California Health Benefit Exchange: Stakeholder Questions
Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability

The California Health Benefit Exchange welcomes your input on Qualified Health Plan policies and strategies under consideration. The policies and strategies are laid out in a Board Recommendation Brief available on the Exchange website. Please use the table below to provide your input. We welcome data and references as well as written comments. Please submit your comments to the Exchange at info@hbex.ca.gov no later than **Monday, August 6, 2012**.

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Section 3: Guidelines for Selection and Oversight of Qualified Health Plans	The National Health Law Program (NHeLP) and the Health Consumer Alliance (HCA) agree that the California Exchange Board should look to its core values when it develops guidelines for selecting and monitoring QHPs and developing the small employer health options program. In general, we believe that the staff's recommendations to the Board on these issues are successful in promoting those values and striking a balance between competing priorities. Our detailed comments and suggestions for improvement follow.
Section 4: Core Minimum Qualified Health Plan Certification Requirements	NHeLP and the HCA appreciate the work that the Exchange staff have done to collaborate with the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to coordinate plan monitoring and oversight. We support the proposed process of identifying plans "in good standing" that will be permitted to bid for QHP status.
Section 5: Plan and Network Design Issues	NHeLP and the HCA have long supported the California Exchange's role as an active purchaser. We appreciate that the recommendations in this section strive to balance consumer choice with simplicity. We share the goal of ensuring that consumers who purchase coverage through the Exchange have a sufficient number of plans to choose from that offer them meaningful choices. But we equally support the goal of offering consumers a streamlined and standardized selection of plans that facilitates choice based on the most important features—cost, provider networks, quality and customer service. For the most part, these recommendations meet those twin goals. Our comments on particular recommendations follow.
Section 5A: Active Purchaser: Number and Mix of Exchange	**Issue 1: Metal Level Tiers of Qualified Health Plan Bids** NHeLP and the HCA support the proposal to require bidders to offer a product in each tier in each region in which it bids. As we understand this proposal, such bids would include similar products that vary primarily on cost sharing, while containing the same covered benefits, product type and provider network. As such, this proposal supports consumer choice by assisting consumers to evaluate plan value and understand the tradeoffs between, for example, premiums and cost-sharing, while holding other factors constant. In addition, this proposal will help the Exchange ensure that it offers equivalent plans in each tier in each region.

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Plans	**Issue 2: Number of Carrier Qualified Health Plan Product Bids** NHeLP and the HCA also support the proposal to allow health plan issuers to propose a limited number of products in each region. This proposal strikes the right balance between the extremes of allowing only one bid per region and allowing an unlimited number of bids. We agree that allowing a small number of bids per issuer per region will facilitate competition and choice, without overwhelming the Exchange and regulators. Although consumers must have meaningful choices of QHP products in the Exchange, too many identical choices may only create confusion. Allowing a small number of bids per region provides the right balance between choice and simplicity. In addition, allowing more than one bid per region could be especially important in rural areas of the state where the Exchange might otherwise be challenged to obtain a sufficient number of bids to ensure such choice. **Issue 3: Geographic Coverage by Health Plans** No comments.
Section 5B: Rating Issues: Family Tiers, Age, Geography, Tobacco and Wellness	NHeLP and the HCA commend the Exchange staff for carefully explicating the various issues pertaining to ratings and for proposing options that have the goal of achieving success for the Exchange (standardization of factors both inside and outside the Exchange), keeping issuers from being able to "cherry-pick" (by allowing varied rating factors that can be manipulated), and making choice as easy as possible for consumers (standardizing plans as much as possible). We are generally supportive of the options that the staff has proposed. We note, however, with so many factors still to be set by either state legislation or federal rules, the issues raised here should be revisited when any such laws or regulations are enacted. **Issue 1: Standardization of Family Structure Rating Factors** No comments. **Issue 2: Standardization of Age Factors** No comments. **Issue 3: Requirement that Issuers Cover Entire Geographic Regions** In regard to geographic access, NHeLP and the HCA agree that issuers should be required to cover the entire region in which they are licensed. We note that the Exchange should be observant that issuers do not use whatever geographic ratings are ultimately allowed to be used as a proxy for experience rating. For example, research indicates that rural areas (or other low-income areas) could have higher premiums that are not merely based on geographic cost differences, but are really intended to raise premiums for populations with higher health risks. *See* ANDREW COBURN *ET AL.*, STATE HEALTH ACCESS REFORM EVALUATION, THE RURAL IMPLICATIONS OF GEOGRAPHIC RATING OF HEALTH INSURANCE PREMIUMS (2012), *available at* http://www.rwjf.org/files/research/74475.ruralimplications.pdf. Even if geographic rating areas are set by state law, the Exchange should monitor the impact and suggest any changes in those areas that will best level the playing field for all consumers.

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	Issue 4: Allowable Rate Adjustment for Tobacco Use In regard to Tobacco Ratings, NHeLP and the HCA agree that rates should not be increased to an extent that discourages coverage. We agree that this topic warrants further research before the Board determines whether to allow tobacco rating at all, and we look forward to reviewing additional materials on this subject. **Issue 5: Wellness Program Incentives** NHeLP and the HCA recognize the valid goals of Wellness Programs, but also acknowledge the very real fact that the use of financial incentives to encourage participation in them can disadvantage certain populations. Unfortunately, it is often much more difficult for racial and ethnic minorities and low-income persons to meet wellness goals due to inherent barriers such as difficulties accessing fresh foods, being forced to work multiple jobs, etc. It is critical that the Exchange closely monitor the impact of such incentives to the extent they are allowed. We offer a more detailed discussion of the issues raised by Wellness Program Incentives below in our comments to section 6C.
Section 5C: Plan Design Standardization	**Issue 1: Standardization of Cost Sharing Provisions** In general, NHeLP and the HCA applaud the recommended approach to offer limited standardized cost-sharing across benefit packages in the Exchange. Not only does this approach limit insurance companies' ability to "cherry-pick" low-risk enrollees, but it will offer consumers a clearer range of options. We agree that too much variation in cost-sharing will lead to major confusion for consumers trying to compare plans. The proposed approach parallels the experience of Massachusetts' Health Connector, which reduced the number of standardized cost-sharing options from 27 to 8, in response to consumer feedback that the original design made comparisons unwieldy and difficult to understand. We urge the Exchange to clarify the rules for insurance plans' use of non-quantitative utilization management (UM), such as prior authorization and step therapy. These UM techniques are not clearly accounted for in HHS' guidance on the actuarial value calculator, but they can directly affect enrollee costs, and may create significant barriers to utilization. At a minimum, the Exchange should specify and limit what UM techniques QHPs will be allowed to apply and require QHPs to clearly indicate in all outreach and enrollment materials how such UM techniques will apply so consumers can effectively compare between plans. In particular, the Exchange should limit UM techniques to ensure that all women have a meaningful choice of contraceptive methods without cost-sharing. The Health Resources and Service Administration requires that new plans cover the all FDA-approved contraceptive drugs, devices and sterilization procedures. U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., *Women's Preventive Services: Required Health Plan Coverage Guidelines*, http://www.hrsa.gov/womensguidelines. Further, not all contraceptive methods are right for every woman, and access to the full range of options allows a woman to choose the most effective method for her lifestyle and health status. Access to all FDA-approved contraceptive methods ensures that women with certain medical conditions or risk factors need not rely on contraceptive methods that are medically contraindicated. We recommend the FamilyPact program as an appropriate model for providing a comprehensive array of contraceptive options. Further, we recommend that step therapy be prohibited in conjunction with contraception given the serious consequences of a contraceptive failure. We also make specific comments about the role of value-based benefit design in cost-sharing below.

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	With regards to cost-sharing distribution, we commend the proposal to offer a range of options in each tier to accommodate applicants' healthcare needs and preferences. The Board Background Brief solicits comment on whether to add a zero deductible silver tier plan to this list of options. Deductibles have been shown to reduce healthcare utilization indiscriminately for both essential and non-essential care. As such deductibles are not consistent with the goals of value-based benefit design (see below). We recommend that the Exchange include a zero-deductible option for silver tier plans, noting that Massachusetts already has a no-deductible option in its plan. *See* MASSACHUSETTS HEALTH CONNECTOR COMMONWEALTH CHOICE, SILVER (2012), *available at* https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/Brochures/Silver_Jan2012.pdf. Our specific suggestions on how to prioritize cost-sharing distribution in the benefit design follow: • Most importantly, to the extent possible **reduce copayments on generic prescription drugs** (and on any brand names that have no generic alternative**), primary care physician (PCP) visits and other routine services** to keep people, especially people with chronic illnesses, from delaying care until they are much sicker and require more expensive options. *See, e.g.,* Dana P. Goldman et al., *Varying Pharmacy Benefits with Clinical Status: The Case of Cholesterol-Lowering Therapy*, 12 AM. J. MANAGED CARE 21 (2006). • Reducing copays is especially important for lower income and vulnerable populations, where fixed copay amounts present a proportionally higher barrier to care. Resulting decreases in pharmaceutical use often lead to higher overall medical spending due to increases in hospitalization and other expensive forms of care. *See, e.g.,* Amitabh Chandra *et al*., *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 AM. ECON. REV. 193 (2010); John Hsu *et al.*, *Unintended Consequences of Caps on Medicare Drug Benefits*, 354 NEW ENGLAND J.MED. 2349 (2006). The Exchange should prioritize prescription drug copay reductions, especially for enrollees who receive cost-sharing reductions. We recognize that tiered pharmaceutical copays are a form of value-based benefit design meant to incentivize shifting to cheaper alternatives, like generics. This goal is desirable, but the practical effect can be less than perfect. At least one study has shown that, perhaps due to poor consumer education, raising copays on brand name drugs caused a reduction in *both* brand name and generic drug utilization. *See* Teresa B. Gibson *et al*., *A Copayment Increase for Prescription Drugs: The Long-Term and Short-Term Effects on Use and Expenditures*, 42 INQUIRY 293 (2005). In addition, this approach may unfairly punish those for whom generic drugs are not a medically appropriate alternative to their brand-name equivalents. • Next, **reduce or eliminate deductibles**, which do not support the value-based benefit design methodology and represent higher barriers to care than co-insurance. Ensure that PCP office visits and prescription drugs require only copayment (if any) and exclude them from the deductible requirement. • The out-of-pocket maximum is, for most people, the least likely to impact service utilization. Thus, raising the out-of-pocket maximum, to the extent permitted by the ACA, might be generally better for consumers as opposed to raising copayments, coinsurance or deductibles. There should be an option with lower out-of-pocket maximums for individuals who have very

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	high expected medical expenses, but the best cost-sharing structure for most consumers would set out-of-pocket limits at the maximum and reduce other types of cost-sharing. Finally, the Exchange will need to clearly define and standardize the different forms of cost-sharing and their interrelationship. In particular, plans vary widely in how they count deductibles and out-of-pocket maximums. One survey of workers in various employer HMO plans found that numerous cost-sharing elements did not count toward their out-of-pocket maximum: 50% of workers could not count office visits, 72% could not count prescription drug expenses, and 35% could not even count their deductible expenses. HENRY J KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2011 ANNUAL SURVEY 118 (2011), *available at* http://ehbs.kff.org/pdf/2011/8225.pdf. Employees with PPOs fared even worse. To ensure transparency and comparability between plans for consumers and to maintain a meaningful definition of out-of-pocket maximum, the Exchange should require that coinsurance, copays and deductibles count towards the out-of-pocket limit in all qualifying plans. Also, all copays and coinsurance should count towards deductible expenses. **Issue 2: Standardization of Benefit Exclusions and Limits** NHeLP and the HCA disagree with the Board Background Brief's recommendation that the Exchange permit limited customization of benefit exclusions and limits. Instead, we recommend the Exchange select Option C: strict standardization of all possible benefit limits and exclusions. We urge the Exchange to prohibit substitution of covered services even if actuarially equivalent. We are concerned that allowing any type of customization will lead to insurer-driven benefit substitutions, which will make it more difficult to compare plans and could segment risk in the market by allowing plans to "cherry-pick" enrollees. **Issue 3: Standardization of Drug Formularies** NHeLP and the HCA support the recommendation that the Exchange require plans to cover at least two drugs per therapeutic class. It is critical that California have such a minimum formulary standard in place to ensure access to low cost alternatives for consumers. Such a policy is consistent with improving consumer choice and is an important tool for providers to treat patients who have complex clinical conditions and/or disabilities. Two drugs per class is also the standard of Medicare Part D, and adopting the same standard will facilitate uniformity and simplicity between coverage programs. We also urge the Exchange to develop a system to standardize therapeutic drug classes. If classes are not standardized, numerous complications result. First, consumers (and providers) lose the ability to effectively compare the formularies of the various plans they might choose. Second, failure to define therapeutic classes allows plans to eviscerate the "two drugs per class rule" by defining their classes so broadly that they effectively offer very few choices despite the rule. For example, if a plan only had three therapeutic classes, that would require only six formulary medications. Medicare Part D has developed model therapeutic classes, which it suggests, but does not require, plans to use. The Exchange, however, should *require* QHP formularies to adopt the Medicare model (or a similar therapeutic class model). We also suggest that the Exchange follow Medicare Part D in requiring coverage for "all or substantially all" medications in six

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	identified prescription coverage areas. We urge the Exchange to implement the Medicare standard for those six coverage areas, and consider other areas where more than two drugs per class are necessary to address historical access problems for some illnesses, ensure robust coverage for especially important health concerns, or simply to meet the clinical treatment needs. Finally, regardless of the formulary design, we encourage the Exchange to standardize rules governing exceptions to the formulary. The Exchange should standardize a medically driven exceptions process in cases where the treating physician confirms that neither of the two formulary options is clinically appropriate for the patient. In such cases, individuals should be able to access a clinically appropriate non-formulary medication as if it were a formulary option (e.g., without off-formulary cost-sharing, etc.). This exceptions standard and the process should be transparent and simple to use for providers and patients alike. **Issue 4: Value-Based Benefit Designs in the Context of Benefit Standardization** NHeLP and the HCA generally support plan flexibility for value-based benefit designs (VBBDs) that *lower* cost-sharing for enrollees. In particular, we support the Exchange's goal of encouraging the provision of health care services at lower cost to consumers, promoting healthy behaviors and patient compliance, and promoting access to high value services. Health plans increasingly rely on VBBDs as a mechanism to steer patients towards high-quality treatments that are considered "high value" (in which the clinical benefits exceed the cost) and minimize overuse of "low value" services (considered low value because the benefits do not justify the cost). Such utilization is controlled by varying out-of-pocket costs for the consumer, lowering costs for high value services and increasing costs for low value services. A VBBD that lowers cost-sharing in line with the Exchange's goals is an important step in the direction of improving the health and well-being of enrollees. For example, encouraging enrollees to begin and adhere to medication regimes by eliminating co-pays for drugs and certain office visits can prevent a costly worsening of their conditions. In fact, other provisions in the ACA rely on value-based incentive designs similar to this one: for example, the provision of preventive services at no cost to consumers, promoting access to high value preventive care by removing cost barriers. We are concerned, however, that plans may seek to institute VBBDs that discourage the use of "low-value" services even when those services are medically necessary. Some of the commonly recognized barriers to VBBD include that the increased utilization for high value services can increase insurer costs, and the savings associated with improved health status can be difficult to measure. *See, e.g.,* Michael E. Chernew, Allison B. Rosen & A. Mark Fendrick, *Value-Based Insurance Design*, 26 HEALTH AFFAIRS w195 (2012). As a result, plans have increasingly turned to cost-containment of so-called "low value" services. But financial incentives to discourage overuse of low value services have the potential to limit access to needed medical care. Plans attempting such a system have, for example, doubled co-pays and deductibles for "low value" services like knee or hip replacement, cardiac bypass surgery, hysterectomies, or emergency room visits. *See* Julie Appleby, *Carrot-And-Stick Health Plans Aim to Cut Costs*, KAISER HEALTH NEWS, Mar. 11, 2010, http://www.kaiserhealthnews.org/stories/2010/march/11/value-based-health-insurance.aspxhttp://www.kaiserhealthnews.org/stories/2010/march/11/value-based-health-insurance.aspx.

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	Thus, while we support plan flexibility for VBBDs that *lower* cost-sharing for enrollees, we urge the Exchange to place limits on that flexibility and adopt strong oversight to ensure that plans do not indirectly or otherwise seek to limit access to "low value" services. The Exchange should be prepared to respond to future requests for additional flexibility to control the cost of "low value" services. Raising out-of-pocket costs for low-value services has been carried out by a few insurers who see it as an important cost-containment mechanism. The Exchange must be aware of the benefits and challenges on this side of value-based incentive designs. We encourage the Exchange to monitor this issue by analyzing how, if at all, value-based benefit design aimed at "low value" services can be successful at improving health and lowering costs, without limiting access to needed care. **Issue 5: Standardization of Minimum Out-of-Network Benefits** NHeLP and the HCA support the recommendation to standardize minimum out-of-network benefits. We also urge the Exchange to adopt additional consumer protection rules for services accessed out-of-network. We recommend that the Exchange standardize minimum out-of-network benefits, including the maximum fee that can be charged by a provider for out-of-network benefits. The Exchange should require that QHP hold its members harmless for paying beyond network cost from non-network providers at *in-network* facilities. Consumers often do not even know that one provider on a team is consider out-of-network until they receive a bill for services. An enrollee should not be required to pay an out-of-network rate for anesthesiology services, for example, when she arranged to have a procedure performed by a facility in her network and did not request that particular anesthesiologist. Further, the Exchange should require that a QHP hold its members harmless for paying beyond network cost for accessing from out-of-network providers emergency services, ambulance services, and covered services not available through a network provider or not available within a reasonable time period. In the event that an enrollee is not able to access covered services or a necessary provider within the existing covered network (for example, due to provider religious or moral objections, or due to an emergency), the Exchange must require the QHP to allow the enrollee to access services out-of-network without penalty without additional cost to the enrollee. The Exchange should prohibit additional cost-sharing and balance billing of consumers for out-of-network emergency services, ambulance services, as well as covered services not available through a network provider or not available within a reasonable time period or geographic distance, including but not limited certain specialty care services such as high-risk pregnancy and abortion care. The Exchange should, at a minimum, apply the Knox Keene balance billing protections, as well as Cal. Health & Safety Code § 127400 *et seq.* protections regarding charges for hospital services for low-to-moderate income individuals. The Exchange could require that in these situations the QHP reimburse the non-network provider for the lesser of: (1) the provider's billed charge, (2) a minimum fee established by the Exchange, or (3) the charge agreed to by the QHP and the provider.
Section 5D: Premium Subsidies and Cost Sharing Reductions	In general, NHeLP and the HCA commend the Background Brief's approach to developing standardized plans for beneficiaries whose income qualifies them for increased cost-sharing reductions. To account for federal cost-sharing subsidies, the brief suggests adjusting each silver level option to reflect three different increased cost-sharing scenarios (94%, 87%, 73%). By statute, the first cost-sharing adjustment must be the out-of-pocket maximum, but any leftover cost-sharing can come from of the other forms of cost-sharing. We strongly recommend that the Exchange standardize any leftover cost-sharing subsidies, and not leave

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	that distribution up to the individual plans. Otherwise, individuals who qualify for subsidies may face a dizzying variety of plan options. Furthermore, the Exchange should apply any cost-sharing reductions beyond the required out-of-pocket reduction first to lowering PCP and pharmaceutical copays, and then to reducing deductibles, according to the above reasoning. Individuals who qualify for extensive cost-sharing subsidies will be coming from the lowest income levels and will be disproportionately impacted by pharmaceutical copays. Even nominal copays lead to reductions in utilization that both negatively impact the health of low-income populations and often lead to higher overall costs due to increased use of more expensive care, like hospitalizations. **Issue 1: Plan Choices for Individuals with Income between 100% and 250% of FPL** The Board Background Brief proposes that the Exchange offer people with income between 100-250% FPL *only* silver or bronze level plans. NHeLP and the HCA agree with this approach for those with income below 200% FPL because it is not cost effective for people to pay higher premiums for gold or platinum tier plans when the cost-sharing levels would be roughly equivalent to a boosted silver plan (87% or 94%). We recommend, however, that the Exchange offer individuals in the 200-250% FPL group a choice from all plan tiers (with the appropriate highly visible warnings that individuals would not qualify for the cost sharing boost if they do not choose a silver plan). This approach mirrors the recommended option for 250-400% FPL applicants, and is appropriate for the same reasons. First, the actuarial value bump for the 200-250% FPL group is only 3% higher than normal silver plan (73% compared to 70%) and amounts to far less than the 80% or 90% cost-sharing levels of gold and platinum plans. Effectively, the 3% cost-sharing subsidy will go towards marginally reducing the silver plan out-of-pocket maximum and will not affect other cost-sharing elements. There may be people in the 200%-250% group who would prefer paying higher premiums to get a much better deal on copays/co-insurance/deductibles in a gold or platinum level plan, and they should have that option. **Issue 2: Plan Choices for Individuals with Income between 250% and 400% of FPL** NHeLP and the HCA support the recommendation that the Exchange permit individuals with income above 250% FPL to choose any plan in the Exchange. This proposal gives consumers maximum choice and allows them to weigh the trade-offs among premiums, out-of-pocket costs, and other factors. We urge the Exchange to work with consumer advocates to ensure that the decision-making process is as transparent and simple as possible to facilitate consumers' making educated choices.
Section 5E: Provider Network Access: Adequacy Standards	**Issue 1: Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification** NHeLP and the HCA do not support the proposal to adopt existing regulatory requirements on network adequacy of QHP bidders' regulatory agency. The network adequacy standards currently required by state law and the regulations of DMHC and CDI set a starting point for appropriate standards for QHPs, but are not sufficient to fully ensure access. Thus, we support the proposal to require QHPs to meet existing standards for providers' geographic availability, and provider types. But to fully ensure access to services, we urge the Exchange to require QHPs to meet additional criteria, including specific provider ratios (by specialty type) that ensure actual availability of services, timeliness access standards, language access standards, and disability access standards.

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	Provider Ratios The proposal before the Board adopts existing laws and regulations, which assure overall provider-patient ratios, and include specific ratios for primary care, but go no further. *See* 28 C.C.R. § 1300.67.2(d); 10 C.C.R. § 2240.1(c)(1). These existing metrics are insufficient to ensure access. Instead, NHeLP and the HCA urge the Exchange to require plans to adopt provider-patient ratios that account for variation in specialty type and geography, similar to those used in the Medicare Advantage program. After enrollment commences, the Exchange could update the criteria based on utilization patterns and clinical needs. Such criteria fulfill the goal of ensuring that enrollees have access to services, while incorporating flexibility to account for local variation. We recommend that such criteria be developed using the 2011, 2012 and 2013 Medicare Advantage Network Adequacy Criteria as a model. *See, e.g.,* Centers for Medicare & Medicaid Services, *2011 Medicare Advantage Network Adequacy Criteria Development Overview*, https://www.cms.gov/MedicareAdvantageApps/Downloads/2011_MA_Network_Adequacy_Criteria_Overview.pdf. In many rural areas of the state, managed care networks do not exist and safety net providers are a main source of health care for the community. The Exchange should develop robust criteria to ensure that enrollees in those regions have access to comprehensive, geographically representative networks of providers, by specialty type. Finally, the goal of developing specific metrics to measure the number of providers in a network is ensuring that enrollees have meaningful access to the health care services they need. Thus, such metrics must account for the range of services actually offered by participating providers to ensure that covered services are actually available, and whether providers are accepting new patients. In addition, as described in greater detail below, the Exchange should require QHPs to contract with essential community providers for the full range of services they offer, rather than only contracting for limited subsets of service. Further, provider-patient ratio calculations must account for whether providers are accepting new patients to ensure that new enrollees have access to the providers they need. *Timeliness Access Standards* The current proposal would follow current California law, which applies timeliness access standards to HMOs and certain PPOs regulated by DMHC, but not to PPOs and other plans regulated by CDI. *See* 28 C.C.R. §§ 1300.67.2.2(c)(5), 1300.67.2(c). But these timeliness access standards should apply to all plans in the Exchange. NHeLP and the HCA urge the Exchange to adopt, for ***all*** plans, the Department of Managed Health Care's clear timeliness access standards for primary care, mental health, urgent care, specialty care, and ancillary care appointments, found at 28 C.C.R. § 1300.67.2.2(c)(5). In addition, the Exchange should affirm that emergency care must be available to Exchange plan enrollees 24 hours a day, 7 days per week, as required by 28 C.C.R. § 1300.67.2(c). While PPOs regulated by CDI typically include broader networks than DMHC-licensed plans, those broader networks do not guarantee that enrollees can actually access services in a timely fashion; thus, specific standards are needed for all plans. Finally, we suggest that the Exchange monitor wait times as a measure for access problems in QHPs.

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	Language Access Standards Existing network adequacy standards in California do not sufficiently account for the capacity of providers to serve limited English proficient (LEP) individuals. Large numbers of LEP individuals will purchase insurance through the Exchange and the Exchange must ensure that linguistically appropriate services are provided by the health plans that are certified for inclusion in the Exchange. Currently, DMHC and CDI regulations implementing SB 853 (Escutia, 2003) require licensed plans to assess the linguistic capacity of enrollees and provide free language assistance service at all points of contact. *See* 28 C.C.R. § 1300.67.04(c) (DMHC); 10 C.C.R. §§ 2538.3 & 2538.6 (CDI). These regulations are a significant step in ensuring access to health care services for LEP individuals, but NHeLP and the HCA urge the Exchange to adopt additional standards to ensure that California's LEP individuals have meaningful access to care, by adopting stronger standards to ensure that enrollees have access to oral interpretation, and by requiring plans to report on bilingual providers. Current standards do not require plans to pay for interpretation services for their contracted providers. The Exchange should require QHPs to arrange in their provider contracts to pay for interpreters directly, even in interactions between provider and patient to ensure the availability of language services and improve compliance by providers who often do not have the resources to evaluate or pay for competent language services. Before the Exchange certifies a plan for participation in the Exchange, the Exchange should require plans to set forth in detail their process for paying for and guaranteeing timely oral interpretation services, both for their own customer service functions and whenever necessary to facilitate communication between enrollees and providers. These language access plan policies should be made available to the public on the Exchange website. Further, the Exchange should ensure that QHP issuers inform potential enrollees of the languages spoken by network providers as a condition of certification. It is critical, however, that any provider or staff member who identifies as speaking another language be competent to do so. The Exchange should require QHPs to assess the language proficiency of its providers, and their staff, who seek to provide services directly in a non-English language. Otherwise, enrollees may suffer ineffective communication that can result in serious medical harm due to a lack of language proficiency, particularly with regards to the specialized medical terminology that someone who is conversationally bilingual will not possess. For example, in a study commissioned by NHeLP examining language barriers and medical malpractice, 32 of 35 claims involving language issues arose from providers failing to use competent interpreters. NHELP, THE HIGH COSTS OF LANGUAGE BARRIERS IN MEDICAL MALPRACTICE (2010), *available at* http://www.healthlaw.org/images/stories/High_Costs_of_Language_Barriers_in_Malpractice.pdf. We recommend the Exchange implement specific competency standards for all those who seek to provide services directly in a non-English language or serve as interpreters and limit those who may list language skills in a provider directory to providers who have established competency. *Disability Access Standards* Finally, existing network adequacy standards in California do not ensure that enrollees with disabilities will have access to appropriate services, or that facilities will be accessible to them. While CDI regulations require that network facilities be "reasonably accessible to the physically handicapped [sic]," what constitutes reasonable accessibility is not delineated. 10 C.C.R. § 2240.1(b)(3). Moreover, by limiting access to those with physical disabilities, the CDI regulations do not account for

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	accommodations that may be needed by people with developmental or mental disabilities. DMHC regulations do not contain any specific requirements on accessibility for enrollees with disabilities. NHeLP and the HCA urge the Exchange to adopt network adequacy criteria that account for the particular needs of persons with disabilities. Such criteria should ensure that, in addition to the usual range of providers and the Essential Community Providers, QHPs are required to offer access to the following providers and services in their networks: interpreters, inpatient and outpatient rehabilitative programs, comprehensive rehabilitative and habilitative services and facilities, applied rehabilitative technology programs, wheelchair seating clinics (including access to wheelchair assessments) independent of durable medical equipment providers, specialty care centers (including those Ryan White Care providers serving people living with HIV), Genetically Handicapped Persons Program certified providers, non-coercive reproductive health services, speech pathologists (including those experienced working with nonverbal individuals, persons with developmental disabilities, and persons who need speech generating devices), occupational therapists, orthotics providers and fabricators, physical therapists, case managers for those with significant non-medical barriers to care, Applied Behavioral Analysis (ABA) therapy, and low vision centers. Finally, the Exchange should require QHPs, and their providers to certify that their facilities and services are accessible to all enrollees, and fully compliant with the Americans with Disabilities Act (ADA) and other state and federal disability and civil rights laws. **Issue 2: Approaches to Evaluating Provider Network Adequacy for QHP Certification** NHeLP and the HCA have concerns about the proposal that the Exchange rely on DMHC and CDI's existing regulatory processes to monitor plans compliance with network adequacy standards. We are concerned that the existing regulatory oversight processes are inadequate to ensure that enrollees truly have access to the providers and services they need. While both regulators evaluate plans' networks with geo-access reports when they are initially licensed, the existing regulatory scheme provides little ongoing review to ensure that plans are meeting network adequacy standards. Rather, plans are generally allowed to self-certify that they meet applicable network adequacy standards without independent verification. The Exchange should work with DMHC and CDI to require QHP issuers to maintain an ongoing monitoring process to ensure that they are meeting network adequacy standards. Existing regulatory oversight of network adequacy standards is too infrequent to identify problems with plan networks. DMHC currently evaluates the access and availability of services, access to emergency services, and language assistance in its licensed plans once every three years through its medical survey process. Cal. Health & Safety Code § 1380(c). Similarly, CDI must examine licensed plans at least once every five years. Cal. Ins. Code § 730(b). CDI is charged with generally evaluating plans compliance with applicable laws in the examination process. Cal. Ins. Code § 733(d). Given the rapid pace at which plans add and drop providers from their networks, a review of network adequacy measured in years is not sufficient to ensure that plans are truly providing access to services. While the existing regulatory review processes will give the Exchange the opportunity to periodically review the adequacy of QHP's networks, the Exchange should monitor compliance more frequently, especially in the first five years of the Exchange, since most problems occur in the early years of a new system. The Exchange should work with DMHC and CDI to require the QHP issuers to establish a written process for monitoring the adequacy of their QHPs' networks at least quarterly; take corrective action if a QHP falls out of compliance; and report the findings of their monitoring and any corrective actions to the Exchange. In addition, the Exchange should require QHP issuers to report

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	any material changes in their QHP provider networks and confidentiality procedures to the Exchange within 30 days. In addition, the Exchange should not only rely on QHP issuers' reporting of compliance with network adequacy standards, but should require independent review to ensure compliance. The existing regulatory review processes are ill-equipped to evaluate whether plans' networks truly comply with network adequacy standards, and largely rely on the plans' own self-assessment of compliance, complaint data, information about grievances and appeals, and enforcement actions to identify problems; plans need not submit geo-access data on their networks again once they are licensed. The data collected in these review processes do not guarantee that DMHC and CDI have a complete picture of plans' compliance with applicable standards. Nor does DMHC or CDI generally attempt to independently verify the information provided by plans. The Exchange should work with DMHC and CDI to take additional steps to hold plans accountable to network adequacy standards. The Exchange, especially in the first five years, should independently assess plans' compliance with network adequacy standards, including by requiring additional geo-access data, and by verifying the number and location of providers, the scope of services they provide, the timeliness of appointments, the availability of appropriate language services, and the accessibility of contracted facilities. Moreover, the Exchange should impose transparency standards to evaluate the primary care capacity of health plan networks in every region by assessing metrics such as ratio of primary care providers to population and other measures of capacity. While we realize that this proposal does add administrative burdens to the Exchange, these additional burdens are justified, especially in the early years of the Exchange, by the need to assure that QHPs are truly providing appropriate access to health care. Finally, any monitoring of QHP networks must be transparent, publicly available, and easy for consumers to understand. While the federal regulations at 45 C.F.R. § 156.220 will establish certain data points that must be made publicly available by QHPs, we urge the Exchange to go further and require that all non-confidential information derived through the monitoring process be broadly disseminated. This data must be accessible online and in written form so that consumers can be made aware of any problems, as well as compare and contrast plan performance. And, like all information provided in connection with the Exchanges, this information should be conveyed in a manner that is easily understood and accessible to people with low literacy, limited English proficiency, and disabilities.
Section 5F: Provider Network Access: Essential Community Provider Standards	Essential community providers provide care to predominately low-income and medically-underserved populations who suffer from disproportionately high rates of illness and disability. In addition to providing more efficient and patient-centered care, the inclusion of essential community providers will support better continuity and coordination of health care, which are top tenets of the ACA. **Issue 1. Definition of Essential Community Providers** Given the critical role that essential community providers play in the health and well-being of low-income and medically underserved populations, NHeLP and the HCA urge the Exchange to adopt a definition of essential community provider that includes the full range of potential essential community providers that currently comprise the safety-net of providers who provide health care to low-income communities. The definition of essential community provider must include safety-net providers who have a demonstrated commitment to providing quality care to underinsured and uninsured clients, including, but not limited to:

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	HIV/AIDS clinics, public hospitals, women's health centers, federally qualified health centers (FQHCs), family planning clinics including Title X-funded reproductive health centers, and community health centers. In addition, as to the unique health needs of women, it is especially important that the Exchange require QHPs to contract with Title X clinics, women's health clinics, and other publicly-funded family planning providers for the full range of covered services that they provide. For example, the Exchange should not permit a QHP to exclude the contraceptive services that a women's health clinic offers. The Exchange should require QHPs to contract with essential community providers for the full range of services they offer, rather than only offering access to certain subsets of services. It is critical that the Exchange prohibit QHPs from excluding a provider on the basis that the provider offers abortion services. The definition of essential community provider should include only those providers that offer unbiased, accurate, and timely access and/or referrals to, and information about, health care services. We are concerned that the staff's recommendation to adopt a "broad definition" of essential community provider will include providers who do not primarily serve underinsured and uninsured clients. Not only would a "broad definition" undermine the purpose of requiring that QHPs contract with essential community providers in the first place, which is to provide more efficient and patient-centered care and to promote better continuity and coordination of care, but it is also unnecessary; QHPs are likely to contract with providers who serve predominately private insurance patients regardless. **Issue 2. Definition of "sufficient" participation of Essential Community Providers** NHeLP and the HCA support the goal of the recommended approach to defining "sufficient" essential community provider participation, but we also encourage the Exchange to adopt more specific criteria. The Exchange should adopt a definition of sufficiency that requires that QHPs not only demonstrate minimum proportion of network overlap among the QHP, Medi-Cal, Health Families networks and among solo and small physician offices and independent physician providers that serve a high volume of Medi-Cal and uninsured patients, as the staff recommends, but also that definition include the criteria discussed above with regard to the establishment of network adequacy standards. To ensure access to services, the Exchange should develop criteria to measure the number of essential community providers that account for variation in specialty type and geography. Specifically, we recommend that the Exchange use the criteria discussed above with regard to the establishment of network adequacy standards. *See supra* Section 5E. In addition, the Exchange should set minimum standards to ensure that there are sufficient types of providers or provider networks, including specialists, who actually provide all covered services. A standard that merely counts the numbers and types of providers is not sufficient. Minimum standards should take into consideration the fact that some hospitals and clinics, particularly religiously controlled ones, may not provide all of the covered services, and individual providers may refuse to offer covered services. Further, the Exchange should require that each QHP show overlap among the QHP, Medi-Cal, Health Families networks and other safety-net providers serving primarily Medi-Cal and uninsured patients. In addition, the Exchange should require that QHPs determine whether potential essential community providers have been successful in providing quality health services in medically-underserved communities for low-income populations (particularly those that are experiencing health disparities and poor health

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	outcomes) that meet recognized scientific and medical standards that any provider would be expected to perform under any circumstance. *See generally* NATIONAL HEALTH LAW PROGRAM, HEALTH CARE REFUSALS: UNDERMINING QUALITY CARE FOR WOMEN (2010). Similarly, QHPs should be required to contract with essential community providers that routinely provide preventive health screenings and treatment including FDA-approved contraceptive drugs, devices and supplies consistent with HHS Required Health Plan Guidelines for those services. *See* U.S. Department of Health and Human Services, Health Resources and Services Administration, "Women's Preventive Services: Required Health Plan Coverage Guidelines," *available at* http://www.hrsa.gov/womensguidelines. The Exchange should also require that QHPs contract only with essential community providers that offer unbiased, accurate, and timely access and/or referrals to, and information about, health care services. **Issue 3: Payment rates to Federally Qualified Health Centers** No comments.
Section 6: Assuring Quality and Affordability	See below for specific comments.
Section 6A: Strategies to Promote Better Quality and More Affordable Care	NHeLP and the HCA generally agree with the recommended four part strategy to foster better health, quality care and lower costs. We are particularly pleased by the emphasis on aligning QHP coverage with that of other purchasers, and have made specific recommendations in other sections about ways in which the Exchange can achieve this goal. We also strongly support the proposal to collect standardized information on health plans' performance and care delivery/payment practices to inform future work, and we look forward to working with the Exchange to identify particular data points and measurement tools that will provide rich insight to inform the Exchange's ongoing operations. We support the proposal to require certain health plan practices that promote better care or standards of performance for participation in the Exchange. To the extent there are already practices and standards that are well-established as improving health, enhancing quality and reducing cost, we urge the Exchange to require QHPs to adopt them now. As one example, we urge the Exchange to consider giving priority to health plans that have established a model for patient centered medical homes (PCMHs). The Affordable Care Act emphasizes the importance of PCMHs. A PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. In 2011, the National Committee on Quality Assurance (NCQA), and the Accreditation Association for Ambulatory Health Care (AAAHC) established model standards and guidelines for certifying PCMHs that could be adapted by the Exchange to assess whether QHPs are able to provide patient-centered, coordinated and effective care to their enrollees, especially those with complex health care needs or multiple chronic conditions. *See* NCQA, *Patient Centered Medical Home*, http://www.ncqa.org/tabid/631/default.aspx; AAAHC, *Medical Home On-Site Certification,* http://application.aaahc.org/MedicalHome.aspx. Plans that contract with providers that have been recognized by the NCQA or AAAHC as meeting their PCMH guidelines should be given priority in the QHP selection process. We look forward to working with the Exchange to identify additional plan practices and standards that

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	will achieve the Exchange's goal of fostering better health, quality care and lower costs. Finally, we strongly support the proposal to use value-elements in the QHP selection process considering a combination of outcomes (e.g. HEDIS and/or CAHPS scores) and practices (e.g. participation and support for pay-for-performance or medical home initiatives). We generally support the use of HEDIS (or equivalent clinical quality measures) and CAHPS scores in the QHP selection process. In particular, the Exchange should consider HEDIS measures that are particularly relevant to people with disabilities or chronic conditions, including measures of comprehensive asthma and diabetes care and mental illness management. We recognize that existing clinical quality measurement tools do not adequately account for the particular needs of people with disabilities and encourage the Exchange to work with consumers, NCQA and URAC to develop better measures. In addition, we suggest that the Exchange adopt measures from California's Maternal and Infant Health Assessment (MIHA) survey scores to evaluate potential QHPs. The MIHA survey is based on the Pregnancy Risk Assessment Monitoring System (PRAMS), developed by the CDC and state health departments to measure of pregnant women's patient experience. At a minimum, the Exchange should take note of whether potential QHPs have reviewed the MIHA survey and whether they have designed covered services and overall systems to address issues that were identified in the surveys. We also support the recommendation that the Exchange give priority to potential QHPs that have adopted established practices that improve health and lower cost, such as PCMHs, as described above. Again, we urge the Exchange to adopt well-established factors for the QHP selection process as soon as possible, to ensure that enrollees have access to the highest quality care at the lowest cost by January 1, 2014.
Section 6B: Accreditation Standards and Reporting for Qualified Health Plans	**Issue 1: Accreditation for Qualified Health Plan** NHeLP and the HCA generally agree with the proposed approach to accreditation, including the timeline for accreditation of new plans and the proposal to require interim accreditation and reporting of those CAHPS and HEDIS measures required by Medi-Cal Managed Care. We note that the federal regulations governing accreditation at 45 C.F.R. § 156.275(a) appear to require the Exchange to accept accreditation from any accrediting entity recognized by HHS. The final rule on QHP accreditation, promulgated in July 2012, recognizes ***both*** NCQA and URAC as accrediting entities for the purposes of accrediting QHPs in the Exchange, subject to those entities' satisfying certain conditions. We believe that both NCQA and URAC will satisfy those conditions, and suggest that the Exchange adopt a variation of the recommended approach that accounts for accreditation by both entities, and requires an interim accreditation status as designated by either entity by 2014, and NCQA commendable status or a URAC-equivalent by 2015. Since URAC has developed its own clinical quality measures that compare to HEDIS, such a variation should require URAC accredited plans to report comparable clinical quality measures to the HEDIS measures required by NCQA accredited plans. We support the proposal to allow new plans and plans that are not currently accredited to phase in accreditation over time. The proposal strikes the right balance between holding plans to high standards and giving new and regional plans, especially those plans that serve low-income populations, enough time to become fully accredited. We appreciate that the Exchange will consider more rigorous accreditation standards and timeframes after it has operated for two to three years. We believe that this timeframe

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	is reasonable to allow the Exchange to work with enrollees and plans to determine how accreditation can provide as much useful information as possible. In addition to the clinical quality and CAHPS measures required by Medi-Cal managed care, we recommend that the Exchange require plans to complete NCQA's Multicultural Health Care (MHC) Distinction standards, or an equivalent for URAC, for QHP accreditation. Requiring such standards to be part of accreditation is consistent with the ACA's emphasis on prohibiting health disparities, see ACA § 1311, and the California Exchange Board's goal of catalyzing change by reducing health disparities. Finally, we urge the Exchange to work with NCQA and URAC to obtain all accreditation survey elements. By reviewing all survey elements for potential QHPs, the Exchange will be best able to evaluate the areas in which QHPs are strong and weak, to help the Exchange determine where additional monitoring may be warranted.
Section 6C: Promoting Wellness and Prevention	**Issue 1: Use of a Health Risk Assessment Tool or Other Plan based Wellness Promotion Initiatives** NHeLP and the HCA do not agree that health plan risk assessments will unduly burden the Exchange, or will significantly lower Exchange participation. Thus, we urge the Exchange to select either Option A or Option B in this area, to require enrollees to complete either an Exchange-created or plan-created health risk assessment tool as part of the enrollment process. As the Board Background Brief recognizes, the ultimate goal of implementing health risk assessment tools is to engage more enrollees in managing their health. But health risk assessment tools also provide plans with valuable information about their enrollees' needs, which will be particularly important as the Exchange enrolls many uninsured people, many of whom will not have received regular care, into coverage. The information provided by a health risk assessment tool can help plans ensure that new enrollees begin receiving appropriate preventative services immediately and avoid use of more costly acute and emergency treatments. In addition, these tools can provide enrollees themselves with important information about their health status and appropriate steps toward wellness before they even see a primary care provider. As wellness programs grow and develop, we hope that the Exchange will consider using these tools to refer enrollees to appropriate plans and programs. There is room for innovation in equipping enrollees with knowledge of their biometric values, including with the use of historical claims information. When DHCS began to move seniors and people with disabilities from fee-for-service Medi-Cal into managed care in 2010, advocates worked with the department to require plans to perform a health risk assessment of new enrollees. We suggest that the Exchange look at the guidelines for health risk assessments that were developed in that context as a model for what might be required in the Exchange. *See* Cal. Welf. & Inst. Code § 14182(a)(11)-(12). **Issue 2: Provision of a Wellness Program by the Exchange** NHeLP and the HCA commend the recommendation that the Exchange establish requirements for the wellness programs that are offered by issuers and that the Exchange promote those programs. It is the role of the Exchange to monitor quality improvement strategies, and the Exchange is also uniquely positioned to promote the benefits of the QHPs that promote wellness programs.

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	Issue 3: Use of Financial Incentives by Plans to Promote Wellness NHeLP and the HCA oppose the recommendation to allow health plan issuers to use incentives as an optional program. If the Exchange chooses to allow such incentives, it must very closely monitor their impact on vulnerable populations. As discussed above, Wellness programs provide robust health tools and activities to support individuals in improving their own health status and outcomes. Incentive programs, in contrast, attempt to promote healthy behaviors (such as encouraging participation in wellness programs) by offering individuals incentives which often have not been proven effective and which may have problematic unintended consequences. We are concerned, for example, that wellness programs that vary health care costs based on achieving certain health outcomes can negatively affect the affordability of health coverage. People who are low income or who have certain health conditions or disabilities may face additional barriers to meeting health status benchmarks. It is essential that the Exchange recognize that some people may face barriers to participating in required activities, depending on when and where the activities take place and whether they involve a cost to participants. FAMILIES USA, WELLNESS PROGRAMS: EVALUATING THE PROMISES AND PITFALLS (2012). While the Exchange might consider some limited implementation of these programs, it should also be aware that there is little research examining the effectiveness of incentive rewards or penalties that specifically raise or lower individuals' health care costs. *Id.* Without strong evidence supporting the effectiveness of rewards programs, the Exchange must carefully monitor such programs for perceived benefits and possible unintended consequences. The Exchange must establish an accountability mechanism to ensure that, where financial incentives are utilized, they are evidence-based programs that actually help people achieve the health outcomes being measured and do not have a disproportionately negative impact on low-income individuals. For example, such programs should have a "reasonable chance of improving the health of or preventing disease in participating individuals." *See* Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 239 (Dec. 13, 2006); 26 C.F.R. 54; 29 C.F.R. 2590; 45 C.F.R. 146. We note that health care dollars are already scarce, and we believe the Exchange should be particularly cautious in allowing limited health care funds to be diverted away from important health care coverage (services, cost-sharing reductions, wellness programs) and towards incentive programs (such as gift cards, free merchandise, etc.). The Exchange must carefully monitor the impact of financial incentives on vulnerable populations. Financial incentive programs can disproportionately harm groups who already face barriers to maintaining health. Racial and ethnic minorities are disproportionately affected by illnesses like hypertension and obesity, for example, and financial incentive programs may end up disproportionately penalizing these groups. Low-income individuals may also face greater difficulty in accessing healthier foods or safe recreation areas, limiting their available resources for achieving incentive program targets. Other unique barriers for low-income individuals can include limited time as a result of working multiple jobs or a lack of childcare or transportation options. These are issues that the Exchange must carefully monitor to prevent indirect discrimination against low-income and vulnerable populations. Finally, these incentives may harm members with disabilities or chronic conditions who cannot comply with or avail themselves of them.

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	Issue 4: Role of the Exchange in Addressing Community and Public Health NHeLP and the HCA commend the recommendations that either the Exchange directly engage with public and community health efforts as part of its outreach and marketing campaign, or that the Exchange encourage health plans to address public health issues. We encourage the Exchange to explore how it can undertake both of these approaches. The Exchange has a unique market position to promote awareness of important public health concerns, but also has a strong incentive to work with health issuers to support their community health initiatives. We strongly encourage the Exchange to identify key issues and create a coherent strategy to manage its resources in this area. The Exchange should ideally adopt a multi-pronged approach that takes advantage of the its unique market position, as well as encourages health plans to promote community and public health.
Section 6D: Administrative Simplification	In general, NHeLP and the HCA support the Exchange's goal of reducing administrative burden to lower costs while improving access to care. We look forward to commenting on specific proposals to achieve this goal in the future.
Section 7: Other	See below for specific comments.
Section 7A: Aligning the Exchange with Medi-Cal and other State Funded Health Programs	NHeLP and the HCA commend the Exchange for thinking ahead and beginning to focus on the issue of how the Exchange can be aligned with Medi-Cal and other state-funded health programs. We look forward to seeing the report that the Exchange plans to commission from Manatt Health Systems on this issue. While we are certain that the Manatt report will be very useful, it is important that the Exchange obtain viewpoints on this issue from a range of stakeholders, including health consumer advocates like the HCA that also have expertise on these issues and in-depth familiarity with the programs and populations in California. While we assume that the Exchange will make the Manatt report public and give stakeholders an opportunity to comment on its conclusions and suggestions, we urge the Exchange to allow ample opportunity for review and comment on the report, rather than allotting only a very brief time frame that will not give interested stakeholders a sufficient opportunity to comment. We note some concern that the Board Background Brief on Alignment discusses only Medi-Cal and Healthy Families, but makes no mention of a possible Basic Health Plan ("BHP") in California. As the Exchange is aware, there is pending legislation proposing a BHP, and many stakeholders are hopeful that one will be established to expand affordable coverage for persons between 133% and 200% FPL. If there is a BHP, issues of alignment with Medi-Cal, Healthy Families, and the Exchange will be even more critical. We urge the Exchange to include considerations of alignment with a BHP as part of the charge given to Manatt to analyze. We would also like to work with the Exchange staff on these issues. The Background Brief appropriately notes that a major issue during the launching of the Exchange will be the transition of Exchange eligible individuals currently enrolled in one of the LIHPs into Exchange coverage (as well as the transition of Medi-Cal eligible persons who are currently LIHP enrollees). The Exchange must coordinate closely with the Department of Health Care

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	Services and the counties operating LIHPs to make sure that there is a smooth transition without gaps in coverage. The Exchange is scheduled to begin enrollment on October 1, 2013, with the California Healthcare Enrollment, Eligibility and Retention System (Cal-HEERS) as the gateway in the Exchange for people to select a health care plan. Due to the novelty of the Exchange and the possible attendant confusion that may accompany the inaugural year of Cal-HEERS, we suggest that the Exchange work closely with DHCS and the counties to ensure that LIHP enrollees who have a higher likelihood of qualifying for Exchange subsidies rather than Medi-Cal receive targeted outreach and education information about the Exchange as soon as possible. Moreover, to the extent possible in those counties where it is feasible, the Exchange should make an effort to see that Exchange health plans include provider networks that are currently serving LIHP enrollees, so that as many LIHP enrollees as possible can continue with their current providers in 2014. We commend the Exchange for recognizing that issues of churning, especially as they affect continuity of care, will be of paramount concern. While the Background Brief notes that current law and regulations give individuals protection to ensure continuity of care when an individual is switching to a new health plan that does not include his/her current provider in its network, this is an area that requires much attention. The issue of continuity of care has been critical in the recent transition of Seniors and Persons with Disabilities from fee-for-service Medi-Cal into managed care, and there have been enormous problems with that transition. We urge the Exchange to look closely at the experience with that transition to avoid the pitfalls that have resulted in many complaints about the process not working to preserve patients' rights to remain with their current providers where appropriate. The Background Brief, on p. 228, notes that analytical support is needed on the issue of "continuity of coverage for pregnant women whose eligibility status may change from the Exchange to Medi-Cal due to their pregnancy." Pregnant women should be able to make informed decisions about the program in which they will enroll, and those choices should not be coerced by administrative hurdles or the potential for discontinuity of care. Pregnant women should have access to the most comprehensive pregnancy care with the least cost-sharing. This is best achieved by a high level of alignment between Medi-Cal (or, if applicable, the BHP) and Exchange provider networks so that women can transition between programs, if they so choose, without experiencing abrupt changes in their sources of care. We note that in the Preamble to the Medicaid Eligibility regulations, CMS has noted that women who become pregnant while enrolled under the new Medicaid expansion category for adults need not be transferred to coverage under 42 C.F.R. 435.116 (Mandatory Coverage of Pregnant Women). The Preamble states: "[In this situation], women should be informed….of the benefits afforded to pregnant women under the State's program. If a woman becomes pregnant and requests a change in coverage category, the State must make the change if she is eligible. But, we will not otherwise expect States to monitor pregnancy status and to shift women into the group for pregnant women once they become pregnant." 57 Fed. Reg. 17144, 17149 (March 23, 2012). When an Exchange enrollee becomes pregnant, she similarly should be informed of all of programs (the Exchange, the BHP, if adopted, or Medi-Cal) for which she is eligible including information about provider networks and differences in cost-sharing. She should then be able to make an informed decision about transitioning to Medi-Cal (or, if adopted, the BHP) or remaining in the

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	Exchange. Regardless of whether her eligibility status changes, the Exchange must ensure that a pregnant woman can continue with her current providers. The Exchange should either require (1) a QHP to participate in Medi-Cal, (and, if adopted, the BHP), at least with regard to pregnant women's coverage, or (2) overlap of provider networks between the Exchange and Medi-Cal (and, if adopted, the BHP) to ensure continuity of care. Such overlap will ensure that pregnant women need not sacrifice continuity of care to benefit from comprehensive Medi-Cal (or, if applicable, BHP) services without cost-sharing to which they are entitled if they choose to move between programs. The Exchange must establish an expedited and seamless process that ensures that there is no break in a pregnant woman's coverage for health care, if she transitions from the Exchange to Medi-Cal or, if adopted, the BHP, during her pregnancy. Finally, given the complexity of these issues, we strongly urge the Exchange to collaborate with DHCS, MRMIB and other departments as needed to gather additional stakeholder input on the coordination and alignment of programs to ensure that pregnant women receive continuity of comprehensive health care coverage. Another area noted in the Background Brief for further analysis is "alignment of eligibility and enrollment appeals processes between the Exchange and Medi-Cal." While guidance on Exchange appeals processes has not yet been issued by CMS, we have urged CMS to model such processes after the current appeals process under the Medicaid program. Whether CMS requires this, or whether the state Exchanges are given flexibility in regard to appeals, we urge the Exchange to look to the Medi-Cal appeals process as a model. NHeLP and the HCA have significant expertise in this area and look forward to providing more detailed comments on due process and appeals in the future. Aligning the appeals process with Medi-Cal will also help low-income individuals who are moving, however frequently, between Medi-Cal and the Exchange to have continuity in exercising their rights and will create more seamlessness and result in less confusion for individuals. The Background Brief notes as "policy options" the encouragement of Medi-Cal Managed Care Plans to participate in the Exchange and the encouragement of issuers to include Medi-Cal providers in their networks. This should not just be an "option," but should be adopted as policy by the Exchange Board. The Exchange should encourage the participation of plans across different programs, so that enrollees moving between Medicaid, CHIP, the Exchange plans and, possibly, BHP will, to the extent possible, be able to remain with the same providers. To that end, plan standards and contracting requirements should be identical, or as similar as possible, to make it easier for health plans to serve enrollees in all programs. Standards should not be lowered, however, in order to achieve simplicity. Rather, the minimum standards should be high for all categories, so that the care available to the lowest income persons in the Medi-Cal program will be as high as that available to those persons enrolled in health plans through the Exchange. The Exchange should work together with the Department of Health Care Services and other government agencies to develop uniform standards and contracts to the extent possible. Finally, the Background Brief suggests monitoring of QHP overlap with Medi-Cal Managed Care plans and monitoring the movement of individuals between Medi-Cal and Exchange plans. Monitoring is critical, and we assume that there will be a larger monitoring plan that will cover all aspects of the Exchange's operations, of which these are just two. In regard to health plan overlap, however, this is not just a question of monitoring, but the Exchange should work actively to convince health plans to operate in both markets and to give precedence in the contracting process to those plans that do.

Input Requested	Comments
Section 7B: Supplemental Benefits: Dental and Vision	**Issue 1: Offering Supplemental Benefits in the Individual and SHOP Exchanges** The Exchange proposes to offer supplemental benefits (i.e., expanded pediatric dental and vision and adult dental and vision) *only* in the SHOP Exchange. NHeLP and the HCA recommend the Exchange offer supplemental benefits to *both* the Individual and SHOP Exchanges, for the following reasons (listed in the Exchange Board Recommendation Brief): • most consumer-friendly approach (one-stop shop for medical, dental and vision coverage), • enables continuous coverage for consumers transferring between SHOP and Individual Exchanges, • contributes to expanding dental and vision coverage of Californians, and • provides families with cohesive coverage options for all family members (adults and children). **Issue 2: Structuring Dental and Vision Benefit Offerings** NHeLP and the HCA agree with the Exchange's recommendation to offer dental and vision benefits in the Exchange through stand-alone dental and medical plans. The Department of Health and Human Services, found that pediatric dental and vision services are generally not included in many health insurance plans. *See* DEPARTMENT OF HEALTH AND HUMAN SERVICES' FREQUENTLY ASKED QUESTIONS ON ESSENTIAL HEALTH BENEFITS BULLETIN, Question 5 (2012), *available at* http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf. Therefore offering these benefits through stand-alone plans is consistent with current market practices.
Section 7C: Multi-State Plans	NHeLP and the HCA share the concerns raised by the Board Background Brief about the role of multi-state plans in California's Exchange, and we support the recommendation that the Exchange staff continue to work closely with OPM and CCIIO staff to monitor any proposals that multi-state plans enter the California market in 2014 or 2015. We also support the Exchange taking any steps possible to ensure that any multi-state plans that participate in California's Exchange are held to the same standards as QHPs and be subject to Exchange oversight.
Section 7D: Consumer Operated and Oriented Plans	NHeLP and the HCA also share the concerns raised by the Board Background Brief about the role of CO-OPs in California's Exchange, and we support the recommendation that Exchange staff continue to work closely with OPM and CCIIO staff to monitor any proposals that CO-OPs enter the California market in 2014 or 2015. We also support the Exchange taking any steps possible to ensure that any CO-Ops that participate in California's Exchange are held to the same standards as QHPs.
Section 7E: Partnering with Health Plan Issuers to Promote Enrollment	NHeLP and the HCA support the Board Background Brief's recommendation that the Exchange work closely with participating plans to coordinate marking and enrollment activities, while simultaneously ensuring that consumers are given complete information about the range of options available to them. In addition, the materials and marketing practices must be regulated and monitored by the Exchange and QHPs should be required to work with community-based advocates and organizations to ensure that their enrollment and marketing activities are appropriately designed and targeted to meet the needs of the particular community or region.