A Public Entity
Inland Empire Health Plan

August 6, 2012

Peter V. Lee
Executive Director
California Health Benefit Exchange
2535 Capitol Oaks Drive, Suite 120
Sacramento, CA 95833

Subject: IEHP's Comments on the Qualified Health Plan (QHP) Proposal

Dear Mr. Lee,

Inland Empire Health Plan (IEHP) is a Local Initiative public health plan under the 2-Plan Medi-Cal managed care model in Riverside and San Bernardino counties. Today we are serving over 560,000 members who are enrolled in Medi-Cal, Healthy Families, Healthy Kids, and Medicare Special Needs Plan. Thank you for giving us an opportunity to comment on the Exchange's Qualified Health Plan (QHP) proposal. Our comments are as follows:

1. The Exchange to allow any public health plan that is not currently providing individual and small group insurance coverage to have the option to join the Exchange as a new entrant in January 2015. Over the next 18 months, IEHP and most of other public health plans will face the following operational and financial challenges:

    - IEHP has absorbed more than 40,000 new Medi-Cal seniors and persons with disabilities (SPD) during DHCS's Mandatory Enrollment of the SPDs that ended in May 2012. These members have many complex medical needs, behavioral health diagnoses and psycho-social issues. It will take up to two years to fully stabilize and integrate these members into our plans.

    - IEHP and six other public plans in eight counties must prepare for the mandatory enrollment of the Medi-Cal portion of the beneficiaries who have both Medi-Cal and Medicare (called "Medi-Medi's"). This mandatory enrollment includes Long Term Care and Long Term Support Services (e.g., IHSS, MSSP, CBAS, etc.) starting in March 2013. In addition, in June 2013 DHCS will start enrolling the Medicare portion of this population into managed care through the passive and voluntary enrollment process. About 60,000 new Medi-Medi members will join us from this transition.

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- All Medi-Cal Managed Care Plans will be preparing for substantial new Medi-Cal enrollment beginning January 2014 under the Medicaid Expansion program. About 150,000 Medi-Cal members will join us from this Medicaid Expansion program.

2. The Exchange to work closely with the California Department of Managed Health Care to ensure that material modifications/license applications related to the Exchange are totally aligned with Exchange proposal submission requirements for those items in common.

3. We support the Exchange to standardize as many aspects of the program as possible, including standard benefits, standard value added options, using current standard industry standards for network adequacy, etc.

4. We support the Exchange to allow health plans with current NCQA accreditation to meet the Exchange's accreditation standard in 2014 through an attestation process. In regards to achieving a commendable level ofNCQA Accreditation by 2016, NCQA Quality Compass data documents that Medicaid plans have lower HEDIS and CARPs scores than commercial plans due to the demographic, cultural and other differences between Medicaid and commercial insurance populations. Given our plan's nature, we expect to serve lower income populations in the Exchange. We respectfully request that our Plan not be required to reach a Commendable Status of accreditation at all, or no earlier than by 2018.

5. The Exchange to withdraw proposal of requiring two drugs per class (Medicare Part D standard) and only to meet current ACA's requirement. Health plans have processes in place to ensure enrolled members receive medically necessary medications. The Medicare Part D standard of two drugs per class will increase costs without improving care.

6. We do not believe using plan provided contracts to attempt to define a limit for out-of-network reimbursement for <u>other</u> Exchange members is practical. It will put us at significant odds with our providers during the contract negotiation process, which will already be challenging for many of us developing a <u>new</u> commercial network.

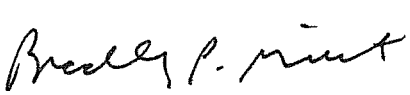
7. In regards to broadening the definition of the Essential Community Providers, we recommend that the Exchange develop a simple methodology for health plans and providers to follow, and the new definition should only apply to the Exchange's products.

8. The Exchange to reconsider the "coinsurance" approach for all benefit packages as the term is more common to the PPO products, but not HMO products. In addition, the "copayment" approach is more user-friendly and transparent to the general population.

9. The Exchange to clarify what criteria or thresholds the Exchange will use to determine "sufficient" marketing budget, and also to describe in what detail of marketing budgets that the Exchange will require from health plans. In regards to marketing review, we suggest the Exchange to leverage existing DMHC's regulatory review of all marketing materials.

We greatly appreciate the Exchange Board and yourself considering the above suggestions. Please contact me if you have any questions.

Sincerely,



Bradley P. Gilbert, M.D., M.P.P.
Chief Executive Officer

Cc: John Ramey, Executive Director, Local Health Plans of California (LHPC)
John Grgurina, Chief Executive Officer, San Francisco Health Plan (LHPC Board Chair)