CALIFORNIA HOSPITAL ASSOCIATION
Providing Leadership in Health Policy and Advocacy

January 14, 2013

Peter Lee, Executive Director
California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814

Submitted Electronically to David.Panush@hbex.ca.gov

Subject: Bridge Plan Discussion Draft

Dear Mr. Lee:

On behalf of our over 400 member hospitals, the California Hospital Association (CHA) appreciates the opportunity to respond to your request for input on the Board Recommendation Brief that proposes a Bridge Plan to help achieve continuity of care and affordability. We applaud your efforts in providing the opportunity to engage with stakeholders on such an important issue. California's hospitals play a vital role in providing medically necessary care to all residents, especially those less fortunate with lower incomes or uninsured.

The proposal described in the Discussion Draft is complex and warrants additional thought and contemplation, especially in relation to other state activities such as the Governor's budget proposal released last week. However, we recognize your continued desire to move quickly on these important issues so we are providing you with our initial reaction – which could be modified as we learn more and discussions become further developed.

Summary

We are framing the discussion on the "Bridge" plan in a manner that describes our understanding so that our feedback is best understood. From our viewpoint, we identify three main areas of discussion:

- Should there be a "Bridge"?
- What is the size of the Bridge?
- Should there be special rules for the Bridge?

The Bridge represents the continuous pathway that links Medi-Cal managed care with Covered California. Since many Medi-Cal managed care beneficiaries are expected to move back and forth between being eligible for Medi-Cal and Covered California, the Bridge is intended to make that transition seamless, keeping more people insured without disruption.

The size of the Bridge will depend on if it needs to accommodate just the population that moves back and forth between being eligible for managed care Medi-Cal and Covered California, or if it needs to be large enough to accommodate everyone that is eligible for subsidized coverage in Covered California (up to 200 percent of the federal poverty level – FPL).

The third area for discussion indicates that the Bridge plans may already be on fragile ground due to other system stresses and pressures; therefore, perhaps the plans creating the Bridge should be given special relief from regulatory and other provisions. The relief is intended to encourage participation from all plans that currently provide managed care Medi-Cal to offer a Bridge.

Discussion

If a Bridge is properly constructed, it could be helpful in keeping people enrolled in health care coverage and ensuring their access to a broader range of providers than if they were uninsured. The larger the Bridge, the greater the stresses and pressures that will be put on the infrastructure. Instead of relaxing standards for developing a Bridge, the opposite is necessary to ensure that those on the Bridge will have a reliable product and will not have access to care jeopardized, especially when they need it most. While the goals of continuity of care and affordability are good, the underlying approaches to achieving those goals include some debatable points as to their merit.

The Discussion Draft indicates that Covered California would use its selective contracting process to provide more affordable options for low income Californians. Practically speaking, the selective contracting process seems to result in a purposeful establishment of a below market rate for a Silver level plan. Because federal subsidies are based on the second lowest Silver level plan, the federal funding is anticipated to be sufficient to cover most or all of the cost of the Bridge plan premium and cost sharing. Selective contracting gives the appearance of establishing premiums with no regard to the cost of providing care. This process would place additional downward pressure on provider rates or it would result in a precarious financial situation for the Bridge plans. Either way, this method places additional pressure on an already challenged system.

Further, the Discussion Draft speaks to the challenges currently faced by plans that would potentially be offering these Bridges. The Draft fails to address the challenges currently facing hospitals and the health care safety net. California's hospitals provide care to the State's Medi-Cal beneficiaries at an annual loss of more than $5 billion. That challenge is not addressed in the Draft. California's hospitals are facing more than $22 billion in payment reductions over the next ten years to help pay for reducing the number of uninsured and lowering government deficits. The Discussion Draft does not list this challenge. There are many facets of the health care safety net that are stressed and would benefit from relaxed oversight or requirements. However, in order to ensure consumers/enrollees have access to the care they need, when they need it, oversight should not be scaled back.

Of particular concern to hospitals is the concept of providing relief to plans because "establishing a provider network and negotiating rates to the extent the plan does not use existing Medi-Cal contracts and needs to negotiate different terms". Covered California is not Medi-Cal. Any

proposal that includes a provision for existing Medi-Cal provider networks and contractual obligations with hospitals to be mirrored into a Bridge plan is not supported by CHA. Hospitals should have the opportunity to make independent decisions about their ability to broaden their service to this population and what rates would be acceptable. As indicated above, Medi-Cal underfunds the hospitals by over $5 billion a year and that level of reimbursement would lead to further cost shifts to the private sector – further weakening the delicate and fragile balance that exists today. Covered California should not support a mechanism that increases the cost shift. This would be in direct conflict with the vision of the California Health Benefit Exchange "to improve the health of ***all*** Californians by assuring their access to affordable, high quality care."

To add complexity to the Bridge plan discussion is the concept included in the Governor's budget proposal for 2013-14 for the Medi-Cal expansion. The budget outlines two possible approaches to the expansion – a state-based approach or a county-based approach. Each approach would have an impact on how the Covered California Bridge plan would be implemented. It seems premature to be making a decision on the development of a Bridge plan without knowing how the California State Legislature will decide on how to roll out the Medi-Cal expansion.

Recommendations

Depending on what new information we may learn, including how California will expand its Medi-Cal program, CHA acknowledges the benefits that could result from creating a "narrow" Bridge for the population that moves back and for the between eligibility for Medi-Cal and Covered California.

However, the Bridge plan must not force providers to accept payment and participation terms that were negotiated under a Medi-Cal contract.

- CHA could support a "narrow" Bridge with no requirement that providers must accept previously negotiated Medi-Cal contractual payment and participation terms.

Consumers must have access to adequate networks as deemed by the appropriate regulatory body. Bridge plans must not be exempt from adhering to network adequacy requirements. Streamlining procedural red-tape for administrative issues could be considered – for the first year - but consumers must have adequate access to necessary health care providers regardless of the plan they choose.

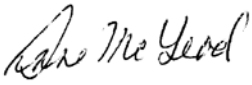
- CHA could support some streamlining for red-tape for administrative processes for Bridge plans (in the first year), but do not remove or relax regulatory oversight to ensure adequate provider networks.

Extending the size of the Bridge to a broader population will only weaken the already stressed system of plans and providers. Broadening eligibility for a Bridge plan would be placing more Californians in a coverage product with a sub-market premium established without regard to the cost of providing safe, effective, high-quality patient care. The broader population does not have the same "churning" concerns that are inherent to the population that moves between eligibility for Medi-Cal and Covered California.

- CHA has concerns over a "wider" Bridge option and federal approval should not be pursued.

CHA appreciates the opportunity to provide our initial comments on the Bridge plan proposal and we look forward to further discussion to enhance our understanding of the risks, benefits and other implications that need to be carefully considered. If you have any questions, please do not hesitate to contact me at amcleod@calhospital.org or 916-552-7536.

Sincerely,



Anne McLeod
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