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April 26, 2013

Via email

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

RE: Covered California Qualified Health Plan Model Contract Version 3.0

Dear Chairwoman Dooley and Members of the Board:

The National Health Law Program and the Western Center on Law & Poverty are pleased to present our input on the latest version of Covered California's Qualified Health Plan Model Contract. Our recommendations and comments address both the issues raised in Andrea Rosen's presentation on the model contract as well as additional issues of particular importance to low-income consumers.

- **Issue # 1: Plans don't want Covered California to be a "third regulator."**

NHeLP and Western Center appreciate the importance of making sure that Covered California operates efficiently, and that QHPs are not over-burdened by duplicative regulatory review. *That said, given Covered California's role as an active purchaser, we urge the Board to ensure that it retains a role in reviewing and evaluating QHPs' performance in areas that are particularly important to Covered California's mission*. To that end, we support the modification to section 7.01 of the model contract to make contracts effective only until Dec 31, 2014, and then allow Covered California to recertify QHPs on an annual basis. A one-year contract term will provide Covered California the opportunity to modify contracts based on changes in law and issues that arise or lessons learned in the first year.

We are very supportive of Covered California's plan to retain an oversight role on changes to QHPs' service area and network

capacity given the centrality of these types of changes to enrollees' access to health care services. We are concerned that while Covered California staff stated during the April 23 Board meeting that Covered California would continue to oversee formulary changes, this oversight role is not clear in the current contract language; we suggest that Article 8 of Attachment 7 be amended to make this role clearer. We are pleased to see that the list of required reports includes network adequacy standards; changes in participating provider network; out-of-network, other benefit costs and network requirements; appeals and grievances; enrollee and marketing materials; further assurance regarding transition and continuity of care; quality, network management and delivery system standards; and customer service standards. By monitoring QHPs' performance in these important areas, Covered California will be well-positioned to call for improvements, where needed, and to work with QHPs so that they stay consumer-focused and affordable.

Covered California should similarly retain an oversight role with respect to marketing materials and notices. *We oppose the removal in section G(i) of Attachment 6 of the requirement that Covered California approve all marketing materials before they can be used by the QHP issuers*. Without prior approval, QHP issuers will be free to design materials that target healthier populations, creating a high risk of cherry picking. In addition, review of marketing materials is essential to help ensure against inaccuracies, misinformation and other types of deceptive marketing practices.

With respect to marketing materials, while Covered California need not duplicate the roles of existing regulators, it should seek to ensure that legally required accommodations are made for LEP plan members and those with disabilities. The model contract does not require that the QHPs provide Covered California with sufficient information to ensure that applicable standards under law are being met. In fact, it does not require QHPs to report to Covered California about their track record in communicating with LEPs and people with disabilities and providing reasonable accommodations. *At a minimum, QHPs should be required to demonstrate that they have consistently provided all materials translated into other languages as required by law, and tailored specifically to meet the particular needs of people with disabilities, including materials in Braille, large font, and other formats that comply with state and federal disability laws.*

- **Issue # 5: Concerns expressed about imposing language requirements other than English beyond what state law currently requires.**

NHeLP and Western Center oppose the deletion of the requirement that QHPs communicate with enrollees in Medi-Cal threshold languages in Attachment 6 to the most recent version of the model contract. Because of the large numbers of limited English proficient (LEP) individuals who will be purchasing insurance through the Exchange, it is absolutely critical that Covered California ensure that linguistically and culturally appropriate services are provided by the QHPs that are accepted for contracting with Covered California. We appreciate that this contract reinforces QHPs' legal obligations with respect to current state language access laws.

Under state law, QHPs will be required to provide oral interpretation in any language and written translations in a Plan's threshold languages as specified under Health and Safety Code 1367.04 and Insurance Code Section 10133.8-9. In addition, QHPs will have the legal

obligation to comply with the requirements of Title VI of the Civil Rights Act of 1964, Section 1557 of the ACA (non-discrimination), Health and Safety Code Section 1367.04 (SB 853), and applicable oversight agency regulations and guidelines. We appreciate the efforts of Covered California to ensure that the required accommodations are being made for LEP plan members. In particular, we laud the requirement in Attachment 6 to the model contract that the telephone system and enrollment materials be available in both English and Spanish, in recognition that Spanish is the second most common language spoken in California, and that many Exchange enrollees will be Spanish-speaking. But, given the large numbers of lower income Californians who speak languages other than English and Spanish, we urge Covered California to do more to ensure that LEP enrollees get crucial information in their primary languages. *We urge Covered California to put the requirement that QHPs use Medi-Cal threshold languages back in. If Covered California determines that this requirement is not feasible for 2014, staff should closely monitor QHPs' performance with respect to LEP enrollees, and phase in this requirement in subsequent years*.

Federal rules make it clear that programs in the Exchange, including QHPs, must be accessible to all consumers, including persons with disabilities and Limited-English Proficient applicants *and* enrollees. (45 C.F.R. §155.205 and §155.210) Accordingly, it will be important for Covered California to monitor how well the QHPs are meeting their legal obligations. We appreciate that section 3.18 of the model contract affirms that Covered California will evaluate the adequacy of language services provided for verbal and written communications during 2014 and that it will consider the adoption of additional standards in 2015. *We suggest adding language that QHPs be required to regularly report on how they are estimating the language needs of their expected enrollment population*. *They should be required to demonstrate that they are providing written translations of documents in accordance with applicable standards for any substantial percentages of their expected enrollment with particular language needs and that they provide tag lines in other languages that do not meet the threshold for full translations. They should be required to report on how they are providing sufficient access to customer service representatives who are bi-lingual in particular languages, and how they provide quickly-available oral translation services for those persons with needs in more uncommon languages. They should be required to demonstrate to Covered California that they are providing interpretation services on a 24-hour basis, at no cost to the member. They should be required to provide information on how they are ensuring the competency of the interpreting services they are providing*.

Additionally, we appreciate that section A(iv) of Attachment 6 to the model contract explicitly affirms that QHPs are required to provide no-cost oral interpreter services for all non-English speaking enrollees. *We urge Covered California to explicitly reference this important requirement in the Model Contract as well*. State language access law requires Health Plans to inform their enrollees of the availability of no-cost oral interpretation in any language. A model best practice for notifying members of these services is through the provision of taglines in non-English languages. *Covered California should at a minimum, require contractors to include taglines in 15 different languages on their materials and websites informing consumers of their right to interpreter services under state law*.

- **Issue #7: Plans concerned about collecting sensitive enrollee information, which is data not currently collected.**

NHeLP and Western Center oppose the revision to the model contract that relieves QHPs from the responsibility of collecting and reporting demographic data on race, ethnicity, primary language, disability status, sexual orientation and gender identity in 2014. We are concerned that the model contract may now be inaccurate and misleading to plans. Under Health and Safety Code §1367.04, many health plans are already required to collect data on the race, ethnicity and primary language of their enrollees. Specifically they must assess their enrollee population to develop a demographic profile every three years. *We urge Covered California to put this requirement back into the model contract as an important reinforcement of QHPs' legal obligations under existing state law*. With regards to the collection of other demographic data, Exchanges are subject to Section 1557 of the Affordable Care Act which extends non-discrimination protections to sexual orientation and gender identity. Thus, Covered California and QHPs are prohibited from discrimination on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. *We strongly urge Covered California to require QHPs to collect demographic data for these characteristics by 2015 as proper data collection will be paramount to ensuring Covered California and its contractors are meeting their obligations under federal and state laws*.

- **Issue #10: Plans expressed concerns about a prescriptive approach to identification and management of "at risk" enrollees.**

NHeLP and Western Center agree that Covered California should not prescribe precise methods of care coordination for "at risk" enrollees. We are very concerned, however, that QHPs will be permitted to devise their own definitions of "at risk" enrollees for identification purposes. Covered California must ensure that at risk members are identified and cared for adequately, and not discriminated against because of health status. *To do so, Covered California should clearly define which enrollees are considered "at risk" and require all QHP issuers to use the same definition for identifying and reporting back about this population to Covered California*.

- **Issue # 12: Certain pregnant women may be eligible for both an Exchange subsidy and expanded services through the Medi-Cal Program. Also, newly Qualified Immigrant Citizens may be eligible for Exchange subsidy products.**

NHeLP and Western Center support the recommendation to include placeholder language requiring QHPs to cooperate with other Exchange partners with regard to pregnant women and certain immigrants. As a preliminary matter, we note that pregnant women, particularly low-income pregnant women, must have access to comprehensive, affordable health insurance coverage. To this end, Medi-Cal must provide pregnant women all medically necessary services; provisions in this contract must not undermine pregnant women's access to comprehensive health care services in Medi-Cal. But, even if legislation securing pregnant women's access to comprehensive health care services in Medi-Cal is enacted, coordination between affordability programs is necessary. Proposed federal rules permit a pregnant woman receiving pregnancy-related Medi-Cal coverage to take advantage of APTCs to purchase

insurance through Covered California, if she so desires and is otherwise eligible. To ensure that a pregnant woman is able to do so requires coordination between Medi-Cal, Covered California, and any optional bridge program or Basic Health Program. QHPs should share responsibility for providing a woman information about all of the programs for which the woman is eligible, including information about benefits and cost. QHPs should also coordinate with other programs to ensure that the woman can access her complete network of providers, as well as all of her covered benefits, in a seamless and timely manner. And, if a pregnant woman's eligibility for a program changes, QHPs must also play a role in coordinating with other coverage programs to ensure that the woman does not experience discontinuity of care or coverage.

Similar issues may arise for certain immigrants or those eligible for other condition-specific coverage. We urge Covered California to work closely with the Department of Health Care Services and other state agencies as appropriate to work through these issues, and determine what role QHPs should play in coordinating coverage.

We recommend that Covered California's placeholder language includes a requirement that there is a seamless process to ensure that pregnant women have access to their full provider networks, all of the health benefits for which they are eligible, as well as all of the subsidies and cost-sharing protections to which they are entitled.

- **Additional issue: Covered California should not require enrollees to pay their first month premium on or before the fourth remaining business day of the month in order to commence coverage on the first day of the following month.**

NHeLP and Western Center oppose the language at section 3.21(a)(i) of the model contract that would require enrollees to pay their first month premium on or before the fourth remaining business day of the month in order to commence coverage on the first day of the following month. Federal rules on effective coverage dates for initial open enrollment and annual open enrollment make no mention of paying premiums to the QHP before enrollment is effectuated. While Covered California staff stated on April 23 that they have received informal guidance from CCIIO to the contrary, we continue to believe that such a requirement violates federal law. The federal regulations base effective coverage dates for initial open enrollment and annual open enrollment from the time the enrollee selects a QHP. See 45 C.F.R. §§ 155.410(c) & 155.410(f), both of which tie "effective coverage dates" to the date when the QHP selection is received by Covered California, not to the date when the premium is paid. Accordingly, effective coverage dates are "the first day of the following benefit year for a qualified individual who has made a QHP selection." 45 C.F.R. § 155.410(f). Nowhere in the federal law do the rules permit enrollment to be conditioned on the QHPs receiving the applicant's initial premium payment in full by a particular due date. Covered California cannot condition enrollment in anExchange plan on proof of premium payment to the QHP issuer. *This contract language should be deleted and replaced with language that reflects the federal rules: "For purposes of this section, enrollment shall be deemed complete when the applicant's coverage is effectuated, which shall occur when the qualified individual has made a QHP selection." At a minimum the QHP contract should be silent on the effective date of enrollment until this issue is settled with the federal authorities*.

- **Additional issue: alternative benefit designs are rightly excluded from the contract, as are high deductible health plans.**

NHeLP and Western Center support the decision to postpone including alternative benefit designs in the first year of Covered California's operation. California has taken a huge step in support of standardizing benefit plans. The decision to limit QHP offerings to the standard plan designs will help to eliminate consumer confusion and give Covered California the opportunity to evaluate the success of those standard designs in the first year.

In addition, *NHeLP and Western Center oppose any proposal to establish separate High Deductible Health Plans (HDHPs) with Health Savings Accounts in the Covered California, especially in the silver tier*. HDHPs are confusing to consumers, and therefore should generally be discouraged in Covered California. HDHPs benefit healthier, wealthier consumers who can get the tax benefits and take the risk that they can pay the deductible if they have an accident or serious health condition. Too often, consumers are attracted to HDHPs due to their relatively low premiums, but they misunderstand their potential liability in terms of out-of-pocket costs. As a result, before meeting their deductible, consumers either end up with large medical bills that they can't afford, or go without needed care in an effort to save money. Covered California should look closely at proposed HDHP designs to evaluate whether they have sufficient consumer protections in place to avoid these results, and should also ensure that, to the extent HDHPs are permitted in Covered California, consumers receive enough information to make an informed decision about choosing an HDHP.

If Covered California continues to believe it has to offer HDHPs, we agree with the proposal to prohibit them from the Silver level plans. First, prohibiting HDHPs in the Silver tier will ensure that advanced premium tax credits are effective for consumers. If HDHPs are permitted in the silver tier, they will likely become the second-lowest cost silver plan, on which consumers' advanced premium tax credits will be based. As a result, many low income consumers may be forced to buy a lower value plan than they wish, because they cannot afford a higher value plan with their advanced premium tax credits. Second, the inclusion of HDHPs in the silver tier may also significantly impact Bridge plan participation. Unlike HDHPs, Bridge plans would provide products within Covered California with both reduced premiums and reasonable out of pocket costs, without compromising benefits. If an HDHP is the second lowest cost plan, Bridge plans would be required to offer a product below the cost of an HDHP, which could limit the number of participating Bridge plans. As a result, enrollment may drop significantly, such that more individuals will churn between Medi-Cal and Covered California.

- **Additional issue: Balance billing protections**

NHeLP and Western Center oppose the deletion of specific protections against balance billing in Section 3.15 of the model contract. Removing protections against balance billing will only lead to more costs for consumers, and will make coverage less affordable for enrollees, contrary to Covered California's core values. Avoiding balance billing will be especially important when issuers offer PPO products regulated under the Insurance Code. Those products are not required to provide timely access to services, which may result in extremely low-income consumers obtaining needed services out-of-network at great cost. *We urge Covered California to make clear that QHPs must ensure that consumers are held harmless*

when a needed service is not available in their plan's network so that they are forced to seek out-of-network care.

In addition, section 3.15(ii) of the contract should be modified to ensure that QHPs will hold enrollees harmless with respect to cost-sharing if their providers mistakenly inform them that a particular provider or facility is in-network, when in fact it is out-of-network. Consumers should not be liable for additional costs when they have reasonably relied on information from their health care provider.

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

Sincerely,

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