Comments
Qualified Health Plan Model Contract
Updated Redline (4-22-13)

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 continue to 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. 8)

The most recent version of the contract adds language that the Exchange will make the determination that a QHP issuer is appropriately licensed and in "good standing." We do not believe that the Exchange has or will have the knowledge, information or expertise to make this determination. The determination of an issuer's regulatory standing should be made by the Contractor's respective health insurance

regulator, California Department of Insurance (CDI) or Department of Managed Health Care (DMHC) (pursuant to the definition that the Exchange has developed and which is included as Attachment 3) based on regulatory filings, investigations and oversight activities that are within the purview of the regulator. California must already work through having two regulators with different sets of laws and putting the Exchange in the role of evaluating issuer compliance with those respective requirements potentially adds a third regulator which could add confusion to the existing complexity. The Exchange is not a regulator but rather is a purchaser and has an inherent conflict in evaluating the extent to which issuers whose QHPs it hopes to offer are in compliance with state licensing requirements as a minimum standard for participation.

Importantly, the federal Affordable Care Act and the implementing federal rule cited in the revised contract (45 C.F.R. §156.200) do **not** require the Exchange to make this determination but only establishes "good standing" as a participation standard for Exchange QHPs.

To clarify this point we offer the following suggested amendment in red text below:

> 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, **each QHP issuer must be in** "good standing" **which shall be determined by the Exchange pursuant to 45 C.F.R. §156.200 (b)(4**) **based on and subject to verification by the Contractor's respective health insurance regulator** shall require~~,~~: (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.

Provider Directory

Government Code 100504 (a)(9) allows the Exchange to require issuers to provide regularly updated information on whether providers are accepting new patients which could be a selling point and marketing advantage for the Exchange and a helpful tool for consumers enrolled in the Exchange.

Primary Care Physicians

We continue to be concerned that the proposed requirement to assign primary care physicians in all coverage model types is based on flawed assumptions and will be confusing to consumers. Physicians in most PPOs are not contracted, obligated or reimbursed to function as primary care physicians **which means much more than being a physician practicing in a primary care specialty**. Physicians contracted to function as PCPs should be involved in care coordination, speaking to other physicians and specialists and tracking referrals, enlisting family members as partners and performing any of a host of other activities required to manage an enrollee's health and health care.

Therefore, if the Exchange continues to persist in its goal of mandatory assignment of PCPs in all coverage models, 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* as a starting point for an enrollee seeking care 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 and obligated to do so.

Definitions

- **Exclusive Provider Organization (EPO).** It remains unclear how the Insurance Code definition of EPO cited in the contract (p. 68, 13.30) could effectively apply to QHP issuers in the individual Exchange since they could be offering individual coverage regulated by either CDI or DMHC. Insurance Code §10133 (c) refers only to the ability of *insurers,* not DMHC-regulated health plans, to offer EPO coverage in the *group* market, and not the individual market, and does not adequately describe the EPO model of health coverage from either the provider or the consumer perspective.

  Insurance Code §10133....

  (c) Alternatively, insurers may, by agreement with ***group policyholders****,* [emphasis added] *limit payments under a policy to services secured by insureds from institutional providers, and after July 1, 1983, from professional providers, charging alternative rates pursuant to contract with the insurer....*

  It is not clear why a definition of EPO is needed in the contract since, as of the last writing, there is no definition of either a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO). The proposed HMO “definition” is simply a reference to the broader category of health care service plans licensed under Knox-Keene which includes but is not limited to HMOs. If a definition of EPO is included, the following definition is suggested as alternative:

  An exclusive provider organization is a health coverage plan that limits coverage of nonemergency care to contracted health care providers. In an EPO, providers may be paid on a discounted fee-for-service or prepaid basis depending on the licensure requirements of the issuer.

- **Health Maintenance Organization**. If a definition of HMO is included, we continue to suggest a textual definition of HMO similar to what is below (p. 69, 13.42).

  “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 model contract and recommend that they be deleted.** California law does not define these terms for products regulated by the CDI or DMHC, thereby allowing issuers to develop their own definitions through various means such as medical research, practice guidelines, and market considerations. Despite this lack of legal definition, California courts have been solicitous over patient welfare, typically resolve uncertainties about the reasonableness of treatment in favor of coverage, and do not allow issuers to make coverage decisions that are arbitrary and capricious or otherwise "significantly at variance with standards of the medical community."[1] The proposed contract definitions only add confusion and could be applied by issuers in an arbitrary manner. For example, some services under the definition of "medically appropriate" could be, but are not necessarily, provided by non-physicians with more limited licenses, such as nurses. The proposed definition of medically appropriate suggests that where non-physicians with "like credentials" could perform such services, then the service would not be medically appropriate and therefore not covered by Exchange issuers. Such a definition is inconsistent with the law and is potentially harmful to consumers.

  Second, we are unclear as to why these terms are even defined in the model contract since the terms are not contained in the contract itself but only appear in other definitions. Coverage for medically necessary basic health care services is a core component of California's essential health benefits requirement (Health and Safety Code §1367.005, Insurance Code §10112.7). Where the terms are used in the contract, they are used in a confusing and inconsistent manner. The only time the phrase "medically appropriate" actually appears in the contract is in the definition of "formulary." Pursuant to the essential health benefits legislation, drugs are covered where "medically necessary" and the definition of medically appropriate makes no sense in the context of a drug formulary.

  Similarly, the inclusion of the term "medically necessary" in the definition of "health care services" is ambiguous. Pursuant to paragraph 13.37, " Health Care Services" is defined as "*Any and all medical services, supplies and benefits provided under through Contractor's QHP by Participating Providers to Enrollees, including medical, Behavioral Health, chemical dependency, inpatient and outpatient and all Medically Necessary Services that are Covered Services*." Given the placement of "medically necessary," it does not appear that medical services need to be medically necessary to be covered but that all other non-specified services must be.

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.

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[1] See, for example, *Saffle v. Sierra Pacific Power Co. Bargaining Unit* 85 F.3d 455 (9th Cir. 1996); see also *Hughes v. Blue Cross of California* 215 Cal. App. 3d 832 (1989).