Qualified Health Plan Model Contract Issues and Responses

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Qualified Health Plan Selection and Contracting Timeline

(subject to revision)

Activity	Date
Provider Networks due to Regulators	February 28, 2013
Premium Bids due to Covered California	April 2, 2013
Second Draft Model Contract Release	April 2, 2013
Public Comments Due - Model contract	April 14, 2013
First Draft Administrative Manual Outline	April 15, 2013
Model Contract – Final	April 25, 2013
Public Comment Due- Administrative Manual Outline	April 30, 2013
Tentative QHP Certifications and Initial Contract Agreement	May 15, 2013
Reasonableness Rate Review by Regulators	May 15 - June 2013
Final Contracting and Certification of Covered California Plans	June 30, 2013
Administrative Manual version 1 issued	May 31, 2013
Covered California Plans Loaded into CalHEERS	Beginning July 1, 2013

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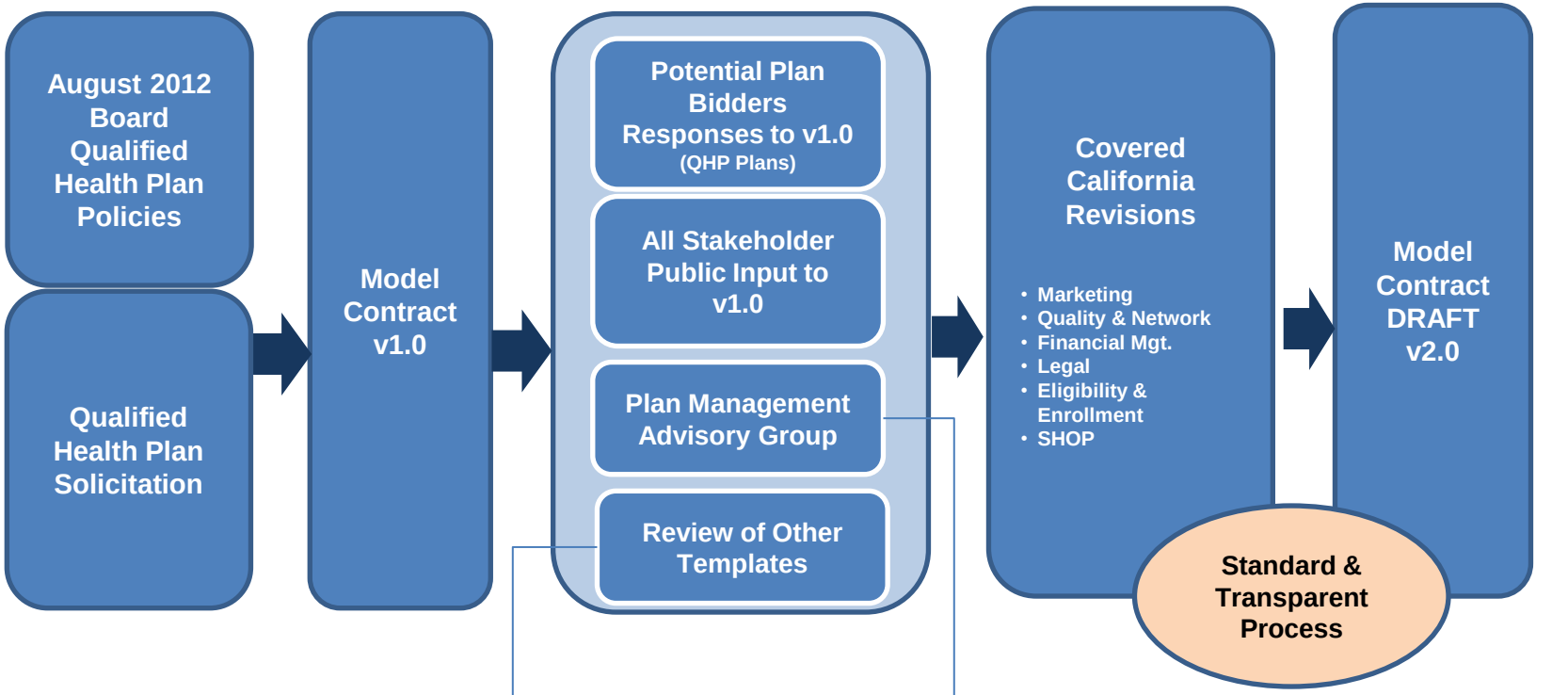
Path to the Draft Model Contract v2.0



Examples:
CalPers, CA Two Plan Model, CA Health Insurance Purchasing Cooperative (HIPC), Office of Personnel Management (OPM), MediCal

Examples:
Consumer's Union, California Medical Association, Pacific Business Group on Health, Catalyst for Payment Reform, California Association of Health Plans, March of Dimes, California Department of Managed Care

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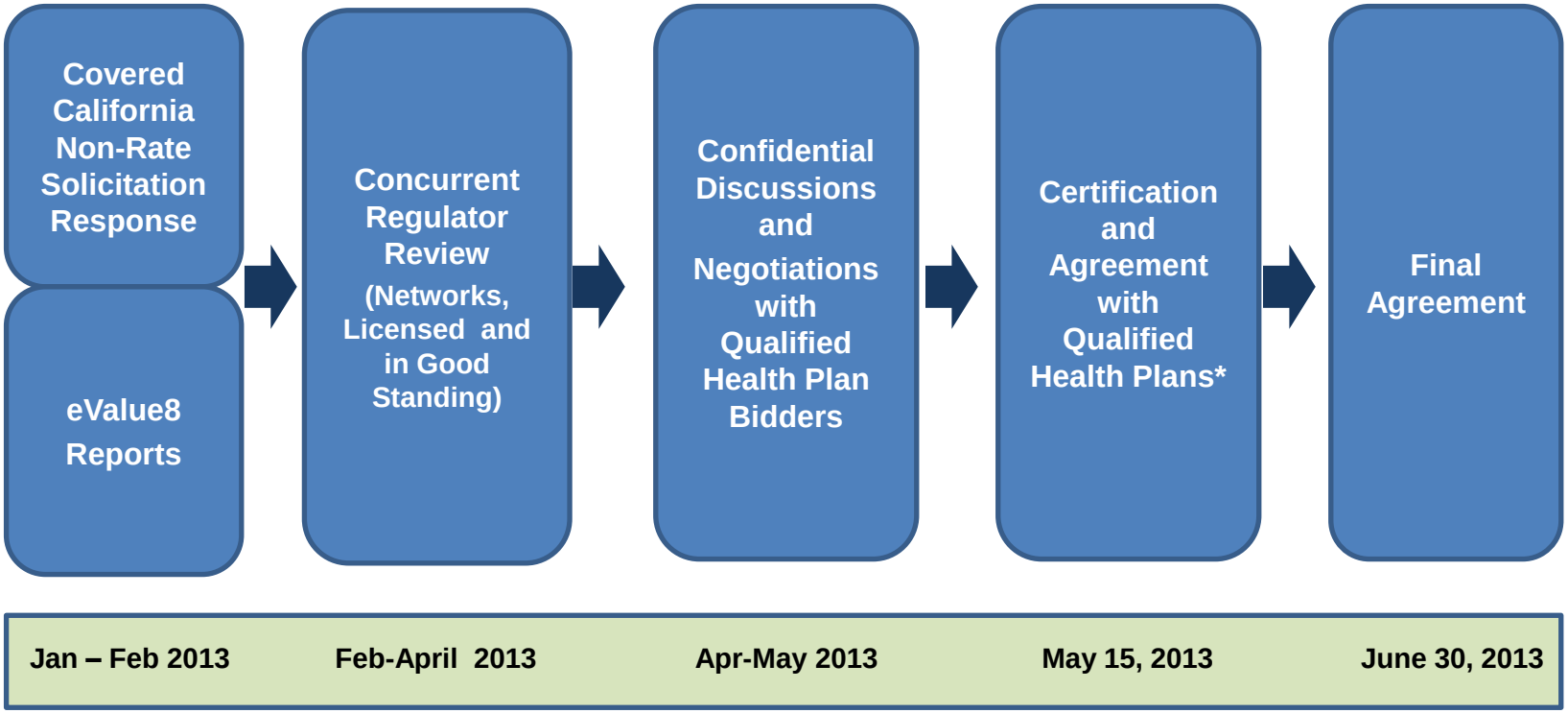
Qualified Health Plan Selection Process



*** Subject to Rate Review**

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Model Contract Concerns
Staff Response to Key Stakeholder Issues - 1

	Issue	Response
1.	Out of Network Services (covered)	Board Directive; Add requirement for implementation of policy
2.	Grievance Processes	Eligibility- Update to comply Federal Regulations Plans- Comply with Health and Safety Code
3.	Consumer's Enrollment Period Trial Rights	Eliminated to make consistent with current commercial market practice.
4.	Participation Fee for Individual Exchange	Describes PMPM will be assessed on Exchange only sales; clarify new federal requirement that all Exchange fees must be spread across issuer's entire book of business.
5.	Participation Fee for SHOP	PMPM will be assessed on Exchange-only sales; federal rules requires spreading fee across issuer's entire book of business.
6.	Use and Promotion of Coordinated Care	PMPM will be assessed on Exchange-only sales; federal rules requires spreading fee across issuer's entire book of business.

Model Contract Concerns
Staff Response to Key Stakeholder Issues - 2

	Issue	Response
7.	Lack of PCP assignment requirements in certain plan designs	Require PCP assignment for all approved plan designs
8.	Assuring Plan Enrollees have a preventive health and wellness visit	Required visit within 120 days of enrollment for " new enrollees" who have not recently had such a visit. Create specified exceptions.
9.	Pro-active management of At-Risk Plan Enrollees	Required an individual plan within 120 days of enrollment; multiple requirements for active transition to assure continuity of care.
10.	Encourage At-Risk Plan Enrollees to pursue evidence-based, optimal care	Rewards-based incentive programs are optional.
11.	Value-based reimbursement	Mandatory requirement to share data If program(s) exist at QHP
12.	Use and standardization of Plan Enrollee Health Assessment	Mandatory requirement; promote standardization of data elements by 2016

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Model Contract Concerns
Staff Response to Key Stakeholder Issues - 3

	Issue	Response
13.	Plans opposed requirement to maintain a dedicated team	Eliminate requirement; require identified point of contact for Exchange
14.	Plans concerned about reporting duplicate information and lack of detail about request	Modify language to provide more detail regarding expectation and to dovetail with premium submission information required for following plan year
15.	Service Performance Guarantee may be too high for year one.	Update to include best practices that reflect measures used by other purchasers
16.	Guarantee Agent & General Agent Commission	Modify language for clarification
17.	Commencement of Coverage	Clarify timing and payment requirements to set consistent rules regarding effective date of coverage.
18.	Hospital Quality Initiatives	Align with CMS Hospital Quality Compare measures and processes through coordination and reporting.

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Model Contract Concerns
Staff Response to Key Stakeholder Issues - 4

	Issue	Response
19.	Develop consumer friendly quality rating system to assist shoppers	Construct quality ratings using HEDIS and CAHPS scores
20.	Value-based reimbursement	Specific expectations set for identifying and actively promoting value-based reimbursement programs and payment
21.	Special Enrollment Periods	Consistent with qualifying events market-wide
22.	Branding Documents	Remove requirement to include employer name on ID card; Postponed decisions regarding use of Covered CA brand vs. Issuer brand
23.	Plan-based Enrollers Program	Staff is currently working on more detailed approach and taking stakeholder comments into account.
24.	Individual Termination of Coverage due to: • voluntary cancellation • loss of eligibility • change in enrollment • non-payment of premium	Clarify language, specifically timing of termination, required notices, grace periods

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Model Contract Concerns
Staff Response to Key Stakeholder Issues - 5

	Issue	Response
25.	Transparency of Plan/Provider Contract Rates	Require Full transparency.
26.	Participation in collaborative quality initiatives	Mandatory requirement for QHPs, potentially phase-in over time. Offer list of initiatives for year one; incorporate into recertification for year 2.
27.	Data submission of full data set to designated repository	Mandatory requirement to submit claims, encounter data
28.	Promotion of shared-decision making	2015 phase-in requirement
29.	Inventory and assess performance under current payments systems linked to quality, performance & value	New requirement
30.	Measure and monitor regional competition among provider networks and hospitals; Impact of increased competition on price and quality.	New requirement

Model Contract Concerns
Staff Response to Key Stakeholder Issues - 6

	Issue	Response
31.	Pilot to improve provider reimbursement and eliminate regional payment discrepancies	New Requirement
32.	Alternative reimbursement methodologies linked to adherence to clinical guidelines.	New Requirement
33.	Develop and implementation of value-pricing programs.	New Requirement
34.	Submission of payment reform information to Covered California.	New Requirement

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Major Fee Components 2014

Consistent with Covered California's Financial Sustainability Plan Analysis (November 2012)

Base Fee Proposal-Individual Market

- Set initial fee based on 3% of premium, but assess on PMPM basis
- No fee assessment on Covered California health plan enrollment outside of the exchange
- Charge fee on Supplemental Plans (Dental and Vision) at same rate (3%) and charge on converted PMPM basis
- Fee charged for entire 2014 year; adjusted downward (or upward) as needed for 2015

Base Fee Proposal-SHOP Market

- For products sold in the SHOP Exchange, the Fee consists of two components:
  - A fee of 4% of premium to support ongoing operations
  - An additional component to cover the estimated cost of agent commissions (amount to be determined
- No fee assessment on Covered California health plan enrollment outside of the exchange
- Fees for Supplemental Plans (Dental and Vision) at same rate as for SHOP products and adjusted as required.

Under to the single risk pool rule codified at 45 C.F.R. Section 156.80, an issuer must spread the cost of the assessment fee across all of its business in the applicable market. That is, issuers who participate in the individual Exchange must spread the cost of the assessment fee across all of their individual customers in the state, and issuers who participate in the SHOP Exchange must spread the cost of the assessment fee across all of their small group customers in the state. Issuers may not pass the cost of the assessment in the form of higher premiums onto Covered California enrollees alone.

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Regulations Overview: Request Board Approval

- **Permanent Rulemaking**
  - Converts Qualified Health Plan Solicitation and its Requirements to permanent
- **Emergency Rulemakings**
  - Qualified Health Plan Standard Plan Designs
  - Pediatric Dental Solicitation Requirements

Permanent Rulemaking

QHP Solicitation and its Requirements

- Emergency regulations currently in effect and will expire on June 17, 2013.
- Must go through regular rulemaking process to make emergency regulations permanent.
- Request the Board approve the draft regulations and direct the Executive Director to initiate permanent rulemaking process.
- Anticipate filing with Office of Administrative Law on April 13, 2013.

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Emergency Rulemakings

QHP Standard Plan Designs

- Emergency regulations will incorporate the standard plan designs by reference, which will require all plans to submit bids using our standard plan designs.
- Request the Board approve the emergency regulations and standard plan designs and direct the Executive Director to initiate emergency rulemaking.
- If approved, these regulations will be filed with Office of Administrative Law on March 25, 2013.
- Anticipate approval by Office of Administrative Law by March 29, 2013.

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Emergency Rulemakings

Pediatric Dental Solicitation Requirements

- Emergency regulations include both the requirements in the Pediatric Dental Solicitation, including the stand-alone pediatric dental Essential Health Benefit standard plan designs.
- Request the Board approve the emergency regulations and direct the Executive Director to initiate emergency rulemaking.
- If approved, these regulations will be filed with Office of Administrative Law on March 25, 2013.
- Anticipate approval by Office of Administrative Law by March 29, 2013.

Send Comments and Suggestions to:

QHP@hbex.ca.gov

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