NATIONAL HEALTH LAW PROGRAM

3701 Wilshire Boulevard
Suite 750
Los Angeles, CA 90010
Ph. (310) 204-6010
Fax (213) 368-0774
nhelp@healthlaw.org

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Via email

The Honorable Diana Dooley, Chair
California Health Benefit Exchange
2535 Capitol Oaks Drive Suite 120
Sacramento, CA 95833

RE: California Health Benefit Exchange 2012-2013 Draft Initial Solicitation to Health Issuers

Dear Chairwoman Dooley and Members of the Board:

We are writing on behalf of the Health Consumer Alliance (HCA), a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, which includes: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Greater Bakersfield Legal Assistance, Legal Aid Society of Orange County, Legal Aid Society of San Diego, Legal Aid Society of San Mateo, Legal Services of Northern California, Neighborhood Legal Services of Los Angeles County, the Western Center on Law and Poverty, and the National Health Law Program. We are pleased to present our input on the Exchange's Draft Qualified Health Plan Solicitation. Our recommendations and comments are below.

- **I.H Key Action Dates**

NHeLP and the HCA appreciate the importance of moving the QHP process along at a pace that ensures plans are certified and ready to market in mid-2013, and we commend the Exchange for being so proactive and moving more quickly with this than other states are doing. While the Key Action Dates set out on pages 4 and 5 of the Draft Solicitation generally sound reasonable given the time constraints, we do have some concerns about the time frames for the two regulatory agencies, Department of Insurance (DOI) and Department of Managed Health Care (DMHC), to perform the considerable amount of regulatory oversight that will be required of them. We want to be sure that the regulators can undertake their review of the new products, including the critical functions of rate review and of approving network adequacy, in sufficient time for the Exchange to effectively carry out the contracting process.

While it may be difficult for the Exchange to adjust the Key Action Dates, we do think that the Draft Solicitation should be clearer about when exactly the various oversight tasks to be carried out by DOI and DMHC fit into the process. It appears that many of the tasks required of the oversight agencies will occur after submission of bidder responses on January 4, 2013, rather than before, leaving a time frame of less than three months before final decisions are made on the plans with which the Exchange will contract. Clearly, the Exchange will need responses from the two other agencies significantly prior to March 30, in order to make decisions about the plans with which it is going to negotiate specific contract terms. It would be helpful if the Draft Solicitation could set out, at a minimum, estimated time frames for the agencies' review. The bidders' would then know how quickly they would have to respond to the agencies' requests for information, so that the process can be completed on time and so that the

Exchange will have a sufficient opportunity to assure that the approvals they are receiving from the agencies appear to have been done properly.

- **I.J Review of Bids for Award / Selection Criteria**

NHeLP and the HCA are disappointed by the lack of information in the Draft Solicitation about the review process and selection criteria that will be used to evaluate bids. We urge the Exchange to quickly develop specific guidelines on the review process (including who will review bids and make decisions about selection, as well as what criteria will be used to make awards), and to seek stakeholder input on those guidelines as soon as possible. For example, we are heartened that the Exchange plans to collect a significant amount of valuable information about plans' cultural and linguistic competency through eValue8 modules. Without knowing how the information collected will be used to evaluate and rank plans, however, it is difficult for us to comment on those modules. Whatever guidelines are selected should give particular weight to plan components that are important to consumers, including network adequacy, adequate protections against balance billing, efforts to address health disparities, and the ability to communicate information clearly and in consumers' preferred languages. Further, we note that, in several places, the Exchange will allow plans to self-attest to their meeting of certain external standards (e.g., licensing, network adequacy, etc.). We urge the Exchange to require plans to provide actual documentation demonstrating that they meet requirements, and also to make provisions to allow the Exchange to independently confirm or verify plans' compliance with external standards.

We appreciate the challenging balance that the Exchange must strike to both make information transparent and available to consumers and also protect confidential proprietary health plan issuer information. But while certain information contained in issuers' bids may require confidentiality protections, other information must be made available to the public—at least in an aggregated form—to allow for meaningful stakeholder engagement and input. At a minimum, the Exchange must ensure that quality, performance, network, and overview data are available in some form, so that consumer advocates and other stakeholders can provide meaningful input during the evaluation and selection process. We urge the Exchange to consider appointing stakeholders, including consumer advocates, to whatever body is designated to review bids. In addition, there is no reason that plans' intent to bid, which is non-binding and does not contain any proprietary information, should not be made public. Stakeholders will benefit greatly from knowing which plans are considering Exchange participation, and which are not.

- **II.B.1 Plan Network Design Issues**

Number of Products

NHeLP and the HCA support the proposal to require bidders to submit a bid for each metal tier and catastrophic plan for each product it proposes. A "product" for this purpose should be defined to include plans that use the same provider network, benefit structure, and administration, but that may vary in terms of cost-sharing design. We urge the Exchange to carefully review and limit the number of "alternative benefit designs" that bidders may submit to ensure that such alternative designs are not a backdoor to adverse selection, and do not create consumer confusion. Massachusetts's experience with its Health Connector indicates that allowing too many variations in design can overwhelm consumers. Thus, in 2010, Massachusetts reduced the number of plan designs from 27 to only nine. We recommend that the Exchange look to ensure that, in each region, it offers at least one low or no deductible option, and one option with a higher deductible and lower copayments / coinsurance.

Two-Tier Networks

NHeLP and the HCA oppose the proposal to allow two-tier networks to overlay benefit designs. First, this proposal was not raised at the August or September 2012 Board meetings, nor did it appear in the QHP policy proposals adopted by the Board, and therefore it was not vetted by stakeholders. Second, while the Draft Solicitation states that actuarial value calculations for two-tiered networks will be based on "likely overall use of tiered networks," Draft Solicitation at 11, such calculations may be highly prone to inaccuracies and to misleading consumers. For the population likely eligible for Exchange subsidies, a two-tier network is likely to expose enrollees to significant cost liability in the second tier, which could result in heavy medical debt. To the extent that two-tiered networks are permitted, the Exchange must work with plans to ensure that consumers must be given sufficient information about the providers included in each tier, and the differences in cost-sharing between tiers, to make an informed decision in selecting a plan. Without this information, it will be impossible for consumers to calculate their likely cost liability in two-tiered networks. Furthermore, the Exchange should take steps to ensure that two-tiered networks don't make an end-run around network adequacy requirements and ECP requirements; any two-tier networks must meet those requirements in the tier that exposes consumers to less cost-liability (i.e., the first tier).

High Deductible Health Plans

Finally, NHeLP and the HCA oppose the proposal to establish separate High Deductible Health Plans (HDHPs) with Health Savings Accounts in the Exchange. First, this proposal was not raised at the August or September 2012 Board meetings nor did it appear in the QHP policies adopted by the Board, and therefore it was never vetted by stakeholders. Second, as we understand the ACA, HDHPs may only be allowed in the Exchange to the extent that their actuarial value fits within one of the metal tiers. As such, bidders already have the option to propose HDHPs as an "alternative benefit design," which would give the Exchange the chance to evaluate whether HDHP designs are consistent with its values. Third, HDHPs are confusing to consumers, and therefore should generally be discouraged in the Exchange. HDHPs benefit healthier, wealthier consumers who can get the tax benefits and take the risk that they can pay the deductible if they have an accident or serious health condition. Too often, consumers are attracted to HDHPs due to their relatively low premiums, but they misunderstand their potential liability in terms of out-of-pocket costs. As a result, before meeting their deductible, consumers either end up with large medical bills that they can't afford, or go without needed care in an effort to save money. The Exchange should look closely at proposed HDHP designs to evaluate whether they have sufficient consumer protections in place to avoid these results, and should also ensure that, to the extent HDHPs are permitted in the Exchange, consumers receive enough information to make an informed decision about choosing an HDHP.

- **II.B.2 Health Plan Provider Network Adequacy**

NHeLP and the HCA oppose the proposal to allow plans to simply attest that they "meet provider network adequacy standards established by the relevant regulatory agency." This attestation alone is not sufficient to ensure that plans actually comply with the relevant standards, much less that their networks are actually adequate.

At the August 23, 2012 Exchange Board meeting, the Board voted to not only look to the respective regulatory agencies to certify network adequacy, but also to perform independent oversight and review of the adequacy of plan's networks. Allowing plans to simply state that they meet the applicable standards will not provide the Exchange with sufficient information to perform its own oversight of plans' networks. The Exchange should require bidders to provide documentation of the relevant agency's certification of their plans' network adequacy, and also documentation of the names, numbers, types,

acceptance of new patients, coverage of essential health benefits, accessibility of network facilities to people with disabilities, and locations of their providers. In addition, the Exchange should require plans to document their relationships with Independent Physician Groups (IPAs) or other delegated groups that serve to limit enrollees' access to the plans' overall networks. The Exchange should also ask bidders to provide geo-access maps of their providers and IPAs relative to the target population for the Exchange in each region.

While we appreciate that, elsewhere in the Draft Solicitation, plans are asked to demonstrate their compliance with ECP network adequacy requirements, to identify the percentage of board certified providers with whom they contract, and to describe their plans for network development, the Exchange must collect additional information on the plans' overall networks to be able to engage in meaningful oversight of the adequacy of their networks. At the very least, plans must be required to attest that their networks have been *certified* by the relevant agency as meeting applicable network adequacy standards, to ensure that the plans have undergone the applicable regulatory review process.

- **II.B.4 Quality Improvement Strategy-Promoting Better Care, Better Health, and Lower Cost**

The Draft Solicitation states that the Exchange intends to apply to be an approved pilot site for the use of preventive and wellness incentives for members who enroll in the Individual Exchange (as well as allowing such incentives in the SHOP). In previous comments submitted by NHeLP and the HCA, we expressed in detail our concerns about the potential negative impacts of such incentives. *See* NHeLP & HCA Comments dated August 6, 2012, at p. 17. Such incentives pose serious challenges for low-income persons, who face barriers to maintaining health and participating in wellness activities that may be required, and for racial and ethnic minorities, who are disproportionately affected by chronic illnesses like hypertension and obesity. Further, there is little research supporting the effectiveness of such programs. If the Exchange does move forward with a pilot project for the Individual Exchange, we urge that such a project be carefully examined, with the results made available for public comment, before any wider application is considered.

- **II.C.2 Member Services**

Complaints and Grievances
NHeLP and the HCA applaud the Exchange for collecting detailed information about the customer service functions and capacities of bidders. We urge the Exchange to also collect information about bidders' complaint and grievance policies, and the ways in which they communicate about those policies to their members. In addition, we suggest that the Exchange ask bidders about their ability to integrate their existing complaint and grievance structure to interface with the formal grievance and appeals procedures established for the Exchange.

Language Access
Because of the large numbers of limited English proficient (LEP) individuals who will be purchasing insurance through the Exchange, it is absolutely critical that the Exchange ensure that linguistically and culturally appropriate services are provided by the QHPs that are accepted for contracting with the Exchange.

While the QHPs will have the legal obligation to comply with the requirements of Title VI of the Civil Rights Act of 1964, Section 1557 of the ACA (non-discrimination), Health and Safety Code Section 1367.04 (SB 853), and applicable oversight agency regulations and guidelines, a large amount of responsibility sits on the shoulders of the Exchange to assure that the required accommodations are

being made for LEP plan members. The current draft of the Solicitation does not adequately require that the bidders provide sufficient information to assure that the required standards are being met.

We are supportive of the requirement that bidders complete Section 1.7 of eValue8, which will give a broad outline of the types of language services provided by the QHPs, as well as the activities undertaken to assure that culturally competent care is being provided. However, the check-the-boxes approach of eValue8 will only provide an overview and does not sufficiently obtain the information necessary to assure that the QHPs will be meeting their members' language needs. Section 1.7.1 addresses what data will be collected from new enrollees and previously-enrolled members, but does not sufficiently address how the QHPs will estimate the needs of their projected members so that services can be in place when the Exchange rolls out. Further, section 1.7.2, while appropriately asking for percentages of physician providers that are proficient in languages other than English, only seeks data for physician providers. It will be critical that communications services for LEP persons be provided for services other than physician services, such as for DME providers and home health providers, to assure that persons with limited language proficiency will be able to properly access needed care.

In order to make up for the deficiencies in the eValue8 tool in regard to language access, we believe that the Member Services section of the Draft Solicitation should be beefed up significantly. Bidders should be required to provide information on how they are estimating the language needs of their expected enrollment population. They should be required to demonstrate that they will be providing written translations of documents in accordance with applicable standards for any substantial percentages of their expected enrollment with particular language needs and that they will be providing tag lines in other languages that do not meet the threshold for full translations. They should be required to demonstrate how they will be providing sufficient access to customer service representatives who are bi-lingual in particular languages, and how they will be providing quickly-available oral translation services for those persons with needs in more uncommon languages. They should be required to assure that they are providing interpretation services on a 24-hour basis, at no cost to the member. They should be required to provide information on how they will be assuring the competency of the interpreting services they are providing. The current draft only seems to ask bidders to indicate "languages spoken" and then "Describe," which is clearly insufficient for the Exchange to determine if the proper LEP services will be in place. Further, the bidders should be required to demonstrate how the language needs of their members will be met by the providers who will be providing services to their members.

In addition to demonstrating that translated documents and interpretation services will be properly provided, QHPs should be required to demonstrate how they intend to assure that their network of providers will provide services that are appropriate and culturally sensitive to the populations that they are serving. The bidders should be required to demonstrate that they will be providing diversity-training for plan employees, including cultural and racial diversity, meeting the needs of the LGBT community, and working with people with disabilities. Further, bidders should commit to providing plan materials, particularly marketing materials, to the Exchange for review to assure that there is no cultural bias in the plans' outreach to their enrollees or potential enrollees.

Disability Access

Similarly, many people with disabilities will purchase coverage through the Exchange. Thus the Exchange must take steps to ensure that QHPs are able to communicate effectively with people with disabilities, including by providing reasonable accommodations, when needed.

While QHPs will have the legal obligation to comply with the requirements of Title VI of the Civil Rights Act of 1964, Section 1557 of the ACA (non-discrimination), the Americans with Disabilities Act, and

Section 504 of the Rehabilitation Act, and applicable oversight agency regulations and guidelines, a large amount of responsibility sits on the shoulders of the Exchange to assure that the required accommodations are made for plan members with disabilities. The Draft Solicitation does not adequately require that the bidders provide sufficient information to assure that the required standards are being met. In fact, it does not collect any information about bidders' ability to communicate with people with disabilities and provide reasonable accommodations. At a minimum, bidders should demonstrate their ability to provide all materials tailored specifically to meet the particular needs of people with disabilities, including the provision of materials in Braille, large font, and other formats that comply with state and federal disability laws.

Tracking Out-of-Pocket Costs
Finally, since the Exchange has elected not to play a role in the collection of premiums, it is critical that the QHP's have robust, accurate, up-to-date and accessible systems for keeping track of premium payments, as well as other aspects of members' personal financial obligations. Members should have easy access to information on premiums paid and other out-of-pocket costs paid. It is important for the QHP to have the responsibility to calculate and track out-of-pocket costs, so that the burden is not on the individual members to determine whether they have met the ACA-required cap.

This information should be easily accessible electronically to the members; for those without internet access, Plan representatives should be available by telephone to provide this information upon request. Periodic statements showing a record of costs paid by the member should be mailed to the member, and members should also be given the option to elect to receive periodic statements electronically. The Draft Solicitation does not appear to seek assurances from the bidders that these functions will be provided. It should seek such assurances and inquire of the bidders to describe the systems they have in place to accomplish these functions.

- **II.C.3 Out of Network Benefits**

NHeLP and the HCA applaud the Exchange for proposing to ask bidders about their ability to reimburse out of network benefits and avoid balance billing to consumers. We urge the Exchange to look closely at bidders responses to this question in evaluating whether or not to award them a bid.

Avoiding balance billing will be especially important when issuers offer PPO products regulated under the Insurance Code. Those products are not required to provide timely access to services, which may result in extremely low-income consumers obtaining needed services out-of-network at great cost. We therefore particularly commend the Exchange for making clear that bidders must ensure that consumers are held harmless when their networks lack contracts with in-network physicians. Draft Solicitation at 45. We are also heartened that the Draft Solicitation requires bidders to describe their cost containment strategies with respect to non-network providers who work in network facilities. Draft Solicitation at 24.This information will help the Exchange to evaluate whether bidders are prepared to protect consumers' financial liability when their networks are not adequate. The Exchange's use of the FAIR health UCR approach to managing consumers' potential cost liability when they have no choice but to access services out-of-network will also help to ensure that consumers are protected, though it does not eliminate a need for robust timely access standards for all QHPs.

- **II.C.6 Medical Management Services**

The Draft Solicitation does not ask bidders to provide any information about their plans to transition enrollees who have existing provider relationships. NHeLP and the HCA suggest that the Exchange request information about bidders' ability to manage these transitions. There are currently over 25,000 persons with income above 133% FPL enrolled in Low Income Health Plans (LIHPs), who will likely be

transitioning to Exchange health plans. The Exchange should take steps to ensure that QHPs pay special attention to them and to people with disabilities and other vulnerable populations as this transition occurs. Where possible, the Exchange should look to contract with health plans that are already serving these populations, so that no transition of providers will be necessary. To the extent such contracting is not possible in certain geographic areas, the Exchange must ensure that bidders have in place a carefully thought-out process for transitioning enrollees to new providers and sharing their medical records, particularly for those currently receiving care for ongoing complex and chronic conditions.

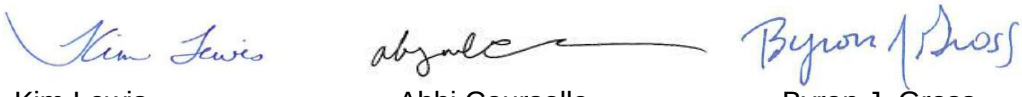
- **II.C.8 Integrated Healthcare Module**

A box on page 32 of this section asks: "Should the Exchange require Issuers to require CAHPS member satisfaction reporting for Exchange enrollees?"

NHeLP and the HCA are not sure why the question on CAHPS reporting is being asked in this section. Regardless, we do believe that the Exchange must require bidders to report CAHPS member satisfaction. The Board resolved at its August 23, 2012 meeting that QHPs would be required to report "CAHPS and HEDIS measures consistent with Medi-Cal Managed Care specifications" by 2014. Requiring issuers to report on CAHPS member satisfaction results in the bidding process is consistent with that policy.

Thank you for the opportunity to comment. We look forward to further discussion of these matters.

Sincerely,



Kim Lewis Abbi Coursolle Byron J. Gross