHC/FQHC - Consolidated Health Center Program / Federally Qualified Health Center

Tribal - Tribal contract/compact with HIS and Urban Indian, DSH - Disproportionate share hospital

Other Clinic - Ryan White (Parts A, B, and C), Family Planning, Sexually Transmitted Diseases, Comprehensive Hemophilia Treatment Center, Tuberculosis

Other Hospital - Children's Hospital, Critical Access Hospital, Sole Community Hospital, The total number of entities in CHC/FQHC, Tribal, Other Clinic, Other Hospital, Medicare DSH and Medicaid DSH Only sum up to Medicaid DSH

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## Assuring Quality and Affordability

### Strategies to Promote Better Quality and More Affordable Care

#### Introduction

The core values of the California Health Benefit Exchange are to be **consumer-focused**, promote **affordability**, operate with **integrity**, be a **catalyst** for change, promote **partnership**, and be accountable for its **results**. 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 aims espoused in the National Quality Strategy, which was developed in response to the Affordable Care Act requirement that the Secretary of the Department of Health and Human Services to establish a National Strategy for Quality Improvement in Health Care to set priorities and recommend a plan for implementation.

The Affordable Care Act calls upon the Exchanges to advance “plan or coverage benefits and health care provider reimbursement structures” that improve health outcomes. The California Health Benefit Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With a long legacy of integrated care delivered through the infrastructure of multispecialty physician groups and independent practice associations, California is uniquely positioned to support delivery system redesign and payment reform through health plans and products offered through the Exchange. In contrast to national trends, a significant portion of California’s insured population is enrolled in health plans that actively promote team-based care and coordination among providers (42% of the insured population are enrolled in HMOs compared to 22% nationally).<sup>28</sup> In addition, the Medi-Cal program is in the process of expanding its three models of managed care to encompass the vast majority of its beneficiaries, including those who are dual eligible, in systems of coordinated care.

#### Background

The rate of increase in health care costs is not sustainable. Even though the rate of increase during the recession has slowed, the United States spends more on health care, both per capita

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<sup>28</sup> <http://www.statehealthfacts.org/profileind.jsp?ind=349&cat=7&rgn=6>

and as a share of GDP, than any other country in the world. Recent analyses of 2009 data by the California HealthCare Foundation highlight<sup>29</sup>:

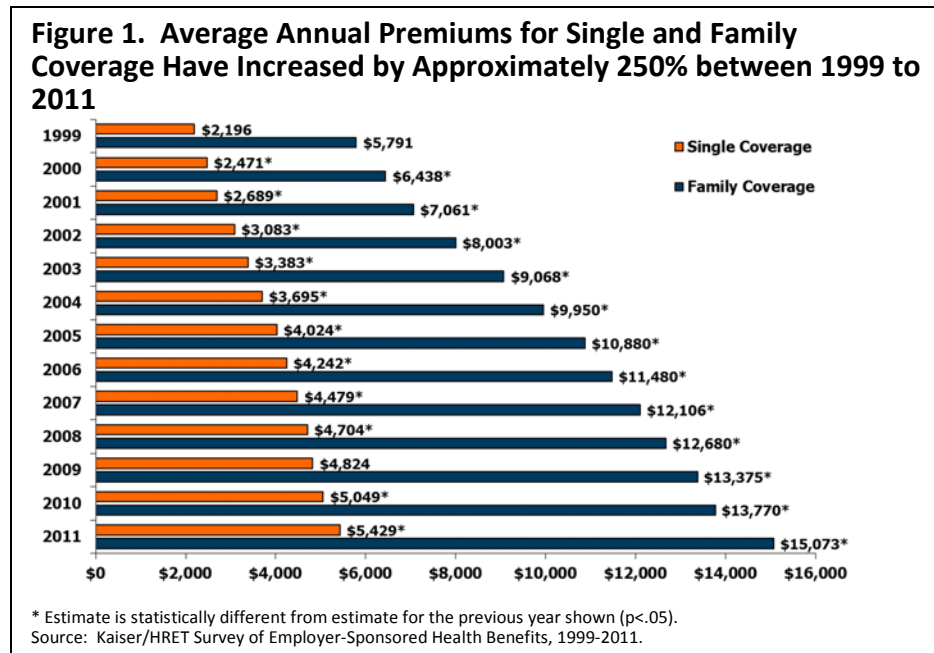
- Health spending in California reached \$230 billion, triple 1991 levels.
- California's per capita spending of \$6,238 was the ninth lowest in the nation. By comparison, US spending per capita was \$6,815.
- Health spending accounted for 12.2% of California's economy — a smaller share of the economy than most states or the nation.
- Hospital and physician services continued to account for the majority of spending, totaling 63%.
- Medicare and Medicaid accounted for nearly 40% of California health spending, up from 27% in 1991.

Over the last decade, the cost for individual and family coverage has more than doubled, far exceeding the Consumer Price Index (CPI), and even the Medical CPI (Figure 1). The rate of health care inflation has outpaced wage increases for a number of years. Between 1999 and 2011, employee contributions to premium increased by 168% while workers' wages increased less than one-third of that amount by 50%. The impact has been felt most dramatically in the small group and individual markets, which have seen a significant shift towards products with greater cost-sharing. From 2006 to 2011, there was a greater than four-fold increase in the number of small employers (3-199 employees) from 6% to 28% enrolled in PPO and account-based plans with a deductible of \$2,000 or more.<sup>30</sup>

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<sup>29</sup> Health Care Costs 101, California HealthCare Foundation, May 2012. Accessed at: <http://www.chcf.org/publications/2012/05/health-care-costs-101>

<sup>30</sup> 2011 Employer Health Benefits Survey, Kaiser Family Foundation/Health Research & Educational Trust, September 2011. Accessed at <http://ehbs.kff.org/>



**Figure: 1 Average Annual Premiums for Single and Family Coverage have Increased by Approximately 250% between 1999 to 2011**

Despite California’s leadership in integrated delivery systems and history of managed care, research shows us that health care quality varies, is often unsafe, and that we are spending far too much on inappropriate and unnecessary care:

- Quality of care varies dramatically between doctors and hospitals, but those differences are invisible to patients.
- Payments reward quantity over quality and fixing problems over prevention.
- Lack of standardized performance measures makes it hard to know which providers are doing a good job, and which are not.
- Consumers lack information to make the choices that are right for them.

Critical to the success of the Exchange is its ability to improve the affordability of health care for individuals and small businesses. But to address the affordability for those who enroll in the Exchange, the Exchange needs to look more broadly at affordability and the drivers of health care costs and cost increases. There is huge variation in the quality of health care and in the cost of care for services provided. In addition to the variation in quality, we also know that people of color, limited English speakers and low income people often receive lower quality health care, even when they have the same health care coverage as other populations.<sup>31</sup>

<sup>31</sup> Lee, PV. “Policy Options to Promote Delivery System Reform, Testimony to US Senate Finance Committee, April 21, 2009.

There is little correlation between cost and quality. Higher cost does not mean the quality of care is better and lower cost does not mean it's worse. Research has demonstrated for individual clinicians, medical groups, and hospitals that on a global level the variation clearly means that we cannot "pay our way" to better quality. The Integrated Healthcare Association (IHA) analysis of Appropriate Resource Use among California medical groups shows significant cost and quality variation even where payments are typically capitated in the aggregate for professional services and where there are often full risk or shared risk arrangements for hospital services (Figure 2).

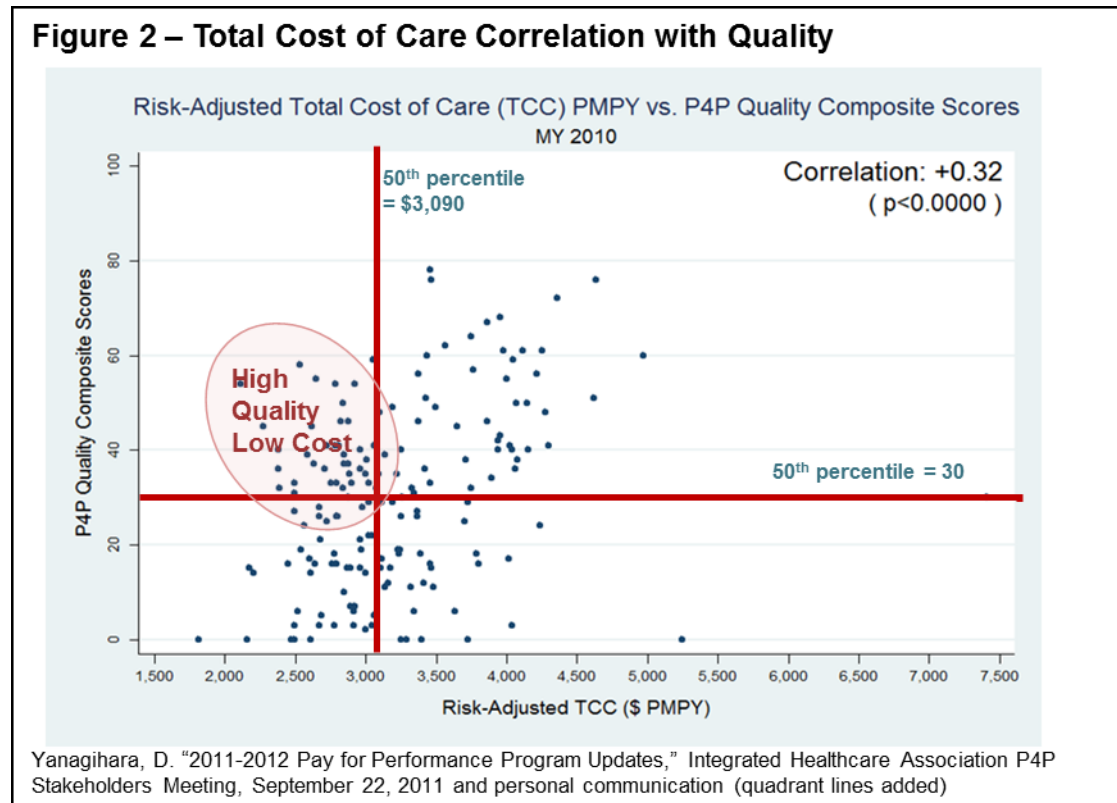


Figure 2: Total Cost of Care correlation with Quality

Cost and quality variation is even greater among PPO providers, where the fee-for-service payment system rewards providers for the number of treatments and procedures they provide and pays more for using expensive technology or surgical interventions. It is neither designed to reward better quality, care coordination or prevention nor to encourage patients to get the right care at the right time.

Contributing to care variation are geographic differences, which are driven by different physician practice patterns and potentially by the supply of hospital beds and clinic, as in some markets. Research by John Wennberg and Dartmouth colleagues reinforce the disparate effect of supply on the volume of services. For example, repair of hip fractures does not vary with



hospital bed supply but cardiac surgery varies significantly. Figure 3 illustrates the variation in service volume related to end-of-life care. Similar research conducted by Laurence Baker in California identified significant variation in cardiac care, joint replacement surgeries, as well as in general surgical services such as gall bladder removal.

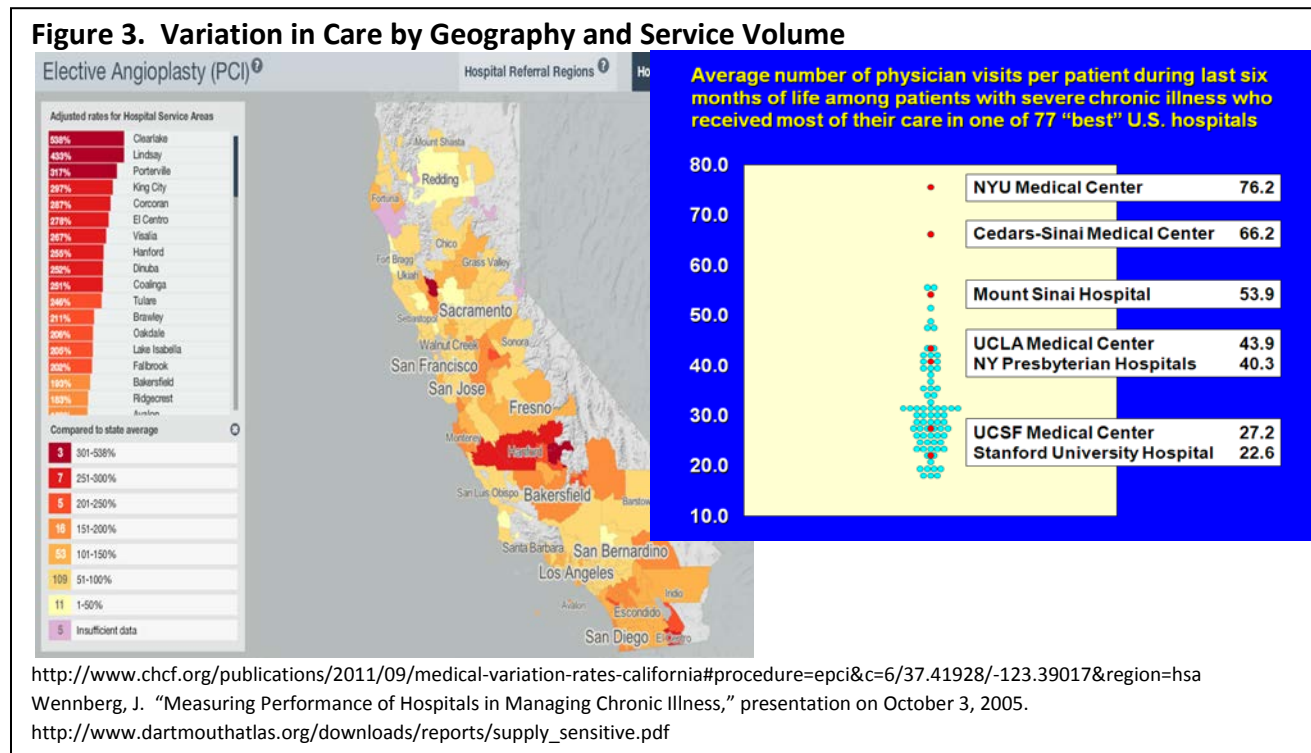


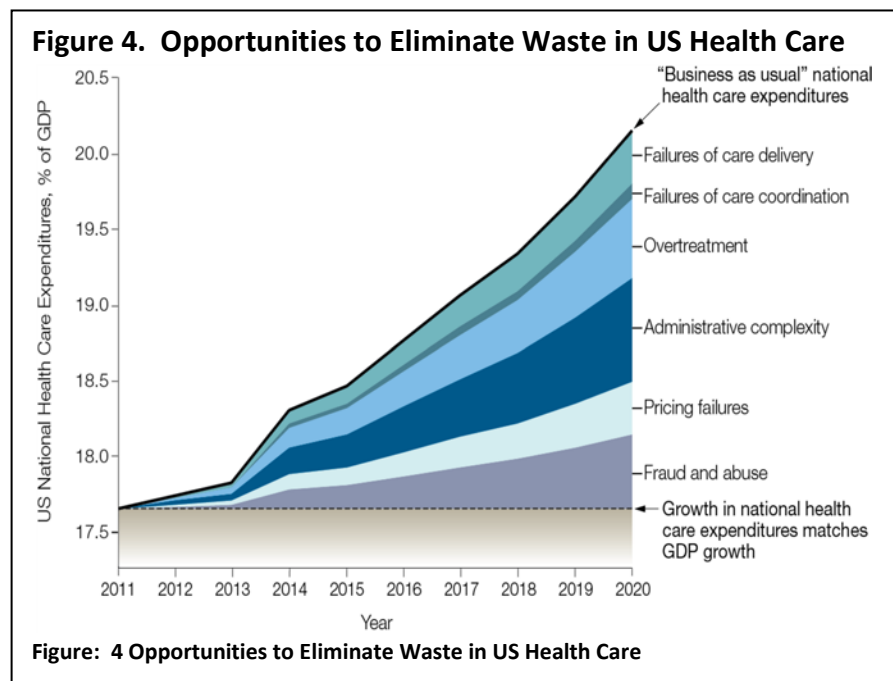
Figure 3: Variation in Care by Geography and Service Volume

Achieving affordable health care and sustaining coverage expansion through the Exchange also necessitates reducing waste in the health care system. Commonly, programs to contain costs use cuts, such as reductions in payment levels, benefit structures, and eligibility. Former Centers for Medicare and Medicaid Administrator, Don Berwick, MD, writes, "The savings potentially achievable from systematic, comprehensive, and cooperative pursuit of even a fractional reduction in waste are far higher than from more direct and blunter cuts in care and coverage." In just 6 categories of waste—overtreatment, failures of care coordination, failures in execution of care processes, administrative complexity, pricing failures, and fraud and abuse—the sum of the lowest available estimates exceeds 20% of total health care expenditures.<sup>32</sup> Figure 4 depicts the anticipated rise in health care costs if we continue to operate "business as usual," and the shaded regions represent health care expenditures as a

<sup>32</sup> Berwick DM and Hackbarth AD. "Eliminating Waste in US Health Care," JAMA. 2012;307(14):1513-1516. Accessed at <http://jama.jamanetwork.com/article.aspx?articleid=1148376>

percentage of GDP that could be eliminated by reduction of spending in that waste category over time.

The shortage of standardized performance measures for health outcomes can make it difficult to know which providers are doing a good job, and which are not. Health care is an information-dependent industry that, all too often, has failed to keep up with the revolution in knowledge and information processing that has transformed the global economy. Patients, clinicians, and policymakers need reliable, real-time information to make



sound decisions – whether about individual patient care or the allocation of societal resources. Beyond alignment with the federal HITECH incentives to report quality data the Exchange has the opportunity to reinforce the use of standardized measures within the California market for public reporting as well as performance management. The HITECH incentives for meaningful use of health information technology pays near-term bonuses, but can reduce hospital and physician payments up to 3% by 2017 for failure to implement electronic health records. California has important foundational elements, such as standardized public reporting of quality measures through the state’s Office of the Patient Advocate, and existing collaboration through the IHA Pay for Performance Program. Additional provider engagement strategies exist through California’s medical specialty and clinical associations, collaboratives such as Collaborative Alliance for Nursing Outcomes (CaNOC) and the California Quality Collaborative, which have sponsored learning networks to spread best practices and support implementation of quality improvement activities.

Consumers lack information to make the choices that are right for them. Too often, health care consumers cannot compare the quality or cost of care offered by medical practitioners, clinics and hospitals or the various treatment options available to them to make good choices. Californians need tools to help them make good health care decisions. Consumers also want information on demand – where they need it, when they need it (Figure 5).

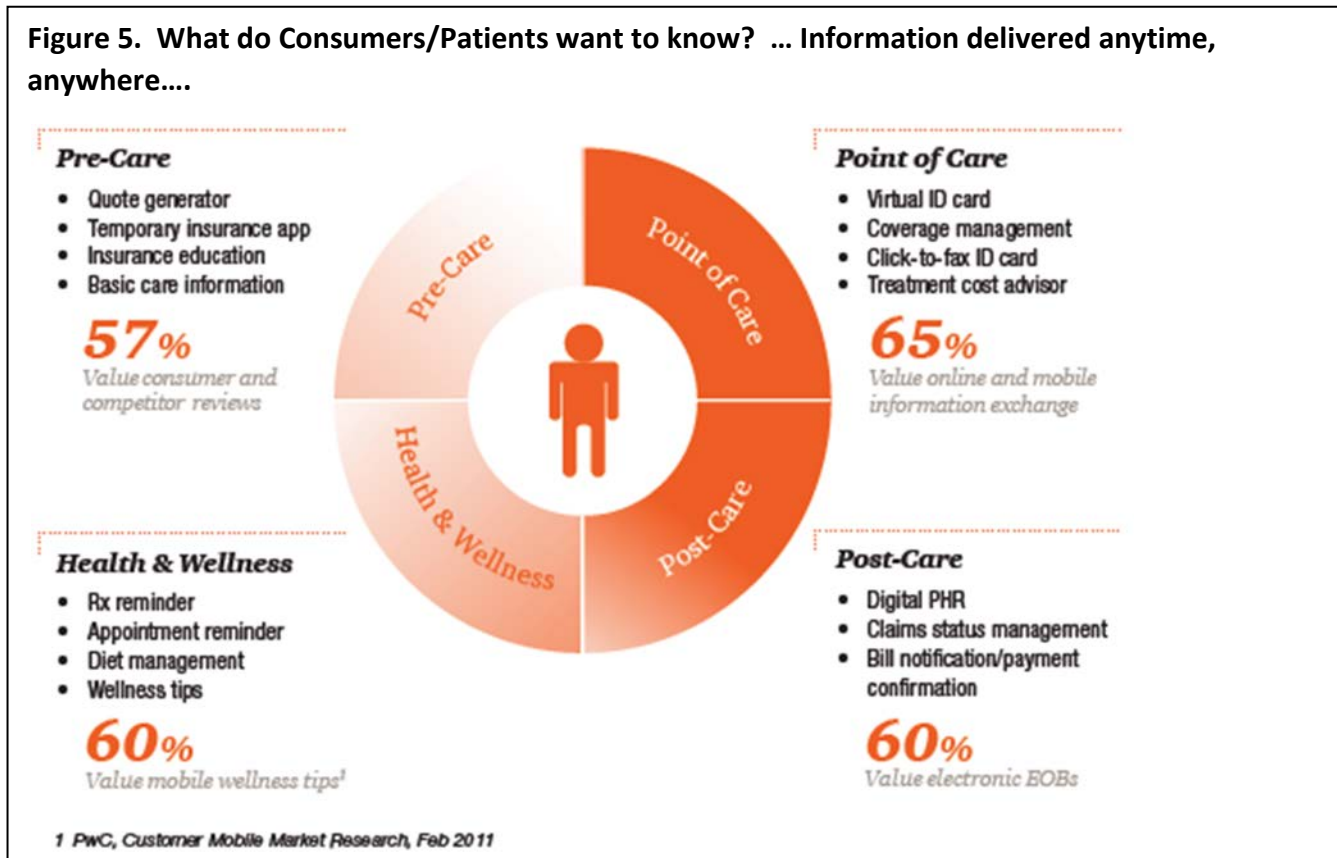


Figure 5: What do Consumers/Patients want to know? Information delivered anytime, anywhere

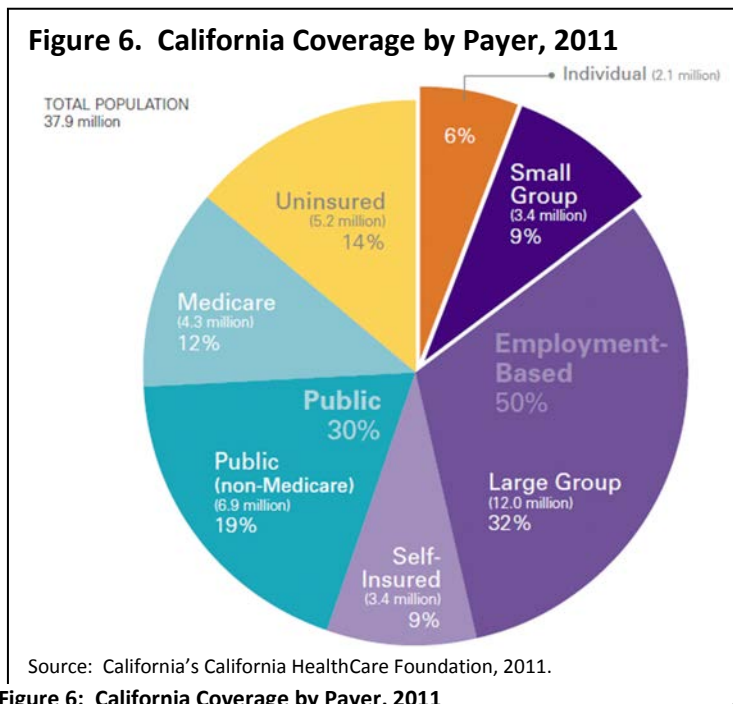
### Stakeholder Perspectives

The Exchange incorporated feedback from diverse stakeholders in this Board Recommendation Brief. A key aspect to improving quality and lowering cost is for the Exchange to use common performance standards not only for Qualified Health Plans, but also for their network of health care providers. Purchasers advocated for *“a meaningful and balanced dashboard of performance measures, starting with those used in existing reporting systems, but with a roadmap to implement more consumer-focused measures; provider-level quality data made available to the consumer at the time of plan selection; transparent plan pricing and quality information paired with decision-support tools; and effective purchasing tools used by large employers.”* The Exchange can support the movement to develop and implement standards and encourage collaboration to address ongoing challenges to quality, value and affordability. Another stakeholder called for using partnership as a criterion: *“A plan that does a smidge less well on a HEDIS measure may bring a true partnership perspective...and that may be more valuable in the end.”*

Additionally, various consumer organizations encouraged the Exchange to support broad plan and provider access, particularly in rural areas, and to assure cultural competency among providers, and some requested a broad view of cultural competency.

Health plans called for harmonizing standards across California’s regulatory agencies. Individual health plans are generally concerned about reporting burden and some have expressed that the Exchange should not establish requirements that exceed state or federal reporting expectations. For example, one issuer suggested, *“If CA HBEX chooses to go beyond the core requirements, it should choose additional strategies from requirements established by CCIIO for Exchanges that reflect ongoing community-based initiatives and are consistent with the Triple Aim identified in the National Quality Strategy, specifically, better care, affordable care and healthy people and communities. In addition, it is important that public reporting of quality measurement and any improvements as a result of Qualified Health Plan quality improvement strategies are appropriately phased in.”*

Provider-centered organizations note: *“the California P4P Program’s traditional focus on quality performance has evolved over the past couple of years to include quality, resource use, and cost performance. Likewise, the payment framework that has accompanied our performance measurement traditionally focused on incremental bonuses to physician organizations based on their quality performance. However, the program is transitioning to “Value Based P4P,” which will be a shared savings model that focuses on the quality, cost, and resource use performance of physician groups.”* This is an example of paying for value in healthcare, but also points to caution against Qualified Health Plan standards that present barriers to new entrants to the marketplace. Provider organizations further call for: *“The Exchange should lead the transformation of the delivery system through requirements upon Qualified Health Plans to pay providers under innovative outcome-based models, rather than fee for service. Outcome-based payment models incent providers to incorporate patient care coordination functions into their delivery of care. In this regard, the Exchange should pay close attention to the recent work of the CMS Innovation Center with Pioneer ACOs – six of which are based in California.”*



## Value-Purchasing Alignment

The Exchange will be a large purchaser of health care on behalf of millions of Californians. But even at two million lives, the Exchange would only represent 5.4% of the California market (Figure 6). To have an impact on the delivery of health care, even the largest single purchaser in the country, the federal government, has recognized that it must align its efforts with those of other public and private purchasers if it is to truly improve the quality and affordability of the American health care system. That imperative of alignment is articulated in the National Quality Strategy which, like the Exchange, was a product of the Affordable Care Act.

Since the release of the National Quality Strategy in March 2011 (and its update in April 2012), it has been a guide for harmonizing public and private purchaser strategies, and served to align Medicare, Medicaid and other federal and state programs. Other opportunities for alignment include elements of the National Prevention Strategy, HITECH Meaningful Use requirements, and the proposed measures for Accountable Care Organizations described in the Medicare Shared Savings Program regulations. The National Quality Strategy articulates a framework (depicted in Figure 7) that supports a broad view of quality measurement and improvement.

Payments must also be reformed to reward higher value and we need to be sure that these efforts align public and private sector efforts. There is “a widespread consensus that the current model of fee-for-service payments undercompensate evaluation and management services as compared with procedures and technical services, does a poor job of providing incentives to clinicians for collaboration, do not improve efficiency, is not focused on quality and outcomes, and does little to encourage wellness and prevention.... Without such harmonization, uncoordinated payment



Figure 7: National Quality Strategy Framework



reforms run the risk of creating a confusing hodgepodge of requirements, incentives, penalties, and rewards for providers and patients alike.”<sup>33</sup>

The Exchange should align its efforts to enhance value, improve quality and lower health care costs with the three-part aim of the National Quality Strategy (See Strategies to Promote Better Care, Appendix A for additional details). Staff also considered the quality reporting requirements of the California Department of Health Care Services Medi-Cal Managed Care Program, which in its 2012 Quality Strategy Report, describes its planned convergence with the National Quality Strategy. Contracting requirements for the California Healthy Families were also considered. These are described in Appendix B.

Specific areas to investigate for current alignment of Exchange policy and federal and statewide efforts include:

1. Federal reforms (e.g. Centers for Medicare and Medicaid Services value-based purchasing initiatives and the many programs of the Center for Medicare and Medicaid Innovation)
2. State reforms (e.g. Medi-Cal Managed Care and Payment reforms)
3. National private initiatives (e.g. promoting the Choosing Wisely initiative of Consumers Union and major Physician Specialty Societies - see Appendix C)
4. State public-private initiatives (e.g., the measurement, payment and delivery reform efforts of public/private collaboratives like the Pacific Business Group on Health and the Integrated Healthcare Association’s Pay for Performance and Bundled Payment Initiatives).

Illustrative examples of current Medicare pilots to redesign care, reform payment and better engage consumers are itemized in Appendix D along with potential opportunities for specific Exchange alignment. While there are literally hundreds of efforts across the country to reform payments, Medicare has become a leader in working to achieve change on a broad scale. The Medicare Hospital Value-Based Purchasing program will increase the portion of hospital payments linked to performance to 10% by 2017. Bonus payments for Medicare Star Quality Rating System has motivated new multi-carrier efforts while the Partnership for Patients effort has fostered development of regional collaboratives focused on patient safety. Recent Center for Medicare and Medicaid Innovation (CMMI) initiatives, such as the Bundled Payment program, holds promise in aligning incentives across physicians and hospitals. The Exchange will also seek to align with the transparency requirements for CMMI’s Pioneer ACO program, whereby accountable care organizations report on shared savings, quality measures, patient experience of care surveys and claims-based measures. CMMI’s Comprehensive Primary Care

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<sup>33</sup> Lee, P, Berenson, R and Tooker, J. “Payment Reform — The Need to Harmonize Approaches in Medicare and the Private Sector,” N Engl J Med 2010; 362:3-5, January 7, 2010.

Initiative in seven communities nationally, along with its recent Intensive Outpatient Care Program grant in California will test intensive medical home approaches to redesign care and align financial incentives.

Given the proliferation of national and statewide initiatives, the Exchange needs to determine the extent to which it requires or encourages Qualified Health Plans to support particular initiatives versus identifying themes or areas of concentration. Efforts such as the IHA Bundled Payment program seek to align incentives among providers and may be complemented by benefit and network designs that use reference pricing. The Medi-Cal Managed Care expansion for dual eligibles may expand primary care access and improve care coordination processes that benefit Exchange enrollees. The Exchange can also leverage the Qualified Health Plan selection process to stimulate change in the delivery of health care outside the Exchange.

In California, one of the main purchaser groups that has brought together both public and private sector purchasers to promote quality and affordability has been the Pacific Business Group on Health (PBGH). Administered by PBGH, the California Collaborative Healthcare Reporting Initiative (CCHRI) pioneered health plan patient experience and quality reporting over 20 years ago. CCHRI also sponsored early development of patient experience measures at the medical group level and helped guide more recent efforts to measure physician-level quality in concert with the state's three largest statewide PPO health plans. The California Joint Replacement Registry (CJRR) is an effort by the California HealthCare Foundation (CHCF), PBGH and the California Orthopaedic Association and goes one step farther to collect and report on the results of hip and knee replacements, including device safety and effectiveness, post-operative complications and patient-reported outcomes. A list of PBGH members along with the affiliated Silicon Valley Employers Forum and the mission statement of PBGH is included as Appendix E.

An active purchaser community has also contributed to important public-private partnerships that promote delivery system reform. The Exchange products can leverage synergies with these efforts by requiring its issuers to offer similar programs for Exchange members or design provider networks and initiatives that parallel these efforts to enhance value and transparency.

- CalPERS seeks to advance use of information about hospital quality and efficiency as the basis for benefit design and differential payments to hospitals.
- CalPERS' early success with its Accountable Care Organization (ACO) pilot program yielded \$15.5 million in health care savings in 2010, and is being modeled in other communities.
- The City and County of San Francisco partnered with Blue Shield to offer two ACO programs that seek to improve care coordination and reduce trend.

- Working with CalPERS and Pacific Gas and Electric Company and in partnership with Anthem Blue Cross and the Humboldt del Norte Foundation IPA, PBGH has replicated an Intensive Outpatient Care Program, which uses a dedicated care manager to support high risk beneficiaries. Boeing is expanding this effort in Southern California.
- Cisco Systems and Intel Corporation initiated a pay for performance program with five provider groups in Silicon Valley to promote adoption of health information technology.
- Pitney Bowes and Wells Fargo use information from the eValue8 Health Plan RFI to enhance consumer information and choice tools for health plan enrollment.

Broadly speaking, Exchange policy can foster effective delivery system reform to achieve better value and the three aims of the National Quality Strategy by translating the National Quality Strategy principles into specific tactics that:

1. Promote better measurement that fosters timely and effective data collection and information-sharing;
2. Support transparency in health plan and provider performance measurement;
3. Foster care redesign and delivery system re-engineering that improves quality and health outcomes, while also enhancing primary care access;
4. Promote payment that rewards higher value and aligns incentives across both public and private sector payers;
5. Engage consumers with information, decision support, and incentives to optimize self-care and make the best choices about their treatment and providers; and
6. Incent evidence-based benefit design and support the use of quality and cost in addressing the comparative effectiveness of treatments, drugs and devices.

In the sections discussing each of these six areas that follow, the Board Recommendation Brief states the Exchange may “encourage Qualified Health Plans to...” The Exchange’s strategies and tactics to promote quality, affordability and better health will evolve over time. In this brief, staff recommendations for how the Exchange should encourage Qualified Health Plans in these areas follow this discussion. Additional strategies are also described in other Board Recommendation Briefs, such as those on Wellness and Health Promotion, Rating and Benefit Design. Other examples of how the Exchange can improve health outcomes through “plan or coverage benefits and health care provider reimbursement structures”<sup>34</sup> are included as **Appendix F**, excerpted from a Commonwealth Fund paper on implementation considerations for health plan quality improvement strategy reporting under the Affordable Care Act:

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<sup>34</sup> Affordable Care Act, Sections 2717 and 1311.



## Better Measurement and Information-Sharing

The Exchange's measurement strategy should take into account the various audiences for health plan and provider quality information. The Exchange should use outcomes measures when they are available and report on clinical process measures and improvement strategies only when outcomes reporting is not yet feasible. Staff is cognizant of reporting burden on both issuers and providers, and recommend the Exchange seek to use nationally standardized measures whenever available, but note that there are important gaps in measures and data infrastructure to capture information on care coordination and patient-reported outcomes. Beyond monitoring and oversight, the Exchange needs to seek to provide robust and meaningful information to beneficiaries in supporting plan, provider and treatment selection.

Similar to large public and private purchasers, the Exchange may rely on both NCQA accreditation and other vehicles, such as health plan Requests for Information to collect program and service operations data and, to varying degrees, to assess the effectiveness of a health plan's quality improvement programs. The Exchange expects issuers to use valid methodologies and the most robust information available to inform high performance network design and network expansion and to include essential community providers. The quality reporting system should also assess whether health plans make information about the performance of individual physicians and hospital service lines available to their members. Such information is becoming more widely available through Medicare value-purchasing requirements and its Physician Quality Reporting System. Research has shown that consumers prefer it to performance information aggregated at physician group or hospital-wide levels. In addition to elements described in the Board Recommendation Brief on Accreditation Standards and Reporting, the Exchange may encourage Qualified Health Plans to:

- Participate in statewide multi-payer claims data initiatives to pool data for performance measurement;
- Include measures of overuse and whether care is appropriate for both measurement and payment; and

The Exchange is further charged with developing a quality rating system that accounts for the cost and quality of Qualified Health Plans and publishing these ratings on the Exchange Web site. Additionally, there must be an enrollee satisfaction survey system with results published on the Web site.

## Transparency

Improving quality requires sharing information about what is happening inside our health care system with everyone who gets, gives or pays for care. Improving value requires independent systems for collecting and reporting performance results on patients' outcomes, cost and patients' views of care, and whether the right processes of care are being delivered by doctors,

medical groups, hospitals, nursing homes, and other providers. The current landscape for quality reporting includes multiple collaborative efforts, but there remain significant gaps in disclosure of cost and efficiency information. Table 34 summarizes major federal and California-based initiatives.

**Table 34: Major Transparency Initiatives**

Level of Reporting	Measures in Use	Sponsoring Organization	Public Reporting Sponsor
Health Plan		Centers for Medicare & Medicaid Services	Medicare Plan Finder
<ul style="list-style-type: none"> <li>▪ Medicare Advantage</li> <li>▪ Commercial HMO &amp; PPO, Medicare</li> <li>▪ Healthy Families</li> <li>▪ Medicaid Managed Care</li> </ul>	<p>HEDIS clinical quality and outcomes</p> <p>CAHPS Patient Experience</p> <p>Operational metrics and access (Medi-Cal)</p>	<p>Star program</p> <p>California Cooperative Healthcare Reporting Initiative</p> <p>Managed Risk Medical Insurance Board</p> <p>California Department of Health Care Services (DHCS)</p>	<p>Office of the Patient Advocate (OPA)</p> <p>OPA</p> <p>DHCS</p>
Hospital	Clinical quality and outcomes Patient safety	Centers for Medicare & Medicaid Services California Hospital Assessment and Reporting Taskforce Leapfrog Group California Office of Statewide Health Planning and Development (OSHPD)	Medicare Hospital Compare California HealthCare Foundation Leapfrog OSHPD
Medical Group	HEDIS clinical quality and outcomes Total Cost of Care Patient Assessment Survey	Integrated Healthcare Association California Cooperative Healthcare Reporting Initiative	Office of the Patient Advocate
Physician	HEDIS clinical quality Patient Assessment Survey (Physician-level)	Centers for Medicare & Medicaid Services California Physician Performance Initiative (managed by CCHRI) Additional voluntary initiatives by specialty area (e.g., California Joint Replacement Registry, California Maternal Quality Care Collaborative)	Medicare Physician Compare Clinical quality data is not publicly reported at this time though individual medical groups may report patient experience

The breadth of support for doing measurement right – expanding our measurement of outcomes, patient-experience, disparities in care and resource use – is critical and charts a path for action. The Exchange may encourage qualified health plans to:

- Participate in statewide or national collaboratives to measure and report on quality and efficiency of provider performance;
- Support expansion of measurement in key domains of the National Quality Strategy, with particular focus on areas where there are limited metrics that are nationally standardized (e.g., care coordination, patient and family engagement, affordability); and
- Make quality and cost information available to consumers.

## Care Redesign and Delivery System Re-engineering

There are opportunities for significant improvements in quality and care coordination and reduced waste from overuse and services that are not evidence-based. To achieve health care transformation rather than affirm the status quo, the Exchange seeks to align with other public and private initiatives to re-engineer care delivery. Specifically, the Exchange may encourage Qualified Health Plans to demonstrate:

- Infrastructure investment and "meaningful use" of technology to improve data collection and sharing of information to optimize access at the right site, with the right provider and at the right time;
- Adoption of electronic health records and data exchange that improves clinical processes and reduces duplication of services;
- Use of information systems for clinical decision support and communication of shared care plan with patients; and
- Use of a patient-centered, team-based approach to care delivery and member engagement.

## Payment Reform

The Exchange needs to be part of the movement to change payment to reward value – the quality and affordability of care – instead of volume. For example, it could encourage Qualified Health Plans to implement payment reform strategies consistent with the principles articulated by the Catalyst for Payment Reform (CPR), which is an independent organization led by health care purchasers seeking to improve quality and reduce costs by identifying and coordinating workable solutions to improve how we pay for health care in the United States. Stakeholders representing providers, health plans, consumers and labor groups are also represented. These principles are well aligned with the Exchange's goals:<sup>35</sup>

- Reward the delivery of quality, cost-effective and affordable care;
- Encourage and reward patient-centered care that coordinates services across the spectrum of health care providers and care settings;
- Foster alignment between public and private health care sectors;
- Make decisions about payment using independent processes;
- Reduce expenditures on administrative and other processes; and
- Balance urgency to implement changes against the need to have realistic goals and timelines.

The Exchange can encourage health plans to design payment systems that reward providers for giving the right care at the right time and encourage patients to be actively engaged in their

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<sup>35</sup> Accessed at: <http://www.catalyzepaymentreform.org/Principles.html>

care. The development of high performance network products and expansion of provider-specific health care performance results hold the promise of reducing premiums and improving quality of care. Some options for the Exchange are to encourage qualified health plans to:

- Reward providers who deliver high-quality, cost effective care or who improve significantly. Potential reporting elements include the percentage of total payments that:
  - Reward better care, participation in reporting programs, improvements in delivery or adoption of health information technology (such as e-prescribing);
  - Reward care coordination;
  - Differentiate payment for services of uncertain value because of gaps in evidence or for which there is no demonstration that the patients' values and preferences were incorporated in the decision process.
- Increase payments for primary care, rewarding better coordination and more efficient care, including recognition of primary care medical home pilots.
- Foster the organization of health care providers systems to establish financial incentives to improve care coordination, including support of:
  - Accountable Care Organizations (ACOs) to align incentives and improve data exchange among physician organizations, hospitals and health plans.
  - Patient Centered Medical Homes (PCMH) to improve primary care access and support for special needs populations
- Encourage plan efforts to undertake quality-based contracting, reference-pricing and/or bundled payment strategies.
- Encourage plan efforts to expand access through telemedicine and use of appropriately trained ancillary providers.

Many of these elements are captured in the eValue8 Health Plan Request for Information as well as in the Catalyst for Payment Reform model contract language which are described in detail below.

To create a higher value system, alignment along multiple fronts is critical. Such alignment must include efforts by public and private payers, as well as federal and California projects. Medicare, Medicaid, and private-sector payers therefore have a common interest not only in creating new payment models, but also in correcting the pricing distortions that currently underlie the fee schedules derived from the resource-based relative-value scale on which all payers rely.<sup>36</sup>

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<sup>36</sup> Ibid.

## Consumer Engagement

Much as there needs to be an infrastructure to support the efficient collection and sharing of information, there must be effective ways to engage patients with information and incentives to make the best decisions. Today, health care consumers rarely are using tools to compare the quality or cost of care offered by medical practitioners, clinics and hospitals or the various treatment options available to them to make good choices. Patients need information and shared decision making tools to help them make good health care decisions. Patient decision aids go beyond traditional informed consent in which risks, benefits, alternatives, and weighing of probabilities are discussed, to better assure that the patient's individual values and preferences are informed by those risks, benefits and potential outcomes. Health plan efforts to foster better engagement of patients could be encouraged by the Exchange encouraging health plans to:

- Promote availability of valid information consumers can use to compare quality and cost of medical treatments and providers.
- Provide information and incentives for wellness and the selection of higher value providers.
- Support shared decision making (SDM) processes through incentives to patients to get coaching and reducing payments to providers in cases where preference sensitive care (i.e., care for which there is more than one medically reasonable choice, with choices that differ in risks and benefits – such as treating chest pain from coronary artery disease or early-stage prostate cancer) was delivered in the absence of patient participation in decision-making.

It should be noted that the Affordable Care Act provides for the establishment of independent standards for certification of patient decision aids; for the development, update, and production of patient decision aids to assist providers in educating patients; and grants to support implementation. It also amends the Public Health Services Act to develop a quality measure that includes the use of Shared Decision-Making (SDM) and preference sensitive care. The Exchange also has an opportunity to leverage lessons from other states in broadening adoption of this approach.<sup>37</sup>

The Exchange may also leverage efforts such as Choosing Wisely, a joint effort of the American Board of Internal Medicine Foundation and Consumers Union to promote conversations between physicians and patients by helping patients choose care that is supported by evidence, not duplicative of the other tests or procedures already received, free from harm, and truly

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<sup>37</sup> Shafir A and Rosenthal J. "Shared Decision Making: Advancing Patient-Centered Care through State and Federal Implementation," Informed Medical Decisions Foundation and National Academy for State Health Policy, March 2012. Accessed at <http://www.nashp.org/sites/default/files/shared.decision.making.report.pdf>

necessary. Initially, nine national medical specialty societies have been asked to “choose wisely” by identifying five tests or procedures commonly used in their field, whose necessity should be questioned and discussed. The resulting list of “Five Things Physicians and Patients Should Question” is intended to spark discussion about the need- or lack thereof- for many frequently ordered tests or treatments. An additional eight specialty societies have joined the effort with plans to issue their five recommendations in the Fall of 2012. The Exchange can foster engagement of the California chapters of these medical specialty organizations to promote this initiative, as well as work with Qualified Health Plans to measure its impact.

### **Evidence Based Benefit Design and Coverage Rules**

The Exchange can encourage Qualified Health Plans to have policies in place that address the comparative effectiveness of treatments, drugs and devices. Consistent with current guidance on Essential Health Benefits, the Exchange could encourage plans to:

- Use value-based benefit design strategies that reduce or waive copayments to improve adherence to chronic care management;
- Implement wellness and health promotion programs that reward risk reduction;
- Use incentives and information to promote effective outreach and engagement in self-care and management.

Additional examples of benefit design tactics that may be used to differentiate plan performance are provided in Appendix F. Other issues related to benefit design are addressed in Section 5C of these Board Recommendation Briefs.

### **Recommended Approach**

The Exchange must recognize that initially its recommendations or requirements on potential health plan partners and through them providers should be limited. The primary focus of the Exchange in its initial years must be on assuring affordability. At the same time, the Exchange needs to clearly articulate its roadmap for promoting higher quality and more affordable care that will help make the California health care system more sustainable for all Californians. Because of this, the Exchange staff recommends the board adopt a set of recommendations that build the foundation needed to work in alignment with other purchasers and collect information of health plan activities, with relatively few “requirements” initially. However, the board should signal that it will seek increased action and alignment across the health plans it contracts with in future years.

The Exchange staff recommends the board adopt a five part strategy to foster better health, quality care and lower costs:

- 1) **Promote alignment** with other purchasers to foster better care, lower costs and improved health.
- 2) **Collect standardized information** on health plans performance and care delivery/payment practices to inform future work.
- 3) **Require certain health plan practices that promote better care or standards of performance** for participation in the Exchange.
- 4) **Use value-elements in its Qualified Health Plan selection** process considering a combination of outcomes (e.g. HEDIS and/or CAHPS scores) and practices (e.g. participation and support for pay-for-performance or medical home initiatives).
- 5) **Adhere to The Patient Charter** for Physician Performance Measurement, Reporting and Tiering.

The expectation is that in the first year the requirements (element #3) and factors weighted in Qualified Health Plan selection (element #4) would be a relatively “low-bar” that would be raised in future years as better data is collected on which health plan practices best contribute to improvements in health, health care and lower costs.

The Exchange staff has developed a set of recommendations specific to promoting health and wellness that are integral to the broader

### About the eValue8 Health Plan Request for Information

The eValue8 Health Plan RFI is sponsored nationally by the National Business Coalition on Health, and is fielded annually across the country by regional employer coalitions, with approximately 70 health plans responding nationally, including being used by six plans in California under the auspices of PBGH. It incorporates health plan accreditation status, HEDIS and CAHPS performance, while also seeking to measure the utilization, spread and impact of various health plan programs. Using a Web-based platform, it collects information on health plans activities that can foster alignment with national Medicare purchasing strategies through questions in emerging areas such as patient-centered medical homes, patient safety and healthcare acquired conditions.

The modules are organized as follows:

1. Plan Profile
2. Consumer Engagement
3. Provider Measurement and Rewards
4. Pharmaceutical Management
5. Prevention and Health Promotion
6. Chronic Disease Management
7. Behavioral Health

eValue8 content is evidence-based and validated through expert input from Centers for Disease Control and Prevention staff and the National Opinion Research Center (NORC) at the University of Chicago. Scoring is based on the extent to which the plan function, service or performance contributes to “value drivers” defined by eValue8 RFI stakeholders and users. Generally, higher point values are assigned to reported outcomes and the extent to which programs, services or information are customized to targeted populations and users.



set of actions in the Exchange's efforts to advance the Three-Part Aim.

Even as the Exchange seeks to align its quality measurement and reporting requirements with the six priority areas of the National Quality Strategy, there are important gaps with respect to current HEDIS and CAHPS measures, particularly in areas such as care coordination and patient/family/caregiver engagement. Standardized Request for Information (RFI) tools used by large purchasers may serve to augment HEDIS and CAHPS, while also providing a greater depth of information regarding the availability and impact of health plan services and programs. Two examples in use by large purchasers and regional coalitions are the eValue8 Health Plan RFI, sponsored by the National Business Coalition on Health and the Catalyst for Payment Reform Health Plan RFI. The eValue8 Health Plan RFI could be used in its entirety or in part to satisfy the Exchange Qualified Health Plan reporting requirements outlined in the Affordable Care Act. The alignment of eValue8 content with the Affordable Care Act, the California Health Benefit Exchange's Guidelines for Selection and Oversight of Qualified Health Plans and NCQA Health Plan Accreditation are summarized in **Appendix G**. The Exchange could establish its own scoring criteria or weight specific components more heavily (e.g., prevention, patient safety or cultural competency and efforts to reduce disparities in care).

What follows is a description of specific actions that staff recommends in each of the four areas.

### **Issue 1. Promote Alignment**

The Exchange should continue its current practice of seeking to work in partnership and collaboration with stakeholders of all types as it pursues its mission. In addition to the review of the contracting requirements for the state's public programs noted above and described in Appendix B, procurement strategies among public purchasers such as CalPERS and the federal Office of Personnel Management (OPM) were also reviewed and summarized in **Appendix H**. There is significant content alignment among these major purchasers in advancing delivery system reform issues such as payment and care redesign, patient safety and transparency of performance information. Further alignment and collaboration with the OPM's qualification of multi-state plans for Exchanges and Center for Consumer Information and Insurance Oversight's (CCIIO's) requirements for the federally facilitated Exchanges will strengthen the ability of the California Health Benefit Exchange – and other state-based exchanges, to benchmark and compare performance.

Detailed assessment and reporting of health plan activities pertaining to their provider reimbursement or benefit design strategies is not routinely captured. Staff researched how the Exchange may address some of these additional performance areas by reviewing common value-purchasing practices by large employers and coalitions such as the Pacific Business Group



on Health. To further align purchasing strategies with public and private purchasers, staff recommends the Exchange undertake two formal steps:

- a. Participate actively in the formation and oversight of a national network of health benefit exchanges. The Exchange can and should learn from shared experiences and seek to align its value-promoting activity with these other exchanges.
- b. The Exchange should join the Pacific Business Group on Health (PBGH) to align its efforts with its public (e.g., CalPERS and the University of California) and private (e.g., Bechtel Corporation, Pitney Bowes and Stanford University, among others) members. Participation in PBGH also enables the Exchange to use the eValue8 health plan RFI results to support the assessment of Qualified Health Plans.

The Exchange would be greatly advantaged by joining with other large purchasers in California through a membership in the Pacific Business Group on Health. First, it would give the Exchange access to the data collection tool-eValue8. Second, many of the smart delivery system reforms and attempts to improve quality and lower the cost of health care that PBGH has pursued would be shared with the Exchange. As an active purchaser, the Exchange shares many of the same goals as current PBGH members.

## **Issue 2. Collect Standardized Information**

The reporting of clinical quality and patient experience results for standardized performance measures through NCQA is routine for most HMO and PPO plans in California, as well as managed care Medi-Cal plans (see Accreditation and Qualified Health Plan Quality Board Recommendation Brief, Appendix B). To foster both improvements in measurement and transparency, staff recommends that the Exchange:

- a. Require completion of the eValue8 Health Plan RFI to collect data that supports Qualified Health Plan oversight and reporting of plans' quality improvement strategies in accordance with the Affordable Care Act. The Exchange may initially require a subset of modules or questions to be completed, and reserves the right to weigh the scoring of eValue8 responses to be consistent with its Guidelines for Selection and Oversight of Qualified Health Plans.
- b. Examine the use of emerging measure sets from the Medicare Shared Savings Program or other measures endorsed by the National Quality Strategy to fill gaps in assessment of key areas such as care coordination, patient, and caregiver engagement.
- c. Encourage health plans to establish provider contracts that include transparency clauses that encourage participation in statewide provider evaluation and rating programs, as well as permit differentiation of individual hospital and medical group operating units in both performance reporting and network design. .

### Issue 3. Require Certain Health Plan Practices.

The Exchange should be careful about requiring too many elements initially, but at the same time it is critical that from the outset the Exchange clearly articulates and acts on its expectation that Qualified Health Plans actively promote better care, improved health and lower costs. What follows is a list of potential “requirements” that will be refined as part of the solicitation development process and in future years.

- a. Consumer information on provider-level performance. Health plans must provide some level of quality information at least at the hospital and medical group level, and describe their plans for physician-level reporting.
- b. To encourage consistency in health plan approaches to measuring provider performance, the Exchange recommends that health plans adhere to The Patient Charter for Physician Performance Measurement, Reporting and Tiering developed by the Consumer-Purchaser Disclosure Project.
- c. Cost of care information. Health plans must articulate how they make readily available to their consumers the potential cost of care (both total costs and the consumer’s share of costs) in general and how that cost differs by provider. Staff will develop a list of conditions, treatments and/or episodes for which plans will be expected to report cost and quality information, where available.
- d. The Exchange recommends using eValue8 as a general framework and standardized data collection tool. Staff may adjust questions and/or their scoring weight to reflect the types of health plans and products available in California. Staff will further determine what aspects of eValue8 health plan responses should be made public for consumer or small group purchaser information, and what data should be held privately for contracting purposes. By example, Appendix I outlines how eValue8 assesses health plan consumer engagement tactics and capabilities in comparison to parallel elements of the Member Connection element of NCQA accreditation. Based on stakeholder feedback, the Exchange may initially focus on responses to specific eValue8 modules. For example, the Maryland Health Care Commission is fielding a set of disparities reduction and cultural competency questions excerpted from eValue8, and these data will be used by the Maryland Exchange to assess quality. The Exchange remains sensitive to potential administrative burden and intends to explore ways in which the eValue8 data may be maintained as a repository of health plan data and performance, while permitting periodic updates to refresh reported information. Using eValue8 will also provide administrative efficiencies for national carriers.
- e. In each of the following areas, health plans must articulate specific strategies they are engaged in (note: in future years the type or results of such efforts would be potentially used as thresholds for selection or “scored”, but for 2014 the Exchange would only require some description of efforts which could be fulfilled by the plans completion of

eValue8). Staff will determine what health plan information should be made public for consumers or small group purchasers, and what data should be held privately for contracting purposes. Required strategies should include:

- Promotion of care coordination and medical homes;
  - Chronic disease management;
  - Data-based targeting of at-risk or underserved populations, or high impact conditions identified through the National Quality Strategy or National Prevention Strategy;
  - Payment or oversight programs aimed at reducing hospital acquired infections including, in particular sepsis, central line infection and pressure ulcers, as well as patient safety and avoidable hospital re-admissions;
  - Initiatives specifically geared at measuring and addressing health disparities, and
  - Demonstrated support for innovations in care that improve care coordination and primary care access, including access in rural geographies.
- f. Designation or differential weighting of specific plan performance elements as core or threshold participation requirements for Qualified Health Plans, or as other issuer selection criteria.

### Next Steps

Staff recommends that the Exchange continue to work with key stakeholders to seek input and refinement of the proposed Qualified Health Plan Quality Value Promotion, including:

- Confer with the California Department of Health Care Services to affirm the adequacy of its HEDIS and CAHPS reporting requirements for the Exchange population.
- Confer with health plans and other stakeholders on the extent to which eValue8 should be used in parts or in its entirety.
- Seek expert input with respect to methodologies to stratify analysis of quality, patient experience and utilization experience among Exchange-based populations.
- Seek expert input with respect to Quality Measurement and Reporting information that can be incorporated into consumer education materials and/or decision support tools.
- Develop strategies to collect race and ethnicity information to support assessment and reduction of disparities in care.
- Monitor progress in other states that are considering similar issues with respect to reporting of Quality Improvement Strategies.

## Appendix A. National Quality Strategy

The three aims of the National Quality Strategy, adapted from the Institute for Healthcare Improvement, seek to:

- Improve the health of the population
- Enhance the patient care experience (including quality, access and reliability)
- Reduce, or at least control, the per capita cost of care.

The National Quality Strategy articulates a set of six initial priorities to make progress towards achieving the “Triple Aim”:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

The National Quality Strategy further articulates 10 tactics for designing specific initiatives to achieve the three aims. Many of the approaches to addressing the health plan reporting requirements can reinforce these tactics:

1. Payment incentives that foster better health, quality improvement, innovation, and greater value.
2. Public reporting initiatives offer consumers and payers vehicles to compare costs, review treatment outcomes, assess patient satisfaction, and hold providers accountable.
3. Public and private collaborative efforts.
4. State and federal regulations create public standards for safe, reliable care, monitor providers, ensure feedback and accountability, and strengthen patient safety and quality improvement.
5. Consumer incentives and value-based insurance.
6. Measurement of care processes and outcomes using consistent, nationally endorsed measures in order to provide information that is timely, actionable, and meaningful to both providers and patients.
7. Adoption of health information technology and electronic data exchange.
8. Timely and actionable feedback for clinicians and other providers.
9. Training, professional certification, and workforce and capacity development.
10. Innovation and rapid-cycle learning.

## Appendix B. Examples of State Purchaser Contracting Requirements

Examples of state purchaser contracting requirements are provided below:

- Medicaid Managed Care HEDIS Reporting
- California Healthy Families

**Table 35: Medicaid Managed Care HEDIS Reporting (Summary)**

<b>Prevention and Health Promotion</b>	
<b>Prenatal and Postpartum Care</b>	Frequency of Ongoing Prenatal care
	Timeliness of Prenatal Care
	Percent of live births weighing less than 2,500 grams
	Cesarean rate for nulliparous singleton vertex
<b>Immunizations</b>	Childhood Immunization Status
	Immunizations for Adolescents
<b>Screenings</b>	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents
	Developmental Screening In the First Three Years of Life
	Chlamydia Screening
<b>Well-Child Visits</b>	Well-Child Visits in the First 15 Months of Life
	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
	Adolescent Well-Care Visit
<b>Dental Care</b>	Total Eligibles Who Received Preventive Dental Services
<b>Management of Acute Conditions</b>	
<b>Appropriate Use of Antibiotics</b>	Appropriate Testing for Children with Pharyngitis
	Otitis media with effusion (OME) – avoidance of inappropriate use of systemic antimicrobials in children – ages 2 through 12
<b>Dental Care</b>	Total eligibles who received dental treatment services
<b>Emergency Care</b>	Ambulatory Care: Emergency Department Visits
<b>Inpatient Safety</b>	Pediatric central-line associated blood stream infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit
<b>Management of Chronic Conditions</b>	
<b>Asthma</b>	Annual number of asthma patients 2 through 20 years old) with one or more asthma-related emergency room visits
<b>Attention Deficit Hyperactivity Disorder</b>	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication
<b>Mental Health</b>	Follow-up after hospitalization for mental illness
<b>Diabetes</b>	Annual Pediatric hemoglobin A1C testing
<b>Availability</b>	
	Child and Adolescent Access to Primary Care Practitioners
<b>Family Experiences of Care</b>	
	CAHPS® 4.0 (child version including Medicaid and Children with Chronic Conditions supplemental items)

MRMIB Healthy Families Contract Elements

Healthy Families is low cost insurance for children and teens. It provides health, dental and vision coverage to children who do not have insurance and do not qualify for free Medi-Cal.

**Table 36: MRMIB Health Families Contract Elements**

	Category	Description
Customer Service	Telephone Service for Subscribers	Provide toll free telephone number for applicant and subscriber inquiries. Telephone service shall be available on regular business days, 8:30am-5pm PST. Provide bilingual staff in English and Spanish. Provide interpretive services for LEP persons.
	Grievance Procedure	DMHC or DOI procedures
	Linguistic Services	Provision of bilingual services. 24 hour access to interpreter services. Use face-to-face interpreter services, if feasible. Competent interpreter for scheduled appointments.
	Translation of Written Materials	Translate written informing materials in Spanish in any other language representing 5% of subscribers.
	Cultural and Linguistic Group Needs Assessment	Conduct and submit to the State a Cultural and Linguistic Needs Assessment.
	Operationalizing Cultural and Linguistic Competency	Develop internal systems that meet cultural and linguistic needs; provide training, provide ongoing evaluation and feedback, etc...
Covered Benefits	Other Public Linkages	Create viable protocols for screening and referring subscribers needing supplemental services outside of the scope of benefits. Public programs may include regional centers, programs administered by Department of Alcohol and Drug Programs, Women, Infants and Children Supplemental Food Program, lead poisoning prevention and programs administered by local education agencies.
Quality	Measuring Clinical Quality	Provide the state annually with audited clinical quality measures. All data reported to the State shall be audited by a certified NCQA HEDIS auditor.
	Measuring Consumer Satisfaction	Conduct an annual consumer satisfaction survey of Program participants and an adolescent survey. Survey results will be released to subscribers. Open Work Group will review survey results.
	Standards Designed to Improve the Quality of Care	Use and monitor most recent recommendations of the American Academy of Pediatrics and ACIP. Notify applicants of the recommended schedule of preventive visits.
	Standards Designed to Improve the Quality of Care	Increase awareness among its providers of the importance of screening for overweight and obese children.
	Quality Management Processes	Maintain a system of accountability for quality improvement activities.
	Quality Management Processes	Review Quality Management processes by one of the following organizations: JCAHO, NCQA, or CA Department of Managed Health Care.
	Quality Management Processes	State will track performance based on specific measures. Provide corrective action plan for performance upon request by the State. State may implement pay-for-performance system.
	Ongoing efforts to Improve Quality Measures and Accountability	Participate in Health Families Quality Reporting Work Group.
Enroll-ment	Public Awareness	Engage in marketing efforts designed to increase public awareness (e.g., internal provider communication, membership publications). Prohibited from in person, door to door, mail, or telephone solicitation.



## Appendix C. Choosing Wisely Campaign to Engage Consumers in Treatment Choice



An initiative of the ABIM Foundation

### The Choosing Wisely™ Campaign

*Five Things Physicians and Patients Should Question*

#### About the Issue

After decades of record growth in health care spending, and unclear evidence of a return on that investment in quality improvements, it's urgent that physicians and patients work together to make wise treatment decisions. That means helping patients choose care that is supported by evidence showing that it works for patients like them; is not duplicative of other tests or procedures already received; won't harm them; and is truly necessary.

The Congressional Budget Office estimates that up to 30 percent of care delivered in the United States goes toward unnecessary tests, procedures, doctor visits, hospital stays and other services that may not improve people's health – and in fact, may actually cause harm. If current trends remain unchanged, the Centers for Medicare & Medicaid Services project U.S. health care spending will reach \$4.3 trillion and increase from 17.3 to 19.3 percent of the nation's gross domestic product by 2019.

#### About the Campaign

In response, medical leaders are trying to do something to address what many believe is an unsustainable health care system. National organizations representing medical specialists are working with the ABIM Foundation to identify and reduce waste in the health care system. Consumer Reports, the nation's leading independent, nonprofit consumer organization, has also joined the campaign to provide resources for consumers and physicians to engage in these important conversations. *Choosing Wisely™* aims to get physicians, patients and other health care stakeholders thinking and talking about the overuse or misuse of medical tests and procedures that provide little benefit, and in some instances harm.

As part of *Choosing Wisely*, each participating specialty society will identify five tests or procedures commonly used in their field, whose use should be discussed or questioned. The resulting lists will spark discussion about the need—or lack thereof—for many frequently ordered tests or treatments. In addition, the ABIM Foundation, along with its partners, will develop tools to help physicians have these kinds of conversations with their patients.

This concept was originally piloted by the National Physicians Alliance, who through an ABIM Foundation Putting the Charter into Practice grant created a set of three lists of specific steps physicians in internal medicine, family medicine and pediatrics could take in their practices to promote the more effective use of health care resources.

Participating specialty societies will work with the ABIM Foundation to engage their members in discussions about the physician's role in making wise choices.

#### Continuing the Professionalism Challenge

*Choosing Wisely* is part of a multi-year effort of the ABIM Foundation to help physicians be better stewards of finite health care resources. It continues the principles and commitments of promoting justice in the health care system through a fair distribution of resources set forth in *Medical Professionalism in the New Millennium: A Physician Charter*.

Learn more about *Choosing Wisely* at [www.ChoosingWisely.org](http://www.ChoosingWisely.org).

#### Choosing Wisely Partners (to date):

- American Academy of Allergy, Asthma & Immunology
- American Academy of Family Physicians
- American College of Cardiology
- American College of Physicians
- American College of Radiology
- American Gastroenterological Association
- American Society of Clinical Oncology
- American Society of Nephrology
- American Society of Nuclear Cardiology
- Consumer Reports

#### About the ABIM Foundation

The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policymakers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice. To learn more about the ABIM Foundation, visit [www.abimfoundation.org](http://www.abimfoundation.org)



Table 37: Appendix D: Examples of Medicare Pilot Programs

INITIATIVE	INITIATIVE START DATE	LENGTH	PARTICIPANTS/ LOCATIONS	NUMBER OF BENEFICIARIES AFFECTED	POTENTIAL ALIGNMENT WITH EXCHANGE	OTHER ISSUES OR CONSIDERATIONS
<b>PRIMARY CARE TRANSFORMATION</b>						
<p><b>Comprehensive Primary Care Initiative Demonstration</b></p> <p>Public-private partnership to enhance primary care services, including 24-hour access, care plans, and care coordination</p>	2012	4 years	Plan for payers and states in 5–7 markets; 75 practices per market	315,000 Medicare 15,750 Medicaid	Pilots have been designated but none are in California.	Design elements are similar to CMMI Intensive Outpatient Care Program noted below
<p><b>Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration</b></p> <p>Care coordination payments to FQHCs in support of team-led care, improved access, and enhanced primary care services</p>	11/1/2011	3 years ending on 10/31/14	500 FQHCs in 44 states	202,000 Medicare	Potential enhancement of FQHCs serving as Essential Health Providers	
<p><b>Multi-payer Advanced Primary Care Practice Demonstration</b></p> <p>State-led, multi-payer collaborations to help primary care practices transform into medical homes</p>	Phased-in starting 07/01/2011	3 years	NC, ME, MI, MN, NY, PA, RI, VT	332,000 Medicare	Pilots have been designated but none are in California.	Design elements are similar to CMMI Intensive Outpatient Care Program noted below
<b>BUNDLED PAYMENTS FOR CARE IMPROVEMENT</b>						
<p><b>Bundled Payment for Care Improvement Initiative</b></p> <p>Episodic payments around inpatient hospitalizations to incentivize care redesign</p>	2012	3 years	To be determined	Not available	Opportunities to align with IHA Bundled Payment initiative and promote engagement among Qualified Health Plans	
<b>ACCOUNTABLE CARE ORGANIZATIONS</b>						
<p><b>Pioneer Accountable Care Organization Model Initiative</b></p> <p>Experienced provider organizations taking on financial risk for improving quality and lowering costs for all of their Medicare patients</p>	January 2012	3 years (with optional 2-year extension)	32 ACOs—see link for full list of orgs	860,000 Medicare	6 Pioneer ACOs designated in California. Opportunities to promote selection of medical groups or offer ACO-based products from Qualified Health Plans. Exchange may consider using incentives to manage high risk population (especially enrollees from California Pre-Existing Condition Insurance Plan (PCIP))	



<p><b>Advanced Payment Accountable Care Organization Model Initiative</b></p> <p>Prepayment of expected shared savings to support ACO infrastructure and care coordination</p>	4/1/2012 or 7/1/2012	Payments end June 2014	Physician-based and rural ACOs in the Shared Savings Program	650,000 Medicare+	Assess geographic alignment	
<p><b>Physician Group Practice Transition Demonstration</b></p> <p>A precursor to the Medicare Shared Savings Program; rewards physician groups for efficient care and high quality</p>	1/1/2011	Up to 3 years	10 group practices started the demo; 3 moved to the Pioneer ACO model	87,700 Medicare	Use evaluation and technical reports to inform evidence basis for payment and rewards programs.	
<b>MEDICARE-MEDICAID ENROLLEES</b>						
<p><b>State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees</b></p> <p>Assistance to help states engage stakeholders in redesigning care for Medicare-Medicaid enrollees</p>	April/May 2011	18 months (with extension option)	CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, WI	Not applicable	Dual eligible beneficiaries who reside in the following eight counties would be able to enroll in new integrated plans: Los Angeles, Orange, San Diego, San Mateo, Alameda, Riverside, San Bernardino, and Santa Clara. Four sites will engage commercial Medi-Cal Managed Care programs which could potentially offer integrated programs to new Exchange enrollees. One-third of dual-eligibles are under age 65.	Unknown what portion of population might have changing income qualifications re Exchange subsidy eligibility or likelihood that members remain in dual eligible program.
<p><b>Financial Alignment Model Demonstrations</b></p> <p>Opportunity for States to implement new care and payment systems to better coordinate care for Medicare-Medicaid enrollees</p>	January 2013	3 years	38 States and DC have submitted letters of intent	2 million Medicare-Medicaid enrollees	To be determined	
<b>CAPACITY TO SPREAD INNOVATION</b>						
<p><b>The Partnership for Patients</b></p> <p>National campaign targeting a 40% reduction in hospital-acquired conditions and a 20% reduction in 30-day readmissions</p>	4/12/2011	Ongoing	26 Hospital Engagement Networks supporting over 3,200 hospitals in all 50 states	Not applicable	Exchange may assess potential Qualified Health Plans for their engagement in this effort and use of financial incentives (or evidence of non-payment policies) to support initiative	Plans report significant data issues regarding identification of Present on Admission indicators from claims.
<p><b>Innovation Advisors Program</b></p> <p>Training health care providers from around the country in achieving the three-part aim</p>	January 2012	Ongoing	73 Advisors selected and started January 2012 with up to 127 more in the next cycle	Not applicable		Potential access to experts but unlikely to have direct impact.

<p><b>Health Care Innovation Challenge</b> A broad appeal for innovations with a focus on developing the workforce for new care models</p>	3/30/2012	3 years	17 California sites awarded grants	Not available	<p>Targeted populations are Medicare Advantage, Medicare FFS or dual eligibles. Review programs for potential alignment with commercial Qualified Health Plan populations (examples):</p> <ul style="list-style-type: none"> <li>▪ Dartmouth College will work with a California provider site to hire Patient and Family Activators who will work with patients and families to engage in shared decision making</li> <li>▪ The Institute for Clinical Systems Improvement with Kaiser focusing on improving care delivery and outcomes for high-risk adult patients with Medicare or Medicaid coverage who have depression plus diabetes or cardiovascular disease.</li> <li>▪ Pacific Business Group on Health will work with 17 medical groups to improve outpatient primary care for high risk individuals</li> <li>▪ University of Southern California will integrate clinical pharmacy services into safety net clinics, providing medication therapy management and reconciliation, patient counseling and education, preventive care for the underserved and vulnerable populations of Santa Ana, Huntington Beach, and Garden Grove.</li> </ul>	
<b>OTHER</b>						
<p><b>Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) Program</b> Collaborating with States to test the effectiveness of preventive services in Medicaid</p>	Sites awarded 09/13/2011	5 years	WI, MN, NY, NV, NH, MT, HI, TX, CA, CT	Not available	To be determined	

\* Note: The budget for the Advance Payment Model was based on an estimated 650,000 Medicare beneficiaries. These beneficiaries would be assigned to Shared Savings Program ACOs.  
 \* Program developed and implemented by the Innovation Center, but funding based on other statutory authorities.

## Appendix E

Pacific Business Group on Health and Silicon Valley Employers Forum Member Companies



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FACSIMILE 415.520.0927

### PBGH and SVEF Member Companies 2012

**Mission:** To improve the quality and availability of health care while moderating costs.

**Vision:** A health care system transparent about the quality, cost and outcomes of care, where consumers are motivated to seek the right care at the right price and providers are incentivized to offer better quality, more affordable care.

#### Pacific Business Group on Health

- AAA Northern California, Utah and Nevada Insurance Exchange
- Bechtel Corporation
- Boeing Company
- California Chamber of Commerce
- California Public Employees' Retirement System
- Chevron Corporation
- Cisco Systems
- Carlson
- Clorox Company
- Del Monte Foods
- Disney Company
- General Electric Company
- Greenbrier Companies, Inc.
- Intel Corporation
- McKesson Corporation
- Pacific Gas and Electric Company
- Pitney Bowes
- Safeway Inc.
- Silicon Valley Employers Forum
- Small Business California
- Southern California Edison
- Stanford University
- Target Corporation
- Tesla Motors
- TriZetto Group
- Union Bank
- University of California
- Wal-Mart Stores, Inc.
- Wells Fargo

#### Silicon Valley Employers Forum

- Adobe Systems
- Agilent Technologies
- Apple
- Applied Materials
- Autodesk
- CA, Inc.
- Cadence Design Systems
- Cisco Systems
- Dell
- eBay
- Electronic Arts
- Facebook
- Google (international)
- Hewlett-Packard
- Intel
- Intuit
- Juniper Networks
- KLA - Tencor
- Lam Research
- LSI
- Marvell
- Mentor Graphics
- Microsoft
- NetApp
- Oracle
- Salesforce.com
- Seagate Technologies
- Sybase
- Symantec
- Synopsys
- Texas Instruments (international)
- VeriSign
- VMware
- Yahoo!

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Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers

Appendix F

Examples of how the Exchange can improve health outcomes through “plan or coverage benefits and health care provider reimbursement structures” as part of health plan quality improvement strategy reporting under the Affordable Care Act (excerpted from Commonwealth Fund paper)<sup>38</sup>.

**Table 38: Appendix F: How the Exchange Can Improve Health Outcomes**

Reporting Domains	Benefit Design	Provider Reimbursement
<b>Health Outcomes</b> <ul style="list-style-type: none"> <li>Quality reporting</li> <li>Effective case management</li> <li>Care coordination</li> <li>Chronic disease management</li> <li>Medication and care compliance initiatives</li> </ul>	<ul style="list-style-type: none"> <li>Premium-differentiated provider networks based on quality performance with reported enrollment, percentage of providers meeting criteria and quality/cost results</li> <li>Inclusion of performance information or designation programs in provider directories</li> <li>Incentives for participation in care management programs</li> <li>Value-based benefit designs to incent engagement in treatment option decision support, adherence to recommended preventive and diagnostic services, adherence to maintenance medications</li> <li>Patient experience &amp; CAHPS-type survey</li> <li>Transparency of cost and quality information for consumers</li> <li>Evidence of patient engagement metrics such as Patient Activation Measure (PAM)</li> </ul>	<ul style="list-style-type: none"> <li>Physician pay for performance based on clinical outcomes, HEDIS results, CAHPS results, evidence of reduced gaps in care or improved adherence to evidence-based guidelines</li> <li>Facility pay for performance based on clinical outcomes, quality, CAHPS results, or mortality rates (severity-adjusted)</li> <li>Percentage of payments (bonus, fee-for-service, etc.) linked to performance</li> <li>Support and payment for accountable care structures or primary care medical home services</li> </ul>
<b>Hospital Readmissions</b>	<ul style="list-style-type: none"> <li>Premium-differentiated hospital networks based on performance in avoidable readmissions or ambulatory care-sensitive admissions</li> <li>Percentage of members receiving welcome home calls upon hospital discharge</li> <li>Percentage of members who have follow-up primary care appointment within 7 days</li> </ul>	<ul style="list-style-type: none"> <li>Payment for care transitions management</li> <li>Gainsharing or risk-sharing based on targeted reduction in readmission rates, potentially avoidable complications, or avoidable emergency department visits</li> <li>Evidence of provider contracts stipulating non-payment for preventable hospital readmissions</li> </ul>
<b>Patient Safety and Medical Errors</b>	<ul style="list-style-type: none"> <li>Premium-differentiated provider networks based on patient safety management</li> <li>Use of reference pricing in conjunction with quality indicators to encourage selection of higher-performing providers or use of Centers of Excellence</li> <li>Coverage for medication reconciliation review, with polypharmacy management and frequency of drug-drug conflicts identified</li> </ul>	<ul style="list-style-type: none"> <li>Differentiated payment based on Health IT adoption (e-prescribing, computerized physician order entry, HITECH Meaningful Use requirements)</li> <li>Frequency and disposition of health care-acquired conditions (HACs) and serious reportable events (SREs)</li> <li>Evidence of provider contract requirements for root cause analysis of medical errors</li> <li>Demonstration of evidence-based practices (e.g., pre-39 week C-sections or elective inductions)</li> </ul>
<b>Wellness and Health Promotion Activities</b> <ul style="list-style-type: none"> <li>Smoking cessation</li> <li>Weight management</li> <li>Stress management</li> <li>Physical fitness</li> <li>Nutrition</li> <li>Heart disease prevention</li> <li>Healthy lifestyle support</li> <li>Diabetes prevention</li> </ul>	<ul style="list-style-type: none"> <li>Value-based benefit designs to incent engagement in treatment option decision support, adherence to recommended preventive and diagnostic services, adherence to maintenance medications, as measured by reduced gaps in care and medication possession rates, respectively</li> <li>Availability and use of incentives for health risk reduction</li> <li>Availability and use of incentives for completing Health Risk Appraisal and related screening tools</li> <li>Incentives to use consumer tools and complete consumer education, treatment decision support, and self-care sessions</li> <li>Percentage of members engaged in condition management programs or health risk reduction programs</li> <li>Evidence of patient reminder programs using various media and response tracking</li> </ul>	<ul style="list-style-type: none"> <li>Preventive HEDIS measures</li> <li>Percentage of providers using standard PHQ-9 depression screening tool with validation through sample chart audit</li> <li>Percentage of members for whom smoking status and BMI are captured</li> <li>Evidence of tailored communications to identify familial health risk factors and/or risk factors associated with race or ethnicity</li> </ul>
<b>Health and Health Care Disparities</b>	<ul style="list-style-type: none"> <li>Evidence of targeted risk identification based on familial risk factors</li> <li>Evidence of tailored member communication strategies</li> <li>Inclusion of self-reported race/ethnicity information in member registration processes or surveys</li> <li>Caregiver support</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of members for whom race/ethnicity information is captured</li> <li>Strategies to improve provider cultural competency</li> <li>Reporting and payment for reduced gaps in care</li> <li>Language translation support</li> </ul>

<sup>38</sup> Hoo E, Lansky D, Roski J and Simpson L. “Health Plan Quality Improvement Strategy Reporting Under the Affordable Care Act: Implementation Considerations,” The Commonwealth Fund, April 2012. Accessed at: <http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Apr/Health-Plan-Quality-Improvement-Strategy.aspx?page=all>

**Table 39: Affordable Care Act Elements -- NCQA Accreditation and eValue8 Health Plan RFI Crosswalk**

Crosswalk between Affordable Care Act Quality Domains, HBEX Qualified Health Plan Guidelines, and Accreditation Requirements (adapted from materials provided by AHIP) and eValue8 Health Plan RFI			
Affordable Care Act Quality Domains	HBEX Qualified Health Plan Guidelines ( <i>abbreviated from April 26, 2012 Draft</i> )	NCQA scoring is typically cumulative based on the number of elements represented in each category. EValue8 scoring may require evidence of core functionality or reported quantified values for engagement, payment rewards, etc.	
		NCQA 2012 MCO Accreditation & PHQ Certification	2012 eValue8 Health Plan RFI
<p><b>Improve Health Outcomes, including through the use of the medical home model</b> (Section 2717(a))</p> <ul style="list-style-type: none"> <li>Quality reporting</li> <li>Effective case management</li> <li>Care coordination</li> <li>Chronic disease management</li> <li>Medication and care compliance initiatives</li> </ul>	<p><b>II. Assure access to quality care for individuals with varying health statuses and conditions</b></p> <p>a. Require robust performance measures in order to ensure that consumers receive high quality care. Exchange measurement strategies should include:</p> <ol style="list-style-type: none"> <li>Align with nationally standardized measures.</li> <li>Build on established quality, performance and patient experience measures currently in use.</li> <li>Support the expansion of measures that focus on health outcomes, patient-reported health status and cost of care.</li> </ol> <p>b. Ensure that plan design, provider network and access standards promote access to care based on patients' needs, health status and personal characteristics</p> <p>c. Expand primary care access through innovations in care delivery such as use of telemedicine and person-centered care that meets the needs of each individual.</p> <p><b>III. Facilitate informed choice of health plans and providers by consumers and small employers.</b></p> <p>c. Contracted plans should provide Exchange enrollees with tools to understand the implications of their coverage selection on provider and treatment choices and tools to choose their providers.</p>	<ul style="list-style-type: none"> <li>Quality Management and Improvement                             <ul style="list-style-type: none"> <li>QI-9: Clinical Practice Guidelines</li> <li>QI-7: Complex Case Management</li> <li>QI-10: Continuity and Coordination of Medical Care</li> <li>QI-8: Disease Management</li> </ul> </li> <li>Sample HEDIS measures:                             <ul style="list-style-type: none"> <li>Antidepressant Medication Management</li> <li>Persistence of Beta-Blocker Treatment after a Heart Attack</li> <li>Comprehensive Diabetes Care</li> <li>HbA1C Poorly Controlled</li> <li>Medical Assistance with smoking and tobacco use cessation</li> </ul> </li> <li>NCQA also offers:                             <ul style="list-style-type: none"> <li>NQCA PCMH 2011 recognition</li> <li>Disease Management Accreditation</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Plan Profile                             <ul style="list-style-type: none"> <li>NCQA Health Plan &amp; Disease Management Accreditation</li> <li>URAC Disease Management, Case Management &amp; Care Coordination Accreditation</li> </ul> </li> <li>Consumer Engagement                             <ul style="list-style-type: none"> <li>Alignment of Plan Design (Value-Based Benefit Design), Use of Incentives and Availability of High Performance Networks</li> <li>Shared Decision Making and Treatment Option Support</li> <li>Electronic Personal Record</li> </ul> </li> <li>Provider Measurement and Rewards                             <ul style="list-style-type: none"> <li>Community Collaboration</li> <li>Physician/Medical Group/Hospital Performance Measurement and Reporting</li> <li>Physician/Medical Group/Hospital Performance Differentiation and Rewards</li> <li>Accountable Care and Primary Care Medical Home Initiatives</li> </ul> </li> <li>Pharmaceutical Management                             <ul style="list-style-type: none"> <li>Appropriate Drug Use</li> <li>Specialty Drug Management</li> </ul> </li> <li>Prevention and Health Promotion                             <ul style="list-style-type: none"> <li>Cancer Screening and Immunization Programs</li> <li>Obstetrics and Maternity</li> </ul> </li> <li>Chronic Disease Management – Diabetes &amp; Coronary Artery Disease                             <ul style="list-style-type: none"> <li>Condition Management Program Scope and Coordination</li> <li>Practitioner Support</li> <li>Member Identification, Screening and Support</li> </ul> </li> </ul>

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		NCQA 2012 MCO Accreditation & PHQ Certification	2012 eValue8 Health Plan RFI
	d. Participate in and support efforts to efficiently collect and appropriately report information that can inform consumers' choice of coverage, providers and treatment options including information on Qualified Health Plan and provider quality, cost and consumer experience		<ul style="list-style-type: none"> <li>• Behavioral Health</li> <li>• Performance Measurement                             <ul style="list-style-type: none"> <li>- CAHPS Patient Experience, Access/Availability of Care</li> <li>- HEDIS Effectiveness of Care Measures</li> </ul> </li> </ul>

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		NCQA 2012 MCO Accreditation & PHQ Certification	2012 eValue8 Health Plan RFI
<p><b>Preventing Hospital Readmissions</b></p> <ul style="list-style-type: none"> <li>Comprehensive program for hospital discharge</li> <li>Patient-centered education and counseling</li> <li>Comprehensive discharge planning</li> <li>Post discharge reinforcement by health professional</li> </ul>	<p><b>II.a. Require robust performance measures in order to ensure that consumers receive high quality care.</b></p> <p><b>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.</b></p> <ol style="list-style-type: none"> <li>Align Exchange strategies to foster improvements in care delivery with other National and state payment and delivery system redesign efforts</li> <li>Adopt policies that encourage and measure provider payment, provider contracting and measurement processes that foster the Exchange's values.</li> <li>Promote consistent evidence-based care while allowing for innovation and person-centered care that meets the individual's needs.</li> <li>Support effective use of health information technology to expand access and foster electronic information exchange.</li> </ol>	<ul style="list-style-type: none"> <li>NCQA plans to update Health Plan Accreditation to reflect these elements.</li> <li>Existing Accreditation looks more toward the collection or hospital discharge data, and measurement of admissions and readmission rates, not education or discharge planning</li> <li>HEDIS All-Cause Readmission Rate</li> </ul>	<ul style="list-style-type: none"> <li>Provider Measurement and Rewards                             <ul style="list-style-type: none"> <li>Community Collaboration</li> <li>Hospital Performance Measurement</li> <li>Hospital Performance Differentiation and Rewards                                     <ul style="list-style-type: none"> <li>Public Performance Reporting</li> <li>Tiered Networks</li> <li>Centers of Excellence</li> </ul> </li> </ul> </li> <li>Payment Reform and Provider Reimbursement Structures                             <ul style="list-style-type: none"> <li>Pay for Performance</li> <li>Non-payment for Healthcare Acquired Conditions and Serious Reportable Events</li> <li>Population management contracts (e.g. Patient-centered medical homes, accountable care models)</li> <li>Bundled payments for specific services or care episodes</li> </ul> </li> <li>Care coordination, care transition, and best practices identified</li> </ul>
<p><b>Improve Patient Safety and Reduce Medical Errors</b></p> <ul style="list-style-type: none"> <li>Use of best clinical practices</li> <li>Evidence based medicine</li> </ul>	<p>II. Assure access to quality care for individuals with varying health statuses and conditions</p> <ol style="list-style-type: none"> <li>Consider how Exchange policies can support improvement in health outcomes, patient safety and reduce</li> </ol>	<ul style="list-style-type: none"> <li>Addresses Patient Safety under QI and UM                             <ul style="list-style-type: none"> <li>QI-9: Clinical Practice Guidelines</li> <li>UM-13: Procedures for Pharmaceutical Management (re. interactions and recalls)</li> <li>MEM -6: Innovations in Member Services</li> <li>Element A: Innovative Technology</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Health Information Technology</li> <li>Consumer Engagement                             <ul style="list-style-type: none"> <li>Hospital Choice Tools</li> </ul> </li> <li>Provider Measurement and Rewards                             <ul style="list-style-type: none"> <li>Community Collaboration</li> <li>Hospital Performance Measurement</li> </ul> </li> </ul>

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Affordable Care Act Quality Domains	HBEX Qualified Health Plan Guidelines (abbreviated from April 26, 2012 Draft)	NCQA scoring is typically cumulative based on the number of elements represented in each category. EValue8 scoring may require evidence of core functionality or reported quantified values for engagement, payment rewards, etc.	
		NCQA 2012 MCO Accreditation & PHQ Certification	2012 eValue8 Health Plan RFI
<ul style="list-style-type: none"> <li>Health information technology</li> </ul>	<p>avoidable readmissions.</p>	<ul style="list-style-type: none"> <li>NCQA also offers:                             <ul style="list-style-type: none"> <li>Health Information Products Certification</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Use of Standardized Measures                             <ul style="list-style-type: none"> <li>Leapfrog</li> <li>AHRQ Patient Safety Indicators</li> </ul> </li> <li>Payment Reform and Provider Reimbursement Structures                             <ul style="list-style-type: none"> <li>Pay for Performance</li> <li>Non-payment for Healthcare Acquired Conditions and Serious Reportable Events</li> <li>Population management contracts (e.g. Patient-centered medical homes, accountable care models)</li> <li>Bundled payments for specific services or care episodes</li> </ul> </li> <li>Pharmaceutical Management                             <ul style="list-style-type: none"> <li>Drug conflicts and drug-drug interactions</li> <li>HEDIS measures</li> </ul> </li> <li>Care coordination, care transition, and best practices identified</li> </ul>
<p><b>Wellness and Health Promotion Activities</b></p> <ul style="list-style-type: none"> <li>Personalized wellness and prevention services and risk assessment for smoking cessation, weight management, stress management, physical fitness, nutrition, heart disease prevention, healthy lifestyle support, diabetes prevention</li> </ul>	<p><b>IV. Promote wellness and prevention</b></p> <ol style="list-style-type: none"> <li>Offer health plans, plan designs and networks that will promote enrollees' maintaining good health and preventing disease</li> <li>Identify opportunities to align with community health and wellness initiatives</li> </ol>	<ul style="list-style-type: none"> <li>Use of Health Appraisals                             <ul style="list-style-type: none"> <li>MEM-1: Health Appraisals, Element A, HA Components (assessment completed)</li> <li>MEM-1: HA, Element C, HA Scope (includes: smoking cessation, physical activity, healthy eating, and stress)</li> <li>MEM-1: HA, Element D, HA Results (references given to improve or aide results)</li> <li>MEM-2: Self-Management Tools, Element A, Topic of Tools (addresses: smoking cessation, BMI, stress, physical activity, healthy eating)</li> </ul> </li> <li>Also addressed under Quality Improvement</li> </ul>	<ul style="list-style-type: none"> <li>Consumer Engagement                             <ul style="list-style-type: none"> <li>Alignment of Plan Design (Value-Based Benefit Design)</li> <li>Shared Decision Making and Treatment Option Support</li> <li>Electronic Personal Record</li> </ul> </li> <li>Provider Measurement and Rewards</li> <li>Pharmaceutical Management                             <ul style="list-style-type: none"> <li>Adherence</li> </ul> </li> <li>Prevention and Health Promotion                             <ul style="list-style-type: none"> <li>Cancer Screening and Immunization Programs</li> <li>Prevention and Treatment of Tobacco Use</li> <li>Obesity and Weight Management</li> <li>Obstetrics and Maternity</li> </ul> </li> <li>Chronic Disease Management – Diabetes &amp; Coronary</li> </ul>

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Affordable Care Act Quality Domains	HBEX Qualified Health Plan Guidelines (abbreviated from April 26, 2012 Draft)	NCQA 2012 MCO Accreditation & PHQ Certification	2012 eValue8 Health Plan RFI
		<ul style="list-style-type: none"> <li>HEDIS measures</li> <li>NCQA also offers:                             <ul style="list-style-type: none"> <li>Wellness &amp; Health Promotion Accreditation and Certification</li> <li>Diabetes Recognition Program</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Artery Disease                             <ul style="list-style-type: none"> <li>Member Identification, Screening and Support</li> </ul> </li> <li>Behavioral Health and Substance Abuse                             <ul style="list-style-type: none"> <li>Member Identification, Screening and Support</li> </ul> </li> <li>Performance Measurement                             <ul style="list-style-type: none"> <li>HEDIS Effectiveness of Care Measures</li> <li>NCQA Health Plan &amp; Disease Management Accreditation</li> <li>URAC Disease Management, Case Management &amp; Care Coordination Accreditation</li> </ul> </li> </ul>
<p>Reduce Health and Health Care Disparities</p> <ul style="list-style-type: none"> <li>Language series</li> <li>Community outreach</li> <li>Cultural competency trainings</li> </ul>	<p><b>V. Reduce health disparities and foster health equity.</b></p> <p>a. Consider and evaluate on an ongoing basis the extent to which Exchange policies promote health equity and the reduction of health disparities.</p> <p>b. Exchange policies shall assure that Qualified Health Plans offer a sufficient number of providers with linguistic and cultural competence to serve diverse enrollment.</p>	<ul style="list-style-type: none"> <li>Quality Management and Improvement                             <ul style="list-style-type: none"> <li>QI-4: Availability of Practitioners, Element A, Cultural needs and Preferences</li> <li>QI-1: Program Structure, Element A, Analyzing existence of healthcare disparities</li> </ul> </li> <li>Includes focus groups as needed as well as the use of training tools</li> <li>NCQA also offers:                             <ul style="list-style-type: none"> <li>Multicultural Health Care Distinction</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Captures of race/ethnicity, language, or interpreter needs through enrollment forms, health risk appraisals, website registrations, imputation and/or upon call to customer or clinical service lines.</li> <li>Capture of race and ethnicity data, and language(s) spoken among                             <ul style="list-style-type: none"> <li>Plan staff (customer relations)</li> <li>Physicians</li> <li>Physician office staff</li> </ul> </li> <li>Use of racial, ethnic, and/or language data                             <ul style="list-style-type: none"> <li>Identify areas for quality improvement/disease management/ health education/promotion</li> <li>Assist providers in providing language assistance and culturally competent care;</li> <li>Identify familial risk factors</li> <li>Develop disease management or other outreach programs that are culturally sensitive</li> </ul> </li> <li>Support of language needs for members includes                             <ul style="list-style-type: none"> <li>Certify and test proficiency of bilingual Plan staff and interpreters</li> <li>Provide patient education materials in different languages</li> </ul> </li> </ul>

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Affordable Care Act Quality Domains	HBEX Qualified Health Plan Guidelines (abbreviated from April 26, 2012 Draft)	NCQA 2012 MCO Accreditation & PHQ Certification	2012 eValue8 Health Plan RFI
			<ul style="list-style-type: none"> <li>- Multi-lingual enrollment materials, Web site content and member education materials</li> <li>• Assure culturally competent health care is delivered</li> <li>• Performance measurement</li> <li>- Multicultural Health Care Distinction</li> </ul>
	<p><b>I. Promote affordability for the consumer and small employer – both in terms of premium and at point of care</b></p> <p>d. Offer benefit plan designs and contribution strategies that encourage small employers to make available robust coverage and support effective employer contribution levels.</p> <p>f. Rely on existing standards, measures or processes for selecting and monitoring health plans and provider performance, building toward more robust standards and outcome measures over time to minimize burden and costs.</p>	<p>NCQA Cost of Care Measures</p> <ul style="list-style-type: none"> <li>• Relative Resource Use (RRU) for People With Diabetes</li> <li>• RRU for People With Asthma</li> <li>• RRU for People With Acute Low Back Pain</li> <li>• RRU for People With Cardiovascular Conditions</li> <li>• RRU for People With Uncomplicated Hypertension</li> <li>• RRU for People With COPD</li> <li>• Potentially Avoidable Readmissions</li> <li>• Potentially Avoidable Complications</li> <li>• Potentially Avoidable Admissions</li> <li>• Potentially Avoidable Emergency Room Visits</li> <li>• Potentially Avoidable Ancillary Services</li> </ul>	<ul style="list-style-type: none"> <li>○ Consumer Engagement                             <ul style="list-style-type: none"> <li>- Alignment of Plan Design (Value-Based Benefit Design), Use of Incentives and Availability of High Performance Networks</li> </ul> </li> <li>• Provider Measurement and Rewards                             <ul style="list-style-type: none"> <li>- Community Collaboration</li> <li>- Hospital Performance Measurement</li> <li>- Hospital Performance Differentiation and Rewards                                     <ul style="list-style-type: none"> <li>• Public Performance Reporting</li> <li>• Tiered Networks</li> <li>• Centers of Excellence</li> </ul> </li> </ul> </li> <li>• Payment Reform and Provider Reimbursement Structures                             <ul style="list-style-type: none"> <li>- Pay for Performance</li> <li>- Non-payment for Healthcare Acquired Conditions and Serious Reportable Events</li> <li>- Population management contracts (e.g. Patient-centered medical homes, accountable care models)</li> <li>- Bundled payments for specific services or care episodes</li> </ul> </li> <li>• NCQA Cost of Care Measures</li> <li>• Prometheus Potentially Avoidable Complications</li> </ul>

## Appendix H. Examples of Public Purchaser Strategies and Quality Reporting

Examples of purchaser strategies and quality reporting are provided below for:

- California Public Employees' Retirement System (CalPERS)
- The Federal Employees Health Benefits (FEHB) Program, administered by the United States Office of Personnel Management (OPM)
- Catalyst for Payment Reform RFI Toolkit

### California Public Employees' Retirement System

#### ***Strategic Goals for Health***

CalPERS is the health benefits purchaser for all of California's State government employees in addition to over 1,300 public agencies, their employees and retirees. It is the second largest health benefits purchaser in the nation and covers over 1.3 million lives. CalPERS offers two HMO plans and three PPO plans. All plans include a commercial and Medicare plan component. CalPERS recently concluded a review of healthcare delivery trends and purchasing strategies, which culminated in the adoption of several healthcare initiatives aimed at improving CalPERS health benefits purchasing processes. With the expiration of one HMO contract and the self-funded PPO TPA contract at the end of 2013, CalPERS has a unique opportunity to make significant innovations through the procurement process.

#### ***Develop and administer quality, sustainable health benefit programs that are responsive to and valued by enrollees and employers.***

CalPERS health benefit products will address our customers' needs for affordable and adequate products. For employers, adequacy and affordability may be defined in terms of the total compensation package they need to offer in order to attract and retain employees. For enrollees, adequacy may be defined in terms of product choices that address their economic and personal health care situation. CalPERS is charged with developing and designing the health benefit products it offers to its customers. Further, these health benefit products are offered in a competitive marketplace where alternative health benefit products exist.

#### ***Promote the ability of members and employers to make informed decisions resulting in improved lifestyle choices and health outcomes.***

There is an imperative to consider strategies that look at both supply and demand market dynamics. The aging CalPERS population, which faces many chronic health conditions, will continue to drive utilization. CalPERS will develop programs and policies that will educate and provide incentives for enrollees and employers to do more to consider the value (both quality and cost) of lifestyle and healthcare choices.

***Engage and influence the healthcare marketplace to provide medical care that optimizes quality, access, and cost.***

In 2003, CalPERS identified several policy imperatives for its Health Benefit Program. Cost, quality, and access were key factors in all health benefit policy strategies. CalPERS recognized that to achieve lower cost, higher quality, and improved access, it needs to focus its attention on healthcare providers, including hospitals, pharmaceutical companies, and physicians. CalPERS remains committed to strategies that impact the drivers of healthcare cost and quality within the provider community.

Table 40: CalPERS 2012 Request for Information Content

Category	Description
<b>Innovation</b>	<ul style="list-style-type: none"> <li>▪ Evidence-Based Medicine (EBM) and treatment variation</li> <li>▪ Bundled Payments</li> <li>▪ Value Based Purchasing Designs such as reference pricing</li> <li>▪ Integrated Health Systems (IHS) &amp; Accountable Care Organizations (ACO)</li> </ul>
<b>Disease Management and Wellness Promotion</b>	<ul style="list-style-type: none"> <li>▪ Clinical quality improvement and incentives for providers</li> <li>▪ Manage of members with multiple complex chronic conditions</li> <li>▪ Worksite wellness programs</li> <li>▪ Pharmacy and medication adherence/reconciliation</li> </ul>
<b>Provider Services</b>	<ul style="list-style-type: none"> <li>▪ Getting best value and improved health status from high performance of competing medical groups and hospitals</li> <li>▪ Care coordination and patient engagement activities including prevention, use of clinical registries, population management</li> <li>▪ Primary care focused systems and provider-based incentive programs like pay for performance to the level of the individual physician.</li> <li>▪ Communication strategies using health information technology (PHRs/EHRs)</li> <li>▪ Patient access standards (same day, urgent care, after hour advice or on-call).</li> </ul>
<b>Member Tools</b>	<ul style="list-style-type: none"> <li>▪ Shared decision making tools</li> <li>▪ Cost transparency</li> <li>▪ Provider quality ratings</li> </ul>
<b>Technology Infrastructure</b>	<ul style="list-style-type: none"> <li>▪ Capture of biometric values and non-claims based medical information</li> <li>▪ Exchange of electronic health information to contracting providers</li> </ul>
<b>Premiums and Procurement</b>	<ul style="list-style-type: none"> <li>▪ Incentives for disease prevention and health promotion</li> <li>▪ Risk assessment/adjustment</li> <li>▪ Self-Funded Plan Designs for capitated services and Medicare Advantage</li> </ul>

Table 41: Sample CalPERS Contract Elements		
Customer Service	Telephone Service for Subscribers	Requirements and standards for telephone medical advice services offered by health plans.
	Telephone Service for Subscribers	Staff providing telephone medical advice must be properly licensed; must provide a physician and surgeon on call; must maintain records of medical advice conversations.
Quality	Quality Management Processes	Plans must establish procedures for ensuring quality.
	Quality Management Processes	DMHC monitoring of health plan and provider quality.
	Quality Management Processes	Annual public record summary of number and types of grievance.
	Reporting	Requires plans to report certain changes to DMHC.
	Reporting	Plan disclosure statements must describe any bonus or financial incentive arrangements.
	Reporting	Health plans must annually report on dispute resolution procedures and outcomes with providers.
	Reporting	Plans must report on compliance with the timeliness of access to care standards. Compliance will be reported in the OPA's report card.
	Reporting	Plans must report to DMHC on internal policies and procedures related to providing culturally appropriate care.
Network	Geographic Access	DMHC must develop regulations for geographic access in less populated counties. Plans intending to withdraw from these counties where two of fewer plans serve the county must hold public hearings.

### U.S. Office of Personnel Management

The Federal Employees Health Benefits (FEHB) Program, administered by the United States Office of Personnel Management (OPM), is an “employee-choice” model through which approximately 200 health plans are offered nationally and regionally to non-military government employees and annuitants. OPM has established the following ten principles for the FEHB Program. All FEHB carriers must be committed to:

- Ensuring enrollees have access to good healthcare benefits;
- Striving to keep FEHB premiums affordable;
- Ensuring enrollees have access to quality provider networks;
- Providing competitive healthcare choices for consumers;
- Strengthening information for consumers so they can be more involved and responsible for their own healthcare decisions;
- Being well managed and financially secure;
- Providing efficient and effective contract administration;
- Ensuring the timely and accurate submission of actuarial data and financial accounting information;

- Maintaining compliance with FEHB laws, regulations, contract requirements and administrative guidance at all times; and
- Guaranteeing that enrollee and Government resources are protected.

The following areas were highlighted in May 2011 Call Letter

- Pilot programs such as integrated healthcare systems.
- Health and wellness, including incentives for HRA completion, engagement in disease management and wellness programs
- Proposals to reduce adult and childhood obesity
- Programs that will demonstrate improved health outcomes, patient safety, and prevent hospital readmissions
- Proposals to reduce racial and ethnic disparities in both health status and healthcare.
- Promote the use of generic drugs and reduce overall pharmacy spending
- Increase the number of health care providers in geriatrics
- Submit the medical loss ratio for your estimate the actuarial value of your plan options.

Other attachments and special questionnaires in 2011 included:

Blue Button Initiative (downloadable health history & data)

Demonstrating Value through Clinical and Financial Integration

Payment Bundling

- Patient-Centered Medical Homes (PCMH)
- Accountable Care Organizations (ACOs)

Smoking Cessation

Fraud and Abuse Management

**Table 42: HEDIS Reporting Required by the Office of Personnel Management**

<b>Effectiveness of Care</b>	
<b>ABA</b>	Adult BMI Assessment
<b>CIS</b>	Childhood Immunization Status
<b>IMA</b>	Immunizations for Adolescents
<b>BCS</b>	Breast Cancer Screening
<b>CCS</b>	Cervical Cancer Screening
<b>COL</b>	Colorectal Cancer Screening
<b>CWP</b>	Appropriate Testing for Children With Pharyngitis
<b>URI</b>	Appropriate Treatment for Children With Upper Respiratory Infection
<b>AAB</b>	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
<b>SPR</b>	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
<b>PCE</b>	Pharmacotherapy of COPD Exacerbation
<b>ASM</b>	Use of Appropriate Medications for People With Asthma
<b>CMC</b>	Cholesterol Management for Patients With Cardiovascular Conditions
<b>CBP</b>	Controlling High Blood Pressure

Table 42: HEDIS Reporting Required by the Office of Personnel Management	
<b>PBH</b>	Persistence of Beta-Blocker Treatment After a Heart Attack
<b>CDC</b>	Comprehensive Diabetes Care
<b>OMW</b>	Osteoporosis Management in Women Who Had a Fracture
<b>LBP</b>	Use of Imaging Studies for Low Back Pain
<b>AMM</b>	Antidepressant Medication Management
<b>ADD</b>	Follow-Up Care for Children Prescribed ADHD Medication
<b>FUH</b>	Follow-Up After Hospitalization for Mental Illness
<b>MPM</b>	Annual Monitoring for Patients on Persistent Medications
<b>MRP</b>	Medication Reconciliation Post-Discharge
<b>MUI</b>	Management of Urinary Incontinence in Older Adults
<b>OTO</b>	Osteoporosis Testing in Older Women
<b>PAO</b>	Physical Activity in Older Adults
<b>ASP</b>	Aspirin Use and Discussion
<b>FSA</b>	Flu Shots for Adults Ages 50–64
<b>FSO</b>	Flu Shots for Older Adults
<b>MSC</b>	Medical Assistance With Smoking and Tobacco Use Cessation
<b>PNU</b>	Pneumonia Vaccination Status for Older Adults
<b>Access/Availability of Care</b>	
<b>PPC</b>	Prenatal and Postpartum Care
<b>Satisfaction With the Experience of Care</b>	
<b>CPA</b>	CAHPS Health Plan Survey 4.0H, Adult Version
<b>CPC</b>	CAHPS Health Plan Survey 4.0H, Child Version
<b>CCC</b>	Children With Chronic Conditions Survey
<b>Use of Services</b>	
<b>W15</b>	Well-Child Visits in the First 15 Months of Life
<b>W34</b>	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
<b>AWC</b>	Adolescent Well-Care Visits
<b>IPU</b>	Inpatient Utilization—General Hospital/ Acute Care
<b>IADa-1/2</b>	Identification of Alcohol and Other Drug Services
<b>MPT</b>	Mental Health Utilization
<b>ABX</b>	Antibiotic Utilization
<b>PCR</b>	Plan All-Cause Readmissions
<b>Cost of Care</b>	
<b>RDI</b>	Relative Resource Use for People With Diabetes
<b>RAS</b>	Relative Resource Use for People With Asthma
<b>RLB</b>	Relative Resource Use for People With Acute Low Back Pain
<b>RCA</b>	Relative Resource Use for People With Cardiovascular Conditions
<b>RHY</b>	Relative Resource Use for People With Uncomplicated Hypertension
<b>RCO</b>	Relative Resource Use for People With COPD
<b>PPE</b>	Potentially Avoidable Readmissions
<b>PPR</b>	Potentially Avoidable Complications
<b>PPC</b>	Potentially Avoidable Admissions
<b>PPA</b>	Potentially Avoidable Emergency Room Visits
<b>PPV</b>	Potentially Avoidable Ancillary Services

### Catalyst for Payment Reform Health Plan RFI

The Catalyst for Payment Reform Health Plan RFI mirrors many aspects of the eValue8 Provider Measurement and Rewards module but includes a deeper dive into paid claims totals. It is used by a number of large private purchasers. It is presented in a Microsoft Excel spreadsheet format. Both require respondents to quantify the value and impact of its provider incentive programs, in addition to gathering information on measurement and public reporting strategies. There is significant overlap with eValue8 content, providing a consistent set of payment reform expectations for the health plans and their network providers. As its name indicates, it focuses on provider measurement and payment issues, organized into these sections:

1. Assessing Performance-Based Payment
2. Evidence of Performance-Based Payment Impact
3. Future Planned Payment Strategies
4. Measuring Performance for Payment Purposes
5. Maternity Care Payment
6. Reference and Value Pricing
7. Price Transparency
8. Aligning with Medicare
9. Assessing Accountable Care Organization Strategies



Table 43 below was adapted from an analysis by Minnesota Exchange staff and compares NCQA MCO Members Connection module and how eValue8 reviews, while also embedding member support elements in prevention and health promotion, disease management and behavioral health modules. Additional information and details regarding how NCQA MCO accreditation and eValue8 map to Section 1311 provisions are presented in Appendix G.

Table 43: Appendix I: eValue8 Consumer Engagement Content Compared to Accreditation Member Connection Model	
eValue8 Health Plan Request for Information	NCQA Member Connection
<p><b>Consumer Engagement</b></p> <ul style="list-style-type: none"> <li>▪ Treatment option decision support and shared decision making</li> <li>▪ Personal health record and self-management tools</li> <li>▪ Encouraging the use of quality data for physician and hospital choice tools</li> <li>▪ Cost calculator and price transparency</li> <li>▪ Performance on CAHPS survey</li> </ul>	<p><b>Self-Management Tools</b></p> <ul style="list-style-type: none"> <li>▪ Topics of Tools</li> <li>▪ Usability Testing (language and member special needs, including vision and hearing)</li> <li>▪ Review and Update Process</li> <li>▪ Formats</li> </ul>
<p><b>Prevention and Health Promotion</b></p> <ul style="list-style-type: none"> <li>▪ Strategies for getting members to complete health risk assessments</li> <li>▪ Plan programs for using health risk assessment information to guide members to needed care</li> </ul>	<p><b>Health Appraisal (HA)</b></p> <ul style="list-style-type: none"> <li>▪ Components, disclosure, scope</li> <li>▪ Accessibility</li> <li>▪ Frequency of HA Completion</li> <li>▪ Review and Update Process</li> </ul>
<p><b>Pharmaceutical Management</b></p> <ul style="list-style-type: none"> <li>▪ How the plan promotes adherence to prescription regimens</li> <li>▪ Identifying and closing gaps in care by monitoring and influencing patient compliance and adherence</li> </ul>	<p><b>Pharmacy Benefit Information</b></p> <ul style="list-style-type: none"> <li>▪ Web and Phone Requests</li> <li>▪ QI Process on Accuracy of Information</li> <li>▪ Pharmacy Benefit Updates</li> </ul>
<p><b>OTHER MODULES</b></p> <p><b>Behavioral Health</b></p> <ul style="list-style-type: none"> <li>▪ Whether and how plans help providers screen members for behavioral health issues</li> <li>▪ How the plan monitors medication compliance</li> </ul> <p><b>Chronic Disease Management and Member Identification</b></p> <ul style="list-style-type: none"> <li>▪ How effectively a plan helps coordinate care for patients with multiple conditions</li> <li>▪ Whether the plan supports patients with a wide variety of tools and interventions that are activated when needed to avoid adverse events and help members understanding their conditions</li> </ul>	<p><b>OTHER MODULES</b></p> <ul style="list-style-type: none"> <li>▪ Functionality of Claims Processing</li> <li>▪ Web Site Functionality</li> <li>▪ Telephone Requests</li> </ul> <p><b>Personalized Information on Health Plan Services</b></p> <ul style="list-style-type: none"> <li>▪ Web and Phone Functionality</li> <li>▪ QI Process on Accuracy of Information</li> <li>▪ E-Mail Response Turnaround Time</li> </ul> <p><b>Innovations in Member Services</b></p> <ul style="list-style-type: none"> <li>▪ Use of New Technologies</li> <li>▪</li> <li>▪ Health Information Line (HIL)</li> <li>▪ Access to HIL, capabilities and monitoring</li> </ul> <p><b>Encouraging Wellness and Prevention</b></p> <ul style="list-style-type: none"> <li>▪ Identifying members, targeted follow-up, use of incentives</li> </ul>

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## Accreditation Standards and Reporting for Qualified Health Plans

### Summary

The California Health Benefit Exchange is establishing performance requirements for qualifying health plans that participate in the Exchange under the Affordable Care Act.<sup>39</sup> This Board Recommendations Brief is intended to address requirements for Qualified Health Plans (or Exchange Plans) related to accreditation and has been developed with a view towards the California Health Benefits Exchange's "Principles Guiding Qualified Health Plan and Small Employer Health Plan Policies and Design." The brief describes a set of options related to those health plan accreditation and certification requirements for consideration by the Board.

The Affordable Care Act requires Qualified Health Plans to be accredited as a condition of certification, but leaves establishment of 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.<sup>40</sup>

There are additional Board briefs that address the related components of quality reporting, and initiatives to improve the coordination, effectiveness and affordability of care. These are: Strategies to Promote Better Quality and More Affordable Care, Administrative Simplification, and Promoting Wellness and Prevention.

### Background

Federal regulations released in draft form June 5, 2012 propose that "*accreditation be through NCQA or URAC, for at least years one and two of the Exchange.*" These regulations propose that baseline criteria include either 1) Health Plan Accreditation (HPA) accreditation by the National Committee for Quality Assurance (NCQA) or 2) core health plan accreditation by URAC, formerly known as Utilization Review Accreditation Commission with the eventual addition of Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys and other measures.

Although many of the major health plans in California have accreditation, there are plans that may wish to participate in the Exchange that do not meet applicable criteria, as well as new entrants that will not be able to undergo accreditation review until they are operational. Therefore, as noted in a white paper from the National Association of Insurance Commissioners (NAIC), "*As part of a national quality strategy, Exchanges will have a significant role in: ensuring that QHPs become accredited and implement quality improvement strategies; providing plan*

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<sup>39</sup> Specified in Sections 2717 and 1311 of the Affordable Care Act. See Appendix A for excerpt.

<sup>40</sup> ACA Section 1311(c)(1)(D)(i)-(ii).

*ratings based on quality and cost; and providing patient satisfaction data. The purposes of these requirements are to improve the quality of health care, ensure that QHPs are focused on promoting quality improvement, and improve transparency so that consumers can compare plans based on quality as well as price.”*

Health plan issuers that are not currently accredited, as well as new entrants, are permitted a transition period. The criteria and length of time to meet the standard is to be established by the Exchange. Accrediting entities assert that the typical accreditation process varies but on average takes 18 months to prepare undergo accreditor organization review, although it may be less for provisional accreditation. Therefore, issuers that are not already accredited may not be able to meet a January 1, 2014 effective date. New plans will face a greater challenge and will need to at least a year of operational experience before they can begin to collect information to support a comprehensive accreditation process.

In consideration of potential options for Qualified Health Plan requirements, this Brief focuses on NCQA and URAC accreditation and other standardized tools commonly used in the marketplace. Specific accreditation programs offered through NCQA and URAC are summarized in Appendix B, with mapping of specific elements of the Affordable Care Act.

Currently, the vast majority of California health plans possess NCQA Health Plan (or “MCO”)<sup>41</sup> accreditation (see Appendix C). A limited number of plans use URAC certification, but only for certain programs, such as case management and utilization management. The high frequency of NCQA Health Plan accreditation is due in large part to large purchaser expectations in California and requirements established by the Medi-Cal Managed Care program. As such, the background information following relies on NCQA as representative of the health plan accreditation process in California generally.

Health plan accreditation is typically granted for a period of several years, with specified performance tiers (e.g. rated Excellent, Commendable, Accredited, Provisional and Denied).

NCQA Health Plan Accreditation is segmented into a wide range of operational, service and quality modules, such as provider credentialing, disease management, and pharmaceutical management. In addition to programmatic criteria, 43% of total NCQA Health Plan scoring is linked to HEDIS™ (Healthcare Effectiveness Data and Information Set) clinical quality measures and CAHPS patient experience ratings of their health plans. Both are generally collected annually, with select quality measures rotated for reporting every other year. While accreditation in the past entailed lengthy site visits, data is now generally reported electronically through a Web-based platform with electronic submission of documentation for inspection.

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<sup>41</sup> MCOs include both HMO and PPO plans.

Over the last decade, NCQA has expanded its suite of accreditation programs to address emerging areas of performance differentiation and programmatic areas, with some being more developed than others. For example,

- NCQA introduced a Member Connection certification to assess the availability of select consumer decision support tools. It is now embedded in core NCQA accreditation. Member Connection does not, however, address the underlying functionality of these tools, such as search capability, member customization or interactive features, which are important to determining how easily consumers can access and use the information. Plans are scored on the cumulative number of selected features in each classification (e.g., health risk appraisals, wellness information, prescription drug cost calculator), but there is no minimum threshold for core functions required to achieve any points. Because the scoring detail is not transparent to plan administrators, purchasers, nor consumers, it is difficult to rely on certification to differentiate plan performance. Furthermore, there are gaps in key areas such as shared decision making and medical services cost calculators which are not assessed as part of the accreditation process.
- Some carriers have also completed the voluntary Physician Hospital Quality module which evaluates how well health plans measure and report the quality and cost of physicians and hospitals. However, it does not fully address quality transparency tools for consumers except for use of NCQA’s physician recognition programs and hospital choice decision support.
- Few points are associated with pay for performance and health plan use of payment incentives for providers, or for use of benefit design to differentiate providers. Additionally, NCQA offers Primary Care Medical Home certification used by some carriers.

While the reporting of results for standardized performance measures through NCQA and URAC is common and routine for most accredited HMO and PPOs plans and Medi-Cal managed care plans, detailed assessment and reporting of health plan activities pertaining to their provider reimbursement or benefit design strategies is not routinely captured. The Board Brief on Strategies to Promote Better Quality Care and More Affordable Care addresses how the Exchange may address some of these additional performance areas.

Note that accreditation of stand-alone dental plans is not included in this brief. Under the Affordable Care Act the Exchange is required to receive bids from stand-alone dental plans.<sup>42</sup> However, industry wide standards for accreditation of dental plans do not exist. As such, dental plans would not be subject to the requirement that Qualified Health Plans not already accredited must become accredited within the uniform period established by the Exchange.

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<sup>42</sup> ACA §1311(d)(2)(B)(ii); 45 CFR 155.1065



## Stakeholder Perspectives

Health plans are generally concerned about reporting burden. Because NCQA and URAC are already in use, they tend to request that their NCQA or URAC accreditation be deemed sufficient to meet any Qualified Health Plan requirements. Further, because accreditation is resource-intensive, some small regional plans are unaccredited and have expressed concern about the cost burden of undergoing new accreditation and the timeframe that will be needed to collect the data to meet full accreditation. Stakeholders urged consideration of the necessary time in establishing standards.

Purchasers and consumer advocates are generally supportive of the Exchange requiring NCQA and URAC accreditation as minimum criteria to assure use of commonly accepted standards and baseline quality performance. Purchasers and consumers further desire Qualified Health Plan requirements to support value differentiation and performance transparency, and that the unit of measurement – plan, hospital, medical group, practice, or physician – is relevant for consumer choice. However, consumer advocates have expressed concern that accreditation could be a barrier to regional and Medi-Cal or Healthy Families local plan participation in the Exchange. Many of these plans contract with community health centers and other providers with a history of serving low income and diverse populations and an accreditation requirement could restrict them and affect member access to essential health providers.

## Issues and Recommendations

Table 46 that follows outlines the key issues related to establishing Qualified Health Plan Accreditation standards for consideration by the Board for the initial years of operation (2014-2016).

- **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.

## Recommended Approach

Staff recommends the Exchange require interim NCQA or Provisional URAC accreditation, and reporting of quality measures consistent with those required by Medi-Cal Managed Care, including CAHPS and HEDIS (Option B). Option B establishes a minimum level of quality reporting and transparency and raises a higher bar than current proposed federal requirements, while also specifying a transitional glide path for newly organized plans and



regional carriers to meet requirements. Option B thereby addresses the needs of new entrants or issuers accredited in categories other than the commercial market and demands commendable standing at minimum for all issuers by the second year of Qualified Health Plan operations. Appendix D lists the CAHPS and HEDIS measures currently in use for commercial, Medicaid and Medicare plans which may be relied upon as reporting measures and on which the Exchange intends to rely.

The Exchange is charged with stimulating competition within the health insurance marketplace including on the criteria of plan quality. Option A does not provide adequate recognition of the current status of regional health plans that may offer competitive networks that have unique cultural competencies for local populations, but do not yet hold any form of accreditation. Option C relies on an existing structure of accreditation standards and provider performance management that reflects the Exchange's stated Guidelines for Selection and Oversight of Qualified Health Plan the Development of the Small Employer Health Plan Options Program; however, it may overly restrict the ability of new entrants to compete.

Because California plans, including Medicaid Managed Care plans are largely accredited by NCQA and URAC currently (see Appendix C), staff recommend accepting NCQA and URAC accreditation as the sole form of accreditation for the Exchange. Staff is concerned that none of the California plans are accredited by URAC for core managed care functions. The Exchange will work with NCQA and URAC to ensure that robust criteria for clinical quality and patient experience survey results are included in accreditation practices to demonstrate a more comprehensive measure of plan performance and assures comparability across all Qualified Health Plans. Appendix B compares elements of NCQA and URAC accreditation to the quality reporting categories defined in the Affordable Care Act.

Option B should be considered in conjunction with other performance elements, including price and efficiency. Accreditation alone is not sufficient to differentiate value among health plans, since it is a minimum standard for contracting under the Affordable Care Act. Current accreditation processes rely heavily on the presence of specific policies and procedures but it does not measure the execution of those policies and procedures or the impact of those policies or procedures, hence the need for monitoring. While plan-level performance information about patient experience and clinical quality may support the Exchange's role in plan oversight and management, the Exchange should seek to advance the types of measurement- performance reporting- and payment that advance delivery system reform and care redesign in a manner that helps sustain longer-term affordability and quality. Current accreditation specifications alone are not sufficient to address consumer information needs in areas such as cost estimation and treatment decision support, and these should be addressed through Exchange oversight of health plan quality improvement strategies in accordance with Sections 2717 and 1311 of the Affordable Care Act.

As noted, Option B is more rigorous than the recent Federal Guidance and Proposed Rules for Federally-Facilitated Exchanges summarized in Table 44 below. The May 2012 Federally Facilitated Exchanges (FFE) guidance indicates that HHS intends to propose that, for the FFE, non-accredited Qualified Health Plan issuers will be required to schedule an accreditation in their first year of Qualified Health Plan certification and be accredited by completion of the second year of Qualified Health Plan certification. They will also be requested to attest that they will submit performance data on Qualified Health Plan product type when such data become available.<sup>43</sup> However, Option B recognizes California’s history of public performance reporting, existing Medi-Cal Managed Care requirements, and is aligned with the recently Medi-Cal Managed Care Program Baseline Quality Report released by the Department of Health Care Services (DHCS). In conjunction with the number of already accredited health plans and use of quality reporting measures equivalent to HEDIS and CAHPS, while Option B is a “higher bar”, it does not set an unjustifiable compliance burden.

**Table 44: Federal Guidance and Proposed Rules for Federally-Facilitated Exchanges**

Certification Year	Qualified Health Plan Issuers without Existing Accreditation	Qualified Health Plan Issuers with Existing Commercial. Medicaid Accreditation for the State
Year 1 (2013)	Schedule Accreditation review	Attest that Accredited Policies and Procedures are Comparable to Qualified Health Plan
Years 2 and 3 (2014-2015)	Accredited Qualified Health Plan Policies and Procedures	Attest that Accredited Policies and Procedures Comparable to Qualified Health Plan
Year 4 (2016)	Qualified Health Plan product type is accredited, Qualified Health Plan product type performance data have has been submitted	

NOTE: FEDERAL GUIDANCE (MAY 16, 2012) AND PROPOSED RULES FOR FEDERALLY-FACILITATED (JUNE 5, 2012)

Option B is also more aggressive than the recently NCQA proposed guidelines for accreditation of exchanges that was released for public comment in March 2012 (Summarized in Table 45). Staff recommends that the Exchange adopt performance requirements beyond evidence of policies and procedures. Because California HMOs and PPOs routinely report CAHPS and HEDIS performance information to the Office of the Patient Advocate, and Medi-Cal Managed Care plans report to DHCS, comparable or consistent reporting should be a requirement adopted by the Exchange. Option B also establishes that Plans obtain Interim or Provisional Accreditation by 2014, which represents scoring of at least 55% among the NCQA requirements (see Appendix E for scoring detail). Commendable Accreditation, which entails achieving a score of at least 70%, would be required by 2016.

<sup>43</sup> Center for Consumer Information and Insurance Oversight (CCIIO,CMS, DHHS). Quality Activities in a Federally Facillitated Exchange. Health Insurance Exchange Systemwide Meeting, May 21-23, 2012. <http://cciio.cms.gov/resources/files/hie-quality-activities-in-a-ffe.pdf>

Table 45: NCQA and URAC Proposed Accreditation for Exchanges (2013)					
Type	Eligibility	Accreditation Status	Duration	Documentation	Measures Reporting
Interim	Plans new to NCQA/URAC (Co-ops)	Denied (non public), Interim+	18 months	Policy and Procedures	Not required
First	Plans new to NCQA /URAC	Denied (not public), Provisional, Accredited	36 months	Policy and Procedures & evidence of implementation	Required during 3rd year but can be scored anytime
Renewal	Plans with NCQA or URAC Accreditation	Denied, Provisional, Accredited, Commendable, Excellent	36 months	Policy and Procedures & evidence of implementation	Required and scored every year

Staff does not recommend immediate inclusion of miscellaneous, topic specific NCQA or URAC certification programs as these areas may be addressed through other quality monitoring mechanisms through which the Exchange can be more flexible in adopting standards consistent with the California marketplace and establish expectations that may not yet be part of NCQA certification programs.

Staff also recommends that, for Qualified Health Plan issuers with current NCQA or URAC accreditation, that the Exchange accepts the most current HEDIS, CAHPS or other consistent, equivalent measures as applicable to the Exchange Plan enrolled population. This will be consistent with expected rule making for the Federally Facilitated Exchanges where DHHS will accept mapping of commercial and/or Medicaid CAHPS results to the Exchange population. They are expected to allow alignment of the measures by the same product type (HMO or PPO) and to require separate reporting for adults and children.

The Exchange may also consider digging deeper into accreditation requirements to advance delivery system re-engineering and payment reform. One example would be to require that health plans have or are building some level of provider level measurement, such as the NCQA Physician Hospital Quality (PHQ) Certification. Staff notes that NCQA PHQ Certification seeks to advance provider-level accountability, but there would still be important information gaps such as the performance of Essential Community Providers,<sup>44</sup> who may not be included in current California-based measurement programs. An additional concern is that small plans are unlikely to have the volume requirements necessary for credible performance measurement at the provider and/or practice level. There may be other ways to support such measurement, such as through a statewide multi-payer claims database for performance reporting. An additional

<sup>44</sup> Essential community providers are providers that serve predominately low-income, medically underserved individuals, including...providers defined in section 340B (a) (4)of the PHS Act; and 1927 (c) (1)(D)(i)(IV)of the Act.

rationale for Exchange-specific provider management and quality improvement reporting is that California plans are also rapidly implementing accountable care strategies that introduce new PPO incentive programs and/or contracting requirements for physicians and hospitals. Also, many HMO health plans representing a significant portion of small business and individual enrollment already participate in the Integrated Healthcare Association's Pay for Performance Program.

Option B is recommended as the initial accreditation standard. It is anticipated that the Exchange will consider more rigorous accreditation standards in the near future. For example, higher accreditation standards could include Exchange specification for HEDIS and CAHPS Reporting, such as 1) threshold levels of performance in CAHPS and HEDIS results, 2) development of measures specific to the Exchange population, or 3) oversampling of target populations on measures that differentiate performance and can be used to evaluate efforts to reduce health disparities. Higher accreditation standards could include required certification in selected areas of plan performance, such as NCQA Physician Hospital Quality Certification. At the same time, the Exchange may also raise the overall certification standards, such as requiring participation and submission of information to an All Payer Claims data base.

See also: Strategies to Promote Better Quality and More Affordable Care Board Brief.

### **Next Steps**

Staff recommends that the Exchange continue to work with key stakeholders to seek input and refinement of the proposed minimum Qualified Health Plan requirements regarding accreditation, including:

- Confer with the California Department of Health Care Services to affirm the adequacy of its HEDIS and CAHPS reporting requirements in their program experience.
- Work with NCQA and URAC to communicate recommendations to potential Exchange Plans.
- Work with the Office of the Patient Advocate to assess inclusion of additional HMO and PPO health plans in its public reporting, including PPO plans regulated by the Department of Insurance
- Affirm with the Integrated Healthcare Association the potential inclusion of additional HMO plans in the Pay for Performance program.
- Consider decertification and recertification rules regarding failure to attain timely accreditation standards.
- Determine how to ensure that Exchange Plans collect race and ethnicity data that may be needed to assess disparities in care. Effort should include outreach to accrediting entities to promote creation or enhancement of existing standards on point.

Table 46: Issue 1: Accreditation for Qualified Health Plans

<p>Option A : Require NCQA or URAC Health Plan Accreditation as a minimum requirement for inclusion as a Qualified Health Plan in the Exchange</p>	<ul style="list-style-type: none"> <li>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.</li> </ul>	<p>Option C: Commendable NCQA Health Plan Accreditation; PHQ Certification required by 2015</p>
<p><b>SUMMARY</b>                      The Exchange would require NCQA Health Plan Accreditation as a minimum requirement for inclusion as a Qualified Health Plan in the Exchange.</p>	<p><b>SUMMARY</b>                      The Exchange would require reporting of quality measures consistent with Medi-Cal Managed Care specifications and a minimum of Interim NCQA or Provisional URAC Accreditation by 2014; Commendable NCQA Accreditation or its URAC equivalent required by 2016.</p>	<p><b>SUMMARY</b>                      The Exchange would require at least Commendable NCQA Health Plan Accreditation and participation in NCQA Physician Hospital Quality Certification; PHQ Certification required by 2015</p>
<p><b>PURPOSE</b>                      The Exchange leverages existing accreditation requirements commonly in use by large purchasers and Medi-Cal Managed Care.</p>	<p><b>PURPOSE</b>                      The Exchange 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.</p>	<p><b>PURPOSE</b>                      The Exchange leverages existing accreditation requirements and incorporates specific elements to advance provider performance accountability.</p>
<p><b>DESCRIPTION</b>                      The Exchange supports a level playing field among health plans by using existing accreditation requirements commonly in use by large purchasers and Medi-Cal Managed Care. Accreditation represents a minimum threshold of achieving 65% of NCQA Health Plan scoring.</p>	<p><b>DESCRIPTION</b>                      The Exchange supports a level playing field among health plans by using existing accreditation requirements commonly in use by large purchasers and Medi-Cal Managed Care, but does not create a barrier for new entrants and regional health plans, which have two years to meet threshold requirements.</p>	<p><b>DESCRIPTION</b>                      The Exchange leverages existing accreditation requirements and incorporates a requirement to undergo Physician Hospital Quality Certification to advance provider performance accountability.</p>

Table 46: Issue 1: Accreditation for Qualified Health Plans

<p>Option A : Require NCQA or URAC Health Plan Accreditation as a minimum requirement for inclusion as a Qualified Health Plan in the Exchange</p>	<ul style="list-style-type: none"> <li>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.</li> </ul>	<p>Option C: Commendable NCQA Health Plan Accreditation; PHQ Certification required by 2015</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>The Exchange minimizes its administrative burden;</li> <li>NCQA Health Plan Accreditation is commonly in use by both commercial and Medi-Cal Managed Care plans (see Appendix C)</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>The Exchange minimizes its administrative burden;</li> <li>The Exchange supports alignment across public and private purchasers in California.</li> <li>The Exchange advances performance transparency by increasing the number of plans reporting patient experience and clinical quality results through the Office of the Patient Advocate.</li> <li>New entrants and regional health plans are provided additional time to meet performance requirements</li> <li>Minimizes burden on existing California plans.</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>The Exchange minimizes its administrative burden;</li> <li>The Exchange sets a higher threshold of Commendable MCO Accreditation</li> <li>The Exchange advances performance expectations by increasing the number of plans undergoing PHQ Certification.</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>New entrants and many regional health plans would be excluded from the Exchange.</li> <li>Exclusion of new entrants and regional health plans may adversely impact competition in the Exchange, or in specific markets where regional health plans have market share.</li> <li>Limits consumer access to providers who may contract primarily with regional health plans.</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>Requires additional Exchange staff resources to monitor compliance</li> <li>May create disruption and added administrative burden should plans need to be terminated for failure to meet requirements by 2016.</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>New entrants and many regional health plans would be challenged to meet participation requirements for the Exchange.</li> <li>PHQ certification may not be sufficient to meet the delivery system goals of the Exchange.</li> <li>PHQ certification may not be sufficiently flexible to reflect evolving programs in the California marketplace.</li> </ul>

## Appendix A. Affordable Care Act Section 1311 Language

The following is an excerpt from the Affordable Care Act that summarizes the quality reporting requirements for Qualified Health Plans participating in Exchanges. These specifications are stated in parallel to Section 2717, which establishes the general quality improvement strategy reporting elements required for all health plans.

Section 1311: Affordable Choices of Health Benefit Plans.

(g) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES. –

(1) STRATEGY DESCRIBED. – A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for –

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

(D) the implementation of wellness and health promotion activities; and

(E) As added by section 10104(g). The implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

(2) GUIDELINES. – The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) REQUIREMENTS. – The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

## Appendix B. Accreditation and Certification Programs

### National Committee for Quality Assurance

#### Accreditation

Health Plan Accreditation (HPA Accreditation uses a unified set of standards for HMOs, MCOs, PPOs and POS plans)  
Accountable Care Organizations (ACO)  
Wellness & Health Promotion (WHP)  
Managed Behavioral Healthcare Organizations (MBHO)  
New Health Plans (NHP)  
Disease Management (DM)  
Case Management (CM)

#### Certification

Multicultural Health Care (MHC)  
Physician Organizations (PO)  
Health Information Products (HIP)  
Credentials Verification Organizations (CVO)  
Utilization Management and Credentialing (UM/CR)  
Disease Management (DM)  
Physician and Hospital Quality (PHQ)  
OC-UM/CR Certification

### URAC Accreditations

#### Case Management

Claims Processing  
Consumer Education & Support

#### Core Accreditation

#### Comprehensive Wellness

Credentials Verification Organization

#### Disease Management

Drug Therapy Management  
Health Content Provider  
Health call center  
Health Network  
Health Plan

#### Health Utilization Management

Health Web Site  
HIPAA Privacy  
HIPAA Security  
Independent Review  
Mail Service Pharmacy  
Medicare Advantage Deeming  
Pharmacy Benefit Management  
Specialty Pharmacy  
Workers Compensation UM  
Workers Compensation Pharmacy  
Workers' Compensation Health Network  
Health Provider Credentialing

\***Bolded** – most commonly used



Table 47. Appendix B:

Crosswalk between Section 1311 Domains and Existing Accreditation Requirements (adapted from materials provided by AHIP)

Section 1311 Domains	Both NCQA and URAC have stated in related information material and press releases that they believe their accreditation programs align with State Health Insurance Exchange plan requirements. Follow the links to access the respective information:	
	NCQA 2012 Accreditation	URAC Accreditation 7.0
<p>Improve Health Outcomes, including through the use of the medical home model (Section 2717(a))</p> <ul style="list-style-type: none"> <li>Quality reporting</li> <li>Effective case management</li> <li>Care coordination</li> <li>Chronic disease management</li> <li>Medication and care compliance initiatives</li> </ul>	<ul style="list-style-type: none"> <li>- Quality Management and Improvement                             <ul style="list-style-type: none"> <li>o QI-9: Clinical Practice Guidelines</li> <li>o QI-7: Complex Case Management</li> <li>o QI-10: Continuity and Coordination of Medical Care</li> <li>o QI-8: Disease Management</li> </ul> </li> <li>- Sample HEDIS measures:                             <ul style="list-style-type: none"> <li>o Antidepressant Medication Management</li> <li>o Persistence of Beta-Blocker Treatment after a Heart Attack</li> <li>o Comprehensive Diabetes Care</li> <li>o HbA1C Poorly Controlled</li> <li>o Medical Assistance with smoking and tobacco use cessation</li> </ul> </li> <li>- NCQA also offers:                             <ul style="list-style-type: none"> <li>o NCQA PCMH 2011 recognition</li> <li>o Disease Management Accreditation</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- Quality Management                             <ul style="list-style-type: none"> <li>o Core 17-24</li> <li>o P-QM 1-9</li> </ul> </li> <li>- Health Plan Operations                             <ul style="list-style-type: none"> <li>o P-OPS 7: Care Coordination Regarding Medication Safety</li> <li>o P-OPS 8 - P&amp;T Formulary Development</li> </ul> </li> <li>- Measurement Reporting to URAC                             <ul style="list-style-type: none"> <li>o P-RPT 1-2</li> </ul> </li> <li>- URAC also offers:                             <ul style="list-style-type: none"> <li>o Patient Centered Health Care Home (PCHCH) Achievement Program</li> <li>o Care Management Accreditation</li> <li>o Disease Management Accreditation</li> <li>o Pharmacy Quality Management Accreditation</li> </ul> </li> </ul>
<p>Preventing Hospital Readmissions</p> <p>Comprehensive program for hospital discharge Patient-centered education and counseling</p> <p>Comprehensive discharge planning</p> <p>Post discharge reinforcement by health professional</p>	<ul style="list-style-type: none"> <li>- NCQA plans to update Health Plan Accreditation to reflect these elements.</li> <li>- Existing Accreditation looks more toward the collection of hospital discharge data, and measurement of admissions and readmission rates, not education or discharge planning</li> </ul>	<ul style="list-style-type: none"> <li>- URAC Health Plan Accreditation plans to incorporate measures and standards that meet quality care and reporting for preventable hospital admissions.</li> <li>- Existing URAC Accreditation includes this element as it relates to MLR expense</li> </ul>

**Table 47. Appendix B:**

**Crosswalk between Section 1311 Domains and Existing Accreditation Requirements (adapted from materials provided by AHIP)**

Section 1311 Domains	Both NCQA and URAC have stated in related information material and press releases that they believe their accreditation programs align with State Health Insurance Exchange plan requirements. Follow the links to access the respective information:	
	NCQA 2012 Accreditation	URAC Accreditation 7.0
Improve Patient Safety and Reduce Medical Errors Use of best clinical practices Evidence based medicine Health information technology	<ul style="list-style-type: none"> <li>- Addresses Patient Safety under QI and UM                             <ul style="list-style-type: none"> <li>o QI-9: Clinical Practice Guidelines</li> <li>o UM-13: Procedures for Pharmaceutical Management (re. interactions and recalls)</li> <li>o MEM -6: Innovations in Member Services Element A: Innovative Technology</li> </ul> </li> <li>- NCQA also offers:                             <ul style="list-style-type: none"> <li>o Health Information Products Certification</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- Health Plan Operations                             <ul style="list-style-type: none"> <li>o P-OPS 7: Care Coordination Regarding Medication Safety</li> <li>o P-OPS 8 - P&amp;T Formulary Development</li> </ul> </li> <li>- Health Unitization Management Accreditation                             <ul style="list-style-type: none"> <li>o HUM 24 – Prospective Review Patient Safety</li> </ul> </li> <li>- URAC also offers:                             <ul style="list-style-type: none"> <li>o Health Information Technology Accreditation</li> </ul> </li> </ul>

Table 47. Appendix B:

Crosswalk between Section 1311 Domains and Existing Accreditation Requirements (adapted from materials provided by AHIP)

Section 1311 Domains	Both NCQA and URAC have stated in related information material and press releases that they believe their accreditation programs align with State Health Insurance Exchange plan requirements. Follow the links to access the respective information:	
	NCQA 2012 Accreditation	URAC Accreditation 7.0
<p>Wellness and Health Promotion Activities Personalized wellness and prevention services and risk assessment for: smoking cessation, weight management, stress management, physical fitness, nutrition, heart disease prevention, healthy lifestyle support, diabetes prevention</p>	<ul style="list-style-type: none"> <li>- Use of Health Appraisals                             <ul style="list-style-type: none"> <li>o MEM-1: Health Appraisals, Element A, HA Components (assessment completed)</li> <li>o MEM-1: HA, Element C, HA Scope (includes: smoking cessation, physical activity, healthy eating, and stress)</li> <li>o MEM-1: HA, Element D, HA Results (references given to improve or aide results)</li> <li>o MEM-2: Self-Management Tools, Element A, Topic of Tools (addresses: smoking cessation, BMI, stress, physical activity, healthy eating)</li> </ul> </li> <li>- Also addressed under QI</li> <li>- Does not directly address the others, only through measures collected for accreditation under HEDIS. For example:                             <ul style="list-style-type: none"> <li>o Cholesterol management for patients with cardiovascular conditions</li> <li>o Comprehensive Diabetes Care</li> <li>o HbA1C Poorly Controlled, and</li> <li>o Medical assistance with smoking and tobacco use cessation</li> <li>o Breast Cancer Screening</li> <li>o Cervical Cancer Screening</li> <li>o Colorectal Cancer Screening</li> <li>o Childhood immunization status</li> <li>o Prenatal and Postpartum Care</li> <li>o Flu shots for adults (50-64)</li> <li>o Flu shots for older adults</li> </ul> </li> <li>- NCQA also offers:                             <ul style="list-style-type: none"> <li>o Wellness &amp; Health Promotion Accreditation and Certification</li> <li>o Diabetes Recognition Program</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- Member Relations                             <ul style="list-style-type: none"> <li>o P-MR 9: Health Risk Assessment Tool</li> </ul> </li> <li>- URAC offers:                             <ul style="list-style-type: none"> <li>o Wellness Accreditation</li> </ul> </li> </ul>
<p>Reduce Health and Health Care Disparities Language series Community outreach Cultural competency trainings</p>	<ul style="list-style-type: none"> <li>- Quality Management and Improvement                             <ul style="list-style-type: none"> <li>o QI-4: Availability of Practitioners, Element A, Cultural needs and Preferences</li> <li>o QI-1: Program Structure, Element A, Analyzing existence of healthcare disparities</li> </ul> </li> <li>- Includes focus groups as needed as well as the use of training tools</li> <li>- NCQA also offers:                             <ul style="list-style-type: none"> <li>o Multicultural Health Care Distinction</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- Consumer Protection and Empowerment                             <ul style="list-style-type: none"> <li>o Core 40 – Health Literacy</li> </ul> </li> <li>- Member Relations                             <ul style="list-style-type: none"> <li>o P-MR 6 – Health Literacy to Support Consumers</li> </ul> </li> </ul>

Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers

TABLE 48: APPENDIX C: CALIFORNIA HEALTH PLAN CURRENT USE OF NCQA ACCREDITATION

<i>PLAN NAME</i>	<i>Health Plan Accreditation</i>	<i>Accreditation Grade</i>	<i>Wellness &amp; Health Promotion</i>	<i>Disease Mgmt</i>	<i>Physician Hospital Quality</i>	<i>Multicultural Health Care</i>
<b>COMMERCIAL HEALTH PLANS</b>						
Aetna Health of California, Inc.	HMO/POS	Commendable			X	
Aetna Life Insurance Company (California)	PPO	Commendable			X	
Anthem Blue Cross Life and Health Insurance Company	PPO	Commendable				
Anthem Blue Cross	HMO/POS	Commendable				
Anthem Blue Cross	PPO	Commendable				
Blue Shield of California	HMO/POS	Excellent				
CIGNA Health and Life Insurance Co - California	PPO	Commendable	X*		X	
CIGNA HealthCare of California, Inc.	HMO/POS	Excellent	X*		X	
Connecticut General Life Insurance Company - California	PPO	Commendable				
Health Net Life Insurance Company	PPO	Commendable				X
Health Net of California, Inc.	HMO/POS	Commendable				X
Kaiser Foundation Health Plan Inc. - Southern California	HMO	Excellent		X**		X
Kaiser Foundation Health Plan, Inc. - Northern California	HMO	Excellent		X**		
UnitedHealthcare of California	HMO/POS	Commendable				
UnitedHealthcare Insurance Company (California)	PPO	Excellent				
Western Health Advantage	HMO	Excellent				
<b>MEDI-CAL MANAGED CARE PLANS</b>						
Anthem Blue Cross of California Partnership Plan	HMO	Accredited				
Care1st Health Plan	HMO	Commendable				
Community Health Group	HMO	Commendable				
Health Net of California, Inc.	HMO	Commendable				X

Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers

TABLE 48: APPENDIX C: CALIFORNIA HEALTH PLAN CURRENT USE OF NCQA ACCREDITATION

<i>PLAN NAME</i>	<i>Health Plan Accreditation</i>	<i>Accreditation Grade</i>	<i>Wellness &amp; Health Promotion</i>	<i>Disease Mgmt</i>	<i>Physician Hospital Quality</i>	<i>Multicultural Health Care</i>
Inland Empire Health Plan	HMO	Commendable				
Local Initiative Health Authority, dba L.A. Care Health Plan	HMO	Commendable				
Molina Healthcare of California Partner Plan, Inc.	HMO	Accredited				
Orange County Health Authority - dba CalOptima	HMO	Scheduled				

AS OF JUNE 2012.

HMO/PPO ACCREDITATION IS COMBINED

\* CIGNA BEHAVIORAL HEALTH, INC. - [HTTP://REPORTCARD.NCQA.ORG/WHP/EXTERNAL/WHPRATINGS.ASPX?ORGNAME=](http://reportcard.ncqa.org/WHP/EXTERNAL/WHPRATINGS.ASPX?ORGNAME=)

\*\* KAISER PERMANENTE CARE MANAGEMENT INSTITUTE - [HTTP://WWW.NCQA.ORG/TABID/145/DEFAULT.ASPX](http://www.ncqa.org/TABID/145/DEFAULT.ASPX)

Table 49: Current California Plan Accreditation Programs Under URAC

<b>Plan Name</b>	Health Utilization Management	Case Management	Health Call Center	Other
Anthem Blue Cross	X			
Blue Shield of California	X	X		
Contra Costa Health Plan			X	
Kaiser Foundation Health Plan, Inc. - Northern California			X	
Kaiser Permanente - Permanente Advantage	X	X		
Molina Healthcare			X	

AS OF MARCH 22, 2012

Table 50: Appendix D: NCQA Summary Table of HEDIS Measures by Product Line			
HEDIS 2012 Measures	Applicable to:		
	Commercial	Medicaid	Medicare
<b>Effectiveness of Care</b>			
Adult BMI Assessment	X	X	X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	X	X	
<b>Effectiveness of Care</b>			
Childhood Immunization Status	X	X	
Immunizations for Adolescents	X	X	
Human Papillomavirus Vaccine for Female Adolescents	X	X	
Lead Screening in Children		X	
Breast Cancer Screening	X	X	X
Cervical Cancer Screening	X	X	
Colorectal Cancer Screening	X		X
Chlamydia Screening in Women	X	X	
Glaucoma Screening in Older Adults			X
Care for Older Adults			X
Appropriate Testing for Children With Pharyngitis	X	X	
Appropriate Treatment for Children With Upper Respiratory Infection	X	X	
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	X	X	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	X	X	X
Pharmacotherapy of COPD Exacerbation	X	X	X
Use of Appropriate Medications for People With Asthma	X	X	
Medication Management for People With Asthma	X	X	
Cholesterol Management for Patients With Cardiovascular Conditions	X	X	X
Controlling High Blood Pressure	X	X	X
Persistence of Beta-Blocker Treatment After a Heart Attack	X	X	X
Comprehensive Diabetes Care	X	X	X
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	X	X	X
Osteoporosis Management in Women Who Had a Fracture			X
Use of Imaging Studies for Low Back Pain	X	X	
Antidepressant Medication Management	X	X	X
Follow-Up Care for Children Prescribed ADHD Medication	X	X	
Follow-Up After Hospitalization for Mental Illness	X	X	x
Annual Monitoring for Patients on Persistent Medications	X	X	X
Medication Reconciliation Post- Discharge			X
Potentially Harmful Drug-Disease Interactions in the Elderly			X
Use of High-Risk Medications in the Elderly			X
Fall Risk Management			X
Management of Urinary Incontinence in Older Adults			X
Osteoporosis Testing in Older Women			X
Physical Activity in Older Adults			X
Aspirin Use and Discussion	X	X	
Flu Shots for Adults Ages 50–64	X		
Flu Shots for Older Adults			X
Medical Assistance With Smoking and Tobacco Use Cessation	X	X	X

Table 50: Appendix D: NCQA Summary Table of HEDIS Measures by Product Line			
HEDIS 2012 Measures	Applicable to:		
	Commercial	Medicaid	Medicare
Pneumonia Vaccination Status for Older Adults			X
<b>Access/Availability of Care</b>			
Adults' Access to Preventive/ Ambulatory Health Services	X	X	X
Children's and Adolescents' Access to Primary Care Practitioners	X	X	
Annual Dental Visit		X	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	X	X	X
Prenatal and Postpartum Care	X	X	
Call Abandonment	X	X	X
Call Answer Timeliness	X	X	X
<b>Experience of Care</b>			
CAHPS Health Plan Survey 4.0H, Adult Version	X	X	
CAHPS Health Plan Survey 4.0H, Child Version	X	X	
Children With Chronic Conditions	X	X	
<b>Utilization and Relative Resource Use</b>			
Guidelines for Utilization Measures	X	X	X
Frequency of Ongoing Prenatal Care		X	
Well-Child Visits in the First 15 Months of Life	X	X	
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	X	X	
Adolescent Well-Care Visits	X	X	
Frequency of Selected Procedures	X	X	X
Ambulatory Care	X	X	X
Inpatient Utilization—General Hospital/ Acute Care	X	X	X
Identification of Alcohol and Other Drug Services	X	X	X
Mental Health Utilization	X	X	X
Antibiotic Utilization	X	X	X
Plan All-Cause Readmissions	X		X
Guidelines for Relative Resource Use Measures	X	X	X
Relative Resource Use for People With Diabetes	X	X	X
Relative Resource Use for People With Cardiovascular Conditions	X	X	
Relative Resource Use for People With Hypertension	X	X	X
Relative Resource Use for People With COPD	X	X	X
Relative Resource Use for People With Asthma	X	X	X
<b>Health Plan Descriptive Information</b>			
Board Certification	X	X	X
Enrollment by Product Line	X	X	X
Enrollment by State	X	X	X
Language Diversity of Membership	X	X	X
Race/Ethnicity Diversity of Membership	X	X	X
Weeks of Pregnancy at Time of Enrollment		X	
Total Membership	X	X	X

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## Promoting Wellness and Prevention

### Summary

The California Health Benefit Exchange (the Exchange) is considering the options related to wellness programs and initiatives and how such initiatives could be factored into the selection and monitoring of Qualified Health Plans and benefit design requirements. This “Promoting Wellness and Prevention” Board Recommendation Brief provides background on the issues and presents options and recommendations for the Exchange in four areas of program design:

1. Use of a health risk assessment tool;
2. Provision of a wellness program by the Exchange;
3. Use of financial incentives as part of benefit plan design, particularly with respect to tobacco use, and
4. Role of the Exchange in addressing community and public health,

### Background

The vision, mission and values adopted by the California Health Benefit Exchange, the California legislation to establish the health benefit exchange, and the federal Affordable Care Act all include provisions to promote wellness and disease prevention. The state law directs the Exchange "to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service" and one of the six primary values adopted by the Exchange is to be "a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities."

The Affordable Care Act created the National Prevention Council, which is comprised of 17 heads of departments, agencies, and offices across the Federal government who are committed to promoting prevention and wellness. The Council developed the National Prevention Strategy to engage a diverse array of stakeholders, from state and local policy makers, to business leaders and philanthropic organizations, to individuals, their families and communities to realize the benefits of prevention for all Americans' health. There is a potential opportunity for the Exchange to support broader public health goals such as promoting healthy lifestyles and reducing obesity.

Under the Affordable Care Act, preventive and wellness services, as well as chronic disease management, are included as Essential Health Benefits. The law authorizes several grant funds that target wellness activities; these include a Prevention and Public Health Fund, a grant program to support the delivery of evidence based and community based prevention and wellness services, and a small employer wellness program grant fund (currently on hold). The law also permits employers to offer up to a 30% premium discount, waiver of cost sharing requirement or benefits that would otherwise not be provided for in exchange for participation

in a wellness program and meeting certain health related standards. Research on incentive strategies has shown the premium discount to be a strong driver for boosting wellness program participation. Further, the Affordable Care Act requires a 10-state demonstration project to extend wellness incentive programs to the individual market.

The goals of prevention and wellness are to prevent chronic diseases, to promote healthy behaviors, to reduce health disparities and ultimately to lower long-term health care costs. In addition, it is the Exchange's vision to promote wellness as one of the core elements of its mission. Most large employers offer wellness programs and they are rapidly evolving to meet the demands of employers and employees alike. However, the level of sophistication varies greatly, even among large employers. Wellness program offerings are much less common in the small group and individual markets, due in part to the higher rate of member turnover in those market segments. Because of the length of time that may be required to achieve a return on investment, wellness and health promotion programs have been perceived as benefiting employers more directly than issuers. The Affordable Care Act provisions present opportunities for the Exchange to implement wellness programs in a more comprehensive way.

### Wellness Programs as Defined by the Affordable Care Act

As part of quality reporting requirements to ensure quality of care, the Affordable Care Act calls for “plan or coverage benefits and health care provider reimbursement structures that....implement wellness and health promotion activities,” which are defined as:

*“... personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program’s participants, and which may include the following wellness and prevention efforts:*

- (1) Smoking cessation.*
- (2) Weight management.*
- (3) Stress management.*
- (4) Physical fitness.*
- (5) Nutrition.*
- (6) Heart disease prevention.*
- (7) Healthy lifestyle support.*
- (8) Diabetes prevention.”*

Under the nondiscrimination rules, beginning in 2014, medical underwriting will be prohibited. Plans and insurers will be allowed to vary premium only based on age, gender, smoking status, and geographic location, but not on any of the health status-related factors including claims experience, receipt of health care, medical history, genetic information, evidence of

insurability, or disability. However, there are exceptions to this requirement for two types of wellness programs:

1. Participation-only wellness programs: These are programs that provide incentives based solely on participation or do not provide a reward and are available to all similarly situated individuals. Examples include programs that reimburse the costs of smoking-cessation classes or cost for gym memberships regardless of outcome.
2. Standard-based wellness programs: These are programs that condition eligibility for a reward upon an individual's ability to meet a certain standard relating to a health factor. These programs must meet five requirements to be permissible under the law. First, the reward must be no more than 30% of the cost of coverage for plan years beginning January 2014. Second, the program must be designed to promote health or prevent disease. Third, the program must give individuals an opportunity to qualify for the reward at least once a year. Fourth, the reward must be available to all similarly situated individuals. Fifth, the program must disclose in all plan materials that reasonable alternative standards (or waivers) are available.

Both of these types of wellness programs will not be subject to the nondiscrimination rules, which mean that insurers can vary benefits, charge different premiums and impose different cost-sharing requirements, such as a deductible, copayment, or coinsurance based on wellness program participation. A more complete description of the allowable variation is provided in the Rating Issues: Family Tiers, Age, Geography, Tobacco, and Wellness Board Recommendations Brief. Of note, the Exchange may establish a premium differential to recognize the higher costs typically incurred by individuals who smoke unless barred by state law.

### **Examples of Wellness Programs in the California Market**

The definition of wellness activities falls along a spectrum; in general, they can be classified into the following categories:

- Risk identification tools: health risk assessments and biometric screenings
- Behavior modification programs: health coaching, tobacco cessation, and weight management
- Educational programs: health fairs and seminars and online resources

Health plans in the California market offer a variety of wellness packages and condition management programs to employers who are interested in improving their employees' health and saving money in the long run. While basic healthy lifestyle education and self-service, online tools are available to all members, telephonic health coaching and support for incentive administration may be limited to larger market segments for additional fees. Some programs are developed and administered internally, while others rely on third party vendors. Examples of health plan offerings include:

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- Anthem offers 360° Health, which includes health risk assessment, disease management programs, dedicated nurse coaches, 24/7 nurse line, online resources via a dedicated web portal, and a prenatal program. A media library provides turnkey employee communications on a wide range of topics.
- Blue Shield of California offers "total health and wellness" programs designed for small businesses with 2 to 50 eligible employees. Some programs are designed to help members identify health risks early and to provide support to adopt healthier habits, such as healthy lifestyle rewards, wellness discount programs, and prenatal program. Others are designed for more complex needs, such as chronic condition management, case management, and a transition of care program. In addition, there is a 24/7 nurse line, online pharmacy services, and other online resources via a web portal.
- Aetna Health Connections<sup>SM</sup> consists of over 70 health and wellness programs, including tobacco cessation, maternity, weight management, and online resources on relieving stress, eating healthy, sleeping better, and managing depression. The disease management program provides support for multiple chronic conditions and care management provides support to "at-risk" members.
- Kaiser Permanente offers group health education sessions, along with online health assessment and healthy lifestyle programs for its members. Results from the health assessment help members identify areas that need attention and customize an action plan to address those areas. The topics addressed by the lifestyle programs include healthy eating, weight loss, smoking cessation, and stress reduction. There are also care management programs targeting specific chronic conditions.

Large employers have implemented a variety of programs to promote healthy lifestyles and prevention, including online tools and health coaching, as well as biometric testing and onsite clinics. While not all of these programs may be scalable for the Exchange, they reflect proactive efforts to engage employees and dependents. Examples include:

- Cisco Systems, Inc. offers a range of member support services beyond health plan-based services through directly contracted health management vendors. In addition to preventive care and health improvement, Cisco offers programs in chronic care, nutrition and fitness, and decision support. Biometric screenings are offered at health promotion events, as well as its onsite clinic. Cisco has also collaborated with local providers to target cultural health differences.

## Cisco's Comprehensive Integrated Health Platform

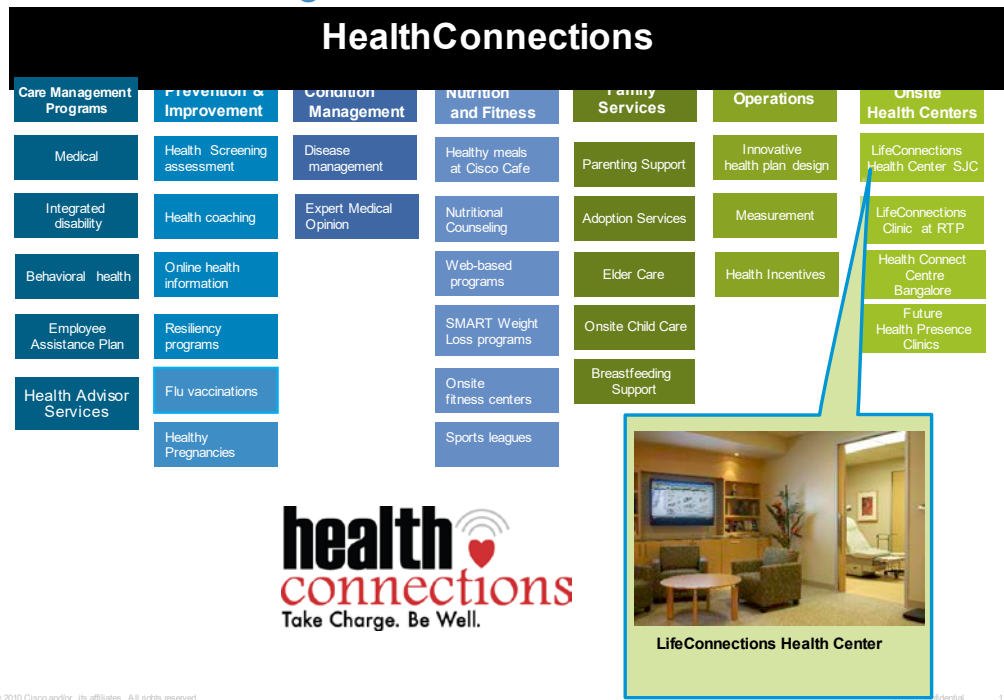


Figure 8 Cisco's Comprehensive Integrated Health Platform

- University of California uses a contracted health promotion vendor to offer a common health risk assessment tool for non-Kaiser beneficiaries, and provides an incentive for completing the online survey. A carve-out vendor supports “mental wellness,” offering the same level of care and consistency across all plans to strategically develop behavioral health care and address population needs across the entire program.
- Bechtel Corporation promotes a culture of safety and health, advancing a global health and wellness strategy. Bechtel also augments health plan-based services with an external health promotion and wellness vendor, which provides an online health risk assessment. Biometric screenings and tobacco cessation programs reinforce a smoke-free workplace and are supported through financial incentive programs. Social media programs provided through plan and other third-party vendors have been introduced to engage members in healthy lifestyle choices (e.g., weight reduction, nutrition, and exercise).

### Incorporating Wellness into Qualified Health Plan Certification

Qualified Health Plan products certified by the Exchange must meet essential health benefits requirements, follow established limits on cost-sharing, and meet other requirements as specified under the Affordable Care Act, federal regulations and as established by the state and/or the Exchange. Those other requirements may include demonstrated efforts by health

plan issuers to implement care management, disease prevention and wellness programs. These may be imposed as part of the minimum Qualified Health Plan certification requirements or as desired Qualified Health Plan factors. The importance of wellness initiatives to the certification process will be clarified in the instructions and scoring that will be assigned to the evaluation of health plan issuer responses to the Qualified Health Plan solicitation.

Decisions on whether and how to incorporate wellness initiatives in the selection of Qualified Health Plans should be considered in conjunction with available information on whether a specific initiative is a widespread industry standard, best practice, or emerging/under development. Other considerations include how the initiative is implemented for the Exchange members, and the results or evidence of effectiveness. For example, health risk assessments may already be implemented by all health plan issuers whereas oncology or other condition-specific specialty care management programs are not widely used.

This Board Recommendation Brief does not address the pros and cons regarding specific examples of wellness programs or recommendations for how health plan issuer wellness initiatives may be evaluated and scored in the Qualified Health Plan solicitation. Rather, this Brief focuses on a series of options that impact initial program parameters and benefit design. Inclusion of wellness initiatives for Qualified Health Plan selection is desirable for the following reasons:

- Supports a key component of the Exchange's mission and the operational value that the Exchange serve as a catalyst for change.
- Signal to the market that the Exchange will be an active purchaser at the point of initial health plan selection and member enrollment.
- Differentiate the Exchange "brand" as providing more value to the members.
- Influence the broader market by emphasizing prevention and accelerating adoption of successful wellness initiatives.

Consideration of wellness initiatives for Qualified Health Plan selection may also take the form of program monitoring rather than plan selection criteria because:

- Many wellness initiatives have not demonstrated consistent, positive Return on Investment. Most published reports rely on studies in the large employer group setting.
- Wellness initiatives may not be consistently available in all Qualified Health Plan products upon launch of the Exchange.
- Member engagement and participation may be difficult. Workplace wellness programs offered by large employers may be more effective because of targeted communications and use of financial incentives.

The Exchange recognizes that there needs to be a multipronged approach to health management and improvement that addresses health promotion and prevention, as well as care coordination for members with complex medical needs. It will be important to establish

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operational metrics to gauge the level of member participation and identify best practices in member engagement. The Exchange should work with partners and researchers to define program goals and metrics. Given the difficulty of attributing impact to specific interventions and selection bias in populations that may choose to participate in health promotion activities, there may be natural experiments in comparing results among health plans that adopt different strategies. The Exchange also seeks to assess the cultural competency of various programs and to measure program impact on various population segments, recognizing potential differences in race and ethnicity, language, education and income levels.

### **Stakeholder Perspectives**

Stakeholders want the Exchange to set criteria for participating health plans that support choice, quality and affordability and underscore that the first priority is to maximize the number of enrolled members in the Exchange. Some encouraged requiring evidence based approaches to achieve this goal, but wanted to balance that with allowing plans the discretion to test innovative ways to promote wellness. Many stakeholders expressed the preference to differentiate Qualified Health Plans that demonstrate commitment to promote disease prevention and improve wellness, particularly for vulnerable populations such as women of childbearing age, infants, children, and ethnic and underserved communities. Specific types of wellness programs mentioned include health education, stress management, substance abuse treatment, and access to exercise opportunities. Many also placed emphasis on promoting health equity and reducing health disparities through defining wellness efforts as part of the additional criteria for certifying and selecting Qualified Health Plans. Stakeholders also recognized the long-term benefits of lowering costs for Qualified Health Plans which translates to slower premium increases for enrollees, greater Exchange financial stability and sustainability, and creating a happier, healthier workforce with fewer days lost to illness and higher workforce productivity.

A number of stakeholders expressed concern regarding the use of financial incentives for participation in wellness programs, stating that such financial incentives may prove to be a barrier to some vulnerable populations. These stakeholders encouraged the offering of wellness programs without financial incentives in the form of premium or cost sharing adjustments.

Stakeholders broadly agreed that a Health Risk Assessment tool should be available to all Exchange members, but should not be a requirement of participation.

Some stakeholders noted that health plans and employers have already implemented next generation innovative wellness initiatives that integrate with member engagement strategies, health management, and enhanced care coordination.

A full compilation of the comments provided by stakeholders is available on the Exchange's web site at



[http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%2022,%202012/HBEX-QHPStakeholderReport\\_5-18-12.pdf](http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%2022,%202012/HBEX-QHPStakeholderReport_5-18-12.pdf)

## Issues and Recommendations

Options are presented below related to:

1. Use of a health risk assessment tool or other plan-based wellness promotion initiatives;
2. Provision of a wellness program by the Exchange;
3. Use of financial incentives by plans to promote wellness, and
4. The role of the Exchange in addressing community and public health.

### Issue 1: Use of a Health Risk Assessment Tool or Other Plan based Wellness Promotion Initiatives

The following options are presented for consideration (see Table 52 for detail):

- **Option A:** The Exchange requires completion of a health risk assessment as part of the enrollment process.
- **Option B:** The Exchange requires 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.

Staff recommends that the Exchange permit health plans to provide an optional health risk assessment tool (Option C), which minimizes the complexity of the enrollment process and allows the plans to provide this as an opportunity. While Option C (making the health risk assessment optional) will certainly result in a lower rate of member participation, it would minimize the administrative burden on the Exchange and avoid creating perceived barriers to using the Exchange. In the future, the Exchange may require common data elements be included in each QHPs Health Risk Assessment tool. The Exchange will require that QHPs share results from the use of HRAs as part of its ongoing evaluation of QHPs impacts on health and wellness.

Although Option A (to require completion of a health risk assessment) is an approach used by large employers, it could place the Exchange at a disadvantage if consumers distrust the use of the information. Option B (health plan requirement) adds administrative burden for health plans and may discourage enrollment through the Exchange. While the goal of Options A and B are to provide general health status information (particularly in the absence of historical claims information) and engage members in managing their health, the predictive power of health risk assessments is modest, and may be particularly limited by new enrollees' knowledge of their biometric values.

The Exchange will require QHPs to submit data from health risk assessment which the Exchange will use to assess the effectiveness of this requirement. This data may also be used as part of ongoing monitoring of QHPs effectiveness in managing chronic disease, pursuing team-based



care and assess similar delivery system reforms. QHP results from its administration of the health risk assessment will permit the Exchange to evaluate progress towards meeting quality metrics as well.

## **Issue 2: Provision of a Wellness Program by the Exchange**

Options for requirements on health plans for wellness programs and/or the provision of a wellness program by the Exchange include (see Table 53 for detail):

- **Option A:** The Exchange selects an additional vendor to augment issuer-based programs.
- **Option B:** The Exchange promotes use of wellness programs offered by issuers.
- **Option C:** The Exchange establishes requirements for the wellness programs that are offered by issuers and promotes those programs.

Staff recommends that the Exchange establish requirements for the wellness programs that are offered by health plans (**Option C**). This approach builds on the Exchange's role to monitor quality improvement strategies among issuers and assures comparability of services among issuers. Option A (the Exchange offers a wellness program directly) requires additional administrative resources from the Exchange, which has a broad set of priority operational issues in qualifying health plans, marketing and outreach. While adding cost to Exchange operations, Option A could be reconsidered at a future date if issuer-based programs do not demonstrate adequate member engagement. Option B, which relies on existing issuer programs, may result in different levels of support from various health plans and potential new market entrants.

The Exchange welcomes comments on the sorts of wellness requirements it may put on health plans. For example, the Exchange could require health plans to target interventions based on analysis of their data and have concerted wellness initiatives. Using data for targeting and having a comprehensive wellness initiative could be assessed through the health plans' responses to the eValue8 Request for Information instrument. The Exchange could have the requirement for activities in these domains to be met by the plans' reporting of any activity in the first year and in future years, the Exchange may increase the requirements and/or assess the plans based on their rates of engagement in particular programs (e.g., smoking cessation, exercise or healthy eating). The Exchange invites specific suggestions on those wellness and prevention elements that should be required of Qualified Health Plans.

## **Issue 3: Use of Financial Incentives by Plans to Promote Wellness**

With respect to the use of financial incentives as part of benefit design, the following options are presented in the context of being offered and administered by the issuer rather than the employer (note that the use of tobacco status as a rating factor is addressed in the Board Recommendation Brief on Rating Issues) (see Table 54 for detail):

- **Option A:** The Exchange allows health plan issuers to use incentives as an optional program.
- **Option B:** The Exchange requires health plan issuers to use a common set of incentives.
- **Option C:** The Exchange prohibits issuers from using incentives.

Staff recommends that the Exchange allow health plans to offer wellness program incentives in small group products (Option A). The Exchange should seek to be one of the HHS-designated pilot geographies where incentives may be offered for individual plan products. Option A permits plans to leverage existing incentive programs and to develop new incentive designs for Exchange plans. However, the Exchange should establish general guidelines among issuers to mitigate potential risk selection among qualified health plans and assure that any incentive program is within the boundaries to be established for allowable variation from the standard benefit designs. Additionally, the Exchange should work with regulators to ensure that wellness program rules are consistent inside and outside the Exchange to minimize the risk of adverse selection within the Exchange. Because there is limited research about the impact of incentives in small group and individual products, Option B (to require a common set of incentives) lacks an evidence base and may limit opportunities for innovation. Option C would create differences among plan designs inside the Exchange if plans outside the Exchange continue to test new products with incentives, and these could contribute to favorable risk selection outside the Exchange.

The Exchange should monitor the uptake in incentive programs, including stratification of populations based on health status, race and/or ethnicity, and income level to identify engagement opportunities as well as unintended consequences. The Exchange should assure that issuers measure the impact of their programs on health status improvement, quality and affordability.

The Board Recommendation Brief on Rating Issues addresses the use of the tobacco use adjustment, balancing the issues of promoting tobacco cessation through financial incentives while also managing affordability and financial burden, access and risk selection.

#### **Issue 4: Role of the Exchange in Addressing Community and Public Health**

With respect to the role of the Exchange in addressing community and public health issues, the following options are presented for consideration (see Table 55 for detail):

- **Option A:** The Exchange engages directly with public and community health efforts in conjunction with its outreach and marketing campaign.
- **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.

Staff recommends either that the Exchange engage in public and community health issues (Option A) or that the Exchange encourage health plans to address public health issues (Option B). As the Exchange invests in outreach and marketing efforts, it is uniquely positioned to

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promote awareness of key issues such as prevention and patient safety, while also leveraging public health efforts in local communities. These may take the form of collaboration with local health departments, community and faith-based organizations, or participation in corporate-sponsored health fairs to promote risk reduction or healthy behaviors such as exercise, weight loss and nutritional food choices. This does not preclude the Exchange from playing a collaborative role with issuers, which may already be engaged in community health initiatives. While local initiatives may vary, the Exchange should identify key issues to manage its resource investment and development of a coherent strategy (e.g., healthy foods, healthy weight, preventive screenings). The degree of resource investment should be balanced with other operational priorities and quality improvement efforts. Option C is not consistent with the Exchange's vision to improve the health of the community.

### **Next Steps**

Staff recommends that the Exchange undertake the following, in consultation with potentially participating Qualified Health Plans and stakeholders:

- Review potential health plan solicitation content to assess current health plan programs in health promotion and wellness, including use of financial incentives.
- Solicit and get suggestions on potential wellness initiatives that should be considered required services for Qualified Health Plans.
- Align use of financial incentives with rating policies concerning tobacco use.
- Establish priority areas of focus with respect to public and community health goals and review alignment with marketing and outreach strategies.
- Monitor HHS for terms of ten state demonstration project and consider applying to participate if consistent with the Exchange's mission and values.

Table 51: 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	Option B: Require completion of an issuer's health risk assessment as part of enrollment	Option C: Health plans provide an optional health risk assessment tool
<p><b>SUMMARY</b> The Exchange requires completion of a health risk assessment.</p>	<p><b>SUMMARY</b> The Exchange requires completion of an issuer's health risk assessment as part of the enrollment process.</p>	<p><b>SUMMARY</b> Health plans are required to provide an optional health risk assessment tool.</p>
<p><b>PURPOSE</b> This option requires individuals to complete a health risk assessment as part of the enrollment process.</p>	<p><b>PURPOSE</b> This option requires individuals to complete an issuer's health risk assessment as part of the enrollment process.</p>	<p><b>PURPOSE</b> This option promotes voluntary use of existing health plan services.</p>
<p><b>DESCRIPTION</b> This option 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.</p>	<p><b>DESCRIPTION</b> This option 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.</p>	<p><b>DESCRIPTION</b> This option promotes use of existing health plan services and relies on voluntary member participation. Enrollment is not contingent on completion of a health risk appraisal.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ High rate of engagement.</li> <li>▪ May provide directional information on risky behaviors based on member self-report.</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ High rate of engagement.</li> <li>▪ Leverages health plan resources and does not require data transfer/integration between the Exchange and issuer.</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Does not create barrier to enrollment</li> <li>▪ Leverages health plan resources and does not require data transfer/integration between the Exchange and issuer.</li> <li>▪ Connects member with health plan tools and health information and coaching resources.</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ May create distrust in the Exchange and create barrier to enrollment.</li> <li>▪ Increases administrative burden on Exchange to track completion and facilitate data transfer with health plans</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ May create distrust in the Exchange and create barrier to enrollment.</li> <li>▪ Increases administrative burden on health plans to track completion</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Reduces member participation significantly.</li> </ul>

Table 52: Issue 2: Provision of a Wellness Program by the Exchange

Option A: Exchange Selects an Additional Vendor to Offer Wellness Program	Option B: Promote Use of Issuer-based Wellness Programs	Option C: Exchange Established Requirements but Uses Issuer-based Wellness Programs
<p><b>SUMMARY</b> The Exchange selects an additional vendor to augment issuer-based programs.</p>	<p><b>SUMMARY</b> The Exchange promotes use of wellness programs offered by issuers.</p>	<p><b>SUMMARY</b> The Exchange establishes requirements for the wellness programs that are offered by issuers and promotes those programs.</p>
<p><b>PURPOSE</b> The Exchange selects an outsourced vendor to offer a common health promotion and wellness program across all issuers.</p>	<p><b>PURPOSE</b> The Exchange leverages existing programs offered by issuers.</p>	<p><b>PURPOSE</b> The Exchange leverages existing programs offered by issuers but establishes requirements for features and services.</p>
<p><b>DESCRIPTION</b> The Exchange selects an outsourced vendor to and brands its own health promotion and wellness program. The design augments issuer-based programs.</p>	<p><b>DESCRIPTION</b> The Exchange leverages existing programs offered by issuers with back-end reporting on consumer engagement and population comparisons.</p>	<p><b>DESCRIPTION</b> The Exchange leverages existing programs offered by issuers with front-end design and content requirements and back-end reporting on consumer engagement and population comparisons.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Positions Exchange to support health improvement and member engagement.</li> <li>▪ Offers single, branded Exchange health management experience.</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Leverages health plan resources and does not require data transfer/integration between the Exchange and issuer.</li> <li>▪ Holds health plans accountable for member engagement.</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Leverages health plan resources and does not require data transfer/integration between the Exchange and issuer.</li> <li>▪ Connects member with health plan tools and health information and coaching resources.</li> <li>▪ Reduces variation among issuers.</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Increases administrative burden for the Exchange</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Member engagement and participation rates tend to be low</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Member engagement and participation rates tend to be low</li> </ul>

Table 53: Issue 3: Use of Financial Incentives by Plans to Promote Wellness

Option A: Allow Health Plans to Offer Incentives on An Optional Basis	Option B: Requires Health Plans to Use a Common Set of Incentives	Option C: Prohibit Plans from Using Incentives
<p><b>SUMMARY</b> The Exchange allows health plans to use incentives as an optional program.</p>	<p><b>SUMMARY</b> The Exchange requires health plans to use a common set of incentives.</p>	<p><b>SUMMARY</b> The Exchange prohibits plans from using incentives to engage members in wellness programs.</p>
<p><b>PURPOSE</b> The Exchange leverages existing health plan programs that use incentives to promote engagement in wellness.</p>	<p><b>PURPOSE</b> The Exchange establishes a common set of incentives across various health plans and benefit designs.</p>	<p><b>PURPOSE</b> The Exchange prohibits plans from using incentives to engage members in wellness programs.</p>
<p><b>DESCRIPTION</b> The Exchange leverages existing health plan programs that use incentives to promote engagement in wellness.</p>	<p><b>DESCRIPTION</b> The Exchange establishes a common set of incentives across various health plans and benefit designs. This potentially enables the Exchange to distinguish its plan offerings and create unified communications.</p>	<p><b>DESCRIPTION</b> The Exchange prohibits plans from using incentives to engage members in wellness programs.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Leverages existing plan programs.</li> <li>▪ Supports plan innovation in consumer engagement.</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Reduces potential for adverse selection among Exchange issuers (but could impact plans inside/outside the Exchange).</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Avoids potential concerns about discriminatory or risk selection issues</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Use of direct to consumer financial incentives has been limited in the small group and individual markets.</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Could create adverse selection among Exchange plans if incentives are linked to improved chronic disease management and those programs are not equally available outside the Exchange.</li> <li>▪ Creates administrative burden on health plans if they lack capacity to administer incentives.</li> <li>▪ Current evidence does not support any one “standard” approach as being the “right” one.</li> <li>▪ Limits opportunity for health plan innovation.</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Limits opportunity for member engagement</li> <li>▪ Precludes alignment with what health plans may develop and use outside the Exchange</li> </ul>

Table 54: Issue 4: Role of the Exchange in Addressing Community and Public Health

Option A: Engage with Public and Community Health Efforts	Option B: Encourage Health Plans to Address Public Health Issues	Option C: No Engagement in Public and Community Health Issues
<p><b>SUMMARY</b> The Exchange engages directly with public and community health efforts.</p>	<p><b>SUMMARY</b> The Exchange encourages health plans to address public health issues.</p>	<p><b>SUMMARY</b> Exchange does not engage in public and community health issues.</p>
<p><b>PURPOSE</b> The Exchange engages directly with public and community health efforts in conjunction with its outreach and marketing campaign.</p>	<p><b>PURPOSE</b> The Exchange encourages health plans to address public health issues. This leverages existing efforts and minimizes potential distraction from other Exchange priorities.</p>	<p><b>PURPOSE</b> The Exchange maintains focus on core operations and does not engage in public and community health issues.</p>
<p><b>DESCRIPTION</b> The Exchange leverages planned outreach efforts to simultaneously promote prevention, wellness and health promotion. The effort helps promote the Exchange as a positive force for health improvement in the community.</p>	<p><b>DESCRIPTION</b> The Exchange encourages health plans to address public health issues. This leverages existing efforts but does not present a coherent Exchange-based program.</p>	<p><b>DESCRIPTION</b> The Exchange does not engage in public and community health issues and relies on other stakeholders to lead these efforts.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Helps raise awareness of key health issues while also expanding recognition of the Exchange.</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Leverages existing efforts.</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Minimizes distraction of resources from operational priorities</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Local community initiatives may vary greatly and could be a distraction to core Exchange operations</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Lacks a unifying strategy or coherent Exchange-based approach</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Not consistent with Exchange’s core values to improve health of the community.</li> </ul>

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## Administrative Simplification

### Summary

The California Health Benefit Exchange is considering how it can promote ways to assure that more of the health care dollar goes to health care services and less to administrative and other costs. This "Administrative Simplification" Board Background Brief provides background on the issues, a summary of the options available to the Exchange, and includes an overview of the Exchange's current planned activities for the Board's consideration and public comment.

### Background

There are numerous opportunities to improve efficiency and lower costs through administrative simplification and standardization in the clinical health care delivery system, in health plan administrative processes, and in the management of the California Health Benefit Exchange. Various research studies and estimates suggest that the average physician spends nearly three weeks a year on health plan and insurance administrative interactions. Overall private physicians and hospitals spend as much as 20 percent of revenue on administration and insurance billing and related functions. Health plan issuers spend 8% to 12% on pure administration (excluding profit but including agent commissions). This level of administrative spending far exceeds international standards—in 2009 (most recent year with available data) the United States spent 60% per capita more than the average across the peer countries.<sup>45</sup> Reducing the burden of unnecessary administrative expenses on all segments of the health care system, that is, not only on health plans but on providers, would free up needed resources for healthcare and prevention efforts.

The Affordable Care Act requires health plans serving individuals and small group to spend 80% or more on health care with any amount over the 20% on administration paid by insurers as a rebate to the customers. This "Medical Loss Ratio" requirement is putting pressure on health plans to reduce administrative costs. Nationally, individuals and employer groups will receive an estimated \$1.3 billion that will be returned by August 2012; small employers and individual purchasers are expected to receive more than \$800 million in rebates.<sup>46</sup> In California, the major insurers announced more than \$50 million in rebates to more than one million individual and small group customers in the state.<sup>47</sup>

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<sup>45</sup> \$163 per capita in the U.S. versus average of \$98 in those other countries; McKinsey Center for U.S. Health System Reform (see References).

<sup>46</sup> Kaiser Family Foundation. Insurer Rebates under the Medical Loss Ratio: 2012 Estimates. Focus on Health Reform. April 2012.

<sup>47</sup> "Health insurers owe rebates to many California policyholders." Los Angeles Times, [June 02, 2012](#)

### Administrative Simplification in the Affordable Care Act

While much of the focus of the health reform legislation is on reforming insurance rules, the coverage expansion, health benefit changes and payment reform initiatives, the Affordable Care Act includes a number of provisions geared to making the system more efficient by simplifying health care administrative processes, e.g. standardizing and reducing clerical burden for health plans, physicians, and patients. For example, the Affordable Care Act requires a single set of operating rules, certification standards, and the application of the Health Insurance Portability and Accountability Act (HIPAA) transaction standards to reduce administrative costs, facilitate transactions between health plans and providers, and promote increased adoption of electronic record keeping and medical records. The Affordable Care Act also focuses on development of standards for financial and administrative transactions. Collectively, the relevant provisions<sup>48</sup> require covered entities, including health plans, health care data clearinghouses, and providers to upgrade to the new standards and a single set of operating rules and sets out a timeline between 2012 and 2016 related to improvements in:

- *Health plan identifier*: unique identification number assigned for each payer and other entity involved in the billing and payment process (October 1, 2012)
- *Eligibility verification and claims status*: expanded fields to communicate information regarding patient eligibility and benefit coverage, such as specific benefit package, in and out of network designation, and patient cost sharing responsibility (January 1, 2013)
- *Electronic funds transfers, health care funds transfers and remittance*: establish and adopt transaction standards to move to elimination of paper checks and remittance in physician and other provider practices (January 1, 2014)
- *Health claims and encounter information, health plan enrollment and disenrollment, premium payment, and referral certification and authorization*: including standards to submit an inquiry and a response to the inquiry, standardized forms and definitions (January 1, 2016)
- *Claims attachments*: standards for electronic claims attachment (January 1, 2016)

The Affordable Care Act directs the Secretary of Health and Human Services to seek recommendations from the National Committee on Vital Statistics regarding the development of the operating rules, whether rules represent a consensus of stakeholders, whether they are consistent with electronic standards and whether they should be adopted. In December 2011, based on a recommendation from a subcommittee of the National Committee, the Centers for Medicare and Medicaid Services adopted the Final Rule, [\*CMS-0032-IFC: Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions\*](#). The final rule came from the recommended operating rules drafted by the Council for Affordable Quality Healthcare's Committee on Operating Rules for

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<sup>48</sup> ACA Sections 1104 and 10109

Information Exchange (CAQH CORE)<sup>49</sup> and the National Council for Prescription Drug Programs (NCPDP).

CAHQ CORE is a multi-stakeholder initiative to develop operating rules to "streamline electronic healthcare administrative data exchange "and "support inter-operability between payers and providers." The CAHQ CORE rules use a two phase system, with Phase I rules focused on eligibility for health plan transactions and confirmation of patient coverage, and permits provider access to patient information. Phase II regulates the health care claims transaction. Both phases must be implemented by January 1, 2013 and plans must certify to the Secretary of the Department of Health and Human Services that they are in compliance with the HIPAA standards and operating rules by the end of that year. There are significant penalties for failure to comply or to certify to the new standards.

Two of the key components to achieve the administrative simplification objectives are an upgrade from HIPAA 4010 to HIPAA 5010 transaction standards and adoption of the expanded diagnosis code set under the International Classification of Diseases, 10th Edition (ICD-10). The HIPAA 5010 requirements apply to standards for electronic transactions and reflect industry changes in requirements for patient privacy, data security, and improvements in transaction processing. These platforms must be in place before ICD-10 can be implemented.

To date, an Interim and Final Rule with Comment Period has been issued for some of the HIPAA transactions, eligibility for a health plan and health care claims status, electronic funds transfer and electronic remittance advice and a proposed rule on health plan and national provider identifiers.

ICD-10 updates the codes used by physicians and other providers to report diagnoses and procedures and it has an expanded format to capture greater detail. It is a significant expansion; diagnosis codes increase from 13,000 under ICD-9 to 68,000 under ICD-10. Procedure codes increase from 3,000 under ICD-9 to 87,000 codes under ICD-10 and the format moves from four to seven digits. Earlier this year, the Federal government announced a one year delay in the implementation date of ICD-10, from October 2013 to October 2014.

These administrative simplification requirements under the Affordable Care Act not only include and accelerate the HIPAA transaction, privacy and security standards, but also occur in the context of the Health Information Technology for Economic and Clinical Health Act (HITECH) Meaningful Use and Electronic Health Record (EHR) Certification process.

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<sup>49</sup> CAQH is a nonprofit alliance of health plans and trade associations, sponsors initiatives to develop and implement administrative solutions that benefit physicians, allied health professionals, their staffs, patients and health plans.

HITECH was enacted as part of the American Recovery and Reinvestment Act in 2009 to provide reimbursement incentives for eligible professionals and hospitals that are successful in becoming “meaningful users” of certified EHR technology. Eligible Medicare and Medicaid hospitals and professionals are required to comply with a set of core objectives (14 for eligible hospitals and 15 for eligible professionals) and 5 of 12 optional (“menu”) objectives in order to receive incentive payments. In addition, providers must adopt certified EHR technology and meet privacy and security requirements.

The expected benefits of HITECH are enhanced quality, efficiency and safety of patient care, cost reduction, and increased provider revenue. Physician providers are expected to see reductions in transcription and medical record charting expense. In hospitals, adoption is expected to reduce nurse documentation time, decrease order turn-around time, and even inpatient length of stay due to consolidation of records to prepare discharge orders. Providers and patients should benefit from increased compliance with prevention services, such as vaccinations, and clinical protocols.

At the State level, there are additional initiatives meant to further administrative simplification: privacy and security law and regulation (such as California's early breach notification requirement), development of all-payer claims databases, unified enrollment eligibility processes for government programs (to be superseded in 2014 in coordination with the Exchange), pharmacy e-prescribing/use of standard prescription drug prior authorization forms, and more.

### **Reducing Burden and Potential Roles for the California Health Benefit Exchange**

Although the Exchange is not a health plan or data clearinghouse, the federal administrative simplification requirements have implications for many Exchange operations and responsibilities. The Exchange will conduct transactions with health plans and the California Department of Health Services (CA DHCS) Medi-Cal program regarding eligibility and enrollment, aggregated billing and reporting functionality for health plans and employers, electronic funds transfer and remittance advice. These transactions will need to comply with federal standards.

The Exchange will build its eligibility, enrollment, billing and transaction systems specifically to take advantage of and to more rapidly advance California's effort to simplify these processes, including attaining administrative simplification Exchange Plan certification standards in future years. Today, the Exchange is already demonstrating a commitment to administrative simplification through the design and implementation of its information technology systems. It has actively worked with agency partners, CA DHCS and Managed Risk Medical Insurance Board, to jointly solicit and select the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). The baseline system must support all the Exchange functions required under the Affordable Care Act, such as determining eligibility for any of the applicable state

health subsidy programs and to integrate with the Medi-Cal Eligibility Data System. It has adopted a "no wrong door" goal to provide a consistent, consumer focused experience that is culturally and linguistically appropriate to facilitate enrollment, smooth transitions between programs and minimize the burden of maintaining eligibility and enrollment. The system will also support consumer decision tools to compare Qualified Health Plan choices on affordability, measures of quality and customer satisfaction, and links to provider directories.

### Exchange Operations

The Exchange should look to its own operations and for opportunities to drive further administrative simplification through its work with health plans, regulators and others. Examples of potential opportunities to reduce burden and further administrative simplification with Exchange operations include:

- Use of standardized tools for the Qualified Health Plan solicitation, application and evaluation process;
- Qualified Health Plan compliance monitoring;
- Quality and performance data collection and reporting;
  - Adopt and build the Exchange program on reporting metrics that are already required by other programs, ranging from HEDIS and CAPHS, NCQA Accreditation requirements, or local efforts such as the Integrated Healthcare Association Pay for Performance program instituted among provider groups.
- Promoting standardization in provider level reporting and adopting guidelines such as the "Patient Charter" developed by the Consumer Purchaser Disclosure Project, and
- Coordination of outreach, enrollment and retention with health plan partners and assisters

### Exchange Plan Solicitation

There may be significant opportunities to drive administrative efficiency improvements through the Qualified Health Plan solicitation process. Examples of this could include:

- Use of on-line tools to guide the Qualified Health Plan bid application process., such as consideration of eValue8 as the Exchange Quality Reporting tool (see Value Purchasing Board Recommendation Brief)
- Requirements for health plan issuers participating in the Exchange to use specified tools, such as a common vendor for provider credentialing. In the case of physician providers, this could facilitate one-stop shopping to confirm valid professional licenses, board certification, and hospital privileges, and permit search for sanctions, malpractice judgments, or other disciplinary actions.
- Requirements in the solicitation to demonstrate health plan administrative simplification efforts

*Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers*

- Requirements in the solicitation to report and certify compliance with the administrative simplification timeline and activities under the Affordable Care Act
- Requirements in the solicitation to report provider progress in adoption of meaningful use of electronic health records

### Opportunities Market-Wide

Looking forward, opportunities for administrative simplification exist in such areas as:

- Provider level (hospital and physician group) performance metrics
- Adoption of other standards, such as the Workgroup on Electronic Data Interchange Strategic National Implementation Process standards for health plan identification cards,
- Standardization of financial audits
- Consistency in claims edit software and payment policies across health plans
- Standardize use of pre-authorization requirements and require transparency of permissible variations
- Definition of operating rules that provide the business rules and guidelines to perform other specified task and identify operational environment standards. Such operational rules could reduce staff time on phone calls and web site assistance.

### Stakeholder Perspectives

Stakeholders expressed broad support for administrative simplification at both the health plan and provider level. They cautioned that care should be taken to leverage current efforts to reduce administrative burden. Numerous comments supported efforts to standardize processes to reduce administrative burden and recognized that effective administrative simplification are a component of reducing costs and improving care that is part of the mission and values of the Exchange.

A full compilation of the comments provided by stakeholders is available on the Exchange's web site at

[http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%2022,%202012/HBEX-QHPStakeholderReport\\_5-18-12.pdf](http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%2022,%202012/HBEX-QHPStakeholderReport_5-18-12.pdf)

## Other

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

#### Summary

Beginning in 2014, the California Health Benefit Exchange will offer Qualified Health Plans (QHPs) to California residents. Many low-income Californians will qualify for either premium subsidies or reduced-cost-sharing or both to help purchase health care coverage in the Exchange. Others will qualify for Medi-Cal, California's Medicaid program, or the Children's Health Insurance Program (formerly Healthy Families). This "Program Alignment" Board Background Brief discusses the issue of how coverage offered through the Exchange should be coordinated with Medi-Cal, and other state health care programs that serve low income Californians and should consider commercial networks. This is a particular concern for individuals who move between the Exchange and other public programs, and families that may have coverage from multiple sources. How programs facilitate a smooth consumer experience, minimize administrative complexity and assure continuity of care are significant issues. Effective coordination among the state agencies that administer these programs may promote both efficiencies and efforts to foster improvements in the delivery of care. The Exchange has been working closely with the Department of Health Care Services and the Managed Risk Medical Insurance Board to begin identifying strategies and options that will result in better coordination and program alignment.

In addition, the brief highlights the importance of also aligning with commercial plans as many Exchange enrollees will migrate in and out of commercial coverage and/or may have family members with Medi-Cal or commercial coverage.

#### Background

California's Medi-Cal program was established in 1965 and today serves approximately 6.8 million low income individuals. The Medi-Cal program reimbursed providers on a fee-for-service basis system until the early 1990's. In 1991, the Legislature authorized the mandatory enrollment of most children and their parents into Managed Care programs. Today approximately 4.5 million Medi-Cal beneficiaries in 30 counties receive their health care through managed care programs. Expansion of Managed Care programs continues to more counties and to new eligibility categories such as seniors and persons with disabilities (SPDs); and individuals with both Medi-Cal and Medicare coverage ("dual eligibles").

In addition to Medi-Cal, California offers several discrete programs which provide funding for health care services for low-income or other vulnerable populations. Such programs are generally very limited in scope (e.g.: family planning services); provide limited coverage periods

*Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers*



(e.g. month to month coverage in County Medical Service Programs); or are limited to children or pregnant women, such as Healthy Families and Aid to Infants and Mothers (AIM). Note: As part of the 2012-13 state budget, trailer bill legislation was enacted to transition the Healthy Families program into Medi-Cal. The first phase of this transition begins in January 2013.

In addition to publicly funded programs, many Exchange enrollees will shift to commercial health plans when they or their family gains coverage as a result of employment changes. This kind of “churn” must be considered by the Exchange and means to make these transitions smooth for all parties should be sought. Further, some families will have one member covered by employer-based coverage, another through the Exchange and yet another, possibly a child through Healthy Families. These “mixed families” should be assisted by the Exchange to facilitate best practices to make their health care decisions more rational and to meet their needs.

### Medi-Cal Coverage

Medi-Cal beneficiaries are low income and have limited resources to pay for the cost of their health care. Under current law – which will change dramatically effective January 2014 -- applicants must fit into one of several possible categories:

- Individuals who are aged, blind, or disabled according to Social Security rules.
- Families with children as long as deprivation<sup>50</sup>(1) exists, linked to the California welfare program - California Work Opportunity and Responsibility to Kids (CalWORKS)
- Children or pregnant women without regard to deprivation or property up to 200% Federal Poverty Level (FPL).
- Individuals with specific health care needs. This category is limited to people in need of:
  - Dialysis
  - Tuberculosis services
  - Total parenteral (intravenous) nutrition services;
  - Breast and cervical cancer treatment;
  - Certain services for minors; or
  - In need of nursing home care.

### Affordable Care Act Medi-Cal Expansion

In January 2014, Medi-Cal coverage will expand to include individuals who do not qualify today --primarily childless adults who earn up to 138% FPL and do not have access to affordable employer-sponsored insurance. To begin the transition process, California received approval in November 2010 from the federal Centers for Medicare & Medicaid Services (CMS) to implement a new section 1115 “Bridge to Reform” Medicaid demonstration. Under the federal

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<sup>50</sup> (1) Deprivation exists when a parent is absent from the home, or is incapacitated, disabled, deceased, employed less than 100 hours per month, or has earnings that are below 100 percent of the Federal Poverty Level.

waiver, the county expenditures for their medically indigent services could be matched with federal funds to enroll low income uninsured individuals into a transitional health coverage program which is offered through the Low Income Health Program (LIHP). The LIHP program is intended to provide interim coverage until the Medi-Cal Coverage Expansion occurs January 1, 2014. Many counties, though not all, are offering LIHP coverage to individuals with incomes up to 133% FPL. However, several counties extend eligibility up to 200% FPL. In January 2014, most LIHP beneficiaries will transfer to Medi-Cal. However, individuals with incomes over 138% FPL will be eligible to purchase subsidized health coverage through the Exchange. Part of the LIHP's transition plan will include coordination of an outreach effort to educate and assist Exchange eligible individuals in the LIHP to obtain coverage through the Exchange.

### **“Churning” and the Consumer Experience**

There are a variety of life experiences that may change an individual's eligibility for subsidized health coverage programs. Examples of life experiences that could affect eligibility include: changes in family income due to getting or losing a job; changes in family structure, perhaps due to the birth of a child or the “aging out” of a child; or re-location for work or to meet family responsibilities. For some individuals, the change could make them eligible for Medi-Cal; others may find themselves losing Medi-Cal but perhaps becoming eligible for subsidized coverage offered through the Exchange. Some may get employer sponsored health coverage by getting a new job; others who lose a job may find themselves without coverage – but eligible for Medi-Cal or Exchange based coverage. This movement between programs is often referred to as “churn”.

Although there are many administrative costs and complexities related to churn, the issue of continuity of care may be a greater concern for many beneficiaries and enrollees. To the extent that churn results in individuals changing health plans with different provider networks, there is always the risk of disruption and confusion.

Under existing law and regulations (both DOI and DMHC), individuals have protections to assure continuity of care. Specifically, an individual with a qualifying health condition can request to continue receiving services from their current provider, even if that provider is not participating in the network of the individual's new health plan. If the individual is moving from private coverage into a Medi-Cal Managed Care Plan, the individual must have a demonstrated span of treatment with a provider; the provider must be willing to accept either the new health plan's or Medi-Cal fee-for-service (FFS) rates, whichever is higher; and the health plan must determine that there are no quality of care issues with the provider.

Another issue relates to the consumer experience of families with mixed households. For example, children residing in a family with an income under 250% of FPL may be eligible for the children's health coverage offered through Medi-Cal; but with Medi-Cal eligibility for the parents capped at 138% of FPL, the parents would be eligible for the coverage through the

Exchange. It is also worth noting that in some families, the children may be Medi-Cal but the parents receive health coverage through their employer.

The Exchange has been working with both the DHCS and MRMIB to consider the programmatic implications of the churn and mixed families. There is a strong commitment to identify strategies that will improve the consumer experience, and minimize unnecessary program complexity.

### Potential Approaches:

The Exchange has contracted with Manatt Health Solutions for the purpose of identifying specific policy options that will facilitate simple and seamless transitions of enrolled individuals between the Exchange and public health care programs. The Exchange staff has been working closely with the DHCS to identify options and opportunities for coordination and integration. Analytical support is needed on several policy topic areas including:

- Modified adulated gross income (MAGI)-based eligibility determination processes including income verification, reasonable compatibility policies, consumer reporting requirements regarding eligibility status changes, and processes for verifying inconsistencies;
- Continuity of coverage for pregnant women whose eligibility status may change from the Exchange to Medi-Cal due to their pregnancy;
- Shared notices that can be developed to inform families about eligibility and enrollment status for multiple programs; and
- Alignment of eligibility and enrollment appeals processes between the Exchange and Medi-Cal.

Further, Manatt Health Solutions will be asked to provide the following services within each of the policy areas identified above:

- Conduct research on requirements under federal statute, regulation and sub-regulatory guidance;
- Compare those requirements to existing state practice and priorities;
- Develop implementation options that comply with federal requirements and comport with state priorities; and
- Identify policy considerations and operational implications for each option based on emerging national dialogue and the experience of other states.

The Exchange and its state partners may also wish to begin consideration and analysis of the following policy options:

- *Encourage Medi-Cal Managed Care Plans to participate in the Exchange.* Plans that participate in both markets (Medi-Cal and the Exchange) can be required to maintain the same Member ID and card for both so that consumers can keep their card as they

move between programs. If the consumer moving between programs selects the same plan, the plans' IT system can manage the member plan assignment thereby reducing the administrative burden on that individual. In addition, QHPs can be requested to prepare transition plans for members moving back and forth between the Exchange plan and the Medi-Cal plan to minimize disruption.

- *Encourage issuers to include Medi-Cal providers in their networks.* As explained in the Essential Community Provider (ECP) brief, plans are encouraged to include ECP's in their QHP networks, increasing the probability that individuals moving between plans can continue to stay under the care of their doctor.
- *Monitor QHP network overlap with Medi-Cal Managed Care program plan overlap.* While it is not required that QHPs have network overlap with Medi-Cal Managed Care, it is conceivable there will be overlap especially if the staff recommendation for ECP networks is adopted. Where overlap exists, members who churn between programs have the potential to retain their provider and continue uninterrupted in any active plans of care.
- *Monitor the movement of individuals between Medi-Cal and Exchange Plans.*
- *Work with commercial plans to track and address churn between Exchange plans, Medi-Cal plans and commercial plans to identify ways to make such transitions easier for consumers, providers and plans.*

### **“No Wrong Door”**

Some families may have members who qualify for Medi-Cal and others who obtain Exchange plans. These are referred to as “mixed families”. For example, the mother and child may be eligible for Medi-Cal and the father eligible for a subsidy to purchase health care through the exchange. The CalHEERS system will be designed to provide a streamlined enrollment experience for individuals, directing the applicant to the appropriate programs/plans for each family member based on their Modified Adjusted Gross Income (MAGI) calculations regardless if they are eligible for Medi-Cal, subsidies, SHOP or no subsidies. If the entire family selects plans from the same issuer, they will also benefit from standard member ID cards for that plan.

### **Alignment for Issuers**

The Exchange is committed to working to align administrative processes for issuers with other large purchasers such as Medi-Cal and Healthy Families to minimize the administrative burden to issuers. This alignment has been discussed in greater detail in Administrative Simplification brief and the Strategies to Promote Better Quality and More Affordable Care brief's discussion of Measurement and Reporting Infrastructure. Provider networks for the various programs are also a significant consideration; having common networks will facilitate continuity of care in the event of a change in coverage.

### Stakeholder Perspectives

Consumer organizations and plans encourage the Exchange to coordinate Exchange standards and contracting with Medi-Cal and other large purchasers to the extent possible and desirable. Where possible, consumer organizations request that the Exchange encourage plan and provider participation across Medi-Cal, Healthy Families, commercial health plans and the Exchange.

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## Supplemental and Pediatric Essential Health Benefits: Dental and Vision

### Summary

The California Health Benefit Exchange is considering the options related to supplemental benefits for dental and vision care to be offered through the Individual and SHOP Health Benefit Exchanges as well as the options for offering required Pediatric Dental and Vision benefits that fall under the definition of Essential Health Benefits. This “Supplemental and Pediatric Essential Health Benefits: Dental and Vision” Board Recommendations Brief provides background on some of the issues and a summary of the options available to the Exchange, and includes final recommendations for the Board's consideration.

### Background

#### Pediatric Oral and Vision Care as Part of EHB Package

Section 1302 of the Affordable Care Act defines ten broad categories of Essential Health Benefits (EHB), all of which must be included in individual or small group plans offered in and out of the Exchange. The Essential Health Benefits categories are:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Issuers must offer benefit packages to individuals and small employers both in and out of the exchanges that include a range of services from all ten categories, but are not obligated to provide any services beyond those stipulated in the EHB package. The inclusion of dental and vision benefits for children as a requirement raises complex issues on how to structure and sell such benefits in the post-reform environment. Specifically, the Affordable Care Act requires that the Exchange accept proposals from stand-alone dental plans, and that it accept proposals from medical plans that exclude pediatric dental services when those services are provided by stand-alone plans. It does not specifically address the offering of pediatric vision benefits through stand-alone plans.

While pediatric dental and vision services are included as Essential Health Benefits, adult coverage for those services is not. Consequently, the Exchange's contracting strategy must address options for providing coverage for pediatric oral and vision care. The Exchange must decide whether to include coverage for pediatric oral and vision care that extend beyond those services included in the Essential Health Benefits definition, and must decide whether and how to offer adult coverage for these services. Those decisions may differ for Individual and SHOP enrollees.

### Pediatric Coverage

The specific scope of services that are to be covered as essential benefits for children is not well defined and the proposed California EHB benchmark plan does not include pediatric dental; consequently an alternative benchmark plan for these services will be required. The US DHHS is considering proposals that would supplement the EHB with dental benefits based upon either 1) the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or 2) The state's Children's Health Insurance Program Healthy Family dental benefit. Current commercial coverage may only include preventive, diagnostic, and emergency dental procedures. FEDVIP dental plan covers preventive and basic dental services such as cleanings and fillings, and advanced dental services such as root canals, crowns and medically necessary orthodontia. The Healthy Families program covers a much wider range of dental services. The definition of services for children will affect how family plans benefits are to be structured. Since adult dental and vision services are not listed as essential health benefits, lifetime and annual dollar limits could be retained and applied for adult services. The FEDVIP vision plan provides for standard exams and supplies, and may provide discounts on other services such as LASIK surgery, while Healthy Families provides for an exam and supplies once per year.

### Adult Coverage

If Adult dental and/or vision services are covered, they will be outside the scope of Essential Health Benefits, and will consequently not be subject to annual and lifetime dollar limit prohibitions. Coverage of these services would be truly supplemental and could be offered either as part of a medical package of benefits or through stand-alone plans.



**Table 55: Comparison of Pediatric Dental and Vision Services**

Federal Vision Program*	Health Families
<p><b>DENTAL</b></p> <ul style="list-style-type: none"> <li>• Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.</li> <li>• Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.</li> <li>• Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.</li> <li>• Class D (Orthodontic) services with up to a 24 month waiting period for eligible dependents up to age 19.</li> </ul>	<p><b>DENTAL</b></p> <ul style="list-style-type: none"> <li>• Preventive care (teeth cleanings, topical fluoride): every 6 months</li> <li>• Fillings: as needed</li> <li>• Sealants: as needed only for permanent 1st and 2nd molars</li> <li>• Diagnostic services: x-rays (bitewing, full-mouth, and panoramic); consultations</li> <li>• Major services: root canals; oral surgery; crowns and bridges; dentures</li> <li>• Orthodontia services: provided to subscribers under the age of 19 through the California Children's Services Program (CCS) when condition meets the CCS program criteria</li> </ul>
<p><b>VISION</b></p> <ul style="list-style-type: none"> <li>• Comprehensive eye examinations</li> <li>• Coverage for lenses, frames and contact lenses</li> <li>• Other benefits such as discounts on lasik surgery may also be available</li> </ul>	<p><b>VISION</b></p> <ul style="list-style-type: none"> <li>• Eye examinations: once every 12 months</li> <li>• Prescription glasses: once every 12 months</li> </ul>

\*If the benchmark plan chosen by a state to determine essential health benefits does not include pediatric dental and vision benefits, federal rules calls for the next most popular federal employee plan to be used for those categorical benefits.

### Other Types of Supplemental Benefits

In discussing supplemental benefits, some have also raised the possibility of other specialty services being covered, such as chiropractic or acupuncture. While these benefits are often included in the base medical plans offered today, it is likely that services beyond the requirements of the "Essential Health Benefits" definition will be excluded from standard benefit plans when the Essential Health Benefits definition is broadly adopted, as a means of reducing premiums.

### Standalone vs Embedded

Under the Affordable Care Act, supplemental services are not subject to new rules that prohibit annual and lifetime limits. Supplemental benefits are also not eligible for premium subsidization, so even coverage that is offered through health plans, a separate premium rate will be needed. When offered on a stand-alone basis, supplemental plans are considered "limited scope." Limited scope plans are not subject to these requirements. And while the health reform legislation includes specific reference to dental plans, there is no reference to vision or other supplemental benefits beyond the requirement of pediatric coverage in the essential benefits package. In the current California health insurance market, dental and vision



coverage is generally not embedded in medical coverage, but rather sold as separate policies. Once exchanges are operational, consumers purchasing medical insurance through the Exchange will be required to buy coverage that includes pediatric oral and vision care services. Most medical policies cover some oral care, including assessments provided by pediatricians as part of well-child preventive care visits and those related to medical conditions such as cleft lip and palate, trauma and accidents, cancer and as prophylaxis for surgical treatments. They do not typically cover services to prevent or treat dental disease.

Current typical benefit designs for stand-alone dental plans include defined preventive services, limits on other covered services, and annual limits ranging from \$500 to \$3000 on total covered services. These plans often require a waiting period of 6 to 12 months before major services are covered, due to significant concerns about adverse selection, particularly when the coverage is purchased on an individual basis. Typical benefit designs for vision benefits provide for one exam per 12 to 24 months, and one pair of glasses and / or contact lenses. Because of the very limited scope of coverage, a waiting period is not usually imposed for Vision benefits.

### Individual and Small Group Supplemental Insurance Markets

Nationwide in 2010, about 54% of the population was covered by dental insurance, a drop from 57% that is attributed to job loss in the recession. Virtually everyone with a dental policy obtains it through group insurance, be it a large or small employer, union or public program. Conversely, stand-alone dental and vision coverage is not common in today's individual market. Of those with coverage, 81% access dental plans through groups, 15% through public programs, and only 1% of dental policies are purchased by individuals. In addition, dental policies are typically stand-alone products, distinct from medical coverage; only 2% of dental offerings are integrated with medical coverage. Most employers who offer both medical and dental coverage to their employees and dependents do so through different carriers (medical is different than dental). Less than a third, or 32%, of employers offer dental policies from the same carrier that underwrites both medical and dental coverage. Even dental policies sold by an affiliate or subsidiary of a medical plan may be offered in conjunction with medical plans sold by other carriers.

In 2007, the most recent state level data available for California, about 60% of the population had some source of dental coverage; 39% of the California population had no dental coverage. The majority of Californians with dental insurance obtain their dental coverage through employment. However, only about 19% of small employers with 1-9 FTEs and 46% of small employers with 10-49 FTEs offer dental insurance. Only 5% of Californians have privately purchased individual dental insurance, higher than the national average. Another 17% had dental insurance through public programs in 2007, primarily Medi-Cal, but this has decreased. In 2009, most of the Medi-Cal adult dental benefits were eliminated due to the state's budget deficit.

## Issues for Considerations

### ***Offering Pediatric Essential Health Benefits***

The Exchange must offer pediatric dental and vision benefits that are within the scope of services defined by the Essential Health Benefits. It may also offer more comprehensive benefits. For dental care, the Exchange must accept proposals from stand-alone dental plans, and must allow medical plans to propose a scope of benefits that excludes dental services if those services are offered on a stand-alone basis. For vision benefits, there is less federal guidance, and the current understanding is that those benefits are to be included in health plan contracts.

### ***Offering Supplemental Benefits***

The Exchange has the option to offer supplemental benefits beyond those required as Essential Health Benefits. Further regulations detailing the Essential Health Benefits requirements are expected to come at a later date. It is expected that Essential Health Benefit "pediatric dental and vision services" would include typical preventive benefits such as oral and vision health assessment, cleanings and fillings. As mentioned above, it is unclear if more specialized pediatric dental and vision benefits, such as periodontal care, orthodontia, surgery or crowns, will be included in the definition of the Essential Health Benefits, and so may be considered supplemental. All dental and vision services offered to adults will be considered supplemental, as they are not included in the scope of Essential Health Benefits. Although the Affordable Care Act does not clearly define the age limit for pediatric benefits, the most common age cited is up to 21.

The Exchange may offer supplemental benefits differently in the Individual and SHOP Exchanges. Both Individual and SHOP have the opportunity to mirror their respective markets and may be considered separately for options and recommendations.

### ***Structuring Dental and Vision Benefits***

The Exchange may fulfill pediatric oral and vision Essential Health Benefits requirements by offering medical plans that incorporate the pediatric dental and vision benefits, or they may offer separate stand-alone plans for some of these services. Federal rules require that, where stand-alone dental and vision plans are offered, medical plans be allowed to be offered without those dental and vision services so long as all other essential benefits are offered. Stand-alone dental plans in the Exchange must offer child only coverage, in addition to any other family plans that may be offered. The Exchange is required to accept bids from both embedded and stand-alone plans and stand-alone plans are held to the same criteria for certification evaluation. Under Section 1311 of the Affordable Care Act, there is language to allow a stand-alone dental benefit plan to be offered within a state exchange; however, there is no specific guidance for vision services coverage.

In the current small and large employer markets, both dental and vision policies are typically sold and purchased separately from the medical policies. Furthermore, only about a third of the time is the medical and dental product offered by the same carrier. The dental and vision services included in the Essential Health Benefits package must be offered as part of an individual or small group health plan, with the exception that inside Exchanges, the dental essential benefits may be offered on a stand-alone dental plan basis. Non-essential and adult dental and vision services not included in the EHB package will have the option to be offered as separate products, or could be included in a comprehensive policy, but a separate premium rate will be required for that coverage.

### ***Additional Related Issues***

There are additional related issues to be considered by the Exchange but options for these issues are outside of scope of this Brief. Some of these topics and are covered by other Briefs or should be considered as part of downstream operational implementation.

- **Cost sharing subsidies.** The Affordable Care Act guidance as of March 12, 2012 includes recommendations that cost sharing limits and the removal of annual and lifetime maximums apply to both stand-alone pediatric dental and when pediatric dental is incorporated in the medical benefits. The regulations do not provide clear guidance around the application of premium and cost sharing subsidies across the medical, dental, and vision Essential Health Benefits. Guidance will be particularly important if pediatric dental and vision benefits are offered as stand-alone dental and vision plans rather than as part of comprehensive QHP plans. One of the implications may be that the Exchange would need to work with the various carriers to develop subsidy aggregation and allocation functions, so they will know when an individual or family has met their cost sharing obligation.
- **Tax credits.** Similar to the cost sharing issue, the Exchange may need to provide aggregation functions to properly calculate tax credits when multiple medical, dental, and vision carriers are involved. Small businesses may qualify for new tax credits if they provide insurance coverage to their employees and meet other criteria.
- **Cost sharing and out-of-pocket maximums.** Today the majority of policy and claims IT systems separately process medical, dental, and vision transactions, presenting difficult to manage combined cost sharing and out-of-pocket maximum requirements. A mechanism will need to be established to combine this information.
- **Metal Tier Determination.** The issue of metal tier application to stand-alone dental and vision plans requires further regulation and guidance and may have implications on how the Exchange structures such benefits.
- **Enrollment IT System Design.** The Exchange must carefully develop the requirements, designs, and perform additional testing to provide proper functionality for presenting

and managing dental and vision coverage options for families with children and applying subsidies only to pediatric dental and vision portions.

- **Qualifying Dental and Vision Plans.** The Exchange is not obligated to solicit nor receive bids from stand-alone vision plans whereas under the Affordable Care Act it is obligated to receive bids for stand-alone dental. It is not obligated to contract with stand-alone plans, and anticipates that review of such plan offerings will be on the same terms as those of health plans, although variation will be needed for such issues as accreditation and network adequacy. The solicitation and accreditation criteria may vary significantly for stand-alone dental and vision plans as compared to medical plans. For example, dental and vision network adequacy may require separate standards from medical network standards due to the nature of these plans, the scope of covered services, and the mix and distribution of providers that deliver the services.
- **Quality Reporting Requirements for Dental Plans.** The Exchange must also consider when and how the quality reporting requirements need to vary for dental plans as compared to the medical plans.
- **Requiring Pediatric Dental and Vision Coverage.** Because Pediatric Dental and Vision coverage are Essential Health Benefits, the Exchange will need to ensure that the packages sold for children include these benefits.
- **Employer Choice in SHOP Exchange.** Should employers have the option to select whether their employees will enroll in dental and /or vision benefits beyond those included in the Essential Health Benefits definition? Can individuals in Small Groups independently enroll in a dental and / or vision plan through the Exchange if their employer opts out? Current market practices generally set a minimum participation rate of 70% for these supplemental benefits (i.e., at least 70% of the employer group must enroll.).
- **Provider Network and Access.** Because pediatric dental and vision coverage are Essential Health Benefits, the Exchange will need to ensure that issuers include sufficient number of dentists and optometrists in their network design.
- **Premium rates.** If stand-alone dental plans are offered, health plans will need to submit premium rate proposals with and without pediatric dental services, since a portion of the services may be covered by a stand-alone plan.

### Stakeholder Perspectives

Many stakeholders expressed their support of the Exchange offering supplemental dental and vision benefits beyond those EHBs required for children. Some agents also indicated that there is a correlation between consumers purchasing multiple products and keeping their medical insurance in the long-term. Others noted that the Exchange would be at a disadvantage in the SHOP market if it did not offer supplemental benefits. Small employers would need to engage the commercial market for these common supplemental/ancillary benefits. And outside of the Exchange, the carriers and the existing small group exchange, Cal Choice, offer employer

*Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers*

sponsored or voluntary ancillary options. This could also put the SHOP at a disadvantage with private exchanges with bundled medical, ancillary and additional value-adds like payroll, compliance, cobra, FSA, and POP plans.

In contrast, other stakeholders raised concerns about allocating resources to offering supplemental benefits in the early years given the great number of challenges the Exchange is facing immediately. There was also skepticism from a small number of stakeholders about the value to the consumer of supplemental benefits given waiting periods and low coverage limits in common benefit designs.

Stakeholders presented varying points of view with regard to stand-alone dental and vision plans, and recognized that the language of the Affordable Care Act specifically provides for the Exchange to receive proposals from stand-alone dental plans, but does not contain such a provision for vision services. Some stakeholders strongly advocated for the offering of stand-alone plans for both dental and vision services, while others urged that those services be incorporated in health plan contract.

Table 56, 58 and 59 follow and detail the major options proposed for consideration by the Board:

- Providing required Pediatric Dental and Vision Benefits
- Offering Supplemental Benefits in the Individual and SHOP Exchanges
- Structuring Supplemental Dental and Vision Benefit Offerings

The decision to offer supplemental benefits in the Individual and SHOP Exchanges must consider current market practices, additional administrative costs, the desire by the Exchange to expand dental and vision coverage of Californians, consumer preferences, and the ability of the Exchange to fulfill the Affordable Care Act requirements while considering the impact of allocating additional resources to offer and manage supplemental benefits.

## Pediatric Coverage

### Issue 1: Offering Pediatric Dental and Vision Essential Health Benefits

Because pediatric dental and vision services are Essential Health Benefits, 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.

### Issue 2: Structuring Pediatric Dental and Vision Essential Health Benefits

The following three main options are available to the Exchange to structure how the pediatric dental and vision benefits are offered within the Exchange (see Table 56 for detail):

- **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

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- **Option C:** Review bids from stand-alone dental plans and comprehensive bids from medical plans, with embedded vision coverage

The Affordable Care Act requires that the Exchange accept bids from stand-alone dental plans for pediatric dental services, and that it permit health plans to exclude pediatric benefits from their bids if there is a stand-alone dental plan. Staff recommends reviewing bids from both stand-alone dental plans and medical plans (Option C) with vision coverage embedded in medical plans. This does not preclude the Exchange from accepting bids from Qualified Health Plans that cover the full complement of pediatric dental and vision Essential Health Benefits. However, allowing stand-alone dental plans to be considered in the Exchange is required by the Affordable Care Act and it follows current market practice. Under this option, all QHP bids will include pediatric vision and QHPs will be required to submit bids that do and do not include pediatric dental services. It will readily allow the Exchange to offer both "Child only" stand-alone plans that cover the required pediatric dental services and adult and family plans that cover the broader scope of services commonly offered through employer group plans. Even with separate vendors for these supplemental services, the employer will receive a single invoice through the Exchange, so issues related to administrative complexity that may arise in the external market with multiple providers will not apply. There will still be complexity related to determining cost sharing requirements, particularly as they relate to deductibles, if the services are provided through separate plans.

## Adult and Family Coverage

### Issue 3: Offering Supplemental Benefits in the Individual and SHOP Exchanges

The following three options related to offering supplemental benefits (expanded pediatric dental and vision and adult and family dental and vision) are being considered (see Table 57 for detail):

- **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 the SHOP Exchanges

Staff recommends that the Exchange offer supplemental dental and vision benefits in the SHOP Exchange as a first step (Option B). Evidence suggests small employers value offering dental and vision coverage to their employees today. The majority of people with dental coverage today purchase dental insurance through an employer group offering and very few people purchase individual dental or vision coverage. Offering supplemental benefits in the SHOP Exchange would support existing market practices. At the same time, the required pediatric dental EHB would be offered in the Individual Exchange either through stand-alone dental plans or with these benefits embedded in comprehensive Qualified Health Plans.

Furthermore, the Exchange should evaluate the additional costs and operational requirements associated with offering supplemental benefits in both Individual and SHOP Exchanges (Option A). If the additional costs and adverse selection risk are found to be acceptable, offering supplemental dental and vision in both Exchanges provides the most consumer-friendly approach, does not disrupt existing market practices, and positions the Exchange as a comprehensive channel for a variety of health insurance coverage.

### Issue 4: Structuring Supplemental Dental and Vision Benefit Offerings

The following three main options are available to the Exchange to structure how the supplemental dental and vision benefits are offered within the Exchange (see Table 58 for detail):

- **Option A:** Offer dental and vision coverage only embedded as part of medical QHP plans
- **Option B:** Offer stand-alone dental and medical plans
- **Option C:** Offer a combination of (a) stand-alone dental, vision, and medical plans; and (b) medical plans with embedded dental and vision benefits

Staff recommends offering stand-alone dental plans and medical plans with vision coverage embedded in medical plans (Option B). This does not preclude the Exchange from accepting bids from Qualified Health Plans that cover the full complement of Essential Health Benefits. However, allowing stand-alone dental plans to be considered in the Exchange is required by the Affordable Care Act for pediatric Essential Health Benefits and it follows current market

practice. It will readily allow the Exchange to offer both "child only" plans that cover the required pediatric dental services and adult and family plans that cover the broader scope of services commonly offered through employer group plans. If the decision is to offer the supplemental coverage only through the SHOP Exchange, Option B does not change the current environment for small group employer decision-making. Also, stand-alone supplemental product design may attract a greater number of health plan bidders. Even with separate vendors for these supplemental services, the employer will receive a single invoice through the Exchange, so issues related to administrative complexity that may arise in the external market with multiple providers will not apply.



Table 56: Issue 2: Structuring Pediatric Dental and Vision Benefit Offerings

Option A - Combined with Medical:	Option B - Stand-alone Plans:	Option C - Hybrid:
<p><b>SUMMARY</b>                      Accept proposals for dental and vision coverage only as embedded as part of medical QHP plans.</p>	<p><b>SUMMARY</b>                      Accept proposals for dental and vision coverage only as stand-alone plans.</p>	<p><b>SUMMARY</b>                      Accept proposals for stand-alone dental and medical plans with embedded vision coverage.</p>
<p><b>PURPOSE</b>                      This option allows consumers to view and understand their comprehensive coverage options more easily but limits choice and competition.</p>	<p><b>PURPOSE</b>                      This option allows clear distinction between medical and dental/vision plans but does not offer comprehensive plans that include a variety of coverage.</p>	<p><b>PURPOSE</b>                      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.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Provides comprehensive (medical, dental, and vision), potentially easy to compare options</li> <li>▪ Provides easier administration to the Exchange</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Consistent with current market practices</li> <li>▪ Provides more choice and competition</li> <li>▪ Allows individual with existing dental coverage outside of the exchange to keep their current coverage</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Provides most choice and competition</li> <li>▪ Allows individual with existing dental coverage outside of the exchange to keep their current coverage</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Disruptive to the current market practices</li> <li>▪ Significantly limits consumer choice and competition</li> <li>▪ Limits competition</li> <li>▪ Potentially duplicates coverage for individuals with existing dental and vision coverage</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ More difficult and costly to administer for the exchange; requires coordination of deductible payments</li> <li>▪ Potentially requires the Exchange to offer aggregation functions to manage subsidies and tax credits across medical and dental plans</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Most difficult and costly to administer for the exchange</li> <li>▪ Potentially requires the Exchange to offer aggregation functions to manage subsidies and tax credits across medical, dental, and vision plans</li> <li>▪ May create confusion by offering too many choices, some comprehensive and some stand-alone</li> <li>▪ Could create adverse selection if Affordable Care Act restrictions on annual and lifetime limits are imposed on dental and vision services.</li> </ul>

Table 57: Issue 3: Offering Supplemental Benefits in the Individual and SHOP Exchanges

Option A - Offer in Individual and SHOP:	Option B - Offer only in SHOP:	Option C - Do Not Offer:
<p><b>SUMMARY</b>                      Offer supplemental benefits (expanded pediatric dental and vision and adult dental and vision) in both Individual and SHOP Exchanges.</p>	<p><b>SUMMARY</b>                      Offer supplemental benefits (expanded pediatric dental and vision and adult dental and vision) only in SHOP Exchange.</p>	<p><b>SUMMARY</b>                      Do not offer supplemental benefits (expanded pediatric dental and vision and adult dental and vision).</p>
<p><b>PURPOSE</b>                      This option 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.</p>	<p><b>PURPOSE</b>                      This option allows employers to offer benefits beyond Essential Health Benefits requirements through SHOP Exchange.</p>	<p><b>PURPOSE</b>                      Meets Affordable Care Act requirements and limits benefits offered only to the Essential Health Benefits.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Provides a one-stop shop to consumers for medical, dental, and vision coverage</li> <li>▪ Enables continuous coverage for consumers transferring between SHOP and Individual Exchanges (assuming common/standardized SHOP and Individual Exchange plans)</li> <li>▪ Contributes to expanding dental and vision coverage of Californians</li> <li>▪ Provides families with cohesive coverage options for all family members (adults and children)</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Enables employers who offer dental and vision coverage today to continue to do so through the Exchange</li> <li>▪ Provides the opportunity for employers to offer enhanced coverage</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Focuses Exchange resources (financial and physical) on Affordable Care Act regulations and Essential Health Benefits requirements</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Increases complexity and administrative costs for Individual and SHOP Exchanges</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Limits opportunity to offer continuous coverage for individuals transferring between Individual and SHOP Exchanges</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Reduces choice for individuals</li> <li>▪ Increases complexity for individuals by potentially forcing them to purchase pediatric dental and vision coverage in the exchanges and adult coverage outside of the exchanges</li> </ul>

Table 58: Issue 4: Structuring Dental and Vision Benefit Offerings

Option A - Combined with Medical:	Option B - Stand-alone Plans:	Option C - Hybrid:
<p><b>SUMMARY</b>                      Offer dental and vision coverage only as embedded as part of medical QHP plans.</p>	<p><b>SUMMARY</b>                      Offer only stand-alone dental and medical plans.</p>	<p><b>SUMMARY</b>                      Offer a combination of (a) stand-alone dental, vision, and medical plans; and (b) medical plans with embedded dental and vision benefits.</p>
<p><b>PURPOSE</b>                      This option allows consumers to view and understand their comprehensive coverage options more easily but limits choice and competition.</p>	<p><b>PURPOSE</b>                      This option allows clear distinction between medical and dental plans, allows financial benefit limits on non-essential health benefit dental services but does not offer comprehensive plans that include a variety of coverage.</p>	<p><b>PURPOSE</b>                      This option provides the most choice to consumers that fits their individual situation but requires careful evaluation of how to present consumers with options in order to avoid too many options and too much information.</p>
<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Provides comprehensive (medical, dental, and vision), potentially easy to compare options</li> <li>▪ Provides easier administration to the Exchange</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Consistent with current market practices</li> <li>▪ Provides more choice and competition</li> <li>▪ Allows individual with existing dental coverage outside of the exchange to keep their current coverage</li> </ul>	<p><b>PROS</b></p> <ul style="list-style-type: none"> <li>▪ Provides most choice and competition</li> <li>▪ Allows individual with existing dental and vision coverage outside of the exchange to keep their current coverage</li> </ul>
<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Disruptive to the current market practices</li> <li>▪ Significantly limits consumer choice</li> <li>▪ Limits competition</li> <li>▪ Potentially duplicates coverage for individuals with existing dental and vision coverage</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ More difficult and costly to administer for the exchange</li> <li>▪ Potentially requires the Exchange to offer aggregation functions to manage subsidies and tax credits across medical and dental plans</li> </ul>	<p><b>CONS</b></p> <ul style="list-style-type: none"> <li>▪ Most difficult and costly to administer for the exchange</li> <li>▪ Potentially requires the Exchange to offer aggregation functions to manage subsidies and tax credits across medical, dental, and vision plans</li> <li>▪ May create confusion by offering too many choices, some comprehensive and some stand-alone</li> <li>▪ Could create adverse selection if Affordable Care Act restrictions on annual and lifetime limits are imposed on dental and vision services.</li> </ul>

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## Multi-State Plans

### Summary

As part of its evaluation of qualified health plan (QHP or Exchange Plans) certification standards, the California Health Benefit Exchange (Exchange) must account for proposals to offer Exchange Plans from two unique entities created under the Affordable Care Act: Multi-State Health Plans and Consumer Operated and Oriented Plans. This brief describes the former, multi-state plans and highlights the implications of such plans for the Exchange.

### Background

The federal Office of Personnel Management (OPM) is required to contract with health insurance issuers to offer at least two multi-state plans (MSPs) through the individual and small business health options program (SHOP) health benefit exchange in each state.<sup>51</sup> MSPs are distinct from interstate compacts or national plans because “MSPs” are only available through an exchange.

*For OPM contracting purposes:*

- At least one MSP must be offered by a non-profit corporation, and one MSP must not provide abortion coverage<sup>52</sup>
- MSP must
  - Be licensed in each state the MSP will be offered<sup>53</sup>
  - Offer a uniform benefit package, including essential health benefits<sup>54</sup> (It is unclear if the uniformity is per each state or across states.)
  - Be offered in all geographic regions statewide and in all states that have adopted adjusted community rating (i.e. system of charging mostly uniform premiums) before March 2010<sup>55</sup>
  - Meet all federal qualified health plan requirements (e.g. accreditation, quality initiatives, network adequacy, actuarial or metal level + catastrophic coverages, premiums in and out of the exchange)
- In the first year an MSP is offered it must be offered in at least 60% of all states; second year of offering, at least 70% of all states; third year, at least 85% of all states; subsequent years, all states<sup>56</sup>
- OPM will oversee or regulate the MSPs

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<sup>51</sup> ACA Section 1334(a)(1)

<sup>52</sup> §1334(a)(3) and (6)

<sup>53</sup> §1334(b)(2)

<sup>54</sup> §1334(c)(1)(A)

<sup>55</sup> §1334(c)(1)(D)

<sup>56</sup> §1334(e)

*For the Exchange qualified health plan purposes:*

- An MSP offered through OPM will be deemed certified by an Exchange,<sup>57</sup> i.e. MSPs are certified to participate in the Exchange by OPM without state certification
- MSPs will need to meet most of the standards for an Exchange Plan
- MSP enrollees are eligible for premium tax credits and cost-sharing reductions
- MSPs are subject to all state requirements so long as they are not inconsistent with the Affordable Care Act. State age rating rules that are more protective than the federal “3:1” ratio are specifically called out as applying to MSPs.
- OPM will oversee or regulate the MSPs including in regard to, premium rates, medical loss ratio, transparency reporting, accreditation timelines and network adequacy.
  - For example, MSPs are exempt from Exchange processes for receiving and considering rate increase justifications and from Exchange processes for receiving annual rate and benefit information.<sup>58</sup>
  - MSPs may vary rating per regions same as other QHPs.<sup>59</sup>

### Oversight of MSPs

OPM was expected to release draft MSP guidelines in spring 2012 but to date has not. OPM has taken steps to prepare for MSP oversight insofar as it formally requested information from stakeholders in 2011 to better understand potential issuers’ interests and capabilities to aid in development of procurement documents. Federal rulemaking from the U.S. Department of Health and Human Services in regard to health benefit exchanges largely defers to OPM to issue implementing regulations regarding MSPs because OPM will administer contracts with MSPs. However, the final federal regulation regarding exchanges nonetheless includes some MSP rules in attempt to avoid duplicate reporting and minimize administrative burden for Exchanges in regard to MSPs.

OPM will, for MSPs, of specific interest to the Exchange: (a) determine the process through which MSPs submit transparency data, (b) establish the accreditation period, (c) determine provider network adequacy as part of the certification of the MSP; and (d) review rates.<sup>60</sup>

In order to create a “level playing field” between MSPs and other insurers and health plans, any state or federal law in the topic area following, if not applied to an MSP, cannot be applied to a health plan or insurer: guaranteed renewal, rating, preexisting conditions, non-discrimination, quality improvement and reporting, fraud and abuse, financial solvency, market conduct, prompt payment, appeals and grievances, privacy and confidentiality, licensure and benefit

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<sup>57</sup> §1334(d), and 45 CFR 155.1010(b)(1)

<sup>58</sup> 45 CFR 155.1020(a), (b)(2), and (c)

<sup>59</sup> 45 CFR 156.255(a)

<sup>60</sup> 45 CFR 155.1040(a), 155.1045, 155.1050(a)-(b)

plan information.<sup>61</sup> The level field requirement assures MSPs meet the same general rules that non-MSP plans meet. Nothing precludes an MSP from going beyond those minimums.

### Deeming Of Exchange Plan Certification

Federal law specifically provides a deeming process for MSPs. Based on this fact, federal rulemaking has determined that MSPs cannot be excluded from participation in a state's health benefit exchange, including in exchanges that adopt selective certification approaches.<sup>62</sup>

MSP satisfaction of Qualified Health Plan standards will be determined by OPM. This is distinct from the non-MSP, Exchange Plan certification process—under which the Exchange will select and certify Exchange Plans.

MSPs are not subject to Exchange recertification or decertification.<sup>63</sup>

MSPs are included in the definition of “participating issuer” for purposes of Exchange fees.<sup>64</sup>

### Stakeholder Perspectives

In response to the Qualified Health Plan stakeholder group sessions and stakeholder comments received February through April 2012 as well as comments received through August 6, 2012, concerns were raised that a multi-state health plan concept may not be consistent with California's decision to pursue a selective contracting approach in the Exchange. The Exchange was encouraged to request that the federal government use its flexibility to select multi-state plans that exclude California, at least in the early years. Co-op plans may be able to provide a more locally sensitive option.

A full compilation of the comments provided by stakeholders is available on the Exchange's web site at

[http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%202022,%202012/HBEX-QHPStakeholderReport\\_5-18-12.pdf](http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%202022,%202012/HBEX-QHPStakeholderReport_5-18-12.pdf)

### Implications for the California Health Benefit Exchange

OPM's target contract date for MSPs is October 2013, well after the Exchange Plan selection and certification process, and into the initial Exchange open enrollment period. At present OPM award of any MSP contracts in California is very uncertain. Despite the improbability of an MSP as a QHP at present, the Exchange should consider the implications now to prepare for the possibility or eventuality.

The Exchange will have to accept MSPs to operate as Exchange Plans pursuant to deeming enacted under federal law. The Exchange will also hold less oversight authority over the

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<sup>61</sup> §1324

<sup>62</sup> Federal Register, March 27, 2012, Final Exchange Rule at page 18406

<sup>63</sup> 45 CFR 155.1075(a) and 155.1080(b)

<sup>64</sup> 45 CFR 156.50(a)

MSP(s). Further, MSPs hold the potential to affect Exchange and in fact market-wide (beyond the Exchange), health plan options. For example, if MSPs are held by OPM to lower standards, those lower standards effectively become the market standards of the state. However, the Exchange and other California health care stakeholders, have the option and interest to voice input and advice to the OPM and the U.S. Center for Consumer Information and Insurance Oversight (CCIIO), both of which continue to seek and rely on California input regarding MSP oversight. The Exchange has the opportunity to encourage the federal regulator (OPM) to require MSPs to adhere to [higher] state health plan standards, while the Exchange itself pursuant to federal law and regulation may enforce Exchange Plan certification standards on the MSP(s).

*Pros:*

- MSPs offer coverage that moves with a mobile population.
- MSPs could help with the alignment of Medi-Cal and Exchange Plan coverage insofar as an MSP could be offered by an issuer operating in the Medicaid and subsidy market.
- It is possible for OPM to meet the level field and state licensure rules yet still design a unique product in the market. OPM could negotiate with plans and use its authorities to establish higher or more detailed standards (e.g. for quality initiatives, rates or network adequacy), to select MSPs that demonstrate commitment to value and affordability.
  - For example, if the uniform benefit requirement for MSPs trigger richer benefits than other plans (in or out of the Exchange), MSPs could offer more comprehensive benefit choices (yet also attract higher risk enrollees) available only through the Exchange.

*Cons:*

- Exchange has no ability to actively negotiate with or select MSPs based on Exchange core values or state-specific selection criteria.
- OPM could hold MSPs to lower standards than the states which would preempt state regulation for all plans because of “level playing field” requirements.
- MSPs could find it difficult to offer uniform benefits in light of: individual states establishing essential health benefit standards, and Exchange plan design standardization.
- Issuers may not be incented to apply for MSP contract with OPM due to the requirements to comply with multiple and possibly conflicting state, federal and Exchange rules.
- Potential for MSPs to provide large issuers with significant, anti-competitive market share.



- Adverse selection possible by underpricing the competitor plans to attract healthier populations, in turn increasing costs in other Exchange Plans.

### Next Steps

Exchange staff should continue to work closely with OPM and CCIIO staff to monitor their activity with respect to multi-state plans that might be proposing to enter the California market in 2014 or 2015. Exchange staff has encouraged OPM and CCIIO staff to require multi-state plans to meet Exchange certification criteria in order to keep a level playing field for California's Qualified Health Plans. In addition, to allow multi-state plans that meet lesser standards is less protective of California consumers and the Exchange should continue to encourage federal endorsement of its Exchange-specific plan certification standards.

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## Consumer Operated and Oriented Plans (CO-OPs)

### Summary

As part of its qualified health plan (QHP or Exchange Plan) certification standards analysis, the California Health Benefit Exchange (Exchange) must account for proposals to offer Exchange Plans from two unique entities created under the Affordable Care Act: Multi-State Health Plans and Consumer Operated and Oriented Plans (CO-OPs). This brief describes the latter, CO-OPs, and attempts to raise the implications of such plans for the Exchange.

### Background

CO-OPs were established under the Affordable Care Act and implementing regulation. CO-OPs are:

- Non-profit health insurance issuers
- Member-owned
- Required to be licensed in the state in which they will offer qualified health plans (QHPs or Exchange Plans) in the individual or small group market<sup>65</sup>
  - However the CO-OP entity may not itself be, or be related to (affiliated with), an [existing] insurance issuer licensed on or before 7/16/09. The affiliation prohibition includes unlicensed affiliates of issuers (e.g. holding companies, foundations, and trade associations).<sup>66</sup>
- *Not* developed by state or local government, nor can state/local government be involved in the organization (including Board) of the CO-OP.
- Subject to state and federal health care law and regulation to ensure a level playing field, including risk adjustment.<sup>67</sup>
- Offered in both the individual Exchange and the Small Business Health Options Program Exchange.
- Required to re-direct any profit to their members' benefit (e.g. by lowering premiums), to repay federal loans, or accumulate reserves.
- Bound to operate primarily in the individual and small group markets, with no more than one-third of their contracts issued outside of the individual and small group markets.
- Intended to *"enhance competition in the Exchanges and provide additional plan choices for consumers and small businesses."* As well the CO-OPs are meant to operate *"with a*

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<sup>65</sup> Affordable Care Act §§1322(a)(2) and (c)(5); 45 CFR 156.515(a)

<sup>66</sup> 45 CFR § 156.510(b)

<sup>67</sup> Affordable Care Act §1322(a)-(b)

*strong consumer focus and greater...accountability and provide... more coordinated care [to] assist in the transformation of the health care delivery system.”<sup>68</sup>*

Federal loans to CO-OPs may<sup>69</sup>:

- Assist with start-up costs
- Assist with meeting state solvency requirements (the solvency loans are referred to as “grants” in statute but in fact must be repaid) so are clarified to be loans)<sup>70</sup>
- *Not* be used for “propaganda” or otherwise attempting to influence legislation<sup>71</sup>
- *Not* be used for marketing

If no issuer applies to be a CO-OP in a given state, federal funding may be used by HHS to award grants to encourage the establishment of a CO-OP within that state; or, the expansion of a CO-OP from another state into the state without one.<sup>72</sup> Funding allocation is based on there being only one CO-OP per state.

### Oversight of CO-OPs

CO-OPs will be overseen by HHS in regard to their federal loans, and overseen in all other regards pursuant to their state license. Legislation is pending in California to specifically authorize the state departments of Insurance and Managed Health Care to regulate CO-OPs.<sup>73</sup> Absent enabling state legislation, CO-OPs are still subject to state licensure requirements and thereafter state oversight.

### Deeming Of Exchange Plan Certification

Federal law and regulation specifically provide a deeming process for multi-State plans and CO-OPs. Based on this fact, federal rulemaking has determined that CO-OPs cannot be excluded from participation in a health benefit exchange, including in exchanges that adopt selective certification approaches.<sup>74</sup>

If the federal government determines that the CO-OP application meets the criteria for funding, and the CO-OP meets all state health insurance requirements, including licensure, then the CO-OP may not be excluded from offering their product(s) through the Exchange. However, CO-OP certification requirements are not different than those imposed on a non-CO-OP Exchange Plan.

CO-OPs are not subject to QHP recertification or decertification.<sup>75</sup>

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<sup>68</sup>U.S. HHS CCIIO October 2011 and April 2012 Webinars

<sup>69</sup>§1322(a)-(b)

<sup>70</sup> Federal Register, December 13, 2011, Final CO-OP Regulation at page 77394

<sup>71</sup>§1322(b)(2)(C)(ii)

<sup>72</sup>§1322(b)(2)(B)

<sup>73</sup>CA AB 1846 (pending)

<sup>74</sup> Federal Register, March 27, 2012, Final Exchange Rule at page 18406

<sup>75</sup> 45 CFR 156.1075(a) and 156.1080(b)

## Stakeholder Perspectives

In response to the Qualified Health Plan stakeholder group sessions and questionnaire conducted February through April 2012, as well as comments received through August 6, 2012 there were several specific references to CO-OPs: As mechanisms for the Exchange to foster health system reform (plans that could bid together for drugs and implants); as an option for the Exchange to fill quality gaps (remove barriers to new entrants such as CO-OPs); and, unlike multi-state plans, CO-OPs were suggested as possibly providing a locally sensitive [Exchange Plan] option.

A full compilation of the comments provided by stakeholders is available on the Exchange's web site at

[http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%202012,%202012/HBEX-QHPStakeholderReport\\_5-18-12.pdf](http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%202012,%202012/HBEX-QHPStakeholderReport_5-18-12.pdf)

## Implications for the California Health Benefit Exchange

At present the creation and licensure of any CO-OPs in California is uncertain. It may be difficult for an entirely new entity to accomplish necessary regulatory and licensing approvals in time to meet first year Exchange start up deadlines, most importantly open enrollment October 2013, such that the conditions precedent are not met for the Exchange to have to anticipate accepting CO-OPs. Despite those factors, the Exchange should consider the implications now to prepare for the possibility or eventuality.

The Exchange will have to accept CO-OPs to operate as Exchange Plans. CO-OPs would not be excused from any requirements that the Exchange imposes as a condition of participation. The only practical impact of CO-OPs that differs from non-CO-OPs is that the Exchange could not selectively contract to exclude CO-OPs from the Exchange.

### *Pros:*

- Provider network and administrative capacity can be built via relationships with rental networks/third party administrators
- Access to purchasing groups that already exist (e.g. labor unions)
- Exchange participation could provide the marketing a CO-OP cannot otherwise afford
- Minimal risk of failed operations resulting in harm to consumers (e.g. unpaid claims) because of federal loans for solvency coupled with state solvency protections.

### *Cons:*

- Disadvantage in competitive pricing because no market “clout” to contract high quality care providers
- Cost prediction in order to set appropriate premiums/Adverse selection
- Existing purchasing groups may be dissuaded by the CO-OP governance requirements

- Prohibition on use of federal funds for marketing insofar as marketing is a necessary and significant expense for new health plans
- Federal funding presumes only one CO-OP per state thereby potentially limiting choice of CO-OPs for California consumers.
- Risk involved in any failure of a new health plan option—enrollee access, continuity of care, financial stability of varied stakeholders.

### **Next Steps**

Exchange staff should continue to work closely with OPM and CCIIO staff to monitor their activity with respect to CO-OPS that might be proposing to enter the California market in 2014 or 2015. Exchange staff has encouraged OPM and CCIIO staff to require CO\_OPS to meet Exchange certification criteria in order to keep a level playing field for California's Qualified Health Plans. In addition, to allow CO\_OPS that meet lesser standards is less protective of California consumers and the Exchange should continue to encourage federal endorsement of its Exchange-specific plan certification standards.

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## Partnering with Health Plan Issuers to Promote Enrollment

### Summary

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. This Board Recommendation Brief discusses the approach the Exchange is proposing to partner with health plan issuers related to marketing and enrollment, as well as some of the technical issues that will need to be addressed to facilitate that collaboration.

### Background

Plan issuers will be integral partners of the Exchange; no other partner is more critical to the success of the Exchange. As the Exchange begins enrollment activities starting in 2013 and into its first years of operations in 2014 and beyond, the investment health plan issuers devote to retention and their marketing and outreach activities will play a critical role in creating consumer awareness of health plans offered in the Exchange, and will be essential to the Exchange's success. High levels of Exchange enrollment will help fulfill the Exchange's goal of increasing overall the number of Californians with affordable health care coverage, and will enhance the long term viability of the Exchange. Partnering with health plan issuers relative to their retention, marketing and outreach activities is also consistent with Exchange values of partnership and being a catalyst for change in California's health care system.

There will be a combination of individuals who are newly covered by health insurance, as well as large numbers of people who have insurance coverage and will have new options available, including standardized health plans, and importantly, premium subsidies based on income. For those with current coverage, health plans have established relationships and can play an important role in providing information to this group. Accordingly, the Exchange is considering options and approaches to incentivize health plan issuers to affirmatively engage in marketing and retention activities that help promote enrollment of existing and new enrollees ranging from helping existing insureds access new plans and subsidies in the Exchange, to co-branding their plans with the Exchange and developing marketing messages emphasizing plan issuer's partnership with the Exchange.

Partnering with health plan issuers is consistent with the approach taken by other exchanges. For example, the Massachusetts Connector's outreach and marketing activities were supported by advertising campaigns of plan issuers. Vermont included provisions in its exchange design that contemplate messaging be coordinated with marketing campaigns of participating health plans.



Health plan issuers and the Exchange can mutually benefit from a cooperative relationship to raise enrollment in health plans and to inform potential enrollees of the benefits of enrolling in the Exchange. At the same time, marketing costs are an important consideration in the affordability of the Exchange, and the efforts made by the Exchange and plan partners should be well coordinated to gain the maximum benefit from the expenditures made for marketing, outreach and enrollment. The partnership should also include plan regulators (the California Department of Insurance and California Department of Managed Health Care,) which provide marketing oversight of health plan issuers and enforce standards in California law relative to plan offerings, market conduct and fraud. The Exchange recognizes the distinct role and function of these regulators and will work collaboratively to ensure all marketing efforts are in full compliance with regulatory requirements. In addition to meeting minimum regulatory requirements, the Exchange has a further goal of ensuring all communications to potential enrollees is fair, accurate, and informative, and assists individuals in making informed choices.

Plan issuers have well established marketing capabilities and distribution channels. They have existing, proven methods of direct marketing of their products to large and small groups, individuals, plan enrollees, those who are uninsured and the general public. Most plans are equipped to market and sell their products in a variety of languages, which is important in reaching the full range of Exchange-eligible individuals. Plans have significant resources including trained sales staff, marketing teams, strong relationships with target groups and an understanding of how to market to targeted demographic groups and the necessary variation in the marketing campaigns, and it is appropriate for the Exchange to leverage these skilled resources.

Among the marketing methods issuers use are:

- Print advertisements (newspapers, magazines, direct mail, etc.)
- Radio and television advertisements
- Web-based advertisements
- Social networking sites
- Telesales (Outbound calling campaigns)
- Culturally and linguistically appropriate advertisements (e.g., Spanish and Chinese newspapers)
- Contract renewal mailings
- Inbound customer service inquiries for existing insureds
- Online enrollment

The Affordable Care Act currently limits the portion of premium dollars health plans may spend on administration, marketing, and profits. Plans must publically report the portion of premium dollars spent on health care and quality improvement and other activities in each state in which they operate. While the law does not require plans to provide detailed expenditures on

marketing activities, it does allow state Exchanges to impose conditions of participation for those plans offered on the Exchanges. The Exchange therefore has the option to require plan issuers to provide marketing expenditure information as a condition of participation in the Exchange in order to determine plan issuers' investment in marketing and outreach to promote plans sold through the Exchange. The Exchange can also make participation in marketing activities a contractual requirement or a preference in selecting Qualified Health Plans, and can provide incentives to issuers to make greater investments in marketing the Exchange.

### Stakeholder Perspectives

Stakeholders expressed agreement that Exchange and Issuer partnership in marketing will be important to the success of the Exchange. They also commented that marketing efforts should be closely monitored to ensure the practices used by health plans are fair and balanced. Some stakeholders expressed concern that any transfer of responsibility for completing enrollment for an individual be seamless, so potential members are not confused and consequently fail to complete their enrollment.

A full compilation of the comments provided by stakeholders is available on the Exchange's web site at

[http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%2022,%202012/HBEX-QHPStakeholderReport\\_5-18-12.pdf](http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%2022,%202012/HBEX-QHPStakeholderReport_5-18-12.pdf)

### Issues and Recommendations

The Exchange must develop strategies to partner with health plan issuers to market to potential enrollees, and to assist in retention of existing enrollees as well as enrolling large numbers of people who are currently uninsured. Approximately 615,000 individuals who are currently covered by individual insurance are estimated to be eligible for subsidies through the Exchange<sup>76</sup>, and these individuals must also be educated about their options. The Exchange must determine the ideal way to partner with health plan issuers to leverage existing resources and to incentivize issuers to make additional investments in marketing the Exchange. There are a number of technical issues that must be addressed to facilitate enrollment that might be generated through issuer marketing and enrollment efforts, and it will be necessary for the Exchange to both understand and work through those technical issues to provide a seamless experience for the enrollee. The Exchange will also need to work through privacy issues that may arise if health plan issuer staff have access to financial information needed to determine subsidy eligibility.

To incentivize issuers to partner with the Exchange to provide marketing resources, the Exchange will want to explore options ranging from imposing specific contractual requirements to providing enhanced scoring in the evaluation of Qualified Health Plans. As a first step, the

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<sup>76</sup> Health Insurance Coverage in California under the Affordable Care Act, California Simulation of Insurance Models (CalSIM) Version 1.7, June 2012. Exhibit 4: Exchange Subsidy Eligible Californians under Age 65 by Source of Insurance Coverage without the ACA, 2019. [http://laborcenter.berkeley.edu/healthcare/aca\\_chartpack.pdf](http://laborcenter.berkeley.edu/healthcare/aca_chartpack.pdf).

Exchange will ask Qualified Health Plans to disclose their marketing budgets (recognizing the information is proprietary and not subject to further disclosure) that are committed to enhancing Exchange enrollment. To provide a clear understanding of the marketing effort, issuers will be requested to provide the information in a detailed manner, and a template will be provided to ensure consistent reporting across all issuers. Categories of information expected to be requested include media buys, distribution channels, agent commissions, and others.

However, the Exchange will likely need a greater level of commitment from issuers, particularly in the early days and will use contractual terms to define the level of effort expected of each issuer. Plans may be requested to show their level of effort based on metrics that relate to their market share. At the start of the effort those metrics will likely tie to market share in the Individual market, and later to market share in the Exchange. Other options include total market share across all lines of service, or others. Comments are solicited from plan issuers and stakeholders to more precisely define creditable marketing efforts.

Issuers that offer additional marketing investments may be rewarded by the Exchange. Such rewards may include discounts off participation fees or co-branding on membership materials. Comment is requested on the types of incentives that may be valuable to issuers and appropriate for members.

In addition to general marketing, the Exchange must collaborate with issuers on methods for enrolling individuals, and the issues addressed must consider:

- Those who are currently enrolled with the Issuer;
- Those who identify through the marketing efforts and preference for enrolling with the issuer; and
- Those who are an "unqualified lead." who may not know their health plan preference.

A key consideration in working with issuers to market the Exchange is the need for consumers to receive broad information on all available options. It is particularly important that issuers not inappropriately withhold information about other options from consumers, so mechanisms must be established to monitor marketing and enrollment efforts, and to link individuals to appropriate resources if they wish to explore health plan options of other issuers. To the extent that health plan issuers enroll individuals in Exchange plans, the Exchange will need to assess how to allow issuers to enroll identified individuals without limiting information available to consumers to make a fully informed choice. Staff believe both newly-identified consumers and those who currently have individual health insurance should be given full information about options and that issuers should have the obligation of providing full information, or referring individuals to Assistants or Agents who will have the ability to provide the details. Agent compensation options are discussed in a separate Agent Compensation Board Recommendations Brief.

Among the issues to be addressed is informing individuals who are currently enrolled with issuers that they now have new options available, including receiving premium subsidies if they are income-eligible. Because these individuals have existing relationships with issuers, the situation is possibly more complex than the treatment of new enrollees. However, it is equally important that these individuals understand their full range of options. Health plan issuers should be required to provide information to their current enrollees at the time their current policy comes up for renewal. At minimum, the information provided to current enrollees should identify where additional information is available and the types of information they may find. However, it is likely that many currently-insured individuals will prefer to retain their current coverage, and those who are satisfied with that coverage should be able to retain it with minimum action on their part. Consequently, staff believe issuers should have the ability to work with their current enrollees to further explore their specific offerings. Such assistance from issuers will lessen the work load for the Exchange in enrolling individuals in plans.

The Exchange will have multiple distribution channels which will include call center staff, navigators, and “unpaid assisters” (a category that includes health care providers and agents that may benefit directly from individuals enrolling in coverage) that both new enrollees and those who currently have health insurance can access. In some cases these distribution channels will have existing relationships with individuals seeking Exchange coverage. Health plans will be best positioned to provide enrollment assistance to those currently enrolled in their products. Issuers can provide broad outreach to their current enrollees and provide information on their new offerings.

Most plan issuers have a large number of direct channel sales staff as well as member service call center staff, and in some cases retail staff, who will be trained and knowledgeable in commercial health coverage, and could be further trained to become certified assisters to the Exchange. Individuals entering the plan issuer’s enrollment/re-enrollment process visiting in person, enrolling through a telephone call, or using on-line enrollment, with or without assistance. The activities of plan issuer staff in assisting members to enroll in the Exchange would be analogous to those performed for the Medicare Advantage program in which plans assist members to enroll and renew under the oversight of the Center for Medicare and Medicaid Services.

Several levels of staff assistance may be provided by health plans, and all require that the Exchange establish policies regarding the interface between issuer staff and the Exchange, including determining the types of information health plan staff must communicate, how to determine when an individual would best be served by an Assister or Agent rather than Issuer staff, and how to connect health plan staff to the Exchange's information systems. Privacy issues will be a key consideration, particularly for individuals who may be eligible for subsidies. The Exchange may provide the ability for health plan staff to access the Exchange’s online enrollment system to facilitate completion of the enrollment process and provide a seamless

experience for the member. As one approach, the health plan staff member may be given access to a view of the member's information and would have the ability to recommend to the individual how to walk through the enrollment process. An alternative is to provide the health plan staff member with access to the generic information on the screen, but without access to the personal information being input by the individual. Which of these options is appropriate will depend on how privacy issues are resolved, and the correct solution for one person needing assistance may be different from the level of assistance needed by others. The Exchange expects to explore these technical and privacy issues to determine how best to provide enrollment assistance through health plans.

Specific types of assistance that may be provided include:

- **Online unassisted enrollment:** Plan issuers provide the option for enrolling on-line. These web sites may be modified to include information on additional options that may be available, including the availability of subsidies and the fact that individuals may have new options available to them due to the requirement for standardized benefit designs, full coverage of Essential Health Benefits, and elimination of pre-existing condition exclusions.
- **Online assisted enrollment:** A next step in the continuum of the enrollment process is to provide assistance during the on-line enrollment process. While web sites can be set up to deliver all of the information that is expected to be needed, it is likely that some individuals will have questions that are more readily or appropriately addressed through a conversation. The additional information needed may relate to the specific issuer, or may include broader questions about subsidy eligibility or health plan options.
- **Telephonic assisted enrollment:** In addition to web-based enrollment, health plans may also be asked to provide telephonic assistance, as there are likely a large number of individuals who do not regularly transact business on the internet.
- **In-person enrollment.** A large number of individuals are likely to prefer in-person enrollment and re-enrollment, either through a retail outlet, a health insurer office, and in some cases, a medical facility. Staff in these locations will need to receive the same training on the available options and will need to have access to the information that can facilitate completing the enrollment process, or be referred to an Assister or Agent.

There is also a need for the Exchange to ensure that marketing and enrollment efforts undertaken by issuers is fair and balanced. The Exchange will need to develop processes that monitor and review those activities. Among the approaches the Exchange may consider include:

1. Marketing material review and approval. The Exchange will require that all marketing materials be reviewed in advance. This review will be in partnership with Regulators, and would include such issues as full disclosure of health plan options for individuals, ensuring that the messages communicated do not appear to incentivize adverse

*Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers*

selection, information on how consumers can get additional information, and other issues to be determined.

2. Scripting review and approval. The Exchange is expected to require that plan sales and member service call center scripting for interaction with members interested in enrollment with the exchange include a reference to the fact that other plans are offered via the exchange and assistance in enrolling with them is available via the exchange's call center staff, navigators, or other assisters.
3. Enrollment process audit. As a mechanism for monitoring the enrollment process, the Exchange could conduct "secret shopper" audits of plan issuers sales and members service call centers to ensure that approved scripts are being consistently used.

### Next Steps

Staff request input from stakeholders on options for partnering with health plan issuers to enhance marketing and enrollment activities, while ensuring that potential enrollees have information that describes the full range of options that are available to them. Changes in Individual insurance coverage make it particularly important that individuals receive full information about new health plan options and premium subsidies as well as cost sharing reductions. Health plan issuers are important partners to the Exchange, and their expertise and resources will be important in enhancing enrollment in the Exchange.

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**RESEARCH**

45 Code of Federal Regulations 156.200. *QHP issuer participation standards*

45 Code of Federal Regulations 158.110. *Reporting requirements related to premiums and expenditures*

*Who Can Participate in the California Health Benefit Exchange? A Profile of Subsidy-Eligible Uninsured and Individually Insured.* UCLA Center for Health Policy Research, Health Policy Brief, May 2011. Accessed at:

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