HEALTH ACCESS

January 14, 2013

Peter Lee, Executive Director
David Panush, Director, External Affairs
California Health Benefits Exchange
560 J St., Ste.
Sacramento, CA 95814

Re: Bridge Plan Alternative

Dear Mr. Lee and Mr. Panush,

Health Access California, the statewide consumer coalition committed to quality, affordable health care for all Californians, commends the bridge plan alternative while also offering comments, questions and concerns about it.

Affordability:

Health Access commends the work of the Exchange staff in developing more affordable alternatives for low-income consumers. Both the bridge plan proposal and the earlier affordability option are significantly more affordable for low-income Californians than the premium structure otherwise available to them. The difference between $117 a month and $44 or $58 a month for someone at 200%FPL may be the difference between paying the electric bill, putting food on the table or going to the doctor for a primary care visit.

We would also encourage the Exchange staff to explore whether cost sharing reductions can be further reduced under this proposal or whether that is precluded by the federal rules.

We support the concept of the bridge plan being available to all low-income consumers, not just those with a connection to Medi-Cal through a family member or prior coverage. If the federal rules limit the concept of bridge plans to those consumers with a connection to Medi-Cal through a family member or prior coverage, Health Access would support a hybrid proposal that included both the bridge plan and the affordability option presented at the December Exchange meeting for those low-income consumers who lack a Medi-Cal connection.

Choice

We recognize that the bridge plan would be a choice for a consumer and that other products in the same tier would require payment of a higher premium. Many Exchange

enrollees will be in transition between one source of employment-based coverage and another source of employment-based coverage: half the uninsured are uninsured for less than a year. If someone is going from a job with coverage to another job with coverage but has a break of some months in between, that consumer may be willing to pay more to keep coverage that includes the same providers as their previous coverage. While the bridge plan board brief focuses on continuity of care for those Californians who were previously on Medi-Cal, continuity of care will equally be a concern for those who previously had employment-based coverage. The bridge plan solves this problem by allowing consumers to choose. (We note that the Basic Health Plan proposal should provide all consumers below 200%FPL better affordability and if a Basic Health Plan did so, we would support that proposal.)

Safety Net for the Remaining Uninsured

Health Access is generally supportive of the bridge plan concept as it relates to the Local Initiatives and County Organized Health Systems. Local Initiatives, as the proposal recognizes, play an important role in supporting county hospitals and community clinics which serve the uninsured as well as Medi-Cal beneficiaries. We very much appreciate the growing recognition by the Exchange of the important role played by these safety net institutions in serving the uninsured as well as Medi-Cal beneficiaries and the acknowledgement that even after full implementation of the Affordable Care Act several million Californians will remain uninsured. A recent OSHPD analysis indicates that uncompensated care amounts to just over 4% of revenue for private hospitals but 26% of revenue for county hospitals: http://www.oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/HospFinanTrends/HospitalTrendsAllCharts.pdf While some private hospitals provide a disproportionate share of care to those on Medi-Cal, it is the county hospitals and community clinics which provide the safety net for the uninsured.

Questions and Concerns

We will want to work with the Exchange in ensuring and crafting such affordability options for counties without LIs or COHS. This is a major question that we would want to be resolved for patients in GMC counties like Sacramento and San Diego, and elsewhere.

Health Access has serious questions about the inclusion of the commercial Medi-Cal managed care plans and the interaction with other provisions of the Exchange QHP contracts. These concerns arise primarily in those instances in which the commercial Medi-Cal managed care plan would also contract with the Exchange as a QHP contractor. For example, both Healthnet and Anthem Blue Cross have significant presence as Medi-Cal managed care plans as well as in the commercial market. Health Access would oppose exempting these major commercial carriers from the requirement to offer coverage in all of the precious metal tiers because these entities offer coverage in the individual and small group markets outside the Exchange. Health Access would not oppose exempting Local Initiatives and COHS from the requirement to offer

coverage in all of the precious metal tiers so long as those entities did not offer coverage in the outside individual or small group markets.

Health Access also questions whether products offered by the same carrier would have different networks at different income levels—and how the consumer would know that they were getting a different network (as well as a lower premium). We also question whether these commercial Medi-Cal managed care plans could meet the federal requirement of only having sufficient capacity to add bridge plan enrollees if these commercial Medi-Cal managed care plans are also bidding for Exchange business in the individual or SHOP exchanges.

Rates

The heart of the bridge plan proposal and the earlier affordability proposal is the rate structure and making that work so coverage is affordable for consumers while reimbursement to participating plans and providers is better than Medi-Cal. The board brief rightly identifies a number of challenges. One challenge that we suggest can be taken off the list is the interaction with California Children's Services: this program already serves as secondary coverage for those with employment-based coverage. It should do the same for any Exchange product. The Exchange is not a Medicaid program: it is a subsidized coverage in the private market. We also wonder whether mental health services rely on a similar model in which public programs are secondary to private coverage?

It is unfortunate that the Exchange staff refused to permit premium aggregation by the Exchange: this decision has created and will continue to create numerous problems, including challenges with brand loyalty as well as the problems for the Local Initiatives in collecting premiums. We thought it was a mistake at the time: we still do. The problems with this decision only multiply.

We recognize that in making the bridge plan proposal, there remain a variety of challenges. Health Access commends the Exchange staff for developing a proposal that has the potential to provide greater affordability to consumers and the opportunity for the safety net of county hospitals and community clinics to survive and thrive as participating providers in the Exchange, while offering a choice of plans to consumers. These are three high-priority goals for Health Access.

We look forward to working with the Exchange as this proposal develops.

Sincerely,

Anthony Wright
Executive Director