California Health Benefit Exchange: Stakeholder Questions

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

The California Health Benefit Exchange welcomes your input on Qualified Health Plan policies and strategies under consideration. The policies and strategies are laid out in a Board Recommendation Brief available on the Exchange website. Please use the table below to provide your input. We welcome data and references as well as written comments. Please submit your comments to the Exchange at info@hbex.ca.gov

Name	Organization	Email	Phone
Mark Morgan	**Anthem Blue Cross**		

Topic (for categorization purposes)	Comments/Questions
5A. Active Purchaser	
Issue 3: Number of QHP Product bids per Issuer (Pg. 48-49)	Anthem believes that the best selling products on the exchange will be Bronze and Silver plans. Therefore, we ask that the exchange consider allowing carriers to design additional plans for those tiers. Anthem recommends that carriers be allowed to design 3-4 Bronze and 3-4 Silver plans to encourage innovative benefit designs and give individuals additional options for the plans that are likely to be most popular. For the Gold and Platinum plans, we recommend that carriers submit one plan design each for the individual exchange and 2 Gold plans and 1 Platinum plan for the small group exchange.
5B. Rating Issues	
Issue 4: Allowable Rate Adjustment for Tobacco Use (Pg.71-72)	Anthem would like to reinforce our support for Option B, which would allow the application of the full magnitude of the tobacco use rating factors permitted by the ACA. We believe that carriers should be allowed to set their own tobacco rating factors within the parameters of the ACA, rather than having them set by the state. We are concerned with the proposal of Option A which would prohibit the application of tobacco use rating factors; we believe this will ultimately drive up premiums for all Californians, even if state legislation ensures common rules market wide.
5C. Plan Design Standardization: (Pg. 80-105)	
Issue 1: Standardization of Cost Sharing Provisions (Pg. 89-90)	Anthem believes that standardizing cost-sharing amounts for the major components of coverage will significantly dampen issuers' ability to design innovative benefits that keep costs down and drive quality improvements for our members. If the Exchange feels strongly that some standardization is required, we urge the Exchange to allow at least two non-standard products per tier, to give issuers the flexibility to offer an HSA in addition to an innovative product. Further, we would like to confirm that the plan design template is correct. Increasing the number of office visits allowed before the deductible would indicate a richer plan. We are therefore concerned that for the Platinum, Gold and Silver levels, there are 2 PCP visits exempt from the deductible but there continues to be 4 PCP visits exempt from the deductible for the Bronze plan.
5E. Provider Network Access: Adequacy Standards (Pg. 114-127)	
Issue 2: Approaches to Evaluating Provider Network	With respect to the approaches to evaluate compliance with provider network adequacy standards, we support the staff's recommendation of Option A, which would have the appropriate regulator certify the QHP's network.

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Adequacy for QHP Certification (Pg. 119-122)	However, we are concerned that the additional language, added as discussion for Option A (on page 120), will result in the potential for state and the Exchange to provide conflicting direction, without a clear resolution for issuers. This could have the unintended consequence of increasing consumer premiums if plans are limited in their ability to gain approval of narrower networks for exchange products.
5F. Provider Network Access: Essential Community Providers Standards (Pg. 128-154)	
Issue 1. Definition of Essential Community Providers (Pg. 135-136)	Anthem originally supported the staff's recommendation to define essential community providers by incorporating the minimum standard as well as broadening the list to include others that have demonstrated service to Medi-Cal, low-income, and medically underserved populations (Option B). However, we are concerned with the additional language that was added. We believe it is now unclear whether the definition still includes "physicians, clinics and hospitals which have demonstrated service to the Medi-Cal, low-income, and medically underserved populations." If the definition still includes the providers mentioned above, Anthem would support this recommendation, but we believe this clarification should be made. If this definition does not include the providers above, we are concerned that this would create a problem because the new definition would exclude doctors who have historically seen Medi-Cal members even if they don't have any formal designation as listed in the new proposed language.
Issue 2. Definition of "sufficient" participation of Essential Community Providers" (Pg. 136-138)	Anthem originally supported the recommendation for QHPs to demonstrate sufficient participation of essential community providers by demonstrating a minimum proportion of network overlap among the QHP and Medi-Cal managed care, Healthy Families, and/or independent providers serving a high volume of Medi-Cal patients. Anthem is now concerned about the additional language that was added, requiring that providers demonstrate contracts with at least 15% of 340B entities per geographic region proposed by a QHP bidder; 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 the essential community provider network as defined above. Anthem is concerned that these requirements would have unintended consequences, if providers are unwilling to contract with issuers. Additionally, without adequate information to know how many 340B providers exist in each region, Anthem is unable to comment on whether or not 15% is an adequate target.
6C. Promoting Wellness and Prevention (Pg. 224-240)	
Issue 1: Use of a Health Risk Assessment Tool or Other Plan based Wellness Promotion Initiatives (Pg. 231-232)	Anthem originally supported the recommendation that health plans provide an optional risk assessment tool, however we are concerned about the additional language added that would measure QHP success in HRA completion. We are concerned that health plans will have little control over an individual's completion of an HRA and should thus not be penalized if members do not complete their HRA.
7. Supplemental and Pediatric Essential Health Benefits: Dental and Vision (Pg. 253-270)	
Issue 1: Offering Pediatric Dental and Vision Essential Health Benefits (Pg. 263)	Anthem agrees with the points of clarification that the Exchange offered in 7.B: Pediatric dental and vision Essential Health Benefits must be offered in both the Individual and SHOP Exchanges.

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	Clarification that the Exchange will consider bids from stand-alone dental plans to cover the pediatric oral care benefit. Pediatric EHB vision benefits must be provided by QHPs. Pediatric EHB dental benefits can be provided by either QHP **or** standalone dental plans.
Issue 2: Structuring Pediatric Dental and Vision Essential Health Benefits (Pg. 263 – 264)	Anthem is concerned by the Exchange's August 23rd recommendation to "Review bids from stand-alone dental plans and comprehensive bids from medical plans, with embedded vision coverage." Specifically, Anthem is concerned that embedded vision coverage is called out here, but not embedded dental coverage. Anthem would appreciate clarification on this issue, as the ACA allows carriers flexibility to either embed or not embed pediatric dental with the medical plan. As noted in the Exchange's QHP recommendations on 7.B above, pediatric EHB vision benefits must be provided by QHPs and pediatric EHB dental benefits can be provided by either QHP or standalone dental plans. Both medical plans that do and do not embed the pediatric dental should be allowed on the Exchange (embedded and stand-alone), as per the ACA.
Adult and Family Coverage Issue 1: Offering Supplemental Benefits in the Individual and SHOP Exchanges (Pg. 265)	Anthem is concerned by the recommendation that "supplemental" dental and vision benefits are enhanced pediatric dental and vision beyond essential health benefits and that adult dental and vision supplemental benefits will be offered only in the SHOP. Anthem believes carriers should reserve the right to offer a stand-alone dental plan on the individual exchange that covers the pediatric dental EHB and also provides non-EHB adult coverage. We believe consumers will demand this, and it also makes sense to allow families to be covered under one policy. This recommendation appears to not allow for such a plan. Anthem also believes carriers should have the flexibility to embed the non-EHB adult dental coverage with the medical on some products, as we've seen a demand for this through our market research. It is not clear from the recommendation if this would be allowed on the individual exchange either.
Issue 2: Structuring Supplemental Dental and Vision Benefit Offerings	Regarding the Exchange's recommendation to "Offer stand-alone dental and medical plans," Anthem requests clarification from the Exchange as to whether or not it will offer adult and family supplemental (non-EHB) benefits only on a stand-alone basis? Anthem believes that consumers should have ability to purchase dental coverage in a way that best meets their needs—via a stand-alone product OR an embedded product. Restricting carrier flexibility will limit consumer choice.