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# Background Comments for the California Health Benefit Exchange: Qualified Health Plan Policies

The Health Insurance Alignment Project (Alignment Project), supported by a grant from the California HealthCare Foundation to the Kelch Policy Group, provides policy analysis, research, technical assistance and policy commentary aimed at improving coordination of health insurance oversight in California. The Alignment Project supports and works in collaboration with state policymakers, legislative and administration staff. One goal of the Project is to focus on and identify strategies that facilitate informed and transparent consumer choice whether a consumer purchases coverage overseen by the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI).

The Project offers these comments to support and inform Board deliberations related to the selection, certification and oversight of the qualified health plans (QHPs) it offers. Essentially, these comments advise the Board to recognize and consider the statutory and regulatory differences which result from California's unique situation of having two state agencies involved in the oversight of health insurance. The differences that result from that structure matter for consumers and for purchasers, including the Exchange.

## Why it Matters

When enacting the federal Affordable Care Act (ACA), Congress established a common federal standard of benefits and market protections. The federal law and regulations also clearly contemplate that Exchanges would apply minimum federal standards equally to QHPs. The federal ACA and implementing rules do not seem to contemplate the dual (and sometimes conflicting) regulatory structure of health insurance regulation such as exists in California. Moreover, the state law creating the California Exchange requires it to determine the minimum requirements a carrier must meet to participate in the Exchange, and requires the board to "consistently and uniformly apply these requirements, standards, and criteria to all carriers."[1]

While the Exchange should not assume the role of a third regulator in California's health insurance markets, as an active purchaser, the Exchange has the opportunity and the responsibility to establish transparent and consistent policies and standards that apply uniformly to all QHPs in the Exchange regardless of the department overseeing the coverage. In developing its QHP policies, and working with DMHC and CDI in the certification process, the Exchange can benefit from and access the distinct expertise of both departments while at the same time ensuring that all QHPs meet a common set of standards and expectations.

Transparent and consistent QHP standards will advance the QHP policy guidelines adopted by the Exchange Board to date, including the principles of facilitating informed consumer choice of health plans and providers and being a catalyst for delivery system reform.

The Board also adopted as a QHP policy guideline promoting affordability of coverage. Affordability will be a critical element in getting people covered starting in 2014. However, while lower premiums may result when a carrier is subject to less regulatory scrutiny or different minimum standards affecting the coverage it offers, consumers may not discern the resulting differences in coverage or consumer protection until it is too late. Affordability is not best promoted through hidden, fine print differences that are not easily understood by consumers.

It is also not clear that different regulatory *processes*, other than major benefit and coverage differences, are key factors in the price and affordability of coverage. For example, a large California health plan which has substantial business subject to oversight by both DMHC and CDI, when asked by DMHC to explain why identical products under DMHC and CDI had different price structures, reported that the primary reason was because the CDI products were closed blocks of business subject to statutory pricing requirements and the CDI products were having to come in to compliance with the federal medical-loss ratio requirements.[2] The health plan did not in any way suggest that lower prices for the CDI product resulted from regulatory differences. Further, most of the large carriers in California offer products under both regulators -- eight national companies cover 93 percent of the lives at CDI in addition to the significant number of enrollees in their products subject to DMHC regulation.[3] Many of these carriers have in the past reported that they voluntarily adopt company-wide processes in many cases, based on meeting the highest standard at DMHC or CDI, to simplify operations and manage administrative costs.

To offer meaningful and transparent consumer choice, it will be important that the Exchange not simply build on and build in the long-standing, remaining regulatory differences among health insurance products but instead set QHP certification and contracting standards so that consumers buying coverage in the Exchange are offered comparable choices they can understand, navigate and compare based on price, quality and access.

## Specific Examples and Suggestions

Below are just a few examples of areas where the Exchange might establish uniform and consistent QHP policies that have an impact on the consumer's experience of coverage.

- ***Benefit uniformity***. All Exchange QHPs will have to meet the minimum benefit standard in the ACA known as essential health benefits. As of this writing, state legislation is pending and it is anticipated that the California Legislature will select a benchmark plan that defines essential health benefits for all individual and small employer coverage.

However, depending on the final legislation adopted, available coverage for essential health benefits could vary depending on the regulatory framework under which a QHP provides coverage. The Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) as enacted in the California Health and Safety Code (HSC) and administered by DMHC, defines in detailed regulations the specific services a health plan must cover while the California Insurance Code (CIC) overseen by CDI does not have the same type or level of regulatory detail.

As just one illustration, under Knox-Keene, inpatient hospitalization, which is a mandated basic health care service, is defined to include drugs, medications, biologicals, anesthesia and oxygen services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and other inpatient diagnostic, therapeutic and rehabilitative services as appropriate. Under the HSC, hospital inpatient care as defined must be covered where medically necessary, prohibiting fixed day or dollar limits. The CIC has no similar detailed definition or medical necessity requirement and the applicable CDI regulations for coverage of hospital services instead impose a standard of "real economic value," which can be met if the policy specifies a blanket amount for "miscellaneous hospital services for unnamed items" that exceeds five times the daily hospital benefit of the policy, or if in the case of separately named and limited benefits the coverage exceeds $15 per item, $150 in the aggregate or at least seven items are covered.[4] The hospital benefit can be deemed sufficient if it exceeds $30 per day or covers at least 60 days.[5] This means that two Californians enrolling in two Exchange QHPs, one regulated by DMHC and the other by CDI, presented as having parallel benefit packages, could experience material differences in coverage and cost-sharing associated with identical hospitalizations.

There are numerous other examples of benefit definition differences and applicable mandates that could affect the provision of essential health benefits. Other basic health care services with regulatory definitions applicable to Knox-Keene plans that are not mirrored in the CIC include physician services, ambulatory outpatient services, including physical, speech and occupational therapy, diagnostic lab and X-ray, home health, preventive health care services and emergency health care. In addition, while not currently a mandated benefit, if a Knox-Keene plan offers prescription drug coverage, the coverage must meet specific standards not applicable to health insurance policies under the CIC, including, just to name a few, the following: provide specified information about drug formularies to enrollees;[6] make available expeditious authorization for non-formulary drugs;[7] cover all medically necessary outpatient drugs including disposable devices, such as syringes for self-injectible drugs;[8] cover appropriately prescribed pain management medications for terminally ill patients;[9] cover inhaler spacers, nebulizers, and peak flow meters for pediatric asthma; and a prohibition on limiting or excluding coverage for drugs previously approved by the health plan for an enrollee.[10]

To address these differences, the Exchange could develop a standardized evidence of coverage for all QHP offerings that ensures consistent benefits and coverage. Consistent benefit definitions will also be important for the calculation of the actuarial value defining the coverage tiers that will be made available through the Exchange. The Exchange will be creating online tools and other materials allowing consumers to compare different products and benefits, but if the underlying coverage is different in undisclosed ways, the Exchange will fall short in supporting informed consumer choice.

- ***Consumer grievance and complaint standards and process***. Another important area of consumer protection is the standards and processes available to consumers when they experience a problem with their health care coverage. Having consistent consumer protections in this area will be an essential element for the Exchange to ensure that enrollees in Exchange coverage can access timely and responsive consumer assistance from participating Exchange health plans. Moreover, consistent requirements for health plan consumer assistance across all Exchange QHPs will facilitate the Exchange making available any additional and complimentary consumer assistance services for its enrollees. This is also an area of statutory and historical difference. For example, DMHC-regulated plans must provide for an internal consumer grievance process that meets specific criteria and response timelines.[11] There is no similar internal grievance process applicable to health insurers under the CIC, but insurers are subject to requirements relating to appeals of claims payment decisions. To address this issue, the Exchange could consider adopting the same approach as the Healthy Families Program (HFP), which requires, by contract, CDI-regulated plans to establish an internal grievance process that includes all of the features of the HSC grievance process, including the requirement to respond in writing to consumer grievances within specified timeframes.

- ***Evaluation of QHP network adequacy***. Federal law and regulations requires QHP issuers participating in the Exchange to ensure sufficient networks of providers "to assure that all services will be accessible without unreasonable delay."[12] In the July 16, 2012 Discussion Draft on QHP Policies, staff recommends that the Exchange meet this requirement by adopting existing but different statutory and regulatory standards applicable to health plans under DMHC and CDI.

  The Board Recommendation Brief on this issue justifies this recommendation in large part based on a distinction between Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) and the stated notion that "network access analysis is quite different for PPOs compared to HMOs." However, this distinction is not actually recognized in state or federal law.

  The federal QHP network adequacy rule does not establish a different standard or process based on the delivery model of the QHP or suggest that states can or should adopt different standards to ensure network sufficiency for HMOs and PPOs. California

law and regulations relating to geographic and timely access included in the HSC apply to both HMOs and PPOs subject to DMHC regulation. As of December 2011, the DMHC estimated that nearly 1.7 million Californians obtained coverage in PPOs under their jurisdiction. There are no exceptions to the DMHC geographic or timely access regulations for PPOs licensed under Knox-Keene.

The Discussion Draft also implies that a less rigorous network standard or network review for PPO coverage versus HMO coverage may be acceptable given that PPO plans offer "a broader network" and "do not require selection of or referral by a primary care provider to access specialty care." However, in both types of plans, an adequate network of contracted providers is important to ensure consumers have access to needed services. HMO plans typically do not provide coverage for non-contracting or out-of-network providers, except in emergencies, making the contracted network the primary way in which consumers must access services to obtain coverage. While PPO plans allow individuals to access non-network providers, coverage generally is substantially less for out-of-network services and a consumer accessing non-network providers can incur substantial, and often not fully anticipated, out-of-pocket costs for those services. Understanding the implications of accessing non-contracted providers, and having a sufficient choice of contracted network providers, will be especially important for enrollees in Exchange QHPs, many of whom will qualify for low-income subsidies and have limited financial ability to access and pay for expensive out-of-network services.

The Exchange could address the issue of consistent and uniform network accessibility standards and oversight through its QHP contracts and in the interagency arrangements made with DMHC and CDI to evaluate and certify potential QHPs. It would be possible and important to ensure that all Exchange QHPs comply with federal Exchange rules and that the Exchange partnership with DMHC and CDI includes the specificity and detail needed to ensure that Exchange QHPs offer the same network adequacy protections for consumers regardless of the model type or the department overseeing the product.

In the coming months, the Exchange will develop and finalize the QHP certification standards and process, including working with DMHC and CDI to establish interagency agreements related to the certification process for Exchange QHPs. In that context, an early public discussion of specifically how each department currently evaluates and monitors benefits and coverage, network adequacy, and plan internal consumer complaint programs could be illuminating for the Board and stakeholders. It could also be helpful to publicly explore specifically how the departments will monitor and enforce QHP certification requirements, as well as how each department will interpret and implement specific proposed requirements. For key consumer protections, the Exchange should establish clear expectations regarding future performance by all QHPs, including how the expectations will be monitored and enforced in collaboration with DMHC and CDI.

These comments have highlighted the importance of consistent and uniform QHP standards for consumers, the challenges in California's dual regulatory system, and a few illustrative examples of how the differences in health insurance oversight directly affect consumer choice and experience. The Project is available to work with the Board and the staff to discuss these specific suggestions and to identify additional opportunities for alignment of QHP standards and oversight in the interest of achieving the shared goal of transparent, informed consumer choice.

## Notes

[1] California Government Code §100503 (c).

[2] Blue Shield of California letter to DMHC. "Commercial Individual Plan Rates Effective on January 1, 2011." April 26, 2011. Obtained online at: www.dmhc.ca.gov

[3] Kelch, D. California HealthCare Foundation. *Ready for Reform? Health Insurance Regulation in California Under the ACA.* June 2011. Available online at: www.chcf.org

[4] California Code of Regulations, Title 10, §2220.15.

[5] California Code of Regulations, Title 10, §2220.16.

[6] HSC §1363.01, §1367.20, and §1367.24.

[7] HSC §1367.24 and California Code of Regulations, Title 28, §1300.67.24.

[8] Ibid.

[9] HSC §1367.215.

[10] HSC §1367.22.

[11] HSC §1368 and California Code of Regulations Title 28, §1300.68.

[12] Federal Register, Volume 77, No 59, 45 Code of Federal Regulations Part 156, §156.230.

KELCH POLICY GROUP

Supported by a grant from the California HealthCare Foundation to the Kelch Policy Group, the ***Health Insurance Alignment Project*** provides policy research, analysis and strategic assistance to advance the goals of reducing duplication, improving transparency and maximizing consumer protections in health insurance oversight in California.

The objectives of the Project are to: (1) Advance federal Affordable Care Act health insurance market reforms by providing California-specific analysis and offering technical assistance and process facilitation to key decision makers and staff; (2) Improve coordination and accountability of health insurance oversight through analysis and commentary, highlighting state challenges and opportunities related to health insurance oversight; and (3) Engage in a process and develop a framework for assessing long-term progress toward implementation of ACA reforms and effective health insurance oversight in California.

Kelch Policy Group is an independent health policy research and consulting firm based in Sacramento, California. The firm founder, Deborah Reidy Kelch, MPPA has more than 30 years of experience in California health policy, including 15 years as policy and fiscal staff to the California State Legislature.

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