October 4, 2012

Background for the California Health Benefit Exchange: Qualified Health Plan Draft Solicitation (Released for comment 9-25-12)

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).

As the Exchange Board deliberates and considers how it will approach the selection, certification and oversight of the qualified health plans (QHPs) it offers, it will be important to recognize that the statutory and regulatory differences which result from having two state agencies involved in oversight of health insurance matter for consumers, for purchasers and for the Exchange. 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 to establish transparent and consistent policies and contracting 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 participation standards.

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. To offer meaningful and transparent consumer choice, it will be important that the Exchange not simply build on and build in the long-standing regulatory differences among health insurance products. The Exchange will need to set and disclose specific QHP certification criteria and contracting standards so that issuers and regulators can determine compliance and consumers have comparable choices they can understand, navigate and compare based on price, quality and access.

In that spirit, the Alignment Project offers the following comments to the Board and staff of the Exchange related to the proposed draft solicitation dated September 25, 2012.

The draft QHP Solicitation, among other things, seeks information and attestations from potential QHP issuers related to regulatory compliance issues, such as the requirement in the federal Patient Protection and Affordable Care Act (ACA) for QHP issuers to be "licensed in good standing" with state regulators. In addition, the solicitation poses questions related to other ACA requirements for QHPs, such as the issuer's provider network adequacy and inclusion of essential community providers. Finally, the solicitation requests issuers to provide information on current and potential quality improvement strategies, performance measurement and other program, care management and quality innovations.

- ***Minimum standards and desirable qualifications***. In general, the solicitation structure provides flexibility for issuers to highlight their current programs, strategies and innovations across multiple dimensions. However, this overall approach could compromise the ability of the Exchange, stakeholders, regulators and ultimately consumers to effectively compare and contrast potential QHP offerings. The Exchange should establish a clear and unambiguous floor of minimum selection criteria and contract standards that all QHPs must meet which are transparent and publicly disclosed. Clear standards and criteria are essential to support a primary purpose of the Exchange, facilitating and promoting informed consumer choice. In addition, clear Exchange standards and expectations will help to clarify and inform the role of DMHC and CDI in the QHP certification process and create a more level playing field for all potential QHP issuers seeking to participate in the Exchange. Consistent and clear minimum standards would not in any way preclude the Exchange from inviting issuers to also identify and propose additional, "desirable" features or product characteristics they believe uniquely position them to most effectively serve the needs of Exchange enrollees.

- ***Role and responsibility of regulators.*** The Exchange proposes to rely heavily on DMHC and CDI to provide critical information as part of the QHP certification process and issuer compliance with ACA requirements, such as network adequacy, benefits and coverage and quality assurance. This is a reasonable approach to the allocation of resources and should limit costly duplication of effort for all participants. To ensure uniformity and clarity, however, the Exchange must work with DMHC and CDI to establish clear roles and responsibilities. To accomplish this, the Exchange should engage now in a public process to surface how each department currently evaluates and monitors key regulatory elements, as well as how the Exchange envisions the departments addressing those same areas in the context of QHP certification. Public discussion of the roles and responsibilities of the Exchange and the regulators, and the differences in legal context and approaches, would inform stronger and more meaningful interagency agreements between the Exchange and DMHC/CDI.

  Significantly, the respective regulator, and *not* the issuer, must provide to the Exchange the certification that the issuer is in good standing with the statutory and regulatory requirements of their license/certificate, in a uniform manner agreed to between the

Exchange and the regulators, consistent with applicable state law and regulations. To the extent that the Exchange establishes any certification criteria or contracting standards beyond the requirements of the issuer's license or certificate, the Exchange must itself evaluate issuer compliance with those criteria and standards or, alternatively, enter into a specific interagency agreement with the regulators to review issuer submissions and compliance. By way of illustration, the Managed Risk Medical Insurance Board (MRMIB) worked through an interagency agreement to have DMHC evaluate compliance with a contract medical loss ratio requirement for Healthy Families Program (HFP) health plans before medical loss ratio was a statutory requirement.

- ***Licensed in "good standing."*** The ACA requirement of issuer compliance with a license or certificate in "good standing" is not a concept mirrored in California law. The Exchange needs to define this concept and the process whereby regulators, QHP issuers and stakeholders clearly understand what it means and how it is measured. This is also important since there are two state regulating agencies, DMHC and CDI, which could potentially interpret the requirement differently.

  The proposed definition of "good standing" in the draft solicitation (page 9) requires issuers and regulators to interpret and report regulatory violations that are "material" or "grievous." At a minimum, the Exchange should provide a clear definition of these terms to facilitate more uniform application. Ideally, the Exchange should require issuers and regulators to disclose in a consistent format all statutory or regulatory violations imposed by the respective regulator over a specified period. This would allow the Exchange to gather more complete information for evaluating potential issuers and to be the single entity making a consistent determination as to whether the violations are "material" or "grievous" for purposes of contracting with the Exchange, regardless of the department under which the issuer is regulated. Further, this approach is more consistent with the intent of the federal government. In comments by the federal Centers for Medicare and Medicaid Services (CMS) in the Final Exchange Rule, CMS interprets "in good standing" to mean that an "issuer faces no outstanding sanctions imposed by a state's department of insurance."[1] No threshold determination of materiality is required in the final Exchange rule.

  The Alignment Project strongly recommends consistent and uniform QHP selection criteria and contracting standards for all QHPs regardless of the applicable regulatory framework as the most effective way to ensure meaningful consumer choice. At a minimum, issuers must have to comply with existing statutory and regulatory requirements applicable to the products they are offering to the Exchange. The list of potential regulatory violations in the draft solicitation (page 9) implies that for some

[1] Final Rule; Establishment of Exchanges and Qualified Health Plans;77 Fed. Reg. No. 59, 3/27/12. Page 18415.

categories there are no requirements applicable to issuers certificated by CDI, including claims payment policies, provider complaints and administrative and organizational capacity. While it is certainly the case that the requirements in law in these areas are very different in the Health and Safety Code and the Insurance Code, and the regulatory processes distinct, there are provisions on these issues in both Codes. By way of illustration, see the following sections of the Insurance Code regarding claims payment policies (Insurance Code §790.3, §10123.13, §10123.147 and §10133.66); provider complaints (Insurance Code §10123.135) and quality improvement (Insurance Code §10133).

- ***Evaluation of QHP network adequacy***. Since the Exchange has so far chosen not to set any selection criteria or contract standards related to network adequacy for QHPs, other than those already required in law and regulation, there is no purpose to a further issuer attestation (page 14) that they comply with existing law on network adequacy. Although under the ACA exchanges must ensure adequate networks for QHPs, the Exchange has chosen to completely defer to DMHC and CDI and the relevant but different standards that apply to issuers. Given this policy choice, regulators, and not the issuers, should attest to the issuer's compliance with the appropriate network adequacy requirements as part of the determination that the issuer is "in good standing" with their license or certificate.

- ***Member services and consumer complaints***. Since there are statutory and regulatory differences related to the handling and timely processing of consumer complaints by issuers under DMHC and CDI, and two different agencies handling consumer complaints, it is critical for the Exchange to set clear expectations for all QHP issuers and clear lines of authority to ensure that consumers are not confused about how and where to go to get assistance. The Solicitation section on Member Services (page 19) deals with customer service center hours and staffing but does not address timing and process expectations the Exchange will impose related to consumer complaints and assistance. Will QHP issuers be required to respond to all consumer complaints in writing and to resolve grievances within specified timeframes as required for all health care services plans under DMHC (Health and Safety Code §1368)? For example, to establish consistent expectations, MRMIB imposes by contract the requirement that HFP health plans, regardless of the department which regulates them, include all features of the Knox-Keene consumer grievance requirements imposed on health care service plans. Will the Exchange require issuers to report complaint outcomes or elapsed time to resolve complaints?

- ***Quality improvement and performance measurement.*** The draft solicitation requests issuers to answer multiple questions and provide detailed information about record keeping, medical management, disease management, wellness programs, medical homes, and numerous other quality improvement strategies and innovations the issuer

may have implemented or will implement. Notably, the solicitation does not establish a clear set of expectations and measurements that would apply consistently for all QHPs in the Exchange. It is not clear if the Exchange expects all issuers to address all possible strategies and approaches or if the listed options are a menu which issuers might choose from in developing their QHP offerings.

The proposed approach in the Solicitation will be administratively complex for the Exchange and QHP issuers to implement and will ultimately undermine and frustrate the goal of simplified consumer choice and comparison. Collecting voluminous information about disparate and distinct issuer programs and processes will make evaluation and comparison of QHP bids complex and difficult for the Exchange. Moreover, if every issuer implements and reports on different programs and offerings it will seriously complicate Exchange evaluation efforts. The Exchange should instead identify and focus on a few early quality and performance initiatives that all QHPs must implement and establish clear performance metrics over time to allow the Exchange (and consumers) to evaluate relative issuer performance. Rather than asking issuers to describe how they might (or might not) currently address a laundry list of options and programs, the Exchange should provide clear direction and goals in specific key program areas and then ask each plan to describe how they would meet those expectations allowing for creativity or delivery system differences. There could also be one section allowing issuers to identify one or two innovations they would like to bring to Exchange coverage beyond the common set of expectations. Simplifying in this way would make QHP selection and monitoring over time more manageable for the Exchange, issuers and consumers.

The Alignment Project is available to work with the Board and the staff to identify opportunities to align Exchange QHP standards and oversight in the interest of achieving the shared goal of transparent, informed consumer choice.

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.