February 7, 2014

Via email

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

RE: Covered California Qualified Health Plan Application for New Entrants and Renewal Application

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 Covered California's draft applications and regulations for Qualified Health Plans. We appreciate the hard work that you and your staff have put into crafting applications that ensure high quality health plans participate in Covered California.

In particular, we appreciate that:

- **Covered California is encouraging plans to offer embedded dental.**

NHeLP and Western Center have urged Covered California to offer plans with embedded dental benefits to ensure children have access to dental care and make coverage more understandable and affordable for consumers.

- **Covered California is encouraging Medi-Cal Managed Care plans to participate.**

NHeLP and Western Center appreciate Covered California's attempts to include as many Medi-Cal plans as possible in the

marketplace when they meet all applicable standards. Including Medi-Cal plans will help to reduce churn and improve continuity of care when enrollees' circumstances change.

- **Covered California will continue efforts to monitor balance billing.**

NHeLP and Western Center appreciate Covered California's continued attention to balance billing when enrollees are required to access benefits out-of-network. New Entrant Application § 6.3. We strongly urge Covered California to monitor this area closely and to develop appropriate consumer protections to ensure that enrollees do not face unaffordable costs when services are not offered in-network in a timely or accessible manner.

- **Covered California will verify plans' compliance with applicable network adequacy standards.**

NHeLP and Western Center highly appreciate Covered California's commitment to performing independent oversight and review of the adequacy of plan's networks. We commend the language in the renewal application that states "provider network adequacy for . . . Covered California products will be determined by the applicable state regulatory agency and verified by Covered California." Renewal App. at § 2.1. We urge Covered California to incorporate similar language into the application for new entrants. We appreciate that, elsewhere in the application for new entrants, plans are asked to demonstrate their compliance with applicable network adequacy requirements, to identify the percentage of board certified providers with whom they contract, and to describe their plans for network development. We encourage Covered California to look closely at this data, and to also collect additional information on the plans' overall networks in order to engage in meaningful oversight of the adequacy of their networks. In particular, Covered California should require plans to document their relationships with Independent Physician Groups (IPAs) or other delegated groups that serve to limit enrollees' access to the plans' overall networks, and should require plans to provide geo-access maps of their providers and IPAs relative to the target population in each region.

- **Covered California will continue to exclude alternative benefits designs from the individual market for 2015.**

We are pleased that Covered California has committed to not allowing alternate benefit for the 2015 benefit year for the individual market. California has taken a huge step in support of standardizing benefit plans. The decision to continue to limit QHP offerings to

the standard plan designs will help to eliminate consumer confusion and will give Covered California more time to evaluate the success of those standard designs. We urge Covered California to similarly exclude alternative benefits designs in the SHOP for at least another year to ensure that it can fully and fairly evaluate the standard designs before adding additional considerations.

We ask Covered California to consider the following changes to the applications for new and renewing plans:

- **Require all plans to ensure continuity of care.**

NHeLP and Western Center are concerned that most, if not all, QHPs may not be legally bound to provide any continuity of care to new enrollees. Already, we have heard reports from consumers who came to Covered California from the LIHPs and the individual market that they are having trouble seeing their existing providers or continuing necessary treatment. This problem has become especially acute given the widespread inaccuracies in Covered California's Provider Directory, which was pulled from Covered California's website just this morning. Even consumers who attempted to choose a plan that contracted with their current providers are finding that sometimes their providers are not covered. While we anticipate that the legislature will extend existing continuity of care requirements to QHPs this year, we urge Covered California to also require plans to, at a minimum, comply with the standards for continuity of care set forth at Health & Safety Code § 1373.96(c). Covered California should give new and renewing plans notice of this requirement in the application, and require their compliance through the contracting process later this year.

- **Require all plans to provide accurate and up-to-date provider information.**

NHeLP and Western Center are extremely disheartened by the continuing problems with Covered California's Provider Directory, described above. We appreciate that both the application for new entrants and renewing plans require the plans to submit provider information for inclusion in Covered California's directory, but we are very concerned that this requirement does not go far enough to ensure that the directory is accurate for consumers. We urge Covered California to require new and renewing plans to assure that the information they provide is accurate and up-to-date. We also strongly urge Covered California to ask renewing plans to account for their performance in this area during the first year, including any corrective action taken to address problems.

- **Prohibit two-tiered network designs.**

NHeLP and Western Center continue to oppose allowing two-tier networks to overlay benefit designs in Covered California. While the application for new entrants states that actuarial value calculations for two-tiered networks will be based on "likely overall use of tiered networks," New Entrant App. at 14, such calculations may be highly prone to inaccuracies and to misleading consumers. For the population eligible for premium tax credits and cost-sharing subsidies, a two-tier network is likely to expose enrollees to significant cost liability in the second tier, which could result in heavy medical debt. To the extent that two-tiered networks are permitted, Covered California must work with plans to ensure that consumers are given sufficient information about the providers included in each tier, and the differences in cost-sharing between tiers, to make an informed decision in selecting a plan. Without this information, it will be impossible for consumers to calculate their likely cost liability in two-tiered networks. Furthermore, Covered California should take steps to ensure that two-tiered networks don't make an end-run around network adequacy requirements and ECP requirements; any two-tier networks must meet those requirements in the tier that exposes consumers to less cost-liability (i.e., the first tier).

- **Require all plans to report on their methods of identifying at-risk enrollees.**

We encourage Covered California to collect more information from both new and renewing plans about their methods of identifying at-risk enrollees and providing them with services such as care management. We appreciate that the application for new entrants asks plans to identify whether they use certain strategies for identifying and assessing the health needs of at-risk enrollees, but we encourage Covered California to collect more detailed information about how these programs will be carried out for plans that are selected to participate in Covered California. The renewal application does not ask plans to provide any information on their progress in identifying at-risk enrollees and creating care management plans for them. At a minimum, renewing plans should be required to provide basic information about how they have identified and assessed the needs of enrollees, what care management services they have provided. To the extent that plans are able to report on any changes in health outcomes for the population that has received care management, they should do so as well. Plans' success at appropriately targeting care management and using it to improve health outcomes must be a part of Covered California's evaluation of their fitness to continue participation in Covered California.

- **Require all plans to meet stringent network adequacy standards.**

In the first month of coverage, NHeLP and Western Center have already heard from consumers who are experiencing difficulty accessing care through their new QHPs. While we believe that many of these problems be solved in the coming months, we urge Covered California to take additional steps to ensure that all enrollees have access to the services they need, when and where they need them.

First, NHeLP and Western Center urge Covered California to require CDI plans to meet the same timely access standards as DMHC plans. The fact that enrollees in a PPO may be able to access needed services out-of-network does not substitute for timely access to services in-network, particularly when enrollees will be subject to significantly increased costs if they access care out-of-network. While we understand that CDI is developing regulation in this area, there is no guarantee as to when this will occur. Covered California should ensure timely access by including standards in its plan contracts in the meantime.

Second, all plans should be required to demonstrate that they contract with an adequate number of providers in all appropriate specialty areas to ensure that enrollees have access to all covered services. We urge Covered California to develop criteria to measure the number of providers that account for variation in specialty type and geography, similar to those used in the Medicare Advantage program. *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. Covered California's criteria should account for the needs of special populations who will use its services, including children, people with disabilities, limited English proficient enrollees and women of reproductive age. 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 offered by participating providers, and whether providers are accepting new patients.

- **Ensure that all plans have adequate customer service capacity to serve enrollees.**

NHeLP and Western Center have heard from far too many consumers who have attempted to reach their new QHPs this year to verify coverage, get information about providers, or to understand the limitations on their coverage but have not been able to reach anyone from their plan. We appreciate that call centers are experiencing

unusually high call volume due to the influx of newly covered enrollees as of January 1. But we are concerned that many participating plans did not adequately prepare for the increase by boosting their customer service capacity. We appreciate that the application for new entrants requests that applicants provide basic information about their capacity and ability to scale up to meet increased demand. Application for New Entrants § 6.2. But we are concerned that Covered California is not requiring renewing plans to provide an assessment of their customer service capacity in the renewal application, but only asks plans to describe how they will "maintain sufficient staffing in the customer service center to meet contractual performance goals." Renewal App. § 5.8. Covered California must obtain sufficient information from renewing plans to understand what went wrong during the first open enrollment period, and use that information to develop appropriate customer service capacity standards for both new and renewing plans for 2015.

- **Ensure that all plans provide full access to people with disabilities.**

Because many people with disabilities will continue to purchase coverage through Covered California, NHeLP and Western Center urge Covered California to take steps to ensure that QHPs are able to communicate effectively with people with disabilities, including by providing reasonable accommodations, when needed.

While QHPs will have the legal obligation to comply with the requirements of Title VI of the Civil Rights Act of 1964, Section 1557 of the ACA (non-discrimination), the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act, and applicable oversight agency regulations and guidelines, a large amount of responsibility sits on the shoulders of Covered California to assure that the required accommodations are made for plan members with disabilities. The Draft applications do not adequately require that the plans provide sufficient information to assure that the required standards are being met. In fact, it does not collect any information about plans' ability to communicate with people with disabilities and provide reasonable accommodations. At a minimum, plans should demonstrate their ability to provide all materials tailored specifically to meet the particular needs of people with disabilities, including the provision of materials in Braille, large font, and other formats that comply with state and federal disability laws.

- **Ensure that all plans provide full access to people with Limited English Proficiency**

NHeLP and Western Center were surprised to see in the materials provided at the January 21 forum on Reducing Health Disparities that some plans reported having very limited data on the primary language of their enrollees – one plan only had data on 6%

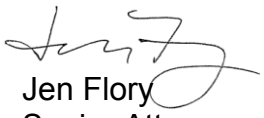
of its members. If a plan does not even know what language an enrollee speaks, how can the plan make appropriate translated materials or translators available?

As Covered California has already identified this area as a current known weakness among some plans, reliance on good standing with DMHC or CDI to ensure language access is insufficient. We urge Covered California to include more specific language in both the renewal and the new entrant applications requiring that such data be required and that consumers be informed of their rights at enrollment. These provisions would ensure that persons who do not speak English as a primary language can actually access health care once enrolled in a plan.

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

Sincerely,

Abbi Coursolle
Staff Attorney
National Health Law Program



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