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POLICY & ACTION FROM CONSUMER REPORTS

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California Health Benefit Exchange

Re: Qualified Health Plans

Consumers Union, the policy and advocacy division of Consumer Reports, is pleased to provide comments to the Exchange board, staff and consultants regarding the options for Qualified Health Plans (QHPs) within the Exchange.

The QHP Recommendations contain a number of laudable provisions that foster access to high quality products and a streamlined process that will enable consumers to make good choices for themselves and their families. The proposed standardization of rating factors, major cost- sharing provisions, and benefit options, for example, have great significance for reaching those goals. At the same time, we also suggest modification of some Recommendations. Each of these is discussed in more detail below.

Section 5A: Active Purchaser: Number and Mix of Exchange Plans

Metal Level Tiers of all Qualified Health Plans

Consumers Union supports Option A, the staff Recommendation, to require health plan issuers to offer QHPS for *all* the metal tiers in each geographic region in which it bids. This is the only option truly consistent with SB 1602, requiring issuers to "fairly and affirmatively offer, market and sell in the Exchange at least one product within each of the five levels of coverage."

Number of Carrier QHP Product Bids

Consumers Union appreciates the balance that staff and consultants struck by limiting the number of QHP product bids per issuer to 2 or 3 per geographic area. In a state as large as California, it is important to encourage competition, but also to limit the number of products up for bid to encourage the "best value and benefit design" from each issuer. We will look to the Exchange, as an "active purchaser," to help refine the number of plans up for bid so that the actual plans that will be offered to the public on the Exchange will strive for an optimal experience for consumers.

Geographic Coverage of Health Plans

Consumers Union supports the balance struck in the Recommendation Brief regarding required geographic coverage, which recognizes and values both regional plans as well as those that cover broader geographic areas. Significantly, the proposal will allow small, community-based health plans to participate as QHPs.

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Section 5B: Rating Issues: Family Tiers, Age, Geography, Tobacco, and Wellness

Family Tiers, Age and Geography

Overall, standardization of rating factors as proposed in various ways in the Recommendation Brief is critically important. Consumer's Union applauds the Exchange's decision to implement standardization in family tiers, age and geography. The standardization of rating factors will allow consumers to compare health insurance policies on an "apples-to-apples" basis while ensuring consistency, clarity, and fairness. Additionally, standardization will significantly reduce the likelihood of risk selection, by limiting the factors by which a plan could "game" the system. Moreover, standardization of rating factors both inside and outside the Exchange is essential in order to reduce the potential for adverse risk selection in the Exchange. If the Exchange determines it lacks legal authority to require this through contract terms, we would support state legislation to allow it (if federal regulations or guidance do not otherwise require standardization of rating factors inside and outside the exchanges).

Tobacco Rating

Consumers Union opposes tobacco use as a rating factor for determining premiums. While we believe it is an important public health policy to undertake measures to encourage smoking cessation, there is no evidence that rate surcharges reduce tobacco addiction. Rather, there is strong evidence that smoking cessation can be accomplished through other public health initiatives. Evidence that exists regarding wellness programs suggests that higher premiums or cost-sharing for tobacco users can actually result in them refraining from purchasing health coverage altogether. Consumers Union supports efforts at the state level to disallow tobacco use rating factors inside and outside the Exchange.

Wellness

Our comments regarding wellness programs and incentives are articulated below (See our comments to Section 6C).

Section 5C: Plan Design Standardization

Cost-Sharing

Consumer's Union applauds the Exchange's decision to implement standardization for major cost-sharing components of benefit plans, including deductibles, co-payments and co-insurance, with limited customization. Standardization of these features is the sine qua non for consumer comparisons and levels the playing field amongst QHPs, thus alleviating the potential for adverse selection.

Consumers need considerable assistance navigating their health insurance choices. The information provided to consumers must be meaningful, timely, and relevant to their situation. When cost-sharing variations are limited to a small number of designs, consumers can more reliably gauge their out-of-pocket cost exposure and better compare plans as well. Cost-sharing

standardization will allow comparability across plans, which will make the available data both meaningful and useful to consumers and purchasers. Standardization is critical for consumer understanding, choice, and ease in obtaining coverage.

Standardization of cost-sharing must occur both inside and outside the Exchange in order to reduce the potential for adverse risk selection in the Exchange. Again, if the Exchange determines that it lacks legal authority to require this through contract terms, we would support state legislation to allow it (if federal regulations or guidance do not otherwise require standardization of cost-sharing provisions).

In addition to cost-sharing standardization, we recommend that the Exchange require use of consistent, industry-wide definitions for common policy terms like "deductible," "out-of-pocket limit," and "hospitalization" to make information about health insurance plans understandable to consumers, allowing them to readily rank their choices.

We urge that any customization allowed for variations in cost-sharing be exercised with caution. We appreciate the goal of encouraging carrier innovations, but want to ensure that customization in areas such as value-based purchasing programs are judged through a consumer-centric lens, guaranteeing that the Exchange permits cost-sharing variations only when they benefit, rather than penalize, consumers. We urge the Exchange to set standards for "value-based" designs that are based on peer-reviewed evidence, are founded in research and outcomes data, and are analyzed independently to identify benefits and drawbacks of such innovations. Where there is lack of data, the Exchange needs to help drive research and policy to fill in gaps and help make the case that a plan design is grounded in evidence, prior to allowing customization. Further, variations permitted by the Exchange should be subject to periodic review of the literature and results in California to determine whether continued approval is warranted.

Benefit Design

As with cost-sharing, Consumers Union supports standardized benefit design for many of the same reasons articulated in the cost-sharing section. Not only will standardization facilitate consumer engagement and informed choice, but it will also reduce beneficiary confusion, marketing abuses, and consumer complaints. Standardizing the plan designs will pave the way for other consumer protections, such as standardized plan disclosure forms, that will in turn, create a more competitive marketplace in the Exchange.

When allowing limited customization, the Exchange should guard against variations in benefit design that actually allow for risk selection. The Exchange may need to provide greater scrutiny of customized benefit design options to ensure they are evidence-based, are not designed to attract healthier individuals, do not result in discouraging consumers to enroll based on health status, and remain justified by developing research and experience.

Standardization of benefit designs will be important both inside and outside the Exchange in order to reduce the potential for risk selection in the Exchange. Consumers Union would support state legislation to effectuate standardization between Exchange and non-Exchange

products for plans that do not offer Exchange products in order to avoid adverse selection in the Exchange.

Drug Formularies

Consumers Union supports the Recommendation that calls for at least two drugs/class or category. It is our understanding that the benchmark plan currently contemplated in proposed legislation would meet that formulary standard and, therefore, the Board recommendation would not trigger a state-mandated benefit requiring general funds.

Value-based Benefit Design

We applaud the Recommendation requiring standardization on cost-sharing, which would allow only value-based incentive structures that will lower patient out-of-pocket costs or provide financial rewards. We support efforts aimed at lowering patient costs, promoting healthy behavior and promoting access to high value services.

The Exchange should be cautious about what kinds of programs it approves that will meet the stated value-based design goals. We do not want to see insurers pushing for cost-containment for certain services deemed overused or inappropriately used (such as cardiac bypass surgery or hysterectomies) which may, however, be medically necessary for a particular patient. In order to have a meaningful program promoting value-based design, the Exchange should scrutinize all proposals and undertake rigorous oversight of approved programs to be sure that QHPs do not intentionally or indirectly limit access to "low value" services that are medically necessary.

We are also concerned with value-based measures that have been effective for cost-containment and consumer choice in some health care arenas being applied in other contexts that end up burdening consumers. For example, reference pricing has been successful in the context of pharmacy payments, but may be detrimental in the context of provider payments, where freedom of choice for consumers is more constrained. Patients have less real choice based on reference pricing in situations where pricing alone does not control important decisions about health care services. Continuity of care (being able to see your regular provider), proximity of a specific provider, and emergent health needs may limit the ability for a consumer to make a choice based on reference pricing and may restrict the consumers' ability to avoid balance billing that can be imposed through reference pricing.

As with any wellness programs, we would expect the Exchange to develop strong criteria required for a value-based design program, rigorous data collection, and strict oversight and accountability measures to ensure any program approved actually is effective at lowering costs and improving quality.

Minimum Out-of-Network Benefits

Consumers Union supports the concept of setting minimum standards for out-of-network benefits and terms. This is an area that currently bedevils PPO consumers who find themselves subject to very large costs through "balance billing," even when they had no choice but to

receive care out-of-network (for example through emergency room services or through an anesthesiologist not under contract with their plan when the surgeon and hospital are in-network). We suggest setting forth a "reasonable person standard" for use of out-of-network emergency care, with a ban on balance billing when a reasonable person would have sought the emergency room services.

Section 5D: Premium Subsidies and Cost Sharing Reductions

Consumers Union is concerned about the Recommendation to limit QHP choice to the bronze and silver levels for people whose income is between 100 and 250% of the federal poverty level. We do not find legal authority in the ACA to limit choice of QHPs for only low-income individuals. While the cost-sharing provision of the ACA limits a person's ability to obtain cost-sharing reductions by requiring her/him to enroll in a silver plan, the only limitation on QHP choice that the ACA permits is on enrolling in a catastrophic plan, which applies equally to individuals from all income levels. (See Section §1312(d)(3)(C).)

While we understand the tension too much choice can provide, we urge the Exchange to provide the same choice to low-income individuals as others in the Exchange. Regardless of income, each individual will need clear and accurate information from the Exchange to help them decide the best plan based on many personal circumstances, including but not limited to income. The Exchange will need to create a system, by using online tools and/or Assisters, to help people understand the implications of their choices. For individuals between 100 and 200% of the FPL, clear communication about the risk of choosing a plan that is not silver will be vital. (For example, the CalHEERS user interface could be structured so that when an applicant's income is 100-200% FPL, the website provides a pop up or other notification that warns the applicant of the valuable cost-sharing reductions associated with a silver plan that are not available in other tiers.)

If the proposal as currently recommended moves forward, at a minimum, the Exchange should ensure the same terms and provider network for the metal tiers. In that way, consumers with incomes between 100 and 200% of the federal poverty level would be assured that their choice of provider and thus continuity of care would not be constricted in bronze or silver plans. Cost-sharing terms would be the sole differentiating characteristic. Consumers Union would further urge the Exchange to limit the proposal to those people whose income is between 100 and 200% of the federal poverty level, rather than up to 250% since the cost-sharing reductions are less meaningful (73% AV) and may make a gold plan beneficial in some individual situations. Moreover, we would recommend that if the Exchange limits choice for low-income people, it narrow the limitation to those between 100 to 200% of FPL who opt-in to insurance affordability programs, rather than limit the choice of the entire class of low-income people to those who may not even exercise their cost-sharing reductions.

Section 5E: Provider Network Access: Adequacy Standards

While we understand the desire of the Exchange to rely on the current regulatory framework for network adequacy, for all consumers with Exchange products to have comparable access to providers no matter which regulator licenses their issuer we suggest that the Exchange ensure

that both regulators use the highest standards for network adequacy, leveling the playing field amongst all QHPs. CDI does have geographic accessibility standards for contracting providers, but DMHC licensed plans are subject to both geographic and time-elapsed standards for access to services and providers. (See, *Ready for Reform? Health Insurance Regulation in California Under the ACA*, California HealthCare Foundation (2012), Table 4, pp. 24-25, for examples of the many differences between CDI and DMHC regulatory provisions.)

ACA implementation may raise the stakes on network adequacy. For example, the essential health benefits requirements will create new demands in the provider community, especially with substance abuse and mental health services that have not traditionally been accessible to low-income and medically underserved communities. California's current regulatory framework may not meet the federal requirements that network adequacy ensure "a sufficient number and type of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be available without unreasonable delay." The Exchange should play an active role in defining and monitoring network adequacy to ensure that these standards are met and that all plans are measured and judged by a uniform set of standards.

Consumers Union, therefore, urges the Exchange to establish minimum uniform standards that meaningfully reflect geographic and time-elapsed standards as in the DMHC statute (Health &Safety Code 1367.03) and regulations, as well as sufficient access to primary care providers accepting new patients, and appropriately qualified specialty and tertiary care providers to offer medically necessary care (Health & Safety Code 1367).

Network adequacy measures should be publicly reported to consumers, particularly in light of the trend of health plans developing tighter networks that may have significant adverse effects on consumers' choice and access to care, particularly those with multiple chronic conditions. QHPs should be required to provide "real time" information on providers in their networks, identifying which providers are accepting new patients, and comparative quality information both directly to consumers and to the Exchange for public directories.

The Exchange also should gather data to substantiate network adequacy and publicly report the data to consumers - not to duplicate the regulators' monitoring, but to make that data easily accessible to the public in one place, rather than dependent upon consumers knowing which regulator would have it and having to access it through the relevant regulator's web site.

For issuers that are not Knox-Keene licensed, the Exchange also should ensure, via contract terms, that the issuer provides consumers the same 24/7 ability to make a complaint about problems with the issuer, including regarding access to providers, and an opportunity to have complaints resolved within 72 hours if urgent, per 28 CRR Article 8.

<u>Section 5F: Provider Network Access: Essential Community Providers</u>

Definition of Essential Community Providers

The Exchange definition of "essential community providers" is extremely broad and will not achieve the policy goal contemplated by the ACA in creating this class of providers: ensuring that low-income populations can continue to receive care from their traditional, pre-ACA safety net

providers. The federal statute defines "essential community providers" as those serving low-income and medically underserved populations. The ACA and regulations thereunder evince the intent to ensure availability of experienced providers familiar with addressing the needs of uninsured, low-income, and medically underserved populations.

In California, community clinics and county hospitals are the primary providers of care for the uninsured, as well as major providers of care for Medi-Cal beneficiaries. The Exchange's proposed definition linking eligibility as an essential community provider to Medicaid is misplaced in that it does not include providers such as clinics that serve the uninsured, but that do not meet the Medicaid thresholds. Essential community providers should include providers that care for uninsured people, so that when these newly eligible individuals come to the Exchange for coverage, they will be able to continue seeing their usual health care providers.

The Public Health Services Act program, section 340B, illustrates the type of provider intended to be "essential community providers." The 340B program provides heavily discounted drugs to qualified programs and their enrollees, to stretch the program budgets and enable them to undertake program improvements to serve vulnerable populations. The list of entities eligible for the 340B Drug Pricing Program is fairly limited and meant to support those providers who care for low-income and medically underserved populations.

The Exchange's proposed definition is too broad in that the ACA did not intend to include all Medicaid providers as "essential community providers." The definition of essential community providers in the ACA, referencing the Public Health Services Act 340B and Social Security Act 1927 programs is not exhaustive, but illustrative of providers that serve otherwise disenfranchised populations.

We support the Exchange defining "essential community providers" specific to the unique provider population in California. Rather than rely on the underutilized 340B program or a standard that judges by participation in Medi-Cal, we suggest that the Exchange establish criteria for providers to show that they are safety net providers and that they have the knowledge, sensitivity and experience to ably serve uninsured, low-income and medically underserved populations. The Exchange should focus its definition so that California "essential community providers" are those hospitals, clinics and providers that deliver health care services to individuals who experience cultural, linguistic, geographic, financial, or other barriers to accessing care, such as public hospitals, federally qualified health centers, Indian health clinics, and/or community clinics and health centers. The Exchange should have evidence that the primary mission of the provider is to serve disenfranchised or underserved populations.

"Sufficient Number" of Essential Community Provider

In addition to putting together meaningful criteria to define "essential community provider," the Exchange should ensure that the standards for a sufficient number of essential community providers are more robust than proposed. Consumers Union recommends that the Exchange work with safety net provider organizations in California that serve uninsured people for non-emergency care to develop a standard for "sufficient number" that assures uninsured, low-

income, and medically underserved individuals continue to have access to their provider networks when they obtain coverage through the Exchange.

Section 6A: Strategies to Promote Better Quality and More Affordable Care

Health system costs are unsustainable and our health care quality needs serious improvement. Sharp variations in quality of care and costs are invisible to consumers and many purchasers, even with superior buying power. Some compare our health care system to going into a restaurant to purchase a meal with the menu that does not state the prices or reveal its Board of Health inspection findings. The Exchange is well positioned to improve transparency of cost and quality information in our health care system and Consumers Union strongly supports that goal.

Some other steps aimed at reducing costs and improving quality are not fully tested and proven. The research shows mixed results, for example, on "pay-for-performance", the practice of paying providers more for meeting certain standards and/or less if they do not. Given the Exchange's primary need to get "up and running" and maximize enrollment, and the fact that many of the steps aimed at promoting better quality and lower costs are not fully proven, it makes sense for the Exchange to phase in some steps for quality improvement and cost reduction. Consumers Union suggests that, rather than institute across the board health delivery reform measures, the Exchange should start by relying most heavily at the outset on transparency measures that will be a significant benefit to systemic reform, to consumers, and to the Exchange as an active purchaser and negotiator for better quality and lower cost.

We suggest that QHP contracts require issuers to collect, provide to the Exchange, and make public quality outcome, cost and efficiency data regarding their contracting providers and provider networks. In addition, to make public disclosure of this information a reality, QHP standards will need to prohibit "gag clauses" in their QHP and non-QHP provider contracts that prevent plans from publicly disclosing provider cost or quality data.

In addition, encouraging the "meaningful use" of health information technology and exchange can promote improved safety and efficiency. Thus, we suggest the following QHP contract terms:

- Require contracted providers to use certified electronic health records;
- Require contracted providers to make meaningful use of electronic health information exchange and certified electronic health records by meeting, at a minimum, Stage 1, Stage 2, and Stage 3 criteria for meaningful use, within the respective established timelines;
- Incorporate electronic exchange in required formats for submissions to the Exchange; and
- Incorporate electronic health information exchange in their interactions with providers and with patients.

To promote patient safety improvements and high quality care, the Exchange's QHP standards should require carriers to contract only with hospitals/providers that participate fully in such

patient safety checklist programs as the Pronovost, Institute for Healthcare Improvement, and/or WHO's Surgical Infection Prevention checklists (including posting check lists in every ICU and general medical ward). Similar checklists should be required for contracted Ambulatory Surgery Centers. Additionally, the Exchange should be sure that any reporting required of QHPs, should require that health plans report on patient safety outcomes, including adverse events.
For example, each plan should provide enrollees with information, in a consumer friendly manner and in languages other than English, about hospital-acquired illness data for each of the hospitals in their network and medical errors (mandated to be reported to California Department of Public Health, but not yet available readily to the public).

eValue8

Consumers Union understands the desire of the Exchange to adopt a simple and meaningful tool to meet plan reporting requirements. However, adopting wholesale an already existing tool before the Exchange begins business is not necessarily the best approach. We appreciate the introduction of eValue8 as one possible tool, and it is certainly appears to be a comprehensive product. There are aspects of some of its modules that raise concerns, including reporting on activities that may violate patient privacy (e.g., section 5.3.6 Health Assessment results/participation communicated to employers). Thus, at this time, Consumers Union would recommend that the Exchange adopt only specific, limited portions of eValue8 and take more time to assess the rest of the tool to ensure that the reporting requirements are consistent with the mission, value and goals of the Exchange and the consumers who will be benefiting from health care coverage.

Consumers Union supports the Exchange adopting Module 1 of eValue8, which focuses on the Plan Profile. Of utmost importance within the Module is the Recommendation to use Section 1.7 "Racial, Cultural and Language Competency" to evaluate QHP bidders. A majority of the California population eligible for Exchange coverage will be people of color, with close to half of the adults unable to speak English very well. Module 1.7 of eValue8 will help ensure that the data the Exchange collects on cultural competency is comprehensive and will allow the Exchange to advance its mission of promoting health equity while ensuring that consumers are able to make informed choices during the health plan selection process.

Requiring plans to collect and report on key data elements and ethnic, race and language access is already required in California. Adoption of the eValue8 Module 1.7 will provide the Exchange with a uniform set of data for all QHPs and ensure the Exchange and QHPs are effectively using the data to improve cultural competency and reduce disparities in health care. Moreover, the Module will provide the Exchange with important baseline data on cultural competency and disparities reduction that can be used as a powerful catalyst for delivery reform moving forward.

<u>Section 6C: Promoting Wellness and Prevention</u>

We appreciate the Exchange Board staff's effort to review the legal framework for wellness programs under the ACA. Like the Exchange Board staff, it is our understanding that wellness programs under the ACA can only move forward in the context of employer-based coverage. The ACA did establish a mechanism for setting up demonstration projects in 10 states that could

be used in the individual market, but California is not currently one of those states. With the ACA limitation restricting wellness programs to employer-based coverage and/or the 10 state demonstration project, our comments below focus on wellness programs offered by employers through the SHOP, rather than through the individual Exchange.

Standards for SHOP Wellness Programs

We appreciate the concept that the Exchange will set standards for any wellness program promoted in the SHOP and that any program offered through SHOP employers must reduce the costs to consumers or provide financial rewards to consumers. We encourage the Exchange to set standards defining the risk factors or goals that employers may target, to ensure that programs are reasonably designed to promote health or prevent disease. Under the ACA, wellness programs cannot be overly burdensome or be a "subterfuge for discriminating based on a health status factor" or "highly suspect in the method chosen to promote health or prevent disease."

For the most part, these programs are not proven and, in addition, Californians don't begin from the same starting line when it comes to health, for reasons ranging from genetics to important environmental influences that may be beyond an individual's control. So, we would not want to see the outcome be the requirement. Thus, we applaud the Exchange's position that standards and metrics should not be based on outcomes, e.g. whether someone loses weight, but rather on the act of participation.

In effect, the Exchange must be sure that they do not allow wellness programs that create a loophole to medical underwriting by allowing employers to charge employees more for their health insurance based on a health status factor – such as obesity, hypertension, diabetes, or high cholesterol. While this overt rate setting based on medical condition is prohibited under the ACA, it will be up to the California Exchange to ensure that programs that look acceptable on paper do not violate the nondiscrimination rules in practice.

For example, some health risk assessments are lengthy and invasive, both for the individuals and their families. Under some versions of health risk assessment incentive programs, failure to complete the assessment can result in higher premiums, even in participation-only programs. While these assessments may have value for some consumers, we are concerned that even "participation only" programs can be a means to backdoor medical underwriting, alerting employers and issuers to consumers' medical risk factors. Consumers Union thus urges the Exchange to bar plans from sharing completed health risk assessments with employers and to allow risk assessments, if at all, only after enrollment in a plan.

Also, overall affordability becomes a critical issue when the cost of providing incentives to one group of employees is financed by raising the base cost of policies for others – harming in particular those who fail to qualify or are unable to take advantage of the wellness program. In effect, employer-based workplace wellness programs may force low- and middle- income individuals to spend a higher percentage of their income on premiums or cost-sharing if they are unable to participate in the wellness programs. This can be a significant problem for low-income individuals who may have more than one job – manage work and family – or have limited access

to healthy food. These are the individuals that need coverage the most to help them address risk factors for chronic disease and other health risks.

There is limited independently evaluated research that shows that varying health insurance premiums or deductibles has an impact on health outcomes. There is no evidence that large incentives will increase employee participation in a health assessment activity, or have a further beneficial effect on their behavior or health. However, there is abundant research indicating that patients are less able to manage chronic conditions such as hypertension or diabetes when their costs related to insurance coverage – co-payments and deductible - are too high. Savings from wellness programs should be the result of improved employee health and not merely cost-shifting or measures to divert employees to alternative coverage.

We commend employers (and unions) who have worked to improve the health of their employees through comprehensive worksite wellness programs. At the February 2012 Exchange Board meeting, the presentation by Elizabeth Gilbertson of Unite Health Here was inspiring, providing detailed evidence of the decreased costs and improved health outcomes that were achieved through support of individual union members, not based on financial incentives, but through better health care management efforts. If the Exchange moves forward to establish standards for wellness programs in the SHOP, we would encourage you to provide guidance that is evidence-based and founded in best practices such as those undertaken by Unite Here Health.

The ideal situation would be for the Exchange to gather data from health plans to understand what programs QHPs are undertaking for wellness promotion in employer-based coverage. In addition to standards, the Exchange should include a commitment to rigorous review and oversight of wellness programs already identified by plans, so as ensure that QHPs are not using Wellness programs that cost shift to consumers or that are not successful.

Section 7E: Health Plan Partnerships to Promote Enrollment

We agree that there is value in having a broad network of partners for outreach to ensure the largest number of individuals is enrolled in health coverage they are eligible for, whether that is a public program or commercial plan. As stated in the Board Recommendations, crafting a set of strategies and standards specifically to address the issues unique to health plan collaboration is warranted.

Marketing Materials

We support the recommended first step of requiring issuers to share with the Exchange their marketing budgets committed to Exchange enrollment. Seeing the marketing budget for non-Exchange products as well would give the Exchange a basis for comparing the commitments. Contractual terms as well would provide better leverage. Consumers Union suggests requiring QHPs to provide the Exchange with copies of their marketing materials for the Exchange; to coordinate messaging with the Exchange for creditable marketing; to use the Exchange name and logo in creditable marketing; and to direct people to the Exchange for eligibility and enrollments "unqualified leads" (without a pre-determined preference for plan choice). Extra

weighting for QHP applicants with a strong commitment to fair, unbiased marketing for the Exchange would be appropriate, though defining assurances that it is unbiased will be critical.

Marketing Oversight

A caution about plan collaborations to promote enrollment is in order: the limited ability of state regulators to monitor issuers' materials and practices, even under their respective pre-ACA statutes. DMHC is charged with prior approval authority of marketing materials, but the law allows for exceptions. Limited staffing means that DMHC does not engage in routine monitoring for deceptive advertising, but rather is solely complaint-driven. CDI engages in market conduct studies and can prosecute fraudulent advertising of insurance, but health insurers are a very small percentage of the Department's licensees and historically have not gotten much of the enforcement attention. Furthermore, with the ACA we are entering a world in which a range of new misrepresentations are possible about requirements of the new federal and state implementing laws. The Exchange will need a system for monitoring the content of all the marketing methods bulleted on p. 252 of the July 16, 2012 Recommendation Brief. Consumers Union urges the Exchange to enter into Memoranda of Understanding with the relevant regulators and other agencies, such as the Attorney General's Office or County District Attorneys, that could perform monitoring and enforcement functions.

Enrollment partnerships

Federal regulations specifically bar plans from doing the Exchange eligibility determinations (section 156.265), so it will be very important that issuers refer consumer applicants to the Exchange for subsidy determinations. The federal limitation is meant to ensure protection of privacy of consumers' financial information needed for tax credit and other subsidy determinations <u>and</u> to ensure that QHPs do not engage in adverse selection. The Recommendation Brief states that the Exchange may chose to allow plans to access the Exchange's online enrollment system to view a member's information and walk them through the enrollment process (p. 255). Consumers Union believes this is contrary to the privacy requirements under the federal regulations and recommends that this option be taken off the table.

Even for conversions of existing insureds to continue coverage, perhaps with subsidies, the "unqualified lead" approach may still be best since there may be a cheaper plan with the same provider in its network and the current plan would have to provide the consumer with a way to get a subsidy determination (i.e. the Exchange web site and Service Center phone number), which the plan itself could not do pursuant to federal regulations. It is unrealistic to expect issuers to do "fair and balanced" enrollment when their duty is to their shareholders (for- profits) and the goal of increasing market share. Because federal rules circumscribe what issuers may do, Consumers Union urges the Exchange to require issuers simply to send applicants to the Exchange for processing as "unqualified leads." We do not see how consumers can get all choices without bias or influence if one plan is providing the information. Even if all are listed in writing. it defies human nature and business practice to assume that a plan employee would make a neutral presentation on its competitors.

We also note that vis á vis the website architecture, the manner of display and default option ordering is very persuasive in leading consumers in one direction or another. Consumer behavior research shows consumers are very influenced by their default set of choices. If the best choice for them is not in the initial display of plans, they may not take the time and trouble to find it. (See this recent report by Consumers Union exploring how six health plan chooser tools use "choice architecture" to array choices for consumers, "Choice Architecture: Design Decisions that Affect Consumers' Health Plan Choices" (July 2012), accessed at http://www.consumersunion.org/pdf/Choice_Architecture_Report.pdf.) Plan websites will naturally favor their own products, even if they mention others. Thus, a simple requirement that new or renewal/conversion inquiries be referred directly to the Exchange is the most likely to lead to full and fair information for consumers and would require little monitoring by the Exchange.

However, if the Board does not accept the "unqualified lead" option we are suggesting, we support the Exchange using the steps mentioned in the Recommendation Brief: (1) requiring scripting of plans with members to mention all options and the availability of assistance through the exchange call center; and (2) performing enrollment process audits by secret shoppers of plans' service call centers. But again, the "unqualified lead" model would eliminate or at least minimize the need for cumbersome oversight of scripting and intensive auditing of plan call centers.

Ensuring Free Enrollment Assistance

In addition, entities other than health plans and Assisters, may seek to perform a role in outreach or enrollment assistance. Some entities, not trained or certified by the Exchange we understand may be contemplating performing this function and charging people to help them get coverage. We urge the Exchange to ascertain its legal authority over such entities and, if found lacking, to enter into Memoranda of Understanding with the relevant agencies, such as the Attorney General's Office or Department of Consumer Affairs, that could perform monitoring and enforcement functions. Charging consumer fees for enrolling or determining eligibility for advanceable tax credits or cost-sharing subsidies should not be permitted, since those services will be available for free through the Exchange or Assisters. We urge the Exchange to prohibit such charges and, in addition, contractually prohibit QHPS from entering into agreements, formal or informal, with entities that charge for enrollment or subsidy determination assistance.

<u>Other</u>

Single Risk Pool

In order to achieve the single risk pool requirement of the ACA, the standards for QHPs should prohibit insurers from using affiliates or other corporate structures that are intended to segregate, or have the effect of segregating, risk pools. The ACA requires an "issuer" to operate a single risk pool (one for the individual market, and one for small groups) in each state in which it operates, containing all its non-grandfathered enrollees, both inside and outside the Exchange. This is crucial for spreading risk since some insurers currently segregate healthy and

sicker people into separate pools, resulting in large premium increases for people in higher risk pools the cost of which is not moderated by healthier people. The Exchange's QHP standards can and should prevent issuers from circumventing this rule. For example, such standards could bar QHPs from using one affiliate to offer plans outside the Exchange and a separate affiliate to offer plans inside, or using one affiliate to offer plans inside and one to offer the same plans outside at lower prices to circumvent the "same plan, same price" rule.

Preventing adverse selection and promoting parity inside and outside the Exchange

Particularly at the outset as the marketplace is adjusting to reform, it will be important for the Exchange to promote practices that will disincentivize issuers and agents from steering consumers to products outside the Exchange. The following recommended contract provisions address current market practices and would help avert steering to products outside the Exchange:

- Pay equal agent/broker commissions for the sale of products inside and outside the Exchange;
- Prohibit preferential direct or indirect consideration to brokers/agents for products both inside and outside the Exchange based upon health status, age, or products with differing benefits;
- Prohibit higher commissions, or other direct or indirect broker/agent consideration, for products inside or outside the Exchange, in the first year of a policy versus renewal years;
- Prohibit volume bonuses to agents/brokers for enrolling a certain number of new lives each year in one or more particular products; and
- Prohibit "fee waivers" for establishing websites, providing e-mail lists, offering preprinted promotional fliers, etc. for those agents/brokers who are deemed "high-producing."

In addition, it would benefit consumers to understand the fee arrangements agents have with their issuer. To that end, we suggest a contract provision requiring that QHPs disclose all fee and payment arrangements with brokers and agents on QHP and non-QHP products, which the Exchange should display in a manner that is readily available to consumers, including on the Exchange website.

Privacy and security protection for consumers

Many aspects of plan operation raise privacy and security issues for consumers. To comply with federal and state law and ensure ongoing trust in Exchange operations, QHP contracts should, for example:

- Prohibit re-identification of any disclosed de-identified data in binding contracts and all policies with sub-contractors, vendors, and providers;
- Incorporate the federal prohibition regarding use and disclosure of Exchange information for non-Exchange purposes in contracts with all other relevant parties.

Other CalHEERS data limitation policies enacted to implement this principle must also be included in the contract;

- Abide by secure electronic health information exchange in each of the plan's electronic interactions with providers [e.g. claims and claims data, case/care management, etc.]; and
- Require contracted providers (and labs, pharmacies etc., if any) to incorporate secure electronic health information exchange throughout their interactions with other providers, patients, pharmacies, laboratories, etc.

Further Protections Against Misrepresentation

As noted above under Section 7E, the state regulators' capacity for monitoring issuers' materials and practices, even under their respective pre-ACA statutes, is quite limited. Furthermore, with the ACA we are entering a new world in which a range of new misrepresentations are possible about **requirements of the new federal and state implementing laws**. The Exchange will need a system for ensuring issuers, agents and others accurately characterize the requirements under the ACA and new state implementing laws. In addition to the protections noted above, Consumers Union urges the Exchange to require QHPs and their agents/brokers to fairly and accurately represent the requirements thereunder and to enter into Memoranda of Understanding with the relevant regulators and other agencies, such as the Attorney General's Office or County District Attorneys, that could perform monitoring, enforcement, and information sharing functions in coordination with the Exchange.

Sincerely,

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