STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
EXECUTIVE OFFICE
300 CAPITOL MALL, SUITE 1700
SACRAMENTO, CA 95814
(916) 492-3500
www.insurance.ca.gov

Dave Jones, *Insurance Commissioner*

August 10, 2012

Peter Lee
Executive Director
California Health Benefit Exchange
2535 Capitol Oaks Drive, Suite 120
Sacramento, CA 95833

Dear Mr. Lee:

The California Department of Insurance (CDI) welcomes the opportunity, as a part of its ongoing collaborative relationship with the California Health Benefit Exchange (Exchange), to offer comments in response to the July 16, 2012 "Discussion Draft", "Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability".

The Exchange Board has a number of significant decisions regarding its Selection of QHPs before it. Your staff has looked at a wide range of issues that will impact California's health insurance marketplace. We share a focus on many of the core principles espoused in the document including the importance of focusing on affordability for consumers, ensuring that consumers are able to make informed choices when choosing their health insurance coverage, ensuring consistency inside and outside the Exchange to prevent adverse selection and ensuring that consumers have access to quality health care in a timely manner. Below is initial feedback about a few of the issues raised in the "Discussion Draft" and we will continue to communicate with you about these and other issues raised in the document.

Section 5A: Active Purchaser: Number and Mix of Exchange Plans
Issue 2: Number of Carrier Qualified Health Plan Product Bids

CDI strongly supports allowing multiple or unlimited Qualified Health Plan (QHP) submissions for each health plan or insurer in order to maximize the Exchange's opportunities to selectively contract based on the combination of choice, value, quality, service and affordability. CDI is very concerned that the discussion draft recommendation to limit the number of issuer bids is contrary to the State of California and the Exchange's goal of providing consumer choice and a vibrant, competitive marketplace (discussion draft, p. 45). Rather than restricting the number of bids provided by insurers, the Exchange could later, through its bid evaluation process, limit the number of QHPs offered in the marketplace. The latter approach will ensure that the Exchange will have a wide range of bids to choose from, while at the same time addressing concerns regarding consumer option overload. The Exchange, not the carriers, should decide which bids are attractive. Permitting the Exchange to have a wealth of available bid choices will provide the highest quality and most comprehensive plan options from which to build a menu for consumer choice.

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

Age bands should be standardized, but age factors should not

CDI agrees that standardization of age bands is necessary and desirable for leveling the playing field in the Exchange, facilitating and improving insurer competition and consumer comparison, and reducing buyer confusion. However, standardizing age factors would be problematic and could be counterproductive because it would unnecessarily limit competition in the Exchange. Furthermore, it requires significant data and expertise—resources which the Exchange may not have—to develop effective standards.

Standardized age bands subdivide the age structure of the population into tiers, such as 0-19 year, 20-39, 40-54, and 55+. Such age banding already exists by statute in the small group market (see, e.g., Insurance Code § 10700(v)(1)). Age factors, in contrast, are quite different. Age factors are the multipliers used against a base premium rate to determine the premium for a given age band. For example, a 20-39 age band might have an age factor of 1.0, while the 40-54 age band might have an age factor of 1.5 (such that premiums would be 1.5 time the 20-39 age band), and a 55+ age band might have an age factor of 3.0 (such that premiums would be 3 times larger than the age band with the 1.0 factor).

Standardizing age factors requires significant resources, would be logistically difficult to implement properly and successfully, and could adversely impact the health insurance market. Age factors must be reflective of an insurer's true cost in order to be viable and actuarially sound. Insurers set age factors based on various criteria, which, at a minimum, typically include the insurer's experience as well as legislative, regulatory and market changes. Thus, setting an effective age factor for an insurer requires access to a significant amount and variety of data, as well as the expertise to properly analyze that data to determine actuarially sound age factors. Setting actuarially sound age factors for *all* QHP issuers (or, as the Exchange's discussion draft alternatively recommends, for the broader market) would require even greater data and expertise, and ultimately may not be feasible given the amount of variation in each insurer's experience and true costs. If the chosen age factor standards are not actuarially sound for every QHP issuer, this could adversely impact the market. Imposing rigid, uniform age factors could artificially decrease premiums for plans whose experience and costs would normally necessitate a higher age factor, thereby jeopardizing those plans' long-term viability in the market. Similarly, imposing rigid age factors could artificially *increase* premiums for plans that could have offered a lower age factor because their true costs are lower.

Furthermore, even if state regulators succeed in developing an effective age factor standard that is actuarially sound for all QHP issuers (or the entire market), the standard would need to be reevaluated periodically in response to changes in insurers' experience, legislative and regulatory requirements, and market climate. Doing so would require the regulators to devote significant resources not just at the outset, but on an ongoing basis, to ensure the age factors remain actuarially sound and are reflective of plans' true costs. Given the vast scale of the task, the limited state resources, and the lack of expertise, the Exchange and state regulators may not be

able to review the age factors every time there is change in the relevant market factors. Accordingly, the standard may not be nimble or flexible enough to be responsive to changes in the market; as a result, the actuarial soundness of the QHPs could be jeopardized. Individual issuers are better equipped and situated than the Exchange to evaluate and revise their age factors as market conditions necessitate.

Additionally, standardizing age factors could in fact limit insurers' abilities to compete on rates. Insurers could not compete with one another by setting the lowest actuarially sound age factors based on their experience and other criteria. As a result, standardizing age factors would reduce insurers' incentives to lower their true costs, and could result in consumers paying artificially higher premiums for plans with lower costs.

As the Exchange's discussion draft noted, standardizing age factors would also place QHPs at a competitive disadvantage compared to non-QHPs. While this issue could be addressed if age factors were standardized across the entire market, the likelihood of such being enacted is questionable, especially given the resource issues noted above. Furthermore, the Exchange may not have enough leverage to get QHP issuers to agree to use the Exchange's age factor standards in their non-QHP products. Also, even if the Exchange were to succeed, there would still be many issuers in the state market who will not participate in the Exchange. Thus, QHP issuers would still have a competitive disadvantage compared to issuers that do not participate in the Exchange. This could lessen willingness of issuers to participate in the Exchange.

Significantly, allowing age factor variation is not likely to confuse consumers. Consumers primarily focus on premiums and benefits when comparing plans. Standardization of age bands already levels the playing field and allows insurers to compete on their true costs, which in turn adequately facilitates consumer comparison of plans through premium comparison while ensuring that consumers do not pay higher premiums for QHPs than for non-QHPs. If QHP issuers were allowed to continue setting their own age factors, any variation would be adequately reflected in the cost of premiums. Thus, standardizing age factors would result in little benefit to consumers.
Given these potential costs and adverse impacts, and the relatively small benefits for consumers, CDI urges the Exchange to not standardize age rating factors. This alternative is reflected in Issue 2, Option A on pages 4 and 62 of the discussion brief.

<u>Family tier structures should be standardized, but not family tier ratios/factors</u>

As with age bands and factors, there is a significant difference between family tier structures and family tier ratios or factors. Family tier structures divide the insureds into groupings such as purchaser only, purchaser + spouse, purchaser + children, or purchaser + spouse + children. Such tier structures are already standardized in the small group market (see, e.g., Insurance Code § 10700(v)(2)). In contrast, family tier ratios or factors involve the multiplier used to adjust each tier against a base premium. For example, a single insured might have a tier factor of 1.0, a purchaser + spouse might have a tier factor of 2.1, and a purchaser + children might have a tier

factor of 2.5 (such that their premium would be 2.5 larger than the premium for a single purchaser).

Standardizing family tier ratios/factors present the same obstacles as discussed above for standardization of age factors, including inadequate data and difficulty in developing factors that would place some products at a competitive disadvantage, in peril of becoming actuarially unsound. These obstacles would impair flexibility and competition, without providing meaning simplification or benefit for consumers. Because standardizing family tier ratios or factors would have substantial adverse consequences, CDI urges the Exchange to not standardize family tier ratios/factors. This alternative is reflected in Issue 1, Option B on pages 4 and 61 of the discussion draft.

Issuers should cover an entire geographic region

The Affordable Care Act requires that states define standardized geographic rating areas. CDI recommends that carriers cover entire geographic regions, rather than permitting bidding for sub-regions, because opening the bidding process to piecemeal division into sub-regions invites gaming and vitiates the purpose of standardizing geographic rating areas. This recommendation is consistent with Issue 3, Option B on pages 5 and 63 of the discussion draft. The Department is aware that the State Legislature is currently considering legislation that could set the geographic regions for the carriers. Once we know what the regions will look like, we may have additional comments about this issue.

Section 5C: Plan Design Standardization

The Department unreservedly endorses the Exchange's policy guideline that the Exchange should facilitate informed consumer choices of health plan and providers. We disagree, however, with the recommendation to promote informed choices by standardizing major cost sharing components of QHPs. Standardizing cost-sharing would unnecessarily limit consumer choice, since the defined "metal levels" assure that plans in each metal level have essentially the same actuarial values. Consumers should be allowed to choose among various combinations of cost sharing provisions among plans of equivalent "value".

Furthermore, even if the Exchange decided to standardize cost sharing provisions, it is not clear that it has the capacity to do so effectively, including both setting initial standards and updating them as conditions change. The Exchange likely lacks both the data and the expertise to do so. Moreover, it is not clear that one set of standards should apply statewide, since market conditions and delivery systems vary substantially by area. Finally, it is not clear that one set of standards should apply to QHPs that use different delivery systems

The Exchange can minimize the possibility of consumer confusion, as in the Medicare Advantage and Medicare Part D examples, by (1) limiting the number of QHPs offered through the Exchange rather than limiting competition by standardizing the cost sharing; and (2) educating purchasers regarding the meaning of the cost sharing components and the actuarial value attached to each product, so that apples-to-apples comparisons can effectively be made.

Section 5D: Premium Subsidies and Cost Sharing Reductions

Full choice of metal tiers for individuals receiving subsidies

With regard to the plan choices for individuals with a family income between 100-250% of federal poverty level (FPL), the discussion draft recommended an approach which only allows such individuals to purchase plans in the bronze or silver metal tiers (p.100).

CDI is concerned that this approach is unduly restrictive. Instead of restricting individual choice of plans, the Exchange should instead educate individuals about the choices they have and why certain plans may better suit their economic needs. This would enable individuals to have free choice and give them the tools necessary to make the choice that is right for them.

Further, income levels will fluctuate. With small windows of opportunity for enrollment into QHPs, overly restrictive policies may delay individuals from enrolling in a more income-suitable plan at later date.

Finally, if an individual is prohibited from purchasing a gold or platinum plan and one of those plans makes more economic sense to that individual, it puts the Exchange in the awkward position of denying people what actually makes more financial and economic sense for those individuals. Education and choice avoid all of these potential downfalls.

Individuals above 200% of FPL should have choice of all metal tiers

If the Exchange concludes that it is necessary to prohibit individuals receiving subsidies from purchasing specific plans - a conclusion with which we disagree as discussed above - the threshold 250% of FPL recommended in the discussion draft is inappropriate. CDI understands that for individuals with incomes at or below 200% of FPL, there is little or no advantage to purchasing a plan with a metal level of gold or platinum, because their cost-sharing will be reduced such that the actuarial value of a silver plan will be at or above 87%. However, individuals with incomes between 201-250% of FPL are not in the same category: the actuarial value of a silver plan for this group will be 73%.

As individuals in this income bracket will receive a much smaller cost-sharing subsidy, these individual should not be restricted to purchasing plans only within the bronze or silver metal tiers. In fact, it may be more cost efficient for a person with major medical problems to seek a plan that is of higher actuarial value to avoid the out of pocket costs associated with plans with a lower actuarial value. Therefore, at a minimum, the Exchange should allow individuals at 201-250% of FPL to purchase plans from any metal tier.

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

CDI applauds the staff recommendations to create a more affordable and consumer friendly health insurance experience. The staff recommendations correctly note at page 134 that "The rate of increase in health care costs is not sustainable".

Accordingly, CDI urges the Exchange to use the power of the Qualified Health Plan (QHP) selection process as a means of encouraging aggressive approaches to cost containment, and to implement this approach from the start of Exchange operations.

Specifically, the Exchange QHP selection process should include explicit quantitative preferences for those QHPs that incorporate innovative and aggressive cost containment initiatives. The discussion draft's recommendation at page 146, and thereafter, that the Exchange "may encourage" such initiatives is important. The draft notes that the "Exchange's strategies and tactics to promote...affordability...will evolve over time." Given the imperative need to improve affordability through cost containment, the Exchange should drive this evolution through incorporating preferences for cost containment measures into the first QHP selection processes. Such cost containment measures include, but are not limited to, the use of Accountable Care Organizations (ACOs), alternatives to traditional fee-for-service payments, and bundled pricing for certain services, as well as other approaches mentioned in the staff recommendations. CDI is ready and willing to work with the Exchange regarding these and other cost-containment initiatives to help the Exchange "bend the cost curve". CDI recommends that such initiatives be incorporated in Exchange operations for the initial selections of QHPs to be offered through the Exchange as of January 1, 2014.

CDI recognizes that the problems of affordability and cost containment are complex. Similarly, concerns regarding network adequacy, and the cost of non-network care, implicate a multitude of considerations. CDI has worked on these problems in the past, and urges the Exchange to continue to work with the respective state regulators on these and other difficult issues. The comments provided above are but an initial discussion of approaches to these problems in the limited time afforded us to make comments; CDI looks forward to continuing to work with the Exchange to refine approaches to contain costs and increase affordability.

The Department of Insurance will continue to collaborate with the Exchange to provide affordable, quality health care coverage through a vibrant, innovative insurance market.

Sincerely,

DAVE JONES
Insurance Commissioner