Cover Page

QHP Model Contract for Individual Market
Third Round Comments

The following is the Covered California response to “Third Round” comments received for the 2023-2025 QHP Individual Model Contract.

All documents will be posted to the Plan Management HBEX webpage: https://hbex.coveredca.com/stakeholders/plan-management/.

Article-Section No.	Article-Section Title	Comment Date	Comment	Response
C.	Recitals	2/11	We appreciate the addition and elevation of robust consumer service as one of 8 factors Covered California will be assessing in connection with application responses.	Thank you for your comment and support.
1.6, 2.2, 2.3 and 2.4	Multiple sections	2/11	Are we right to assume these sections were moved but essentially unchanged as they are no longer counted as performance standards under the new 2023-2025 contract?	These were among the contract sections reorganized in 2023 to create a new Article 3 - Promoting Enrollment, consolidating all items into one contract location for the purpose of clarity.
3.1	Transitions of Coverage	2/11/22	We respectfully request the following change: To the extent Contractor has enrollees in small and large group ESI or Medi-Cal, to further the parties' commitment to maximizing enrollment in health insurance coverage, Contractor will work with Covered California to develop and implement operational processes to ensure continuity of coverage for Enrollees transitioning from Contractor's non-exchange lines of businesses to Contractor's on-exchange business.	Covered California declines to make this contract update, but has updated "...to Covered California."

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3.1	Transitions of Coverage	2/11/22	We recommend inserting "by those statutes" in the following paragraph on page 23 of the clean document: "Contractor shall conduct Consumer outreach to include an annual notification to Enrollees in Contractor's individual and group health care coverage regarding their potential eligibility for reduced or no-cost coverage through Covered California and Medi-Cal as required by Health and Safety Code § 1366.50 and California Insurance Code §10786, and as further required by those statutes, shall provide Enrollee contact data for Covered California's outreach to consumers who terminated from ESI coverage and are not known to have transitioned to other health coverage."	Covered California agrees to make this contract update.

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3.2.1	Marketing	2/11	We believe that setting a marketing spend floor tied to premiums will lead to inefficient, yet mandated administrative costs for health plan. To illustrate this point, this requirement would expect NCAL based plans to spend more on marketing than a SCAL based plan, as NCAL premiums are generally higher than SCAL due to underlying provider costs . Marketing costs vary by region, as costs to advertise in a crowded, SCAL market often are likely higher than more rural parts of the state. Lastly, we have significant concerns with a requirement that would mandate increasing in advertising spend with increases in medical or RX trend, QTI payments, and even the Covered CA admin fee. We support the expectation that all QHPs spend appropriately on marketing, and appreciate the challenges in measuring it given lack of established metrics. As such, we recommend the contract language be modified to 1) Account for non-cobranded marketing that encourages "getting coverage" which can support multiple lines of business, including Medi-Cal 2) Allow for less than 0.4% if the cost per acquisition or PMPM type metric is in alignment with other QHPs	Covered California declines to make the suggested contract change.

Article-Section No.	Article-Section Title	Comment Date	Comment	Response
3.2.1	Enrollment and Marketing Coordination and Cooperation	2/8/22	We do not believe that a percent of premium should be expected relative to direct marketing spend. We believe that a more appropriate metric for deciding whether to increase the amount being spent would be acquisition cost per new member. If contractual language regarding spending levels is desired we suggest adding the following language to clarify the intent: "Should a carrier not meet the expected spending level they will provide justification for not meeting it."	Covered California declines to make this contract change.
3.2.1	Enrollment and Marketing Coordination and Cooperation	2/11	We appreciate Covered California's clarification that Contractors are expected to spend at least 0.4% of premium on marketing etc. that includes co-branding of Covered California.	Thank you for your comment and support.
4.2.2 c)	Patient Centered Standard Benefit Designs	2/11/22	Since Agreement is with singular Contractor, consider rephrasing c) to start: c) Contractor is encouraged…	Covered California agrees to make this contract update.
4.2.3 b)	Offerings Outside of Covered California	2/11/22	Please consider clarifying b) to be for health products.	Covered California agrees to make this contract update.

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4.2.3 b)	Offerings Outside of Covered California	2/11/22	Products offered outside of the Exchange are not required to be approved by Covered California. If Covered California wishes to be notified of such filings, this should occur at the same time as the applicable regulator is notified or no later than 30 days prior to the filing. There is no similar 90 day advance notice to the licensed regulator. We recommend the following changes to the QHP Contract language: To the extent that Contractor intends to offer and sell products in the individual market outside of Covered California that are not the required offering of identical benefits described in Section 4.2.3 (a), and not already marketed, Contractor shall notify Covered California of its intention to do so ~~at least 90 days~~ at the same time the applicable regulator is notified or not later than 30 days prior to filing such products with the applicable regulator. Such notice must include the proposed network of providers, benefits designs, service area, and any unique features of these products	Covered California agrees to limit to "new" products but will maintain the current 90 day requirement.

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5.2.1 (b)	Culture of equity wihtin plan operations	2/11	We appreciate Covered California's language encouraging health plans to foster a culture of equity within its health plan operations. We hope to see this culture extend beyond health plans to the hospitals and providers a plan contracts with. To that end, we suggest the following amendment: Suggested Amendment: "Contractor shall take steps to foster a culture of equity within its health plan operations, contracted medical facilities and health care providers. Contractor shall maintain..."	Covered California agrees to make this contract update.
5.2.2	Potential Payment Obligations for Quality Performance	2/8/22	Our understanding is that it is CC's intent to carve out 0.2% of premium from the at risk amount for the QTI in order to place continuing funds at risk for the performance guarantee program. The amounts referenced in this section should be changed to reflect this.	Covered California intends to place a total amount of premium at risk at 1% of total Gross Premium per product for Plan Year 2023 and increase by an additional 1% of total Gross Premium per product per Plan Year up to 3% maximum over the contract period and up to 4% in future contract years. This total amount is combined across Attachment 4 - Quality Transformation Initiative and Attachment 2 - Performance Standards with Penalties. Covered California is reserving flexibility to adjust the amount at risk between these attachments over the contract period during the amendment process. Attachment 4 - Quality Transformation Initiative will remain the majority of the amount at risk over the contract period. No contract change will be made.

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5.2.2 c)	Potential Payment Obligations for Quality Performance		Is there language forthcoming for Attachment 4 - Quality Transformation Initiative?	Covered California has added contract langauge to this section.
5.2.3	Removal from the Exchange	2/11/22	The contract language indicates that the observation period for performance on the QRS Clinical Quality Management Summary Indicator would begin in 2021. We would like to kindly suggest that Covered California change the observation period to begin in 2023.	Covered California will maintain the observation period beginning in 2021 for existing issuers. No contract change will be made.
5.2.3	Removal from the Exchange	2/11/22	Since it takes 4 years to be removed for poor performance, if the region would have 4 plans remaining with the removal of a non-complaint plan (5 prior to removal), but one or two of the Plans have less than two-years' experience in the market, is there a maturity period that the remaining Plans must have in the market before they are considered part of the 4 Plan minimum?	There is no maturity period prior to being considered part of the three remaining issuer minimum.
5.2.3	Removal from Exchange	2/11	The Observation Period should start with 2023, not 2021. We are concerned about contract provisions with material retroactive or lookback components. We believe this could disadvantage existing carriers with history (and thus measurements) against new entrants, who not have sufficient enrollment for credible scoring.	Covered California will maintain the observation period beginning in 2021 for existing issuers. No contract change will be made.

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5.2.3.	Removal from the Exchange	2/11	We strongly support contract language that more clearly ties poor performance on quality measurement to removal from the exchange. Despite previous attempts to hold plans accountable for health plan performance on quality and equity measures through contract updates and revisions, Qualified Health Plan (QHP) performance has not consistently or substantively improved over time. In fact, three QHPs – Anthem, Molina and Oscar (representing 13% enrollees) received 2 stars for three consecutive years (2019, 2020 and 2021) for Getting the Right care. Quality measurement scores range from 1-star to 5-stars for the best performing plans. A score of 1-star is the equivalent of an F and a score of 2-stars is a D: neither one is a passing grade. Even a score of 3-stars is the equivalent of a C letter grade. Consumers deserve health plans that get at least a C, if not even higher grades. Covered California's new contract language which specifies that plans, which perform below the 25% percentile composite performance using the Quality Rating System (QRS) Clinical Quality Management Summary Indicator for two years, shall face removal is an important step towards restoring health plan accountability to the state and consumers.	Thank you for your comment and support.

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5.2.3.	Removal from the Exchange	2/11	As part of this accountability initiative, we urge Covered California to add contract language ensuring consumers are properly notified should a QHP be removed and/or at risk of removal from the Exchange. Advocates ask that consumers be informed if the plan they have selected, or are thinking about selecting, is under threat of removal. Very few consumers change coverage once they have enrolled. If their choice might be gone the next year, they should know that when initially enrolling or when re-enrolling so that the consumer has the opportunity to select another, higher quality plan either at initial enrollment or re-enrollment. Suggested Amendment: "f) At the end of the two (2) -year observation period if the QHP has not improved to meet the necessary quality performance requirements, that QHP will not be certified for the upcoming Plan Year. QHP enrollees will be notified when a plan is in a period of observation and at risk of removal. In the event of removal, QHP enrollees will be notified and allowed a special enrollment period so they have time to select and enroll in a different plan if the removal occurs outside the open enrollment period.	Covered California is still developing the timeline and approach for notifying consumers, and the current contract doesn't prevent adoption of this reccomendation. We will take this under consideration and will bring proposed policies regarding enrollee notification to Plan Management Advisory for discussion prior to implementation. No contract change will be made.
5.2.3 b)	Removal from the Exchange	3/16/22	How will the composite performance using the QRS Clinical Quality Management Summary Indicator be calculated? **Do we calculate an average, taking the percentile achieved by each metric?**	Covered California will be publishing measure rules and scoring rules for the removal from the exchange policy.

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5.2.3 b)	Removal from the Exchange	2/11/22	NCQA made significant technical specification changes to measures included in the QRS Clinical Quality Management Summary Indicator since 2018. Particularly, the inclusion of telehealth in 2020 impacted over 40 HEDIS measures, which resulted in year-over-year rates not being trendable or trended with caution, per NCQA's guidance. To ensure we are assessing against accurate benchmarks, we recommend using a more recent year for the 25th percentile composite performance. 2022 would be an appropriate benchmark year to select post-pandemic due to deferred care in 2020 and 2021.	Covered California will use 2018 measurement year performance as the benchmark year to enable the observation period to begin in 2021 for existing issuers. We will follow established guidelines by CMS and NCQA on changes to measure specifications and trending. No contract change will be made.
5.2.3 b)	Removal from the Exchange	2/11/22	DHCS sends carriers the historical claims data for new Medi-Cal members whenever they transition between carriers. Now that Covered CA has historical HEI data from IBM Watson, we would like to request that Covered CA mirror this policy and send the historical claims data for the QRS Clinical Quality Management Summary Indicator to issuers so that we can have more accurate data. This is especially important for measures with long look-back periods, such as Cervical Cancer Screening (5 years) and Colorectal Cancer Screening (10 years). Additionally, if Covered CA and DHCS have a data sharing agreement, it would be beneficial to have data shared for enrollees transitioning between Medi-Cal and Covered CA coverage.	We are researching if this type of data exchange is feasible. We will follow up with issuers on this issue.

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5.2.3 b)	Removal from the Exchange	2/11/22	Due to changes in measures over the years, the plan recommends MY 2022 as baseline composite year	Covered California will use 2018 measurement year performance as the benchmark year to enable the observation period to begin in 2021 for existing issuers. We will follow established guidelines by CMS and NCQA on changes to measure specifications and trending. No contract change will be made.
5.2.3 c)	Removal from the Exchange	2/11/22	In order to account for a revised benchmark year of 2022, as we have recommended, we request that the first measurement year be moved to 2023. This will align with the start of the QHP Contract and will allow inclusion of new QHP entrants. This change will also allow for reporting on the Childhood Immunization Combo 10 measure instead of Combo 3.	Covered California will use 2018 measurement year performance as the benchmark year to enable the observation period to begin in 2021 for existing issuers. No contract change will be made.
5.2.3 f)	Removal from the Exchange	2/11/22	Please clarify the timeline for administering the QHP removal. QRS performance is reported with a year look-back period, which may push out plan removal by 1-2 years. For example, if a QHP is on a Quality Improvement Plan in 2024/2025, then the audited QRS results for 2025 will be reported in late June of 2026. Would the plan be removed in 2027? The QHP will need enough time to send discontinuance notices and implement required regulator discontinuance filings etc.	We will be publishing a timeline and more details on the methodology for the removal from the exchange policy. As an exampe, if the issuer has QHPs that were offered by Covered California in 2021 and had QRS measures scores for that year, the observation period begins in 2021. For a QHP that performs below the 25th percentile composite beginning in 2021 and does not improve performance over the observation (2021-2022) and remediation period (2023-2024), then the QHP will be removed from the Exchange for plan year 2025.
5.2.3.f)	Removal from Exchange	2/11	Subsection F refers to removal after the observation period, we understood it to be remediation period.	Covered California will make the adjustment.

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5.2.3 g)	Removal from the Exchange	2/11/22	If the QHP is removed from the Exchange, they will not have reportable QRS rates for that product. How will performance be assessed? Will this assessment use the same criteria as the review for a new entrant participating in the Exchange?	Covered California will apply the same policy to QHP issuers that have been removed from the Exchange as it applies to new entrant QHP issuers. We will use a combination of NCQA, IHA, and other data sources to estimate the quality of new entrants.
5.2.4.	Quality Improvement Plans	2/11	We urge Covered California to add contract language specifying public reporting of Quality Improvement Plans (QIPs) so that advocates can evaluate whether the QIPs are likely to improve the quality and equity of care received by consumers. Since these QIPs are just for plans under threat of removal, we suggest Covered California consider using a different title that more accurately reflects the corrective action steps that the plans will be required to take. Finally, for plans choosing to eliminate providers from their networks based on poor performance, Covered California should require Contractors to take into account differences in populations served and demonstrate that their remaining networks can still meet the needs of their diverse members. Specifically, Covered California should require Contractors to replace their networks and assess QHPs to ensure they can adequately meet Knox-Keene requirements with regards to cultural competency and language access, timely access, geographic access and network adequacy. Proposed Amendments: 5.2.4 Change Title: “Quality Improvement Plans” to “Corrective Action Quality Improvement Plans”	Covered California will be coordinating closely with the applicable regulator, especially on network adequacy, regarding any issuers that are required to submit a Quality Improvement Plan. In our review process, we will be focusing on the impact of provider network changes on access to care for diverse members. Covered California is bound and committed to report quailty improvement activities.

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5.2.4 b)(iv)	Quality Improvement Plans	2/11	From the advocates' perspective, most consumer incentive programs are likely to worsen racial disparities, income inequality, or other inequities so we are very cautious about most so-called "consumer" "incentive" programs. We ask that any such proposal be reviewed through the Plan Management process.	Covered California intends to summarize and review QHP practices of consumer incentive programs in a future Plan Advisory Group meeting. As a reminder, Covered California is stratifying several quality measures by race and ethnicity in order to ensure racial and ethnic disparities do not worsen. Disparity reduction initiatives will be tied to financial consequences in Attachment 2 - Performance Standards with Penalties, and as soon as feasible in Attachment 4 - Quality Transformation Initiative.