Comments
Qualified Health Plan Model Contract
Revised Draft (4-3-13) and Updated Redline (4-12-13)

The Health Insurance Alignment Project (Project) has reviewed the model Qualified Health Plan (QHP) contract proposed by the California Health Benefit Exchange (Covered California) to solicit health insurance issuers in providing health care coverage. The Project engages in independent policy research, analysis and strategic assistance to advance the goals of reducing duplication, improving transparency and maximizing consumer protections in health insurance oversight in California. Kelch Policy Group administers the Project through a grant from the California HealthCare Foundation. Deborah Kelch serves as a member of the Covered California Health Plan Management Advisory Work Group.

With that as background, the Project offers the following comments on the proposed QHP model contract for consideration by the Board and staff of the Exchange.

The revised contract addresses several of the comments we previously submitted and the overall format and structure is easier to follow and review. In that sense, the revised contract is an improvement to the previous versions.

We raise the following remaining questions and issues with the revised contract as are possible for us to identify and articulate given the extraordinary short timeline for review of major and sweeping changes some of which were just proposed late on the prior business day. We would be happy to discuss any of the comments provided directly with staff or through the Health Plan Management Advisory Group. For questions about these comments or the Health Insurance Alignment Project, please contact Deborah Kelch of the Kelch Policy Group at dk@kelchpolicy.com

SPECIFIC COMMENTS

Uniform Model Contract

As an overarching policy, we recommend that the model contract apply to all QHP issuers participating in the Exchange. Having one common contract will contribute to consistency, transparency and ultimately to the accountability needed to support informed consumer choice. The Exchange should not individually negotiate contract provisions with participating issuers except for those elements which are unique among issuers such provider network, service areas and rate provisions.

Licensed in Good Standing (§3.02, p. 7)

The model contract leaves room for interpretation that applicant issuer, or the Exchange, make the determination that the issuer is in good standing. As a definitional matter, under the ACA QHPs must be offered by an issuer that "is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage."[1] The federal regulations mirror, and do not

expand upon, this requirement.[2] According to CMS comments to the Final Rules implementing the Exchange statutes, CMS interprets "in good standing" to mean that an "issuer faces no outstanding sanctions imposed by a state's department of insurance." CMS did not prescribe how Exchanges would determine licensure and standing, but suggested that Exchanges could use a number of means such as "attestation or verifying the information directly with State departments of insurance." Given CMS' statements, it is reasonable to conclude that state regulators, not QHPs issuers or the Exchange, should verify the good standing requirement. To clarify this point we offer the following amendment:

> 3.02 Licensure and Good Standing.
>
> Contractor shall be licensed and in good standing to offer health insurance coverage through its Certified QHPs offered under this Agreement and its other health plans offered outside the Exchange. For purposes of this Agreement, "good standing" shall require, **subject to verification by the Contractor's respective health insurance regulator**: (i) Contractor to hold a certificate of authority from CDI or a health care service plan ("HCSP") license from DMHC, as applicable, and (ii) the absence of any material statutory or regulatory violations, including, penalties, during the last two years prior to the date of the Agreement and throughout the term of Agreement, with respect to the regulatory categories identified at Attachment 3 ("Good Standing**")**. For purposes of this Agreement, "material" violations shall represent a relevant and significant departure from normal business standards required to be adhered to by a Health Insurance Issuer.

Marketing

California has a history of challenges and marketing abuses dating back to the early days of Medi-Cal managed care and further consideration and discussion in this area is warranted. As discussed at the Health Plan Management Work Group, we recommend that the Exchange review state marketing regulations and contract requirements applicable to Medi-Cal managed care plans and the Healthy Families Program to identify specific provisions for possible application to QHP issuer marketing and enrollment assistance. For example, the Exchange may wish to mirror requirements that prohibit door-to-door marketing and in-home presentations by QHP issuers, limit issuer comparisons among Exchange offerings and require all issuer marketing materials and promotions to be approved by the Exchange prior to their use. The existing well-established and tested program rules and standards can easily form the basis for guidelines, expectations and standards applicable to the marketing plan now included in the model contract. We are available to provide background on the existing regulations and contract requirements in state law and programs that might be used to set uniform Exchange standards.

Primary Care Physicians

Section 3.01 would require the assignment of a primary care physician (PCP) for all enrollees regardless of coverage model type. Despite the positive intent, this provision may fail to ensure that QHP enrollees have access to a physician who is contractually obligated and compensated to coordinate and manage their health care. The model contract defines a PCP as follows:

> A California licensed doctor of medicine or osteopathy who is a general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist or pediatrician who has a contract with Contractor as a primary care physician and who has the primary responsibility

for providing initial and primary Health Care Services to Enrollees, initiating referrals for specialist and hospital care, and maintaining the continuity of the Enrollee's medical care. (Para. 13.74, pg 67).

Despite this proposed comprehensive and appropriate role and definition of PCPs, the model contract requires the assignment of all enrollees to a PCP, even in coverage models based on fundamentally different contractual roles and responsibilities. For example, in PPOs, physicians in primary care specialty areas are, like other contracted physicians, typically paid for the medical services they provide during an office visit based on the applicable CPT billing code. Unlike the HMO context, they generally do not contract and are not compensated for care coordination, speaking to other specialists, enlisting family members as partners or any of the other activities required to manage care in a primary care medical home model. Existing fee-for service systems do not reimburse physicians for care coordination.[3]

Without additional changes, the proposed Exchange policy regarding PCP assignment could result in assignment of enrollees to physicians who are not contracted or compensated to actively serve as PCPs. Physicians will either be unable or unwilling to fully function as PCPs given their practice demands and payment structure or will do so outside the compensation structure generally regarded as appropriate for physicians who function as PCPs. Requiring assignment of enrollees to physicians who are not signed up to serve as primary care physicians devalues the comprehensive role of PCPs in integrated coverage models and could create unrealistic enrollee expectations of the role an assigned provider will play in the coordination of their health care.

In order to implement the Exchange goal of mandatory assignment of PCPs in all settings, the model contract should require that issuers assign enrollees only to physicians contracted to serve as PCPs. Alternatively, the model contract could require issuers to assign all enrollees to a contracted *physician* but not specifically imply or communicate with enrollees that those physicians will fully function as PCPs or primary care medical homes unless the physicians are contracted to do so.

Definitions

- **Exclusive Provider Organization (EPO).** The definition of EPOs cited (p. 64, 13.31) references a specific regulation for a defunct program, the Health Insurance Plan of California (HIPC). Rather than cite a definition that is not in active force and may be deleted at any time we recommend that the contract include the full text of the definition from the regulations. The Exchange may also wish to consider and seek guidance from CDI because it appears from our review that EPOs under the Insurance Code are only authorized for group coverage and not for individual coverage. See California Insurance Code (CIC) §10133 (c) which applies to EPO agreements between insurers and group policyholders.

- **Health Insurance Issuer.** In addition to referencing the federal definition of issuer, we continue to recommend the clarity afforded by defining for California purposes that issuers are entities appropriately licensed by either DMHC or CDI to sell health coverage (p. 65, 13.40).

- **Health Maintenance Organization**. This definition continues to be inaccurate (p. 65, 1343). All licensed health care service plans are not HMOs. Products offered by licensed health care service plans include Point of Service and PPO product plans. To continue to use this incorrect definition

is confusing for regulators and consumers and could affect later contract enforcement. There is a definition of HMOs included in the HIPC regulations that could help reduce confusion at California Code of Regulations ,Title 10, section 2699.6000 (x). Again, we do not believe this regulation should be cited for the reasons set forth above, but the text from the regulation rather used as the contract's definition as follows:

"Health maintenance organization" means [a health care service plan licensed pursuant to Health and Safety Code §1345] and either of the following:

(1) Comprehensive group practice prepayment plans which offer benefits, in whole or in substantial part, on a prepaid basis, with professional services thereunder provided by physicians or other providers of health services practicing as a group in a common center or centers. This group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds.

(2) Individual practice prepayment plans or network model prepayment plans which offer health services in whole or in part on a prepaid basis, with professional services thereunder provided by individual physicians or groups of physicians or other providers of health services who agree to accept the payment provided by the plans as full payment for covered services rendered by them."

- **Medical Necessity** and **Medically Appropriate** – ***We continue to have concerns with the inclusion of these definitions in the contract.*** Is the Exchange seeking to expand Exchange coverage beyond the statutory requirements in state and federal law relating to medically necessary essential health benefits and the state essential health benefit benchmark enacted in 2012 (See HSC §1367.005 and California Insurance Code (CIC) §10112.27)? Does the Exchange intend to standardize the definition of medical necessity among all participating plans and expect that state regulators will enforce the requirement? If so, what is the source of the proposed definition and what are the implications and goals for imposing it as a standard definition? What is the purpose and intended effect of including the definition of "medically appropriate"?

Quality Initiatives

The model contract and proposed quality changes in Attachment 7 still do not establish with clarity a set of specific and clear quality initiatives for the initial first year of the contract to promote uniformity and allow for reasonable monitoring and evaluation. Rather than trying to address many potential quality improvement activities and existing known strategies across a wide spectrum of topics, the Exchange has the opportunity to select a few quality initiatives based on emerging evidence, existing national benchmarks and the diverse needs of expected Exchange enrollees.

The most recent contract version appears to reduce the number of mandatory expectations and change them to primarily reporting and data collection, but fails to set forth a clear path for the Exchange related to quality improvement. A few specific quality initiatives in the first year, with a focus on the appropriate role of health plans as the locus of responsibility, along with uniform reporting on the additional models, initiatives and collaboratives issuers are implementing once 2014 open enrollment is completed, could

form the basis for deliberative staff and stakeholder work on further quality initiatives in 2015 and 2016. Clearly identified and specific first year initiatives, as well as clear and simple contract language requiring Contractors to help develop and implement additional quality initiatives in future contract years, could launch the Exchange as a leader in quality measurement and improvement while providing sufficient time to carefully consider year-to-year progress that is realistic, measureable, and achievable given the role the Exchange plays as a contractor with health plans.

[1] 42 USC §18021.
[2] 45 CFR §156.200.
[3] See Anne S. O'Malley et al. "Coordination of Care by Primary Care Practices: Strategies, Lessons and Implications," Center for Health Systems Change, Research Brief No. 12, April 2009.