TITLE 10. INVESTMENT
CHAPTER 12. CALIFORNIA HEALTH BENEFIT EXCHANGE (§6400 ET SEQ.)

ARTICLE 2: DEFINITIONS

SECTION 6410: DEFINITIONS

As used in this Chapter, the following terms shall mean:

340B Entity: A "covered entity" as defined in Public Health Service Act Section 340B(a)(4), 42 U.S.C. 256b(a)(4).

Accountable Care Organization (ACO): A voluntary group of physicians, hospitals and other health care providers that are willing to assume responsibility and some financial risk for the care of a clearly defined patient population attributed to them on the basis of patients' use of primary care services. Characteristics of an ACO may include robust use of Electronic Health Record infrastructure, defined quality metrics including outcomes, shared savings formulas affecting reimbursement, coordinated care requirements or pay for performance reimbursement components.

Alternate Benefit Plan Design: A QHP proposed benefit plan design which features different cost-sharing requirements than the Exchange's Standardized Qualified Health Plan Designs.

Benefit Plan Requirements: Coverage that provides for all of the following as under 45 CFR § 156.20:

(a) The essential health benefits as described in Section 1302(b) of the Affordable Care Act;
(b) Cost-sharing limits as described in Section 1302(c) of the Affordable Care Act; and
(c) A bronze, silver, gold, or platinum level of coverage as described in section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in Section 1302(e) of the Affordable Care Act.

Bidder: A Health Insurance Issuer seeking to enter into a Qualified Health Plan contract.

Board: The Board of the California Health Benefit Exchange, established by Government Code 100500.

CAHPS: Consumer Assessment of Healthcare Providers and Systems. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care. CAHPS develops surveys that are taken by hospitals, health plans, and home health agencies and are designed to measure patient experience with these entities.

CalHEERS: The California Healthcare Eligibility, Enrollment and Retention System, created pursuant to Government Code 100502 and 100503, as well as 42 U.S.C. 18031, to enable enrollees and prospective enrollees of QHPs to obtain standardized comparative information on the QHPs as well as apply for eligibility, enrollment, and reenrollment in the Exchange.

California Health Benefit Exchange or Exchange: The entity established pursuant to Government Code 100500. The Exchange also does business as and may be referred to as Covered California.

Certified QHP: Any QHP that is selected by the Exchange and has entered into a contract with the Exchange for the provision of health insurance coverage for enrollees who purchase health insurance coverage through the Individual and/or Small Business Health Options Program (SHOP) Exchanges.

Cost-share: Any expenditure required by or on behalf of an enrollee with respect to receipt of Essential Health Benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.
Day: A calendar day unless a business day is specified.

EPO: An Exclusive Provider Organization, as defined in California Code of Regulations, title 10, Section 2699.6000(r).

Essential Community Providers: Providers that serve predominantly low-income, medically underserved individuals, as defined in 45 C.F.R. 156.235.

Essential Health Benefits: The benefits listed in 42 U.S.C. 18022, 2012 Cal. Stat. 854 (AB 1453), and 2012 Cal. Stat. 866 (SB 951).

Evidence-Based Medicine: The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.

Exchange Evaluation Team: The team selected by the Exchange to conduct the QHP bid response evaluation by consensus and assess whether the response is responsive and may proceed to the evaluation of the Response to Requirements.

Executive Director: The Executive Director of the Exchange.

Federally-Qualified Health Center (FQHC): Federally-Qualified Health Center has the same meaning as that term is defined in Public Health Service Act Section 1905(l)(2)(B) (42 U.S.C. 300w-5(l)(2)(B)).

Geographic Service Area: A defined geographic area within the State of California that a proposed QHP proposes to serve and is approved by the applicable State Health Insurance Regulator to serve.

Health Insurance Issuer: Health Insurance Issuer has the same meaning as that term is defined in 42 U.S.C. 300gg-91 and 45 C.F.R. 144.103. Also referred to as "Health Issuer" or "Issuer."

Health Maintenance Organization (HMO): A Health Care Service Plan (as that term is defined in Health & Safety Code 1345) holding a current license from and in good standing with the California Department of Managed Health Care.

HEDIS: Health Effectiveness Data and Information Set, a set of managed care performance measures developed and maintained by the National Committee for Quality Assurance.

HSA: Health Savings Account, as defined in 26 U.S.C. 223.

Independent Practice Association (IPA): An IPA is a legal entity organized and directed by physicians in private practice to negotiate contracts with Health Insurance Issuers on their behalf.

Individual and Small Business Health Options Program (SHOP) Exchanges: The programs administered by the Exchange pursuant to 2010 Cal. Stat. 655 (AB 1602), the federal Patient Protection Affordable Care Act (Public Law 111-148) and other applicable laws to furnish and to pay for health insurance plans for Qualified Individuals and Qualified Employers.

Ineligible Bidder: A prospective Bidder who is not in good standing with the applicable State Health Insurance Regulator, or does not meet the qualifications for consideration as a Qualified Health Plan under this Chapter, or has not provided complete responses or conforming responses to the QHP solicitation.

Initial Open Enrollment Period: The initial period in which Qualified Individuals may enroll in QHPs, from October 1, 2013 to March 31, 2014, subject to 45 C.F.R. 155.410(b).

Internet Web Portal: The web portal made available through a link on the Exchange's website, www.healthexchange.ca.gov, through which the Exchange will make the Solicitation available electronically.

Level of Coverage: One of four standardized actuarial values and the catastrophic level of coverage as defined in 42 U.S.C. 18022(d) and (e).

Medical Group: A group of physicians and other health care providers who have organized themselves to provide services to a defined patient population or contract with a Health Issuer or hospital.

Network or Provider Network: The collection of Providers who have entered into contracts with a Health Insurance Issuer which govern payment and other terms of the business relationship between the Health Insurance Issuer and the Providers. Provider Networks are integral to an Issuer's proposed QHPs.

POS: Point of Service as defined in Health & Safety Code 1374.60.

Patient-Centered Medical Home: a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.

Preferred Provider Organization: A network of medical doctors, hospitals, and other health care providers who have contracted with a Health Insurance Issuer to provide health care at reduced rates to the Issuer's insureds or enrollees.

Provider or Network Provider: An appropriately credentialed or licensed individual, facility, agency, institution, organization or other entity that has a written agreement with a proposed QHP Bidder for the delivery of health care services.

QHP Issuer: A Health Insurance Issuer whose proposed QHP has been selected and certified by the Exchange for offering to Qualified Individuals and Qualified Employers purchasing health insurance coverage through the Exchange

Qualified Employer: Qualified Employer has the same meaning as that term is defined in 42 U.S.C. 18032(f)(2) and 45 C.F.R. 155.710.

Qualified Health Plan (QHP): Qualified Health Plan (QHP) has the same meaning as that term is defined in Patient Protection and Affordable Care Act Section 1301, 42 U.S.C. 18021. If a Standalone Dental Plan is offered through the Exchange, another health plan offered through the Exchange shall not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the standalone plan under 42 U.S.C. 18022(b)(1)(J).

Qualified Health Plan Solicitation or Solicitation: The final Exchange QHP Solicitation document released November 13, 2012, labeled the California Health Benefit Exchange 2012-13 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond, and used to solicit responses from Health Insurance Issuers that wish to propose QHPs to be certified by the Exchange to offer market and sell coverage to individuals and employers through the Exchange.

Qualified Individual: Qualified Individual is an individual who meets the requirements of 42 U.S.C. 18032(f)(1) and 45 C.F.R. 155.305(a).

Quality Assurance: Processes used by proposed QHPs to monitor and improve the quality of care provided to enrollees.

Rating Region: The geographic regions for purposes of rating defined in Health & Safety Code 1357.512 and Insurance Code 10753.14.

SHOP Plan Year: A 12-month period beginning with the Qualified Employer's effective date of coverage.

Solicitation Official: The Exchange's single point of contact for the Solicitation.

Standalone Dental Plan: A plan providing limited scope dental benefits as defined in 26 U.S.C. 9832(c)(2)(A), including the pediatric dental benefits meeting the requirements of 42 U.S.C. 18022(b)(1)(J).

Standardized QHP Benefit Design(s): Benefit plan designs that the Board determines to be standard pursuant to Government Code 100504(c), as described in Solicitation Section II.B.1.

State Health Insurance Regulators: The Department of Managed Health Care and California Department of Insurance.

State Mandates: Health care benefits required to be covered by California statutes.

Telemedecine: The ability of physicians and patients to connect via technology other than through Virtual Interactive Physician/Patient capabilities, especially enabling rural and out-of-area patients to be seen by specialists remotely.

Two-Tiered Network: A benefit design with two in-network benefit levels. Standard plan cost-share is applied to most cost-effective network with higher cost-share allowed for more expensive in-network choice. Actuarial value is based on likely overall use of tiered networks.

Value-Based Insurance Design: Value-Based Benefit Design includes explicit use of plan incentives to encourage enrollee adoption of one or more of the following: appropriate use of high-value services, including certain prescription drugs and preventive services and use of high-performance providers who adhere to evidence-based treatment guidelines.

Authority: Gov. Code §§ 100502, 100503, 100504, 100505
Reference: Gov. Code §§ 1005001, 100502, 100503, 100505

ARTICLE 3: COMPETITIVE PROCESS FOR SELECTING QUALIFIED HEALTH PLANS

SECTION 6420: 2012-2013 QUALIFIED HEALTH PLAN SOLICITATION

(a) Qualified Health Plan Solicitation. The Exchange will solicit bids from Health Insurance Issuers to offer, market, and sell QHPs through the Exchange beginning in the Initial Open Enrollment Period. The Exchange will exercise its statutory authority as an "active purchaser" to review submitted bids and reserves the right to select or reject any Bidder or to cancel the Solicitation at any time for any reason. The Qualified Health Plan Solicitation is hereby incorporated by reference.

(1) Bidders must be available before selection and certification by the Exchange to offer their QHPs to start working with the Exchange to establish all operational procedures necessary to integrate and test data interfaces with CalHEERS, and to provide any additional information necessary for the Exchange to market, to enroll members, and to provide QHP services effective January 1, 2014.

Authority: Gov. Code §§ 100503, 100504, 100505
Reference: Gov. Code §§ 100503, 100505

SECTION 6422: BIDDER REQUIREMENTS

Health Insurance Issuers interested in offering, marketing, and selling QHPs through the Exchange must comply with and respond to the questions and information requested in the Qualified Health Plan Solicitation, Section II, Technical Requirements, including appendices attached thereto. A Health Insurance Issuer must comply with Section II. Technical Requirements of the Qualified Health Plan Solicitation and meet all of the criteria listed in this Article in order to submit a bid in response to the Solicitation.

Authority: Gov. Code §§ 100503, 100504
Reference: Gov. Code §§ 100503, 100507; 42 U.S.C. § 18021; 45 C.F.R. § 156.200

SECTION 6424: PROPOSAL PREPARATION INSTRUCTIONS

(a) Final response format and content

(1) For the development and presentation of response data, Bidders must adhere to all format instructions required by the Exchange in Solicitation Section III.

(2) Notwithstanding the above, a Bidder may explain in its response why it cannot respond to any given question or section of the Solicitation. The Exchange reserves the right to accept or reject such explanations at its sole discretion.

(3) The Exchange will make the entire Solicitation available through an Internet Web Portal where Bidders are required to submit their responses. Bidders' entire response must be submitted electronically. The Exchange will assign Bidders a login identification to access the Internet Web Portal. Each Bidder must identify a primary Solicitation respondent, but that individual may, in turn, designate internal subject matter experts for responding. Bidders must participate in two training sessions conducted by the Exchange in order to submit a response to the Solicitation. The Exchange will provide Bidders with written documentation in support of their use of the Internet Web Portal at the training sessions.

(b) General instructions

(1) Each Bidder is limited to a submission of a single response to the Solicitation. For the purposes of this paragraph, "Bidder" includes a parent corporation of a Bidder and any other subsidiary of that parent corporation. If a Bidder submits more than one response, the Exchange will reject all responses submitted by that Bidder.

(2) Before submitting a response, Bidders may seek timely written clarification of any requirements or instructions in the Solicitation by submitting a written inquiry to the Exchange. Bidders must make these inquiries during the timeframe outlined in the Solicitation timeline in Section I.H. of the Solicitation.

(3) Bidders' responses must be delivered to the Solicitation Official by the date and time listed in Solicitation Section I.H. under Key Action Dates for response submission.

(4) Bidders' responses must be submitted in phases as indicated by the Exchange in Solicitation Section I.H.

Authority: Gov. Code §§ 100502, 100504, 100505
Reference: Gov. Code §§ 100502, 100505

SECTION 6440: EVALUATION

(a) Initial Selection: During initial selection, the Exchange Evaluation Team will check each response in detail to determine its compliance with the requirements in this Article. Failure to respond to or meet a mandatory requirement may result in the Exchange considering a Bidder's final response as non-responsive.

(b) Evaluation of Issuers: the Exchange Evaluation Team will consider the mix of QHPs that best meet the Exchange's goal of providing an appropriate range of high-quality choice to participants at the best available price in every part of California. Through its evaluation process, the Exchange will give greater consideration to proposed QHPs that promote the following:

(1) Affordability for the consumer and small employer – both in terms of premium and at point of care.

(2) "Value" competition based upon quality, service, and price.

(3) Competition based upon meaningful QHP choice and product differentiation.

(4) Competition throughout the state.

(5) Alignment with providers and delivery systems that serve the low-income population.

(6) Delivery system improvement, effective prevention programs and payment reform.

(7) Long-term partnerships between the Exchange and Health Insurance Issuers.

Authority: Gov. Code §§ 100502, 100503, 100504, 100505
Reference: Gov. Code §§ 100502, 100503, 100505

SECTION 6442: QHP CERTIFICATION

The Exchange will provide each successful Bidder with a certification that each health plan it offers in the Exchange is a QHP.

Authority: Gov. Code §§ 100502, 100504.
Reference: Gov. Code §§ 100502, 100503; 42 U.S.C. § 18031; 45 C.F.R. 156.200.

SECTION 6444: PROTEST PROCESS

(a) If a Bidder has submitted a proposal which it believes to be totally responsive to the Solicitation's requirements and believes the Bidder should have been selected as a successful Bidder, the Bidder may submit a protest of the selection as described below.

(b) All protests must be made in writing, signed by an individual who is authorized to contractually bind the Bidder, and contain a statement of the reason(s) for protest, citing the law, rule, regulation or procedure on which the protest is based. The Bidder must provide facts and evidence to support its claim. The Bidder must send its protest by certified or registered mail, unless delivered in person, in which case the protester should obtain a receipt of delivery. The Exchange must receive all protests by 5:00 pm on the fifth (5th) calendar day following Bidder selection.

(c) Protests must be mailed or delivered to:

California Health Benefit Exchange
Attn: Executive Director
560 J Street, Suite 290
Sacramento, CA 95814

(d) Protests will be heard and resolved by the Executive Director's designee.

Authority: Gov. Code §§ 100502, 100504, 100505
Reference: Gov. Code §§ 100502, 100505