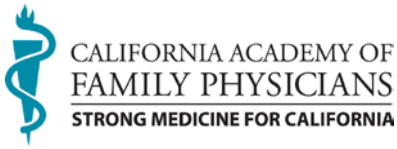

ASSOCIATION OF
NORTHERN CALIFORNIA
ONCOLOGISTS

August 6, 2012

Peter Lee, Director
California Health Benefit Exchange Board
2535 Capitol Oaks Drive, Suite 120
Sacramento, California 95833

Submitted electronically to *info@hbex.ca.gov*.

RE: Impact of the Final Federal Exchange Rule's Grace Period Revision (45 CFR § 156.270) on Qualified Health Plan Enrollees and Providers

Dear Mr. Lee and Members of the Board:

On behalf of the undersigned organizations, we want to thank you for considering stakeholder input throughout the Exchange's rapidly evolving development. Such engagement is particularly critical in the creation of standards for the selection and oversight of qualified health plans (QHP), as they will have a significant role in determining the success of California's Exchange.

We are extremely concerned about the potential impact of the final federal exchange rule's grace period provision[1] on access and the continuity of care for QHP enrollees. Under this significant change in the final exchange rule[2], providers would render services to delinquent, subsidy-eligible QHP enrollees for two months with no advance notice of the patient's delinquency, and, upon the patient's termination for unpaid premiums, issuers could choose not to pay the providers for those two months of services rendered in good faith. In other words, contracting with a QHP has become a risky proposition for providers.

Furthermore, this practice will lead to adverse selection due to relatively thinner networks in QHPs, strain rural and other providers who rely on predictable payments, saddle California's

[1] Codified at 45 C.F.R. § 156.270.
[2] Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310-18475 (March 27, 2012) (amending 45 C.F.R. Parts 155, 156, & 157).

delivery system with more bad debt, and add to the problem of medical bankruptcy among Californians – all of which are irreconcilable with the Exchange's vision statement and guiding principles.

We therefore ask that the Exchange formally provide its understanding of section 156.270's grace period. Specifically, we ask for clarification as to whether and to what extent this provision preempts state law. Should the Exchange see QHP issuers as having the option to pend 60 days of claims, we ask the Exchange to propose options and recommendations to minimize the impact of this change before the Exchange becomes operational.

The Grace Period as Described in the Final Federal Exchange Rule

The federal Department of Health and Human Services (HHS) revised its grace period provisions from the proposed exchange rule to the final rule. In the proposed exchange rule, Establishment of Exchanges and Qualified Health Plans[3], HHS required QHP issuers to pay all appropriate claims submitted on behalf of subsidy-eligible enrollees during the three month grace period for non-payment of premiums. In the final exchange rule, HHS reduced this issuer payment requirement to one month and allowed issuers the option to pend and deny claims upon termination of the enrollee at the end of the three-month grace period for non-payment of his or her share of the premium.

Understanding that this revision shifts the risk and burden to providers, HHS requires issuers to provide notice. Under 45 C.F.R. § 156.270(d)(3) and the comments and responses to the rule, HHS requires that "providers who submit claims for services rendered during the second and third months of the grace period" be notified of "the possibility for denied claims when an enrollee is in the second and third months of the grace period." The HHS responses imply that such notice would be after or upon claims submission, though the regulatory language itself does not specify when notice is expected to occur.

The final rule is also ambiguous regarding the grace period's preemption of state law. The HHS responses in the final rule state that "QHP issuers may still decide to pay claims for services rendered during that time period in accordance with company policy or State laws, but the option to pend claims exists." Yet, issuers must still be licensed in the state, which requires adherence to myriad laws, such as those prohibiting a plan or insurer that authorizes treatment from rescinding or modifying the authorization after the physician renders the service in good faith[4] and the significant statutory and case law requiring plan or insurer reimbursement for emergency care services.

The Pending and Denial of Claims by QHPs Will Result in Adverse Selection

Contrary to the Exchange's vision statement and guiding values, forcing California's health care delivery system to absorb the costs of 60 days of rendered services to some segment of the nearly 2.4 million estimated to be eligible for subsidies in 2016 will hinder "access to affordable, high

[3] Establishment of Exchanges and Qualified Health Plans; Proposed Rule. 76 Fed. Reg. 41866-41927 (July 15, 2011) (amending 45 C.F.R. Parts 155 and 156).
[4] Health & Safety Code §1371.8; Insurance Code §796.04.

quality care" for all Californians. Furthermore, by creating a major disincentive for providers to contract with QHPs, this practice of pending claims will lead to adverse selection as a result of provider networks outside of the Exchange being more comprehensive.

Providers in rural, disadvantaged, and/or provider shortage areas, especially solo and small practice physicians, no doubt would be disparately impacted. For the most part, these practices rely on relatively predictable fee-for-service payments and do not have the margins to absorb significant unpaid claims. Unfortunately, these are precisely the types of providers the Exchange should be encouraging to contract with QHPs, as they are the providers currently caring for much of the Exchange's anticipated enrollee population.

Providers of emergency services also would be particularly hard hit by such pending and claims denials. Many emergency physicians already are reimbursed at unreasonably low rates by non-contracted payers. Forcing these providers of emergency care services to further absorb the cost of these denied claims will jeopardize emergency care access for all Californians.

Networks of specialist physicians in QHPs, however, may be where the effects of the grace period policy would be most evident. Specialists tend to be reimbursed on a fee-for-service basis precisely because of the significant risks posed by patients with complications under a capitated rate. If QHPs are permitted to pend two months of claims, then fee-for-service also becomes risky, and consequently unappealing to specialists, under these plans.

Finally, because fee-for-service providers will be discouraged from contracting with QHPs, adverse selection will occur within the Exchange between QHPs with largely fee-for-service networks (e.g., PPO products) and those QHPs relying on capitation. This will occur as sicker individuals seek the more comprehensive networks of the capitation-based QHPs, avoiding the skimpier networks of fee-for-service-based QHPs in greater numbers.

Recommendations:

- Because of the broad impact of 45 C.F.R. § 156.270 on all Exchange stakeholders, as well as partners in state government, the Exchange should address its understanding and approach to this provision separate from other QHP selection and oversight issues, using the same discussion brief, options, and recommendation stages as with other major issues.
- Adopt QHP standards which require, penalize, and/or strongly encourage that issuers seeking QHP certification include provisions in their provider contracts that bind the issuer to pay claims submitted in the second and third months of the grace period.

Putting the Burden on Patients and Providers Negatively Affects Continuity of Care

Continuity of care will also suffer under QHPs' pending of claims. The physician-patient relationship often suffers when the physician is put in the position of creditor with no indication of whether or when any reimbursement for the services rendered might be paid.

Alternatively, as the California Medical Association learned through member polling around assignments of benefits, a patient put in the position of debtor often ceases communication with his or her physician and is often lost to follow-up. Similar behavior might be expected in instances where the patient is doubtful of his or her ability to pay the remaining premium balance and is thus fearful of being liable for the full cost of care.

In addition, for many physicians, outlays are such that just a few patients' worth of ultimately rejected claims under the grace period would threaten the practice's solvency and consequently jeopardize its ability to care for all other patients. For instance, an oncologist might pay $93,000 for a course of treatment of Provenge to be administered to a patient but only recoups that cost when the plan reimburses the practice for its administration. If the oncologist is not reimbursed for these services, other patients may also be impacted as the oncologist will not be able to provide these expensive treatments to other patients. The oncologist's patients are also more likely to suffer income disruptions as a result of the illness and treatment.

If the oncologist were to receive a notice of the patient's premium delinquency midway through a long-term treatment plan, it is unclear how HHS and the Exchange would expect the oncologist to proceed. More importantly, what about the patient who will be liable for the cost of services upon termination for inability to pay his or her premium share? What if the patient loses his or her job during the third month of delinquency and transitions into Medi-Cal, but is unable to pay the remaining premium balance?

Finally, as HHS acknowledges, patients may "game" the system by taking advantage of the grace period for the three months prior to open enrollment, then switching QHPs under the federal guaranteed issue requirements. HHS further acknowledged that it did not yet have a response to such gaming. In addition to driving a cost shift to other Californians, this policy gap encourages plan switching, preventing long-term patient-physician relationships where networks do not overlap.

Recommendations:

- The Exchange should maintain reinsurance for all QHPs to cover these uncompensated costs, at least until the potential scope of risk and its consequences are better understood. Such reinsurance also would remove disincentives to provider contracting with QHPs, help to spread the financial risks generally, and provide a mechanism through which the Exchange can address QHP insolvency or bankruptcy – so that individual physicians or small hospitals do not suffer the brunt of a potentially significant drain on the system.

- The Exchange should consider funding options for such reinsurance or for a special fund under Government Code § 100503(n) to help defray the cost of uncompensated care rendered in the grace period.

- As previously stated, the Exchange should also consider the use of its active purchasing power to drive QHPs to pay those claims submitted during an enrollee's grace period.

- In conjunction with the above, the Exchange should explore options pursuant to Government Code § 100504(a)(7), which provides for Exchange "[collaborations] with the State Department of Health Care Services and the Managed Risk Medical Insurance

Board, to the extent possible, to allow an individual the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a [change in eligibility status]," and may allow for the "seamless transitions between coverage" envisioned in Government Code § 100503(a).

If Such QHP Pending and Denial of Claims is Permitted, Then Enrollees' Real-Time Eligibility Status must be Available to Providers

For the reasons stated above, after-the-fact notice of delinquency would prove meaningless for many physicians seeing these grace period patients if QHPs are given the grace period denial option. Physicians must have access to the real-time eligibility status of QHP enrollees, which is something plans in California are capable of providing.

If the final rule is unaltered before exchange implementation, then HHS must ensure that exchanges require QHPs to provide accurate, binding, and real-time notification to physicians and other health care providers, so that they are aware that patients are entering the second month of the grace period and that claims submitted on their behalf may be pended and ultimately denied. HHS should also investigate with physicians, hospitals, and health insurance issuers the best ways to accomplish this, preferably through electronic transaction notifications and traditional routes, such as certified mail.

As mentioned above in the patient churn discussion, real-time, binding information from the QHPs would be the best solution to the churn issue and could help significantly with this problem as well. Physicians should also receive timely notification from issuers about patient terminations from QHPs.

While proper notification may mitigate some of the problems caused by this change in the final rule, it fails to address situations where the patient and the physician and/or hospital do not have a pre-existing relationship. Without accurate, binding, and real-time information and without notice, the physician or the hospital would not have any knowledge that the patient is in the grace period and that the QHP will pend his or her claims.

Recommendation:

- Ensure that the CalHEERS system or another easily accessible all-QHPs portal provides real-time eligibility status such that a provider can efficiently determine whether a patient is in the grace period.

Concluding Remarks

Thank you again for the opportunity to provide input on this key component of Exchange design at such an important stage of development. We look forward to continuing to work with the Exchange Board and staff to realize the vision of improving the health of all Californians by assuring access to affordable, high quality care.

Please direct any questions or comments to:

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Respectfully Submitted,

California Medical Association

California Hospital Association

California Academy of Family Physicians

California ACEP

American Congress of Obstetricians and Gynecologists, District IX

Medical Oncology Association of Southern California, Inc.

California Academy of Eye Physicians and Surgeons

Association of Northern California Oncologists