THE CALIFORNIA PATH TO ACHIEVING EFFECTIVE HEALTH PLAN DESIGN and SELECTION and CATALYZING DELIVERY SYSTEM REFORM

Stakeholder Input On Key Strategies

MAY 18, 2012

CALIFORNIA HEALTH BENEFIT EXCHANGE

www.HealthExchange.ca.gov

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I. Introduction

Background

The mission of the California Health Benefit Exchange ("Exchange") is to increase the number of insured Californians, improve health care quality, lower costs, and reduce disparities by providing an innovative and competitive marketplace in which consumers can choose health plans and providers that give them the best value. The Exchange also has the opportunity and the commitment to be a catalyst for change and delivery system improvement. The Exchange's initial success in achieving its mission will be shaped, in large part, by decisions the Exchange will make about the selection of qualified health plans and the Exchange's role as a catalyst for health system reform. To support the Exchange board making the best decisions possible, it conducted a wide range of stakeholder engagement efforts to get input on how it should structure its qualified health plan and delivery system reform strategies. This report summarizes the feedback provided by stakeholders.

Stakeholder Input Process Overview

One of the Exchange's six key values is partnership. The Exchange seeks out partnerships and believes its efforts should be guided by work with stakeholder groups. The Exchange has used multiple avenues to solicit stakeholder input into its health plan strategy.

- In addition to the formal Stakeholder Input process described in this Report, Exchange board members and staff leadership meet with a wide variety of interested groups, organizations and individuals and listens to their viewpoints about mutual concerns concerning many issues facing the Exchange and its role in improving the health of Californians. The Exchange has also invited public testimony at its board meetings, submission of comments in writing to the board and has organized panel presentations at board meetings. In particular, at its March 2012 board meeting, the board heard from three panels of stakeholders on issues related to health plan selection and promoting delivery reform. (Appendix D).

- In February and March 2012 the Exchange convened in-person stakeholder group sessions. These sessions were held in: Los Angeles, Redding, Sacramento, San Diego and San Francisco to get input on plan selection and design issues. Over a hundred stakeholders were invited and participants included health care providers, consumer advocates, brokers and business representatives (see Appendix B). At these sessions, Peter V. Lee, Exchange executive director, asked stakeholders to focus on six key questions to get input on plan selection and design issues:

    - Regarding the **optimal number of plans** with which to contract, stakeholders were asked: *As the Exchange exercises its authority to be a selective contractor, what considerations should be taken into account in deciding how many plans to contract with?*
    - Regarding **criteria for plan selection***,* stakeholders were asked: *What would be important criteria to set for plans who participate in the Exchange?*

- Regarding **network criteria**, stakeholders were asked: *What would be important criteria for the provider networks offered by plans who participate in the Exchange?*
- Regarding **out-of-pocket cost design**, stakeholders were asked: *What are important considerations in designing a framework for out-of-pocket costs?*
- Regarding **dental and vision coverage**, stakeholders were asked: *Would it be advisable for the Exchange to offer dental and vision plans for those who wish to purchase them?*
- Regarding **health system reform**, stakeholders were asked: *What roles could the Exchange play in catalyzing health system reform?*

- The Exchange encouraged stakeholders to respond in writing by April 1, 2012 to 31 questions (see Appendix A) posted on the Exchange website and broadly distributed to stakeholders. Responses were received from 47stakeholder groups (see Appendix C).

- The Exchange board reviewed reports and background material more broadly to inform its work (see Appendix E).

- The Exchange has engaged PricewaterhouseCoopers, LLP (PwC) to assist it in reviewing this input and in developing options to inform the Exchange's future decisions related to determining its qualified health plan certification standards and processes as well as delivery system reform strategies. This report on stakeholder input will inform both the Exchange's board and staff and PwC in developing qualified health plan contracting criteria and delivery system reform strategies.

The Exchange plans to use this input as it develops its policies, which it plans to release for comment in July to be finalized in August. The Exchange plans to release its health plan solicitation in fall of 2012. It intends to make preliminary selections of health plans in early 2013 and final selections so that promotion can begin in July 2013 with enrollment starting October 2013 for coverage as of January 1, 2014.

The Exchange reported on stakeholder input on topics related to enrollee engagement in a March, 2012 Exchange report, "Achieving Health Care Coverage Success in 2014 and Beyond: Stakeholder Input on Strategies for Marketing, Eligibility, Enrollment and Retention."

Major Highlights

Below are key highlights that Exchange staff heard at the in-person stakeholder sessions:

- Most stakeholders believe that making care affordable is the key to the Exchange's success. Some stakeholders are concerned that - even taking subsidies into account - higher cost would equal fewer enrollees overall and, in particular, fewer enrollees among healthy people. Many made the point that a strong start in January 2014 will be critical to long-term success.

- Most stakeholders felt that the Exchange should exercise the authority the legislature offered to be an active, selective contractor in making decisions about how many and which health plans to contract with.

> *"Affordability, affordability, affordability -- that has to be the paramount goal. Do not try to get to the perfect system. First, nail down the foundation and then add changes later."*
>
> *Jean S. Fraser*
> *San Mateo County Health System*

- Stakeholders want the Exchange to set criteria for participating health plans that support choice, quality and affordability. Some encouraged requiring evidence-based approaches to achieve this goal, but wanted to balance that with allowing plans discretion to test promising innovations. There was broad support for heading in the direction of some standardization of plan offerings to enable consumers to make informed choices.

- Many stakeholders urged the Exchange to use *existing* measures of quality and access in the short term, so as not to overburden providers and plans with excessive reporting.

- While they recommended relying on entities that already have responsibilities for monitoring plans, some articulated an expectation that the Exchange may need to step in over time to monitor where existing monitoring proves inadequate.

- Stakeholders grappled with the pros and cons of offering narrow and broad networks of providers and the direct implications for affordability, choice, and access. There were particular concerns about creating processes to assure access to subspecialists for those who need them without "breaking the bank."

- Many stakeholders urged the Exchange to consider approaches, such as inclusion of safety net providers in plans' provider networks, to support continuity of care for enrollees whose eligibility for enrollment in Medi-Cal and the Exchange will change based on fluctuations in their income.

- There was widespread appreciation of the value of cultural and linguistic competency to genuine access and the challenges in assuring access to experienced and committed essential health providers.

- Stakeholders raised concerns that, with so many new enrollees in the Exchange and Medi-Cal, access to providers, particularly primary care providers, may not be adequate. The Exchange was urged to closely monitor whether providers networks are actually meeting the rising demand.

- While the federal Affordable Care Act and California legislative authority will constrain the Exchange's discretion in relation to the benefit package**,** many stakeholders weighed in on the scope of benefits to be offered by the Exchange, with recommendations ranging from urging that certain benefits be included to encouraging that the benefit package be limited.

- Many stakeholders hold out a lot of hope on the Exchange's potential role in promoting health system reform and point to smart reforms as the only way to bend the cost curve over time. Access to primary care physicians and mid-level providers, chronic care management, and the importance of medical homes were key concepts raised many times. However, some stakeholders also point out that system reform takes time and the first priority for the Exchange is to maximize the number of uninsured who get affordable coverage.

Across geographies and across constituencies, stakeholders were very willing to think through implications of various positions and to think through what might be the best alternatives for the whole system the Exchange is working to create. There was a strong sense that California together is building something new and important and that the prospect of expanding coverage and access to millions of uninsured people is a shared aspiration and a real priority.

II. Stakeholder Input From The Field

Below is a detailed summary of the input gathered from stakeholders in face-to-face meetings in Los Angeles, Redding, Sacramento, San Diego and San Francisco that took place in February and March 2012 (see Appendix B)[1].

A. Optimal Number of Plans to Offer Through Exchange

The federal Affordable Care Act establishes the requirement that coverage in the Exchange be offered by health insurance issuers who are licensed by the state, in good standing with the state and who meet specific standards and requirements outlined in the Affordable Care Act. The Affordable Care Act requires the Exchange to establish and use a competitive process to select participating plans. The Affordable Care Act does not proscribe the number or mix of plans that must be contracted with statewide or regionally. The California Affordable Care Act expressly permits the Exchange to be selective in its plan selection

Stakeholders were asked: If the exchange exercises its authority to be a selective contractor, what considerations should be taken into account in deciding how many plans to contract with? (Question #16, Appendix A)

Offer consumers a limited number of plans they are able to compare efficiently and effectively.

- Multiple stakeholders expressed concern that too many choices may create frustration for people already "on the fence" about whether or not to sign up for a plan. Even well-educated and well-informed consumers may become discouraged in the face of too many choices.

- Stakeholders urged that, in deciding the optimal number of plans to offer, consideration be given to the importance of being able to communicate clearly, concisely and effectively with consumers who have varied literacy levels. Technology, like that used for travel websites, may be able to help resolve some of the complexity of choosing amongst health plans.

- A consumer advocate urged awareness of the "paradox of choice," citing research that found Medicare patients responding to many Part D choices often ended up only choosing the plan that was in their best financial interest 6% of the time.[2]

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[1] It is worth noting here that the Exchange must function within parameters set by federal and state laws and regulations. In March of this year, during the time that the stakeholder input process that informs this report was underway; the US Department of Health and Human Services issued a set of interim final regulations. Some of the stakeholder input we have included here may offer suggestions that are now outside of what the Exchange is permitted by law to implement.

[2] *Simplifying Health Insurance Choices*, Consumer Union, June 2009; original source *Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?* By Jonathan Gruber, Henry J. Kaiser Foundation, March 2009.

- It was suggested that the Exchange develop a process to check in with consumers over time about how the process of choosing plans is working.

Offer only plan choices that have meaningful differences and that consumers are likely to find satisfactory over time.

- Stakeholders advised that many individual consumers and small businesses will want to consider options that allow them to compare provider networks and quality, in addition to cost, in making their choices.

- Many of California's large plans use the same provider networks. Some stakeholders urged that consumers not be burdened with sorting through "look alike" plans. Offering options that provide a real choice of providers should be the goal.

> *"Large employers devote a lot of resources to managing health benefits for their employees. The Exchange can do that for the rest of us. Health benefits are complex; the Exchange can serve as a sort of Good Housekeeping seal, ensuring the value of the plans it offers."*
>
> *Anthony Wright*
> *Health Access*

- Stakeholders pointed out that local health plans may include more geographically-sensitive provider networks and should be encouraged to participate in the Exchange.

- If criteria the Exchange uses for plan selection limits the number of plans eligible to participate, stakeholders urged care in limiting offerings to good quality plans only; consumers don't want plans marked by "gotchas," loopholes and gaps.

- A few stakeholders articulated the importance of not offering any plans that the Exchange does not feel confident will be able to "make it" in the long run.

Choosing the right number of plans may lead to better quality, more innovation and success generally.

- Multiple stakeholders talked about the Exchange's job to monitor the plans it selects and said the Exchange may be able to do this better if it does not offer too many plans.

- A few stakeholders suggested the Exchange seek to engage collaboratively with plans in designing products. The Exchange will be able to be more attentive to relationships with plans if it limits the number of plans it works with. However, if the Exchange chooses too few plans, the Exchange may feel pressure to continue with a plan even if the plan turns out to be less that optimal. If the Exchange chooses a plan that fails to perform well that will reflect poorly on the Exchange.

- It was pointed out that, if the Exchange chooses too few plans, chosen plans may not feel as driven to compete on customer service and innovation.

- Stakeholders pointed out that California is big and diverse and that a single statewide solution may not be suitable. Plan offerings may need to vary from one geographic market to another, and, in some cases, local health plans may have better networks.

- It was suggested that the Exchange have a numerical goal. For example, the Exchange may want to consider offering a couple of statewide plans, plus a local plan – suggesting a total offering of 3 or 4 plans for a geographic area; each of those plans would offer a range of options.

- A few stakeholders suggested that the Exchange have a marketing perspective in mind as it selects plans. It may be important to include big "name brand" plans to help consumers feel more confident with the Exchange's offerings.

- Consumer advocates observed that health plans and health benefits are complex and the Exchange should strive to develop the branding and credibility to allow it to serve as a 'Good Housekeeping seal of approval' for consumers who may otherwise be confused and daunted by the prospect of choosing among plans.

- Stakeholders pointed out that in rural communities, where there is a dearth of plan options, questions related to narrowing choice are not relevant.

B. Health Plan Selection Criteria

The Affordable Care Act requires that qualified health plans meet certification requirements established by Exchanges. California law requires the Exchange to set minimum requirements for participating plans as well as the standards and criteria for selecting qualified health plans, to "provide health care coverage choices that offer the optimal combination of choice, value, quality and service.[3]"

Stakeholders were asked: What would be important criteria to set for plans who participate in the Exchange? (Question #5, Appendix A)

Consider criteria based on past performance and capacity in selecting plans.

[3] AB 1602, Chapter 655, Statutes of 2010.

- Stakeholders urged looking at a plan's history including: its customer service; CAHPS and HEDIS scores; the nature of its provider networks; its financial stability; and whether it has raised premiums frequently.[4]

> *"Criteria have a cost and the cost to health plans will affect enrollment. Every jump in cost is someone's break point."*
>
> *Micah Weinberg*
> *Bay Area Council*

- In addition to looking at plans' history, many stakeholders urged establishing expectations and closely monitoring plans' ongoing performance. Stakeholders also urged caution with respect to plans that come in with very low cost the first year but who will not be able to sustain the rate over time, suggesting that the Exchange attempt to negotiate rates for a time period longer than one year.

- Some stakeholders encouraged looking for evidence to indicate whether a plan will be a good partner to the Exchange. This could include evaluating whether the plan is philosophically aligned with the Exchange's mission and vision.

- It was urged that the Exchange assure that plans have the capacity to take on the upcoming growth in enrollment and pent-up demand for health services among the newly insured. Many people will enter their health plans seeking checkups and other health services immediately. If plans and providers are not prepared to meet this demand immediately, some people may become dissatisfied and let their participation lapse. It's not only important to get people enrolled, it is essential that plans and providers be prepared to cement these new relationships. Stakeholders were concerned that disenrollment is more likely to happen among healthy people and could leave the Exchange with a pool of higher cost subscribers.

- Some stakeholders recommended considering the size of plans in making selections since smaller plans may not have adequate resources to drive innovations.

- It was suggested that criteria be set for how to evaluate new plans that may be established in response to new opportunities the Exchange provides.

It will be important to favor criteria related to improving quality and access over time.

- Many stakeholders urged favoring plans whose reimbursement practices encourage better quality care through: cultural and linguistic competence; prevention models; primary care; care coordination; models for managing chronic conditions; medical

[4] See additional discussion on networks in section on Provider Network Criteria

homes; use of ancillary providers; palliative care; telehealth; and improved patient experience/engagement.

- Some stakeholders suggested comparing Department of Manage Health Care Knox-Keene Act Requirements and Department of Insurance requirements and imposing the better, more robust of the standards on the plans it selects. Other stakeholders suggested the Exchange only consider Knox-Keene licensed health plans.

- Some stakeholders suggested giving priority to plans that reduce the administrative burden on providers and free up dollars for care by exceeding the medical loss ratio requirement.

- Many stakeholders felt that, in the short term, it will be important to strike a balance between requiring criteria be met and asking plans how they plan to meet new criteria in the coming years.

It will be important for the Exchange to consider and balance the ripple effects plan selection criteria may create.

- Many stakeholders shared concerns about adverse selection. While stakeholders recognize affordability is essential to the Exchange's success, they also acknowledge that, at least in the short term, many of the suggested criteria may add cost to premiums. Even taking subsidies into account, stakeholders expect that increased premium costs will result in lower enrollment. Since healthy people are more likely to forgo coverage than those who are sick, the Exchange pool could become unbalanced and costs may sky rocket, putting coverage even further out of reach for those who would be necessary to a more balanced, healthier pool. Stakeholders urged the Exchange to balance these considerations in shaping plan criteria.

> *"The other side of criteria is partnership. A plan that does a smidge less well on a HEDIS measure may bring a true partnership perspective, a willingness to engage collaboratively to address challenges . . . and that may be more valuable in the end. Hard and fast measures may not be what makes the Exchange most successful."*
>
> *Rae Lee Olson*
> *The Vita Companies*

- Providers expressed feeling burdened by existing reporting requirements and urged that the Exchange rely on existing measures to monitor and evaluate plans. Stakeholders generally felt the Exchange should only create new measures down the road if it finds gaps that cannot otherwise be filled; they urged that any new measures be as standardized as possible across payers.

- Multiple stakeholders urged that criteria not be permanently set in stone. It was suggested that where the Exchange requires certain criteria be met, it be willing to reconsider and replace that criteria as future innovations lead to new best practices.

C. Provider Network Criteria: Access, Cost, Choice

Licensed health plans will need to continue to meet existing Department of Managed Health Care and Department of Insurance provider access standards. The Exchange may require that plans meet additional criteria designed to impact the nature of the provider networks with whom plans contract.

Stakeholders were asked: What would be important criteria for the provider networks offered by plans who participate in the Exchange? (Question #6, Appendix A)

Breadth/narrowness of networks is central to choice and may be an important cost driver.

- Many stakeholders felt that it is important that plans offer narrow networks in the belief that this gives plans better leverage in negotiating with providers and may help keep premium costs down. Other stakeholders felt broad networks were preferable over narrow ones. One stakeholder suggested that each plan include a broad network product as well as a narrow network option.

> *"Narrow networks may restrict women's access to hospitals with low C-section rates. Narrow networks would make the need for hospital incentives and transparency more important than ever."*
>
> *Lynn Kersey*
> *Maternal and Child Health Access*

- Many stakeholders believe plans will compete, in large part, based on price and on which providers are in their networks. For some consumers and small businesses, even in the face of rising health care costs, finding the providers they want may be central to plan choice.

- Multiple stakeholders felt it is important to make transparent to consumers the relationship between the breadth of networks and the cost of a plan.

- Some stakeholders felt that, where multiple plans offer the same networks, consumer options in choice of plan may become too limited and urged that plan selection take this into account.

- The Exchange will need to decide which standards to set for determining network adequacy. Several stakeholders suggested that in setting standards the Exchange examine existing standards and consider choosing the existing standard that is most rigorous.

- Some consumers will choose a plan because its network includes a particular provider. Stakeholders are concerned that it is not uncommon now for a physician to be listed as being in a network but, when patients contact the provider for a first appointment, they may learn the provider is not taking new patients or is no longer in the network. Stakeholders urged that the Exchange track whether existing monitoring is effective in remedying this problem; if it is not, some stakeholders urged the Exchange to address the issue.

Coverage needs to be coupled with a commitment to genuine access and continuity of care.

- Many stakeholders emphasized that many consumers who enter the Exchange will have a history of being served by traditional safety net providers; also, some may gain and lose Exchange and Medi-Cal eligibility periodically as their incomes fluctuate. Networks that support continuity of care will be important to these patients, particularly those with chronic conditions. To achieve this, the Exchange will need to include plans that can demonstrate engagement and fair payment of essential community providers whose cultural and linguistic competency, experience and demonstrated commitment is key to genuine access.

- Stakeholders urged the Exchange to work with Healthy Families and Medi-Cal to find approaches that support family members being included in the same plan rather than spread across two or more plans because of differing eligibility requirements.

Creative approaches will be needed to benefit from the value of narrow networks while providing access to necessary specialty and subspecialty care.

- While the Exchange may in some cases favor plans with narrow networks, stakeholders urged that it assure access to necessary specialty care for those who need it. In cases of narrow networks, people who need it will have to be provided access to second opinions, specialists and subspecialists, specialists with years of experience with particular populations, academic medical centers, children's hospitals, quaternary hospitals, and facilities with full access for the disabled. Approaches to assure this access while guarding against unnecessary costs may need to be phased in, tested for effectiveness and allowed to evolve over time. The Exchange will need to monitor access and seek the balance between guarding against overutilization and underutilization.

- It was suggested that the Exchange consider including California Children's Services provider panels in its networks.

- Rural stakeholders urged special consideration in those parts of the state where there is not sufficient population to support specialists and subspecialists and where patients are required travel to distant communities for this type of care.

- Stakeholders pointed out that, despite state and federal laws requiring mental health parity, in fact, benefits are often more limited that they should be. The Exchange was urged to monitor provider networks and benefit design to assure that mental health parity is ensured in practice.

- Stakeholders urged that plans be held accountable for integration among providers within the plan's networks. Some stakeholders encouraged that, for example, when plans carve out services, such as in the case of behavioral health, they establish lines of communication that support integration of carved out care with care offered by other providers in one or more of the plan's networks.

Assuring provider access will require a mix of approaches.

- Many participants noted that the key driver to keeping care affordable will be the nature of networks and payment rates within those networks; many participants noted the tension of having broad/accessible networks and the potential that those networks being more expensive.

- Some providers are concerned that a rich benefit package, coupled with an imperative to keep premiums low, may result in provider rates so low that some physicians will not participate. The Exchange was urged to use its power with plans to encourage fair provider rates.

- Stakeholders urged that the special expertise of essential community providers and other providers with experience serving special populations be recognized and fairly compensated to recognize their expertise and assure their participation.

- It was suggested that encouraging risks and rewards through capitated rates for providers may create a greater sense of provider ownership and encourage participation.

- Rural stakeholders believed that low reimbursement rates are responsible for much of poor access to specialists and urged the Exchange to use its power to encourage rates that will support recruitment and network participation in rural communities.

- Some stakeholders noted the need to monitor state and federal cuts to health care services to understand gaps in reimbursement for services to the population served by the Exchange. It was also urged that the Exchange keep abreast of new, effective medications and whether they are included in plan formularies.

Effective inclusion of allied health professionals may be a key to affordability.

- Stakeholders are generally concerned about the primary care provider shortage. Some encouraged that plans reimburse health providers who are currently used to support care but are not commonly reimbursed by health plans. These included: peer-to-peer and certified mental health/substance abuse counselors; nutritionists; teams supporting care coordination, management and medical homes; lactation counselors; and social workers.

- Some urged the Exchange to use its powers to encourage changes in licensing to help fill in this gap.

D. Benefits – Out-of-Pocket Cost Design

Certain parameters of the benefit package have been shaped under the Affordable Care Act and will probably be further shaped by choices the California legislature will make. However, the Affordable Care Act has created a set of income-related subsidies to offset premiums and other out-of-pocket costs; the Exchange has discretion to design out-of-pocket payments including deductibles, copays, and/or co-insurance payments. These incentives can be designed to impact utilization of care as well as patient behaviors.

Stakeholders were asked: What are important considerations in designing a framework for out-of-pocket costs? (Questions #20 - 25, Appendix A)

Subsidies do not mean care will be affordable for everyone.

- Stakeholders saw out-of-pocket payments as a potentially effective tool for encouraging healthy behaviors and smart use of health care services. Many stakeholders thought it important that the Exchange shape out-of-pocket payments in a way that will not negatively impact appropriate utilization by low income populations and people with catastrophic or chronic conditions. If the Exchange chooses to standardize out-of-pocket expenses, they should be designed keeping in mind the impact these costs can have on these populations.

Out-of-pocket costs can be an effective way to guide people toward appropriate utilization but there are some caveats to consider.

- Many stakeholders were enthusiastic about the power of out-of-pocket costs to increase healthy behaviors and appropriate health care utilization. They pointed to a number of possibilities: encouraging smoking cessation and improved exercise and

diet; increased use of primary care including medical homes; improved management of chronic disease; improved adherence to proven medications; early and consistent use of maternity care; reductions in elective inductions; and reduced emergency room use. Some highlighted that encouraging people will not be enough and financial incentives should be used to broadly affect behavior.

- The suggestion of using financial incentives to promote smoking cessation received a mixed response from stakeholders. Some were concerned that penalties for smokers might keep some people out of coverage and might harm some people the Exchange was created to help; some of these stakeholders encouraged using carrots first before resorting to sticks. Other stakeholders pointed out that these incentives might result in fewer people smoking and that that would be a great benefit for the people who quit.

> *"I would like to see people shop for health care like they shop for other things. It's important for them to have some skin in the game, but, out-of-pocket costs for low income people can be counterproductive. If a person does not have the money to pay for the basics for their family, they don't have the money to pay a deductible."*
>
> *John Nelson Warner*
> *Pacific Insurance Services*

- Stakeholders liked "value-based benefit design", such as first dollar coverage for effective medications to control chronic health conditions, as a tool to provide better care, but were concerned that it may attract enrollees with serious and costly medical conditions to join the Exchange. While the medication adherence encouraged by this first dollar coverage may reduce illness over time and save money in the long run, the benefits of this policy may not accrue to the Exchange since patients may have moved out of the Exchange by the time the associated savings are realized. It was suggested that perhaps the Exchange can encourage a common approach to this issue among multiple payers and plans, as a way of moving toward better quality care and a more level playing field. In the meantime, attracting sick people to the Exchange will have to be balanced by attracting much greater numbers of healthy people or premiums in the Exchange will eventually become too expensive for healthy people to afford.

- It was suggested that the Exchange consider designing out-of-pocket costs to encourage patients to choose high quality, low cost medical devices and medications.

- Many stakeholders agreed that incentivizing healthy behavior is a good idea but some urged that the Exchange not penalize people for their current health status.

Creative approaches for encouraging appropriate use and healthy behaviors should be considered.

- One stakeholder suggested affecting a culture of wellness in the community by creating a wellness benefit that is centrally administered and travels with the consumer wherever she goes. This wellness program could be separate from the health plan and consumers could take it with them when they change plans. Each consumer could be assigned a wellness score based on their behaviors and good scores could positively affect out-of-pocket requirements.

- It was pointed out that small employers may be more likely to encourage healthy behaviors among their employees if the employer is offered an associated reduction in premiums.

E. Dental and Vision Coverage

The Exchange is considering offering dental and vision coverage for those who would like to purchase them. These would be beyond those pediatric vision and dental services required as Essential Health Benefits.

Stakeholders were asked: Would it be advisable for the Exchange to offer dental and vision plans for those who wish to purchase them? (Question #26, Appendix A)

Offering dental and vision benefits may create additional incentives for enrollment in the Exchange.

- There was widespread support among stakeholders for the Exchange offering supplemental dental and vision coverage. Many pointed to the positive relationships dental care has to overall health.

- Several brokers pointed to the phenomenon that people who buy more than one kind of coverage are less likely to drop any of their coverage in the long run. They also noted that offering all three types of coverage relieves small employers of an administrative burden and would make the Exchange more competitive in that market.

- A few expressed concerns that the Exchange has such big challenges ahead and suggested that it wait and begin offering dental converge in the future so all resources can now go toward a successful launch of medical coverage in 2014. Also, there was some skepticism about the value of dental coverage that includes waiting periods and caps on coverage.

F. Delivery System Reform

One of the values the Exchange embraces is to be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.

Stakeholders were asked: What roles could the Exchange play in catalyzing health system reform? (Questions #27 - 31, Appendix A)

Stakeholders see the Exchange as a source of hope for health system reform.

- Most stakeholders were enthusiastic about the Exchange's role as a catalyst for health system reform. Some said the Exchange: should be the "big game changer"; should "drive delivery system and reimbursement reform"; "may be our last hope for delivery system reform"; should not be "just one more cog in the system".

> *"The Exchange is morally obligated to try to be creative about how you do this and to move the system into effective managed care models."*
>
> *Dean Germano*
> *Shasta Community Health Center*

- Many stakeholders acknowledged that health system reform is a big job that takes time and getting its basic program in place should be the Exchange's first priority. Some stakeholders were clear that the Exchange's number one priority should be to have a successful January 2014 launch with mix of affordable health plans, significant enrollment and the capacity to serve and retain a sustainable mix of enrollees.

- A few stakeholders felt the Exchange should not aggressively work to reform the health system, raising concerns that efforts might artificially constrain the market and lead to unintended consequences.

The Exchange should ask what's most important for 2014 and what should happen over time.

- Some stakeholders recommended that, to begin with, the Exchange should commit to benchmarking, transparency and monitoring outcomes. Over time, after the Exchange has some experience, it should consider creating new plan criteria that support health system reform.

- Many stakeholders urged that the Exchange should learn from and partner with other purchasers.

- Some liked the idea of the Exchange aligning with cost and quality work being done by the Center for Medicare and Medicaid Services. Some urged that the Exchange should proceed with caution on ideas that have not yet been proven; and that, in choosing innovations, the adequacy of reimbursement should be considered.

Stakeholders recommended the Exchange explore ways it could foster delivery system improvements.

- Stakeholders had many suggestions for roles the Exchange could play in fostering health system reform:

    - Developing reimbursement schemes that promote better access to primary care, medical homes, care coordination, and use of IT to improve network integration;
    - Learning about new effective medical home models for chronically ill children and adults;
    - Forming a co-op so that plans may bid together for drugs and implants;
    - Supporting the creation of clearinghouses that can provide: centralized standardized billing, a standardized prior authorization process, and a common formulary;
    - Creating transparency so consumers can understand and compare underlying costs and quality outcomes;
    - Designing risk adjustment models that the Exchange, plans and providers can trust;
    - Engaging patients and providers to control costs;
    - Moving the system out of “upside down payments” that go to acute care and not to primary care; and
    - Controlling the drivers of increased premiums and asking contracted plans to commit to guaranteed rates over multiple years.

III. Highlights Of Written Stakeholder Input

Written input was submitted by 47 stakeholder organizations in response to 31 questions posed by the Exchange (see Appendix A). What follows is a summary of those responses. A list of the organizations that provided comments and a link to the full comments submitted can be found at Appendix C.

1. **What minimum standards for qualified health plans in the Exchange would ensure a basic level of service, access, consumer protection and health care quality?**

   - Many respondents suggested that the minimum standards for qualified health plans be those standards set by federal law and by the California Department of Managed Health Care (DMHC) under the Knox-Keene Act. Some suggested that plans governed by the California Department of Insurance (CDI) be subject to DMHC standards where those standards were more rigorous than CDI requirements.

   - A number of respondents suggested that additional specific standards be added where existing state licensing standards are not comprehensive or effective in ensuring access, particularly to the special populations that will be served by the Exchange.

   - Concerns were expressed about the effectiveness of current monitoring and enforcement of existing standards and it was recommended that the Exchange conduct monitoring itself to determine how well existing standards are implemented by the plans it contracts with.

   - Health plans suggested that plans only be subject to existing state and federal requirements. They believe that these standards are rigorous and are a familiar framework that will encourage participation by plans. They maintained that this would allow for a wider choice of plans to be available for the Exchange and consumers.

Qualified Health Plan Certification and Selection Standards

2. **What criteria should the Exchange consider to determine whether carriers offering coverage through the Exchange are "in good standing" with regulators, as required under the Affordable Care Act and how best does the Exchange align and coordinate its efforts with DMHC and CDI? What data, resources or performance history might the Exchange use to evaluate a carrier's track record of compliance with existing California statutory and regulatory requirements?**

- Many respondents recommended that the Exchange consider data collected by DMHC and CDI as it determines "good standing." It was suggested that CDI plans be required to have further complied with DMHC Knox-Keene standards to ensure more uniform determinations.

- It was suggested that the Exchange pay special attention to DMHC, CDI and Office of the Patient Advocate records of complaints filed against payers by patients and providers.

- It was recommended, in cases where a plan delegates to a risk-bearing organization, that that entity be required to meet financial solvency requirements.

- The Exchange was encouraged to look at additional sources of information in making its determination:
    - metrics that consider child-specific measures including Consumer Assessment of Healthcare Providers and Systems Child Version;
    - mystery shopper surveys to measure the ability to get appointments timely, especially with specialists; consumer assistance entities;
    - Department of Mental Health data suggesting lack of access to appropriate providers undermine progress toward achieving mental health parity;
    - 'medical surveys' as described in the Health and Safety Code;
    - criteria employed in the state's Medi-Cal managed care program;
    - the Attorney General's Office;
    - accreditors; and
    - court records.

- It was suggested that any plan that has had its license suspended or revoked not be considered for inclusion by the Exchange.

3. **Given that health coverage is regulated by two agencies in California, to what extent should the Exchange implement strategies and approaches in the selection and oversight of potential participating carriers to ensure that all qualified health plans in the Exchange meet similar minimum standards? What strategies, if any, might the Exchange employ to work with DMHC and CDI to accomplish maximum uniformity and consistency across carriers?**

- Respondents suggested working closely with DMHC and CDI, perhaps through an interagency agreement or working group, to maximize uniform standards consistent with the ACA and federal regulatory requirements. Here again, a number of respondents suggested, where there are inconsistencies, DMHC's higher standards be used. Concerns were raised that inconsistencies could lead to differences that support cherry-picking and undermine goals of reducing health disparities.

- Health plans felt that there is already a great deal of uniformity and consistency across plans and that disruption of current standards may create unintended consequences. Plans suggested, however, that, where further common performance standards are needed, it be addressed through the Exchange RFP process for selecting plans.

- Several respondents recommended that the Exchange consider allowing Medi-Cal managed care plans to be considered based on having already been approved by DHCS. This was urged based on the importance of continuity for the many patients who are expected will move between Medi-Cal and Exchange eligibility.

4. What strategies and approaches should the Exchange consider, and what existing standards in areas such as level of service, consumer protection and quality measurement can it incorporate, in order to develop a timely and streamlined process for certification and selection of carriers and qualified health plans?

- Several respondents, here and throughout, recommended that the Exchange rely on existing required standards and refrain from adding "bells and whistles" at least in the short run. Respondents also suggested here, and in response to several other questions, that the Exchange initially rely on forthcoming federal standards. Respondents suggested that, if, over time, the Exchange identifies gaps, it should then consider adding additional measures.

- Respondents mentioned a number of existing standards/measures the Exchange could consider using, including:

    - *National Committee for Quality Assurance (NCQA)* accreditation;
    - *Consumer Assessment of Healthcare Providers and Systems* (CAHPS*);*
    - *Healthcare Effectiveness Data and Information Set (HEDIS);*
    - IS9000 quality management standards; eValue8;
    - HIV-related quality measure endorsed by the National Quality Forum;
    - the March of Dimes' 12 priority pediatric and perinatal quality measures; and
    - Healthy Families program standards.

- Some respondents recommended the Exchange act in certain areas to fill gaps in existing measurement or activity:

    - help overcome existing barriers for entry for new entities including Accountable Care Organizations (ACOs), local health plans, Medicare Advantage plans and Co-Ops;
    - encourage new, innovative outcomes-based payments;
    - assure network adequacy with special attention in a number of areas including mental health providers and providers with HIV experience; and
    - assure continuity of care for patients who have a provider now and who will be served by a health plan under the Exchange.

- Some plans suggested considering the establishment of a timeline within which plans be required to meet standards.

5. **What criteria should be considered a priority for the Exchange in certifying and selecting qualified health plans that might either reference or exceed regulatory minimums?**

- Many respondents believed affordability should be a chief concern for the Exchange in its early days and encouraged a number of things to foster affordability including:

    - limit the number of plans to allow economies of scale within plans;
    - allow network flexibility;
    - give priority to plans that exceed the medical loss ratio, i.e., spend more premium dollars on health care;
    - consider past rate increases and favor plans whose increases have been slower and less frequent than average; and
    - encourage payment reforms.

- Respondents felt that consumer friendliness of plans could be demonstrated by: models like patient-centered medical homes; avoiding a one-size-fits all approach and offering a variety of coordinated care models; offering shared-decision making opportunities; encouraging plans to be clear in their written materials that they do not discriminate based on factors such as sex, gender identity, sexual orientation, disability, etc. thus signaling to patients that they have protections.

- Some respondents recognized that federal and state law already have in place certain language translation requirements and that US Department of Health and Human Services (HHS) has said it expects to provide further guidance in this area. Some respondents called for vigilance and suggested, among other things, that:

    - plans be required to demonstrate the ability to provide in-language care;
    - the quality of translation and interpretation services be demonstrated; and
    - plans demonstrate how they will collect related data.

- Respondents pointed to the importance of addressing health disparities and recommended contracting with essential community providers and collecting data. It was suggested that the Exchange encourage a collaborative effort, among its many stakeholders, to address disparities statewide.

- Many respondents underscored the importance that plans have a good track record on preventive services but, it was pointed out, not at the expense of a record of excellent care of chronic health conditions.

- It was recommended that the Exchange prioritize access to primary care providers.

- Early risk assessment will be important for new enrollees some of whom may have been without regular care. Respondents encouraged greater consideration be given to plans that can demonstrate a history of effective care management strategies. Some pointed out that the Exchange should look for evidence of coordinated care management at the provider level - rather than at the plan-level. It was also suggested that the Exchange give priority to plans whose reimbursement schemes incentivize coordinated care.

6. As the Exchange develops standards or policies regarding provider contracting and other provider management practices of potential Exchange carriers, in what ways might the Exchange consider and evaluate carriers?

- Respondents called for relying on existing standards governing network adequacy, timeliness and language access and other features. However, respondents also suggested that careful monitoring by the Exchange could be very important to ensuring access to primary care providers and to specialists and subspecialists. Respondents noted the phenomenon of “phantom networks," i.e. when plans supply a list of network providers but inquiring consumers learn that some of the listed providers are not actually part of the network, or, are not taking new patients.

- Many respondents urged the Exchange to pay special attention to including plans that contract with providers who have demonstrated cultural and linguistic competency and commitment to serving the special populations that will make up a significant portion of the Exchange’s enrolment including:

    - low income people;
    - children with special needs;
    - adolescents and adults with needs for a full scope of confidential reproductive service;
    - HIV patients;
    - mental health/substance abuse patients;
    - people with chronic health conditions;
    - LEP populations; and
    - populations who have had disparate health access and outcomes.

- Some urged that the Exchange seek out plans with non-overlapping networks to foster competition on quality, service and price. However, many pointed out the importance of overlapping networks to support continuity of care in the case of patients who may move back and forth between Medi-Cal and the Exchange because of fluctuations in their income.

- Respondents urged the Exchange that, as it considers care coordination efforts, it take advantage of existing collaborations and also seek out plans whose care coordination efforts are models that can spur broader delivery system reform. Respondents emphasized the importance of innovative and patient-centered approaches in primary care, medical homes and care management. They encouraged consideration of payment reforms, like ACOs, that have the potential to catalyze delivery system reforms.

- Respondents suggested the Exchange should foster the use of health information technology (HIT) and should query plans about their use and the use their providers make of HIT.

- Respondents encouraged that the Exchange ensure consumer access to quality outcome, cost and efficiency data on facilities, medical groups and providers. It was suggested that “gag clauses” that prohibit plans from discussing provider cost or quality data be prohibited.

7. **With regard to any of the potential criteria listed in Questions 5 or 6 above: What approaches should the Exchange consider in certifying qualified health plans and in developing Exchange strategies for ongoing monitoring? Are there any criteria that should be waived or implemented after 2014 to permit new entrants to offer coverage through the Exchange?**

- A number of respondents called for the use of existing, clear and consistent performance measures. Many mentioned NCQA accreditation, CAHPS and HEDIS measures. Some plans suggested allowing a grace period for plans to secure their NCQA accreditation.

- It was suggested that the Exchange adopt a core definition of quality improvement strategies based on existing state, federal or private accreditation standards established for all Exchanges by the Center for Consumer Information and Insurance Oversight.

- It was recommended that the Exchange focus on establishing conditions under which consumers can readily determine value among competing plans. The Exchange was urged to display easily understandable indicators of quality and service performance.

- It was suggested that the Exchange post insurers' justifications for rate increases and that these postings be standardized and also posted by DMHC and CDI.

- Respondents recommended that the Exchange cross check data across state and federal entities to ensure consistency.

- It was urged that habitually low scoring plans be subject to freezing of enrollment and eventual termination from Exchange participation.

- Some respondents encouraged flexibility to support plans that are new entrants into the market while others raised concerns about doing this at the same time the Exchange is demanding vigorous investment in quality and service improvements from existing plans.

8. **What opportunities are there for the Exchange to integrate, coordinate or build on health plan standards and contracting requirements in other state-administered coverage programs, including Medi-Cal, Healthy Families, and the California Public Employees Retirement System, and with federally-administered coverage programs such as Medicare and the Federal Employees Health Benefits Program? What opportunities are there to build on private sector standards, accreditation or contracting requirements?**

- Generally, respondents were enthusiastic about building on Medi-Cal, Healthy Families and the California Public Employees' Retirement System (CalPERS) where possible. Some urged the Exchange to create efficiencies by using, for example, Medi-Cal standards and contracting practices.

- Since there are significant differences among these state and federal programs it was suggested that the Exchange seek an agreement among the programs to all abide by existing nationally recognized standards.

- Several respondents cited certain Medi-Cal practices and suggested that the Exchange consider them:

    - health plans in the Medi-Cal two plan model are required to execute agreements with local school services to support the provision of the Child Health and Disability Prevention services;
    - when a managed health care organization reimburses an Federally Qualified Health Center *(*FQHC*)* at less than the FQHC's full rate, the state must pay a wrap-around payment;
    - Medi-Cal managed care plans must meet requirements for coordination of mental health services with counties; and
    - a state statute allows optometrists to deliver certain care for enrollees in state-administered Medi-Cal;

9. **To what extent, if any, should requirements, standards or contract terms for qualified health plans and participating carriers be different in the Small Business Health Options Program than in individual Exchange coverage?**

- Generally, respondents felt that the SHOP standards should be the same as standards for individual coverage.

- Concerns were raised that if employees are allowed to select among plans this may lead to adverse selection and a market unattractive to health plans and, so, the Exchange may want to limit the choices an employee may be offered.

- It was recommended that plans that wish to participate in the SHOP demonstrate a network of brokers who will market Exchange plans to small employers.

10. **What would be the potential implications and impacts to enrollees if California does or does not have a Basic Health Program? What are the potential implications for providers and for carrier participation in the Exchange?**

- Some respondents believe that a Basic Health Program (BHP) would provide great benefit to low income people in terms of reduced cost and improved continuity of care. Reduced costs could result in more people being insured and fewer people dependent on the safety net which will have fewer resources for uncompensated care.

- Respondents also raised some concerns about the BHP.

    - While rates are expected to be higher than Medi-Cal rates, some providers may be distrustful that they can count on this over time.
    - BHP rates for providers would be expected to be lower than rates that would have been available through Exchange plans and would perpetuate cost shifting.
    - The BHP could remove young and healthy people from the Exchange leaving a smaller, sicker, higher cost risk pool.

11. **Under the Affordable Care Act, qualified health plans in the Exchange must include within the provider network those essential community providers, where available, that serve predominantly low-income, medically underserved individuals. What criteria and processes might the Exchange use to ensure the inclusion of essential community providers in qualified health plans it offers? What are the implications of such criteria for Exchange enrollees, providers and participating health plans?**

- Many respondents pointed to the value to enrollees of ready access to essential community providers who are at the forefront of providing culturally and linguistically competent communications and services in the geographic areas where they are needed. Their long history of serving many of the populations who will be enrolled in the Exchange, including patients diagnosed with multiple

conditions, make them trusted and expert providers whose inclusion can help in guaranteeing continuity of care.

- Some suggested that plans be required to demonstrate contracting with a range of essential community providers who provide services including primary care, reproductive services, mental health services, specialty care, hospitalization, trauma, burn etc. It was also suggested that health plans be required to contract with:
    - all essential community providers who provide reproductive services;
    - providers currently offering care in the Medi-Cal program;
    - school-based health centers; and
    - all willing primary care providers.

- It was suggested that the Exchange proactively assign enrollees to community clinics and health center providers in every community.

- Different perspectives were articulated on how essential community providers rates should be set. Some recommended allowing providers to negotiate rates while others recommended adopting the federal “generally applicable payment rate” as sufficient and only move to a more prescriptive standard if experience warrants that.

- Health plans were concerned that plans should not be required to contract with all willing essential community providers because to do so could inhibit attempts to use network design to incentivize cost effective care. The point was raised that, in the Exchange, enrollees have access to coverage protected by state law, and, essential community providers are already facing capacity constraints. It was argued that, rather than setting a specific “all willing essential community providers” requirement, the Exchange should recognize and reward plans in the contracting process if they include significant essential community providers in their networks.

- It was suggested that the Exchange evaluate Medi-Cal data about provider distribution, as well as federal geographic measures of provider shortage areas, and, local mental health department data to assist in the development of an inventory of essential community providers.

- It was recommended that the Exchange keep in mind the role of solo/small group practitioners in serving safety net patients.

- It was recommended that in rural communities and in communities with low numbers of people affected by a particular condition, and, where no appropriate network provider is available, out-of-network referrals be readily provided at no additional cost to the patient.

12. Given that many individuals and family members' eligibility for subsidies in the Exchange and public programs such as Medi-Cal may change over time, what strategies and approaches might the Exchange implement to reduce the potential for frequent and disruptive switching among health plans, switching among providers and changes in coverage inside and coverage outside of the Exchange?

- Respondents had a number of suggestions for ways the Exchange could promote continuity of care:
    - ensure participation in each region of at least one "safety-net linked" plan so patients who wish to can remain in a safety-net provider setting as they transition from Medi-Cal;
    - create automatic enrollment of members as they move between Medi-Cal and the Exchange if the carrier is in both programs (but give members the opportunity to opt out);
    - adopt 12-month continuous eligibility, and, allow pregnant women to remain in a program until 60 days post-partum);
    - if an individual is transitioning from Medi-Cal to qualified health plan (QHP) coverage, require the QHP to contract with that individual's provider for at least a one year continuity-of-care transition period;
    - create broad provider networks; encourage significant overlap in provider networks in Exchange and Medi-Cal plans;
    - compare plan networks to each other based on overlap and make this information transparent to enrollees;
    - permit plans that participate in Medi-Cal and Healthy Families to be permitted to supply coverage through the Exchange;
    - include, as part of the certification criteria, a requirement QHPs participate in all of the following: Medi-Cal, Healthy Families, the SHOP and individual coverage in the Exchange; and
    - permit the market to innovate around solving the churning issue.

13. With what frequency should the Exchange change its selection of qualified health plans?

- Several respondents suggested that chosen plans be contracted to participate for a preset number of years (specific suggestions ranged from two to five years), providing that contract terms were observed. This would provide stability for plans and for consumers.

- Some respondents urged that there be an annual selection process to encourage innovation, competition and the "weeding out of bad actors." Respondents thought it would be important to encourage new entrants to avoid entrenchment of existing Exchange participants.

- Some respondents expressed concern that plans not be readily permitted to join the Exchange in future years, to provide an incentive to participate early.

14. What selection criteria, policies, program strategies and payment approaches might the Exchange implement to minimize or reduce the impact of adverse selection in Exchange coverage, including strategies affecting coverage and carriers both inside and outside of the Exchange?

- Respondents identified adverse selection, both for the Exchange and the individual market as a whole, as a serious consideration and made several suggestions the Exchange could consider to minimize adverse selection:

    - simplify and standardize product design;
    - maximize consistency of rules and products in and out of the Exchange;
    - work with the Legislature to adopt uniform open enrollment and special enrollment opportunities inside and outside the Exchange; minimize opportunities for "special" enrollment;
    - closely monitor to assure that plans are following rules related to fairly marketing products in and out of the Exchange;
    - since plans that are in the Exchange need to pool risks in and out of the Exchange in developing their rates, the larger the selection of plans in the Exchange, the greater the level of protection against adverse selection, thus, contracting with a greater number of plans would create greater protection against adverse selection;
    - carefully limit the options that SHOP employers can offer employees by requiring each employer to select a single metal level; and
    - consider an outreach campaign targeted at healthier populations and stressing the value of carrying health insurance.

15. What standards, requirements, data collection and methodologies should the Exchange consider related to carrier risk selection and risk management? What specific collaborations should the Exchange undertake with state partners, such as DMHC and CDI to manage issues of risk mix among plans inside and outside of the Exchange?

- It was recommended that the Exchange adopt a fair and well-managed risk adjustment model to ensure the distribution of dollars fairly among plans based on the risk of the members they serve. Suggestions included using:

    - the risk assessment model set forth by the HHS;
    - a standardized nationally recognized risk adjustment methodology; and
    - a model developed by the Exchange.

- It was suggested that the Exchange maximize the use of clinical information as opposed to a heavy reliance on demographic data only.

- The Exchange was urged to establish, through an MOU, a formal working group with DMHC and CDI to monitor and share information about rate growth and risk score trends for similar products offered inside and outside the Exchange.

- It was encouraged that there be a role for plans to review and appeal risk adjustment results.

Qualified Health Plan Selection Process

16. What approaches, processes and strategies can the Exchange employ in designating an optimal number and type of qualified health plan offerings to: maximize value for enrollees; provide meaningful and informed consumer choice; achieve the most effective mix of county, regional and/or statewide plan offerings; address the needs of special populations; and support seamless continuity of coverage for individuals and families whose eligibility fluctuates between the Exchange, Medi- Cal and Healthy Families.

- Respondents varied in the number of plans they recommended the Exchange offer. Some expressed that a “free market” should be encouraged with any plans that meet minimum requirements being allowed to participate. However, many respondents expressed that too much choice can cause cognitive overload for consumers and prevent them from choosing the plan that best matches their needs. It was also noted that, while choice is often touted as encouraging innovation, it can easily assist plans who wish to avoid competition on quality and price and prefer competition based on risk selection strategies. Standardized cost sharing structures were encouraged for ease of comparison. Actual numbers respondents mentioned as optimal included: four or more; a minimum of three; and a maximum of six.

- Some encouraged contracting with plans with non-overlapping networks so consumers would have meaningful choices based on offerings of providers. However, it was urged that the Exchange seek network overlap in the case of Medi-Cal and private plans to support continuity of care for enrollees for whom a change in income may require a change in plan.

- The Exchange was encouraged to include local Medi-Cal and regional plans in each geographic area; it was suggested that this might help drive statewide plans to apply levels of attention to local networks similar to that found in local plans.

- It was encouraged that the Exchange learn from local Medi-Cal managed care plans that help families effectively navigate eligibility and enrollment among Medi-Cal, Medicare and Healthy Families.

17. **What are the most important objectives or considerations the Exchange should consider in selecting qualified health plans and carriers to ensure a mix of plan offerings for consumers?**

- Many respondents mentioned affordability as the key consideration and some coupled that with access, quality, provider networks, value and transparency. The Exchange was also encouraged to look for:
    - plans' ability to produce data;
    - use of payment reforms that incentivize quality;
    - the ability to meet patients' full range of behavioral health needs with qualified providers;
    - the ability to provide access to care in rural communities;
    - use of the Integrated Healthcare Association's (IHA) pay for performance (P4P) program or other models that encourage participants to meet improved performance and increase service over time; and
    - plans that are popular with consumers.

18. **How might the Exchange coordinate or align its qualified health plan selection process with health coverage purchasing strategies used by other state agencies, such as Department of Health Care Services, Managed Risk Medical Insurance Board and California Public Employees Retirement System? Federal agencies, such as Medicare and the Federal Employees Health Benefits Program? Private purchasers?**

- It was suggested that the Exchange might be able to identify plan performance concerns by consulting with other purchasers. It was also suggested that standards and monitoring criteria could be standardized between Medi-Cal plans and QHPs as a way to support consistency of care and reduce administrative burden on providers.

19. **What are the potential considerations and impacts for qualified health plan selection and management posed by the multi-state health plans that must be permitted to participate in the Exchange under federal law? Co-Op plans?**

- Concerns were raised that a multi-state health plan concept may not be consistent with California's decision to pursue a selective contracting approach in the Exchange. The Exchange was encouraged to request that the federal government use its flexibility to select multi-state plans that exclude California, at least in the early years. Co-op plans may be able to provide a more locally sensitive option.

Benefit Plan Design

20. **What should the Exchange take into account (benefits covered, cost-sharing, networks, premium cost and care management features, etc.) as it develops the benefit plan designs to be offered through the Exchange?**

- Many respondents urged attention to affordability as the Exchange makes choices related to benefit design.

- Several respondents advised that the Exchange not set any benefit design requirements beyond those already set by the federal government and state regulators. It was recommended that the Exchange shape benefit packages based on packages that have already been shown to be attractive to consumers and to allow subsequent consumer choices to shape the market.

- It was urged that the Exchange keep in mind impacts on low income people and populations with special health needs in shaping cost-sharing designs. It was suggested that there be no co-pays for preventive services including family planning and maternity.

- It was suggested that the Exchange consider following a Medicare Part D approach that plans offer “all or substantially” all medications in six named classes

- It was recommended that the Exchange not include difficult-to-track deductibles and instead employ co-pays in its cost sharing designs.

- Respondents recommended that the Exchange be particularly vigilant in ensuring that plans follow mental health care parity laws. It was recommended that: covered mental health services be based on a treatment plan not on a pre-set service limitation; qualified mental health professionals be available; and, in the case of carve outs, that care be well integrated with other plan benefits.

21. How might the Exchange promote and ensure affordability and appropriate utilization by Exchange enrollees through the benefit plan design(s) it offers? How might the Exchange use benefit design strategies to encourage cost-conscious and appropriate use of high-value (based on clinical evidence) health care services by enrollees in Exchange coverage?

- Some respondents pointed to the importance of making benefit design, as well as provider cost and quality information, transparent to consumers. However, it was noted that the Exchange should exercise caution in implementing benefit design options that rest on availability of comprehensive, transparent data since the collection and reporting of price and quality data, particularly about physicians, is still at an early evolutionary stage.

- The Exchange was encouraged to urge state policymakers to select the benchmark plan for essential health benefits that is most affordable.

- Respondents recommended that the Exchange encourage members to enroll in high-value plans and choose high performing providers, determined by member satisfaction, clinical outcomes, affordability, and, high levels of consumer and provider engagement.

- The Exchange was encouraged to select plans that provide designs that support members, doctors and hospital to be accountable for ensuring good outcomes while eliminating inefficiencies.

22. How might Exchange implement benefit plan design(s) that contribute to the following goals: improving access to primary care, chronic disease management, patient education, engagement and shared decision-making; measuring and achieving better health outcomes; promoting healthy lifestyles and healthy behaviors; and, improving care coordination, service integration and continuity of care.

- Some respondents suggested giving experienced plans flexibility to design packages to meet these goals.

- It was urged that cost sharing for evidence-based, high-value services be minimized. Cost-sharing designs should encourage patient-centered and coordinated care services, preventive and primary care.

- The Exchange was urged to contract with plans that provide directly, or through their provider network, intensified primary care to patients predicted to incur the highest level of cost.

- The Exchange was urged to favor plans that:

    - steer members to high performing providers;
    - invest more dollars in primary care providers; and
    - share savings resulting from better management of chronic conditions.

- Respondents suggested that the Exchange encourage plans to reimburse a variety of providers such as nurse practitioners, physician assistants, optometrists and certified mental health professionals, as well as alternative access points such as school based health centers to expand access to affordable primary care, disease management and patient education. Engagement of Ryan White providers was also encouraged as was including partnerships with community-based organizations that have shown evidence-based success in engaging and serving underserved communities.

- The Exchange was urged to encourage formal shared design-making processes including providing:

    - clinical information about treatment options;
    - tools to help patients identify their values and priorities; and
    - structured guidance to help patients make informed choices.

This approach could be backed with incentives in the form of copay waivers for use of decision support tools.

- Some respondents pointed out that provider incentives, including reimbursements and shared savings, may be more important levers than benefit design for achieving these goals. It was urged that the Exchange encourage rating of providers/medical groups on relevant measures and make the results transparent to consumers.

23. What goals not listed above should the Exchange seek to promote through the benefit plan design(s) it offers?

- The Exchange was urged to encourage or require that plans engage in disease management, case management, and, care coordination through existing multi-payer collaborative organized at the provider level. It was suggested that learnings from these efforts then be applied inside and outside of the Exchange.

- The Exchange was encouraged to consider: shaping benefit design with the goal of reducing health disparities; and, including routine screening for HIV and sexually transmitted disease, viral hepatitis and domestic violence.

24. How might certain benefit plan designs and features potentially result in adverse selection for the Exchange? How could the Exchange mitigate these potential impacts? What benefit plan design issues should the Exchange consider related to risk selection in coverage inside versus outside of the Exchange? What resources, best practices, approaches and methodologies should the Exchange consider related to risk assessment and risk adjustment?

- Respondents suggested several approaches to addressing adverse selection including:

    - holding a single, limited annual enrollment period;
    - keeping plans affordable so they attract healthy individuals;
    - offering simplified and standardized benefits; and
    - offering a limited range of choices for SHOP employees.

- The Exchange was cautioned to be wary of claims of “innovation” and to be sure to measure the value of innovations against their potential to lead to adverse selection.

- Several suggested that the Exchange adopt the federal risk adjustment methodology and make adjustments to it over time if needed; a UC Berkeley methodology was also mentioned.

- Rigorous oversight and enforcement were suggested including a strong validation to monitor the quality of the data submitted.

- It was pointed out that the risk assessment requirements may create a new shared value in enrollees being managed to optimize health and lower costs.

25. What resources or best practices in benefit plan design might the Exchange consider as it develops qualified health plan benefit design offerings for Exchange coverage?

- Some sources respondents suggested: the Institute of Medicine Quality Chasm Report; the Coalition for Whole Essential Health Benefit Principles; SAMHSA Good and Modern Report; and SCHIP.

Supplemental Benefits

26. Should the Exchange offer optional supplemental benefits in areas such as dental and/or vision care? And, if so, to what extent should the Exchange: establish minimum standards, requirements, or contract terms? What specific measures, criteria and carrier structure(s) should be considered in the certification, selection and contracting with carriers for dental and vision coverage? What criteria, standards or value determinations should the Exchange consider specific to dental and vision benefit designs and scope of coverage?

- There was broad support among respondents for the Exchange to offer optional dental and vision benefits.

- Some respondents recommended that, to the extent the standards are relevant, plan offerings of vision and dental coverage should be held to the same certification standards as medical health plans. However, it was acknowledged that some elements, including network adequacy, access requirements and contract terms will differ from the standards required of medical plans. It was pointed out that in dental coverage waiting periods, frequency limits, cost sharing and annual limits are commonplace.

- Some suggested that current state standards and performance measures applied by DMHC, CDI and Medi-Cal are adequate and the Exchange should refrain from imposing additional standards for certification.

- It was recommended that choice of HMO, PPO or fee-for-service coverage be offered.

- A number of respondents emphasized the importance of first dollar coverage for dental services for pregnant women. There was also encouragement for first dollar coverage for dental diagnostics and preventive services.

- Many respondents spoke of stand-alone plans for dental and vision. However, some medical health plans suggested the Exchange allow QHPs the option to include dental and/or vision care in their plan products.

- It was suggested that the Exchange might be better served at this early stage by focusing its resources on achieving success in its core function before considering offering supplemental coverage.

Delivery System Improvement

27. How might the Exchange promote better value and improve the health delivery system to best facilitate the Exchange's vision and mission to: improve the health and wellness of Californians; improve health care quality; lower health care costs; and reduce health disparities?

- Respondents suggested a number of ways the Exchange could further its vision and mission with respect to these goals by:
    - facilitating a marketplace where plans are required to compete on value;
    - providing consumers with robust choices and displaying those choices to consumers in a transparent and accessible manner;
    - ensuring, through contract language and performance measures, that plans are fully offering all covered services;
    - encouraging medical groups and other providers to organize themselves into well-integrated systems of care;
    - ensuring that utilization management is based on evidence-based criteria;
    - ensuring that plans are prepared to offer early intervention for substance abuse, and, that plans do not divert patients to public programs; and
    - creating incentives and accountability systems that encourage plans to work with school-based health centers.

- The Exchange was urged to be sure their integration and innovation efforts invest in the primary care safety net which will continue to be the source of care for those who will remain uninsured.

- Some respondents urged that the Exchange focus its energies, for 2014, on its "nuts and bolts," but, encouraged that it sow seeds of reform now, in its contracting process, by giving weight to plans with innovative features that have the potential to incentivize enrollees and providers toward improved quality and efficiency.

28. What potential delivery system improvements can be made through the Exchange's contracting and payment strategies and through payment strategies implemented by participating carriers?

- Respondents had a number of suggestions for ways the Exchange could affect delivery system improvement through payment strategies:
    - promote payment reforms that move toward increasing provider risk sharing and away from fee-for-service. These payment reforms could include reimbursement for: increased use of non-physician professionals, patient and caregiver centered end-of-life care, better chronic disease management, reductions in preventable hospitalizations, and better clinical guidelines adherence;
    - encourage values-based reimbursement for outcomes to reward providers for taking a more active role in management of care rather than

reimbursing solely for visits and procedures; these payments could include prepayment, global payments, capitation and bundled payment;
    - offer bonuses for quality and service based on nationally recognized standards;
    - ensure that there are adequate provider incentives to ensure providers have sufficient resources to devote to care coordination;
    - link reimbursements to reduction in adverse events and healthcare-facility acquired infections;
    - require plans to present data on the quality and price of providers for use by consumers in making choices.

- It was noted that the Exchange has a potentially important role in standardizing performance measures and driving greater transparency in the system in ways that a single health plan cannot achieve.

29. How can the Exchange through its rules, policies or procedures related to qualified health plans – alone or in partnership with other purchasers – reduce the administrative complexity and burden on providers? How could such administrative simplification efforts be aligned with public or private sector efforts?

- Respondents made suggestions for ways the Exchange could help reduce administrative burdens:

    - foster the use of standardized electronic transactions;
    - align with other public sector payers to incentivize the use of electronic transactions;
    - create a single, consolidated procedure for provider data collection;
    - ensure the use of uniform forms and processes by QHPs where possible;
    - standardize performance measurements as the IHA has done across plans with its P4P program;
    - reduce onerous treatment authorization requirements to assure that administrative burdens do not alter the preferred course of treatment;
    - harmonize DMHC and CDI regulatory standards; and
    - encourage plans to participate both as Medi-Cal plans and as QHPs.

30. What current best practices and examples of successful public and private performance and quality measurement, payment, consumer engagement or transparency strategies can help to inform the Exchange approach to delivery system reform through its qualified health plans?

- Respondents recommended the Exchange encourage plans to adopt solutions that are not stand alone but are integrated with current clinical workflow and incentives such as: accountable care organizations; shared consumer-physician decision making; wellness programs; and disease and care management programs with proven results.

- Also encouraged were: out-of-pocket cost calculators that allow consumers to discern the highest value plans; and publicly reported granular measures of clinical quality, patient experience and cost/resource use so consumers can drill down for more detailed information on quality and cost.

- The Exchange was encouraged to look particularly at the work of: IHA, Leapfrog, NCQA, HEDIS, JD Power, Bridges to Excellence; Smart Buy Alliance; Cal Hospital Compare, the Managed Risk Medical Insurance Board and CalPERS.

31. How can the Exchange best partner and coordinate with other public and private purchasers in the state, the Centers for Medicare and Medicaid Services Innovations Center, or other federal programs, to improve the overall health delivery system?

- Respondents suggested the Exchange explore coordinating with, or expanding upon, the work of a number of entities:

    - the Health Resources and Services Administration and the Center for Medicare and Medicaid Services on delivery system transition pilots underway at Community Clinics and Health Centers including projects related to accountable care organizations and patient-centered medical homes;
    - the Center for Medicare and Medicaid Innovation (CMMI) Pioneer ACO Programs;
    - best practices of private-public essential community providers pilot programs funded by the CMMI;
    - DHCS/Medi-Cal;
    - Medicare Advantage;
    - Pacific Business Group on Health; and
    - county mental health.

IV. Appendices

Appendix A California Health Benefit Exchange: Stakeholder Questions Developing Options for the Exchange -- Qualified Health Plan, Benefit Design and Promoting Delivery System Reform

Appendix B Attendee Lists

Appendix C Organizations Submitting Written Input

Appendix D Related Reference material at March 2012 Exchange Board Meeting

Appendix E Other Reference Material Submitted and Reviewed

Appendix A: California Health Benefit Exchange: Stakeholder Questions Developing Options for the Exchange -- Qualified Health Plan, Benefit Design and Promoting Delivery System Reform February 16, 2012

The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce disparities by providing an innovative and competitive marketplace in which consumers can choose health plans and providers that give them the best value. The Exchange also has the opportunity and the commitment to be a catalyst for change and delivery system improvement in coverage provided through the Exchange and in the broader health care system.

The federal Affordable Care Act requires that coverage in the Exchange be offered by health insurance issuers who are licensed and in good standing with the state. In addition, qualified health plans in the Exchange must meet specific standards and requirements outlined in the Affordable Care Act and the California Patient Protection and Affordable Care Act of 2010, including requirements related to provider network, quality reporting, disclosure, marketing and product offerings. The Exchange will engage a vendor for assistance in determining its qualified health plan certification and selection standards and processes as well as delivery system reform strategies.

The questions that follow have been developed to provide direction to the Exchange's vendor and to assist the Exchange Board and staff in developing qualified health plan contracting and delivery system reform strategies. As part of that effort, we are seeking stakeholder input on these questions to share with our vendor. The Exchange seeks recommendations for strategies it might implement to foster better value and enhanced quality in California's health delivery system.

The list of questions is robust, so please do not feel the need to answer each question. We welcome all input including opinions and/or facts or reference materials that address the questions or issues raised by the questions.

Please use the comment form on the Stakeholder tab of the Exchange website (http://www.healthexchange.ca.gov/StakeHolders/Pages/Default.aspx) to record your comments. Comment forms should be emailed to info@hbex.ca.gov. Please provide comments by April 1, 2012 (though comments received earlier would be appreciated). Thank you in advance for your feedback.

Background and Introduction

The federal Affordable Care Act requires health coverage in exchanges to be offered by what are referred to as qualified health plans, which must meet federal requirements and certification standards established by exchanges. Qualified health plans must be offered by "health insurance issuers" who are "licensed and in good standing with the state." In California, issuers (carriers) may either be licensed as health care service plans under the Knox-Keene Health Care Service Plan Act of 1975 administered by the Department of Managed Health Care (DMHC), or obtain a certificate of authority as an insurer from the California Department of Insurance (CDI).

The California Patient Protection and Affordable Care Act of 2010 requires the Exchange to establish and use a competitive process to select participating carriers who must have a license or certificate and be in good standing with the respective regulator. The 2010 California law also requires the Exchange to set minimum requirements for participating carriers as well as the standards and criteria for selecting qualified health plans, to "provide health care coverage choices that offer the optimal combination of choice, value, quality and service."[5]

Qualified Health Plan Certification and Selection Standards

In offering coverage through qualified health plans, the Exchange will be guided by its core values which include: centering efforts on meeting the needs of patients and their families; providing affordable coverage and access to care that recognizes the diversity of California; and being a catalyst to stimulate new strategies for providing high-quality affordable health care, promoting prevention and wellness, and reducing health disparities.

The questions below are aimed at identifying criteria and processes for qualified health plan certification and selection standards consistent with the values of the Exchange.

1. What minimum standards for qualified health plans in the Exchange would ensure a basic level of service, access, consumer protection and health care quality?

2. What criteria should the Exchange consider to determine whether carriers offering coverage through the Exchange are "in good standing" with regulators, as required under the Affordable Care Act and how best does the Exchange align and coordinate its efforts with DMHC and CDI? What data, resources or performance history might the Exchange use to evaluate a carrier's track record of compliance with existing California statutory and regulatory requirements?

[5] AB 1602, Chapter 655, Statutes of 2010, Section 7(c).

3. Given that health coverage is regulated by two agencies in California, to what extent should the Exchange implement strategies and approaches in the selection and oversight of potential participating carriers to ensure that all qualified health plans in the Exchange meet similar minimum standards? What strategies, if any, might the Exchange employ to work with DMHC and CDI to accomplish maximum uniformity and consistency across carriers?

4. What strategies and approaches should the Exchange consider, and what existing standards in areas such as level of service, consumer protection and quality measurement can it incorporate, in order to develop a timely and streamlined process for certification and selection of carriers and qualified health plans?

5. What criteria should be considered a priority for the Exchange in certifying and selecting qualified health plans that might either reference or exceed regulatory minimums, including but not be limited to:

    a. Evidence of consumer-focused and consumer-friendly coverage and services;
    b. Assuring culturally and linguistically appropriate services and providers;
    c. Affordability, competitive pricing and value for the benefits provided;
    d. Past carrier performance on measures of quality, service and patient experience;
    e. Promoting healthy lifestyles and ensuring the provision of recommended clinical preventive services;
    f. Care coordination programs and risk stratification to target individuals in highest need of services;
    g. Implementing strategies to reduce and eliminate health disparities in ethnic and underserved communities; and
    h. Success in fostering consumer involvement and shared decision making regarding health care services and treatment options.

6. As the Exchange develops standards or policies regarding provider contracting and other provider management practices of potential Exchange carriers, in what ways might the Exchange consider and evaluate the following:

    a. Accessibility, timeliness, and geographic and language access of a qualified health plan's proposed provider network and whether that network serves the best interests of potential enrollees in the Exchange;
    b. Demonstrated service history of caring for low-income populations and populations that have less experience with health insurance coverage;
    c. Demonstrated operational and service capacity to assist enrollees in selecting, navigating and accessing health care services;
    d. Innovations such as primary care medical homes, chronic disease management and care coordination;
    e. Accuracy and timeliness of information on network provider accessibility and capacity;

f. The relative benefits, limitations and impacts for enrollees and Exchange offerings where multiple plans in a geographic area utilize the same or overlapping providers and provider networks;
g. Fostering adoption, use and access to health information technology for consumers, providers and purchasers;
h. The provision of provider-level quality and cost information to inform consumer choice;
i. Mechanisms through which the Exchange can ensure that carriers monitor and evaluate the quality of network providers; and
j. Data and reporting requirements for carriers participating in the Exchange regarding the quality and efficiency of network providers either by reference to or exceeding state or federal standards or performance measures.

7. With regard to any of the potential criteria listed in Questions 5 or 6 above:

    a. What benchmarks, performance measures or value determinations should the Exchange consider in certifying qualified health plans?
    b. What existing quality measurement tools, accreditation programs, and quality frameworks might the Exchange adopt or modify in developing Exchange standards for qualified health plans?
    c. Are there any criteria that should be waived or implemented after 2014 to permit new entrants to offer coverage through the Exchange in the interest of enhanced access, affordability or market competition?
    d. What strategies and approaches might the Exchange use to conduct ongoing monitoring of certification and quality standards for participating carriers?

8. What opportunities are there for the Exchange to integrate, coordinate or build on health plan standards and contracting requirements in other state-administered coverage programs, including Medi-Cal, Healthy Families, and the California Public Employees Retirement System, and with federally-administered coverage programs such as Medicare and the Federal Employees Health Benefits Program? What opportunities are there to build on private sector standards, accreditation or contracting requirements?

9. To what extent, if any, should requirements, standards or contract terms for qualified health plans and participating carriers be different in the Small Business Health Options Program than in individual Exchange coverage?

10. What would be the potential implications and impacts to enrollees if California does or does not have a Basic Health Program? What are the potential implications for providers and for carrier participation in the Exchange?

11. Under the Affordable Care Act, qualified health plans in the Exchange must include within the provider network those essential community providers, where available, that serve predominantly low-income, medically underserved individuals. What criteria and processes might the Exchange use to ensure the inclusion of essential community providers in qualified health plans it offers? What are the implications of such criteria for Exchange enrollees, providers and participating health plans?

12. Given that many individuals and family members' eligibility for subsidies in the Exchange and public programs such as Medi-Cal may change over time, what strategies and approaches might the Exchange implement to reduce the potential for frequent and disruptive switching among health plans, switching among providers and changes in coverage inside and coverage outside of the Exchange?

13. With what frequency should the Exchange change its selection of qualified health plans?

14. What selection criteria, policies, program strategies and payment approaches might the Exchange implement to minimize or reduce the impact of adverse selection in Exchange coverage, including strategies affecting coverage and carriers both inside and outside of the Exchange?

15. What standards, requirements, data collection and methodologies should the Exchange consider related to carrier risk selection and risk management? What specific collaborations should the Exchange undertake with state partners, such as DMHC and CDI to manage issues of risk mix among plans inside and outside of the Exchange?

Qualified Health Plan Selection Process

16. What approaches, processes and strategies can the Exchange employ to accomplish the following through its qualified health plan selection process:

    a. Designate an optimal number and type of qualified health plan offerings in the Exchange to maximize value for enrollees and to balance value in network design with sufficient access to providers;
    b. Designate an optimal number and type of qualified health plan offerings to maximize and facilitate both meaningful and informed consumer choice as well as designing a coverage selection process that is easy and simple for consumers to navigate;
    c. Designate an optimal number and type of qualified health plan offerings for each county, region and/or on a statewide basis. What criteria might the Exchange use to determine the most effective mix of county, regional and/or statewide plan offerings?;
    d. Provide a choice of health plan offerings that effectively address the needs of special populations and hard-to reach communities likely to be served in Exchange programs; and
    e. Provide health plan offerings to support seamless continuity of coverage for individuals and families whose eligibility fluctuates between the Exchange, Medi- Cal and Healthy Families.

17. What are the most important objectives or considerations the Exchange should consider in selecting qualified health plans and carriers to ensure a mix of plan offerings for consumers?

18. How might the Exchange coordinate or align its qualified health plan selection process with health coverage purchasing strategies used by other state agencies, such as Department of Health Care Services, Managed Risk Medical Insurance Board and California Public Employees Retirement System? Federal agencies, such as Medicare and the Federal Employees Health Benefits Program? Private purchasers?

19. What are the potential considerations and impacts for qualified health plan selection and management posed by the multi-state health plans that must be permitted to participate in the Exchange under federal law? Co-Op plans?

Benefit Plan Design

20. What should the Exchange take into account (benefits covered, cost-sharing, networks, premium cost and care management features, etc.) as it develops the benefit plan designs to be offered through the Exchange?

21. How might the Exchange promote and ensure affordability and appropriate utilization by Exchange enrollees through the benefit plan design(s) it offers? How might the Exchange use benefit design strategies to encourage cost-conscious and appropriate use of high-value (based on clinical evidence) health care services by enrollees in Exchange coverage?

22. How might the Exchange implement benefit plan design(s) that contribute to the following goals:

    a. Improving access to primary care;
    b. Promoting alternative approaches for primary care, such as medical home models;
    c. Implementing effective chronic disease management;
    d. Improving patient education, engagement and shared decision-making;
    e. Measuring and achieving better health outcomes;
    f. Promoting healthy lifestyles and healthy behaviors; and
    g. Improving care coordination, service integration and continuity of care.

23. What goals not listed above should the Exchange seek to promote through the benefit plan design(s) it offers?

24. How might certain benefit plan designs and features potentially result in adverse selection for the Exchange? How could the Exchange mitigate these potential impacts? What benefit plan design issues should the Exchange consider related to risk selection in coverage inside versus outside of the Exchange? What resources, best practices, approaches and methodologies should the Exchange consider related to risk assessment and risk adjustment?

25. What resources or best practices in benefit plan design might the Exchange consider as it develops qualified health plan benefit design offerings for Exchange coverage?

Supplemental Benefits

26. Should the Exchange offer optional supplemental benefits in areas such as dental and/or vision care? And, if so, to what extent should the Exchange:

    a. Establish minimum standards, requirements, or contract terms, such as carrier type and license, provider network, and accessibility of services, applicable to qualified health plans and participating carriers offering health coverage be different for dental and vision coverage?
    b. What specific measures, criteria and carrier structure(s) should be considered in the certification, selection and contracting with carriers for dental and vision coverage?
    c. What criteria, standards or value determinations should the Exchange consider specific to dental and vision benefit designs and scope of coverage?

Delivery System Improvement

27. How might the Exchange promote better value and improve the health delivery system to best facilitate the Exchange's vision and mission to:

    a. Improve the health and wellness of Californians;
    b. Improve health care quality;
    c. Lower health care costs; and
    d. Reduce health disparities.

28. What potential delivery system improvements can be made through the Exchange's contracting and payment strategies and through payment strategies implemented by participating carriers?

29. How can the Exchange through its rules, policies or procedures related to qualified health plans – alone or in partnership with other purchasers – reduce the administrative complexity and burden on providers? How could such administrative simplification efforts be aligned with public or private sector efforts?

30. What current best practices and examples of successful public and private performance and quality measurement, payment, consumer engagement or transparency strategies can help to inform the Exchange approach to delivery system reform through its qualified health plans?

31. How can the Exchange best partner and coordinate with other public and private purchasers in the state, the Centers for Medicare and Medicaid Services Innovations Center, or other federal programs, to improve the overall health delivery system?

Appendix B: Small Group Input Session Attendee List

The California Health Benefit Exchange convened nine in-person stakeholder group sessions to provide input to the Exchange on a series of questions related to how the Exchange should structure its qualified health plan and delivery system reform strategies. These meetings were held in Los Angeles, Redding, Sacramento, San Diego and San Francisco in February and March 2012. Below is a list of those who attended these meetings.

Aaberg Givans, Erin Children's Specialty Care Coalition Sacramento	Hay, James California Medical Association San Diego
Anderson, Peter Sutter Health San Francisco	Helfenstein, Carolyn Catholic Health Care West North State Redding
Barrales, Ruben San Diego Chamber of Commerce San Diego	Hirota, Sherry Asian Health Services San Francisco
Bradshaw, Doreen Health Alliance of Northern California Redding	Hsu, Lambert Benefit Pro Insurance Services and Asian Business Association San Diego
Bright, Jackie Brown and Toland San Francisco	Imholtz, Betsy Consumers Union San Francisco
Chase, David Small Business Majority San Francisco	Janulewicz, Melissa Shasta Health and Human Services Agency Redding
Colburn, Gordon Colburn Insurance Services, Inc. Los Angeles	Jones, Dave Mountain Valley Health Center Redding
Costello, Chad Mental Health America Los Angeles	Kays, Lisa Medi-Cal Care Coordination Program Redding
de Ghetaldi, Larry CMA San Francisco	Kersey, Lynn Maternal and Child Health Access Los Angeles
Donnelly, Anne Project Inform Sacramento	Khalfani, Nomsa St. John's Children Health and Wellness Center Los Angeles
Farley, Karen California WIC Association Sacramento	Koehler, Linda Rose Herzog Insurance Agency San Francisco
Flynn, Meredith UCLA Medical Center Los Angeles	Margolis, Gail Children's Hospital Los Angeles
Franklin, Sherry San Diego County Medical Society (also CMA Board of Trustees) San Diego	Maxwell, Judy Maxwell Insurance & Financial Redding
Fraser, Jean San Mateo County Health System San Francisco	McClaskey, Barbara Barbara McClaskey Insurance Services Redding

Galloway-Gilliam, Lark Community Health Councils Los Angeles	Mendoza, Gary Latino Business Chamber Greater LA Los Angeles
Garrett, Justin March of Dimes Sacramento	Moore, Tom Community Campaigns for Quality Care/IBEW San Francisco
Germano, Dean Shasta Community Health Center Redding	Morris Wilson, Susan Youth Violence Prevention Council Redding
Morrison, Jim Morrison Insurance Services San Diego	Smith, Sam Genesis Financial/Creative Employee Benefits, Inc. Los Angeles
Nelson, John Warner Pacific Insurance Los Angeles	Spencley, Jan San Diegans for Healthcare Coverage San Diego
Nord, Steve Paradise Medical Group Redding	Toccoli, Betty Jo CA Small Business Association Los Angeles
O'Kane, Steve San Diego Council of Community Clinics San Diego	Toebben, Gary LA Chamber of Commerce Los Angeles
O'Brien Ramey, Alison American Cancer Society Sacramento	Wallner, Patrick Wallner Plumbing Redding
Olson, Rae Lee The Vita Companies San Francisco	Weinberg, Micah Bay Area Business Council San Francisco
Phillips, Mike Jewish Family Services Patient Advocacy Program San Diego	Williams, Leslie Leslie A. Williams Insurance Services Redding
Proctor, Diana Breathe California of Sacramento Sacramento	Woodruff, Heather Barney and Barney San Diego
Rosen, Chuck CPR Insurance and Financial Services Los Angeles	Wright, Anthony Health Access San Francisco
Schoenthaler, Deb North Valley Medical Association Redding	Wu, Ellen California Pan-Ethnic Health Network San Francisco
Sebastian, Christine Children's Partnership Los Angeles	Wulsin, Lucien ITUP Los Angeles
Senella, Al Tarzana Treatment Center Los Angeles	Yee, Sylvia Disability Rights, Education Defense Fund San Francisco

Appendix C: Organizations Submitting Written Input

The following organizations and individuals submitted written comments or letters to the Exchange on the questions listed in Appendix A. Comments were summarized above. Full length comments are available online at: http://www.healthexchange.ca.gov/StakeHolders/Pages/Default.aspx

100% Campaign
Anthem Blue Cross
Association of CA Life & Health Insurance Companies
Blue Shield of California
California Association of Alcoholism and Drug Abuse Counselors
California Association of Alcoholism and Drug Program Executives
California Association of Health Plans
California Association of Nurse Anesthesia
California Association of Physician Groups
California Association of Public Hospitals and Health Systems
California Association of Social Rehabilitation Agencies
California Children's Hospital Association
California Chiropractic Association
California Coalition for Reproductive Freedom
California Coalition for Whole Health
California Dental Association
California Family Health Council
California Healthcare Institute
California Medical Association
California Optometric Association
California Pan – Ethnic Health Network
California Primary Care Association
California School Health Centers Association
Children Now and The Center for Oral Health
Consumers Union
Delta Dental of California
Greenlining Institute
Insure the Uninsured Project
Integrated Healthcare Association
Kaiser Permanente
LA Trust for Children's Health
March of Dimes
Maternal and Child Health Access
Molina Healthcare of California
NHELP and the Health Consumer Alliance
Pacific Business Group on Health
PEACH
Petris Center on Healthcare Markets & Consumer Welfare; UC Berkeley School of Public Health
Preconception Health Council of California
Project Inform and San Francisco AIDS Foundation
Transgender Law Center
United Concordia Dental
Unite Here Health
UnitedHealth Group
URAC
Vision Service Plan
Western Dental Services, Inc.

Appendix D: Related Reference Material at March 2012 Exchange Board Meeting

The following reports were provided to Exchange Board members as background for discussions on qualified health plan contracting and delivery system reform. Included in the link to the February 21, 2012 board meeting are presentations made by panelist exploring these issues. All materials are linked below and available online at:

http://www.healthexchange.ca.gov/BoardMeetings/Pages/MeetingMaterialsforFebruary21_2012.aspx.

Georgetown Health Policy Institute - The Role of Exchanges in Quality Improvement

Report to Congress - National Strategy for Quality Improvement in Health Care

Health Affairs - Applying Value-Based Insurance Design to High-Cost Health Services

Health Affairs - Applying Value-Based Insurance Design to Low-Value Health Services

Health Affairs - Assessing the Evidence for Value-Based Insurance Design

Massachusetts Health Connector - Determining Health Benefit Design to be Offered in Exchange

National Business Coalition on Health - Value-Based Benefit Design

CHCF - Implementing HCR in CA, Payment and Delivery System Changes

Commonwealth Fund - Delivery System Reform Tracking

Commonwealth Fund - How Payment Reforms Can Help Achieve a High Performance Health System

Commonwealth Fund - The Path to High Performance US Health System

The New Yorker - Lower Costs and Better Care for Neediest Patients

NGA - State Roles in Delivery System Reform 2010

Appendix E: Other Stakeholder Submissions

In addition to the written comments submitted in response to the questions in Appendix A, stakeholders submitted the following letters and reference materials related to qualified health plan contracting and delivery system reform. All materials are linked below and available online at http://www.healthexchange.ca.gov/BoardMeetings/Pages/Default.aspx.

California Children's Hospital Association - Key Issues for Children's Hospitals in Exchange Implementation (1/26/12)

Pacific Business Group on Health - Comments on QHP Management and Delivery Reform Planning (2/15/12)

Integrated Healthcare Association – Recommendations for Success (2/16/12)

National Committee for Quality Assurance – QHP and Delivery System Reform Comments (2/23/12)

Integrated Healthcare Association – Contracting Between Commercial HMOs and Medical Groups (2/27/12)

Bay Area Council – Comments on QHPs and Delivery System Reform (3/21/12)

Latino Coalition for a Healthy California – Latino Priorities for an Effective and Equitable Health Benefit Exchange (3/27/12)