Qualified Health Plan Solicitation: Content, Timeline & Stakeholder Input

Andrea Rosen
California Health Benefit Exchange

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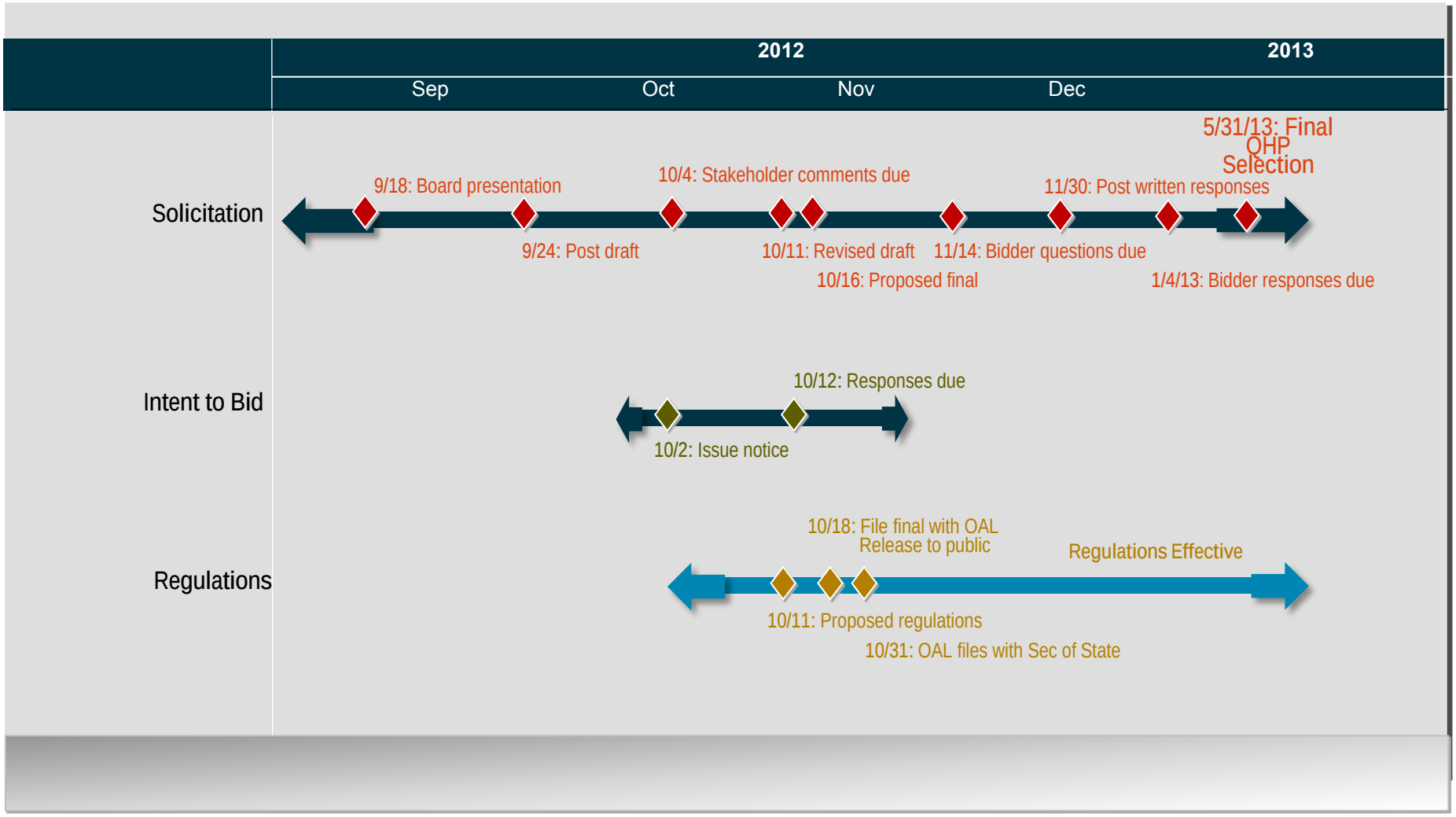
Qualified Health Plan Solicitation: Content and Approach

- Implements QHP policies adopted by Exchange in August.
- Will coordinate with regulators' findings that QHP bidders must be licensed and in good standing.
- Requests information about plans and policies that have been filed with regulators including changes to geographic service areas, networks and other plan features that are subject to material modification review or insurance regulator review.
- Includes standardized benefit plan designs which are being refined based on stakeholder input.
- Incorporates key information requests from CalPERS RFP.
- Solicitation will be converted to electronic version and responses must be submitted electronically.
- Many state and federal rule dependencies still outstanding: rating regions, actuarial value calculator, family tiers, age bands, rating factors to name a few.

Qualified Health Plans Solicitation Timeline



Qualified Health Plan Solicitation: Content

Plan Network Design and Cost Information

- Certification that bid includes standard plan design(s) for each metal tier
- Certification of actuarial value for each plan submitted
- Confirm geographic service area and rating region for plan bid.
- Complete matrix indicating zip codes of licensed service areas proposed by QHP bidder by plan/product
- Submission of cost proposal by plan by rating region.
- Certify that all family tiers and child only are included in plan designs
- Identify plans that include and exclude pediatric dental essential health benefit
- Multi-year contract proposal
- Description of delivery system reform features such as patient-centered medical homes, ACO, narrow network, chronic disease management programs, quality and patient safety initiatives,etc.

Qualified Health Plan Solicitation: Content

Provider Network Adequacy and Essential Community Provider(ECP) Network Requirements

- Certify that QHP provider network has been approved by regulator.
- Submission of ECP network maps demonstrating sufficient geographic distribution of contracted ECP to serve low income population
- Submit lists of Hospital and Ambulatory Care Providers who are in-network ECPs by geographic service areas
- Provide overlap analysis demonstrating geographic distribution of both ECP hospital and ambulatory care providers and demonstrate contracts with at least 15% of 340B providers within proposed service area.
- Solicitation library for QHP bidders will include links to: 340B provider list, Health and Safety Code 1204 and 1206 community and free clinics list; doctors on Medi-Cal Electronic Health Record Incentive list, DSH hospital list and maps showing distribution of low-income population by county.

Qualified Health Plan Solicitation: Content

Incorporates Some Modules of 2012 eValue8 Request for Information

Robust data collection tool used nationally by large employers

- Permits Exchange evaluators to compare QHP bids easily using electronic tool
- Allows generation of custom reports that facilitate and streamline comparison of QHP bidders' responses
- Lays foundation for ongoing plan monitoring of quality and other data
- Plans who currently use eValue8 can import data already reported

Qualified Health Plan Solicitation: Content

Selected Modules of 2012 eValue8 Request for Information Include

- Enrollment data by HMO and PPO (1.3)
- Accreditation Status by NCQA or URAC (1.4)
- Provider Management and Health Management of Chronic Conditions (1.5)
- Data on Racial, Cultural and Language Competency (1.7)
- Alignment of Plan Design: Value- Based Benefit Features such as Patient-Centered Medical Homes, High Performance Provider Networks, Health Assessments, Shared Decision Making, Consumer Tools, Web Consultation (2.2)
- Practitioner Connectivity and Health Literacy Tools (2.3): Use of EMRs, ePrescribing, Consumer tools to assist in Provider Selection
- Hospital Choice Support (2.4)
- Shared Decision-Making and Treatment Option Support (2.5)
- Electronic Personal Health Record (2.6)
- Claims Management and Transparency to Consumers and Providers (2.7)

Qualified Health Plan Solicitation: Content

Selected Modules of 2012 eValue8 Request for Information

- Performance Measurement: Select CAHPS ratings including health plan, member communications (2.8)
- Provider measurement including Community Collaboration, Use of Leapfrog Hospital Data (3.2)
- Physician Performance Measurement and Reporting (3.4)
- Physician/Practice Site and Medical Group/IPA Value Differentiation and Incentives: payment rewards and payment structures other than fee for service ACO data, PCMH doctors (3.5)
- Hospital Performance Measurement and Feedback (3.6)
- Hospital Value Differentiation and Incentives (3.8)
- Centers of Excellence and High Performance Hospital Networks (3.9)
- Value-Based Formularies and other pharmaceutical management (4.2, 4.3, 4.4, 4.5)
- Worksite Wellness and Health Promotion Programs (5.2)
- Health Assessments (5.3)

Qualified Health Plan Solicitation: Content

Selected Modules of 2012 eValue8 Request for Information

- Cancer Screening Program and Results (5.4)
- Immunization Programs (5.5)
- Prevention and Treatment of Tobacco Use (5.6)
- Obesity (5.7 partial)
- Obstetrics and Maternity and Child (5.8)
- Chronic Disease Management and Performance Measurements (6)
- Member Identification and Support for Chronic Disease Management (6.3)
- Behavioral Health (7)

Qualified Health Plans: Outstanding Plan Design Issues

- Should issuers be required to submit all standard plan designs for every metal tier or should they be allowed to select one standard plan design per metal tier.

- Issuers have the option of submitting an alternate plan design that is non-standard ; should other selected QHPs for that geographic service area be allowed to offer their competitor's alternate plan design.

- HMO plans report considerable challenges in administrative ability to track and accumulate member's share of cost across all benefit categories and apply to single annual deductible and out of pocket maximum
  - This hurdle is due to current business arrangements between HMO plans and delegated groups. (Groups keep visit copays and don't report to HMO plan.)
  - Using encounter data to calculate member's accumulated share of cost reportedly not reliable.
  - Some HMO plans advocate facility-only deductible in lieu of overall annual deductible. Does not solve problem of cost-sharing for other benefit categories which must be applied to out of pocket maximum.

Qualified Health Plans: Undecided Policy Issues – Plan Design

- Plans report great difficulty in building a bronze-tier HMO plan due to 40% cost share; most bronze plans may be on PPO platforms.
- Request to consider separate urgent care benefit category and assign a higher co-payment to it than PCP visit co-pay.
- Request to consider different standard benefit plans for HMOs vs. PPOs vs. HDHPs
- Need to add Standard plan design that comports with High Deductible Health Plans(HDHP) rules to meet market demand.
- Some report difficulty in creating a bronze small group plan due to the maximum of $2000 annual deductible requirement.
- Some concern about tracking the first two PCP visits that are co-pay.
- Consider adding separate benefit category for specialty pharmacy.

Qualified Health Plan Solicitation: Stakeholder Input

- Convening Individual Exchange Workgroup to consider remaining plan design policy issues.
- Kicked off ongoing meetings with plans' technical staff to figure out operational interfaces between Exchange and future QHPs.
- Major topic areas include eligibility and enrollment (e.g. type, content and frequency of electronic communications), financial management, provider network data, plan data to support shopping/ enrollment and customer service.
- Stakeholder input on solicitation will be sought when drafts are issued and refined.