CONGRESS OF CALIFORNIA SENIORS

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Peter V. Lee
Executive Director
California Health Benefit Exchange
Sacramento, CA

Dear Director Lee:

Thank you for the opportunity to comment on selection policies for Qualified Health Plans under the California Health Benefit Exchange (Exchange). We appreciate as well the extensive discussion of this issue at the Board meeting in Oakland, the thoughtful background paper prepared by Exchange staff, and the webinars on important topics related to this discussion.

I am writing on behalf of the Congress of California Seniors (CCS) and our many members and affiliates across the state. While many of our members have coverage under Medicare (and a few have Medi-Cal) we are interested in the work of the Exchange and how it will affect the 50-64 year old population in the state, many of whom have lost workplace health coverage and look to the Exchange to bridge the period until they become eligible for public insurance.

We believe the selection criteria for insurance plans under the Exchange are one of the most important topics you and the Board have addressed thus far. Before I list some our concerns and comments, allow me to share two important goals we have for the Exchange which impact our comments. First, we strongly hope that the Exchange standards will influence and shape the entire health insurance market in California, if for no other reason because of the share of the market you will influence. Second, we would hope that, over time, policies outside the Exchange would begin to conform to those offered inside the Exchange so there is symmetry in the market, certainly for individual coverage but for employer sponsored coverage as well. In these ways, the Exchange can reform the market in California, not just enable coverage for millions now uninsured.

Additionally, we hope to see as little "churn" as possible between Medi-Cal coverage and Exchange coverage, and support policies which can minimize it. We advocate a "no wrong door" system to ease transitions and promote enrollment in the most appropriate plan. We hope existing (and future) Medi-Cal managed care plans will participate in the Exchange. Eventually, we would like to see the Exchange promote integration of long-term care coverage with medical coverage to provide better service coordination for enrollees. In this regard, we are generally in support of the Rules for Certification listed in the staff's Power Point presentation # 4 which identifies six specific criteria.

Our comments fall into several broad areas. First, on standardization, we support efforts to create standardization wherever possible.

We support standardized cost sharing to reduce complexity for consumers. We believe cost sharing provisions should be the same across all plans in each level, with some exceptions or innovations allowed with approval by the Exchange. This assures consistency with some opportunity for plans to develop value-based innovations.

We believe benefits and exclusions should be standard for all plans, with VERY limited opportunity for customization by plans with approval by the Exchange. We would hope the Exchange would propose specific goals for allowing variation.

We believe the Medicare Part D system of formularies has worked well for our population and encourage its adoption as the standard for the Exchange.

We believe plans should be prevented from offering new value-based benefit designs, unless specifically approved by the Exchange under an exception process with clearly articulated goals for the exception. The exception should be narrowly used.

We support standardized out-of-network benefits with narrow exceptions proposed by Exchange staff under their “Option B”.

With regard to network design and adequacy, we submit the following comments:

We support the policy of requiring an issuer to offer a product in each tier and for catastrophic coverage in each geographic region it covers. (As a footnote, we would hope to see fewer geographic regions than the number being proposed in pending legislation, but we recognize this is a Legislative issue, not one for the Exchange.)

We support the staff recommendation to allow each issuer to provide a small number of products in each geographic region. We would also hope the Exchange would monitor this policy after several years to determine whether it has created distortions in the market.

On geographic coverage, we would prefer plans to bid for service areas where they can demonstrate coverage for an entire geographic area (Option C).

On rating issues, we support standardized rate tiers, composition and tier ratios to be used by all issuers.

We believe there should be standardized age factors for rate development for all issuers. We support the notion of graduated rate changes (over two to three years) to better allow consumers to handle increases between rate bands.

We support policies that encourage healthy lifestyles or reward participation in prevention activities such as screening and education programs. We oppose policies that link rate discounts to certain behaviors. There is little reliable information that these work, and we believe they tend to penalize certain demographics and income groups.

We support establishing network adequacy standards used for managed care for all plans, including those licensed under CDI. We further urge the Exchange to determine whether stronger adequacy and access standards are desirable.

We accept, in the short run, that monitoring network adequacy should fall to the existing licensing entity. We want to note, however, that this is an area of great concern to CCS. In some areas of the state, and for some populations, the current provider networks are insufficient. This seems especially true in the managed care plans. The expansion of populations under the Affordable Care Act will be the fourth wave of new enrollees into Medi-Cal managed care (following 475,000 seniors and people with disabilities in 2010-2011, 800,000 children in Healthy Families in 2012-2013, and 1.1 million Dually Eligible persons in 2013-2015). Since the new people enrolled in Medi-Cal have, by definition, not had health coverage they are likely to represent new clients for the health care system. We have deep misgivings about whether California’s system is prepared to meet this expansion of coverage and demand for access. We believe there will be great pressures on existing networks.

Despite this, we understand that one of the largest managed care plans in Los Angeles County has determined that they need not expand their network while facing enrollment of 375,000 dual eligibles in that one county alone.

Health care reform will be judged not just on how many uninsured people get insurance. It will be judged on whether people get care and stay healthy, and this rests on access to sufficient numbers of qualified providers.

Our goal with regard to Essential Community Providers is to protect the system we have in place and encourage their growth within the overall system of care. We support the staff recommendations with regard to this issue.

Finally, on quality and affordability, we make the following comments:

We believe that Qualified Health Plans should be required to report CAHPS and HEDIS measures and the interim NCQA Health Plan Accreditation by 2014, and achieve a commendable NCQA accreditation by 2015 to achieve a high level of reporting of both quality and transparency.

We agree with suggested staff strategies to promote quality and affordable care.

We hope the Exchange would work to create a universal health risk assessment tool to be used by all plans as part of the enrollment process. We would also hope the data derived from the assessment would be used to create a plan of care for the enrollee and, within the restrictions imposed by law, the data could be used to evaluate plan performance in increasing enrollee wellness. This is Option A in the staff analysis.

With regard to wellness and prevention programs, we believe the Exchange should develop or cause to be developed model programs with common branding, front end design and back end reporting, with stakeholder involvement in both processes.

We strongly support making available supplemental benefits in both the individual and SHOP exchanges and offering them both as stand-alone plans and embedded coverage in a medical plan.

CCS believes all these areas are important for the Exchange to achieve its goals. We place emphasis on network adequacy issues and quality monitoring. We believe that the Exchange must fulfill the expectation of making health care available, not just a health insurance card. We also believe the Exchange gives us an excellent opportunity
To track utilization and outcomes, which are essential if we are to reduce the long term costs of quality health care for everyone.

We strongly support the development of specific, quantifiable performance standards against which the performance of all plans is measured. This would allow for an absolute scoring which we would expect be made public for policy makers and the consuming public alike. We find relative rankings such as the Medicare star system to be particularly unhelpful.

Thank you for considering our views. If your staff has questions, please feel free to contact us.

Sincerely,

Gary Passmore, Vice President