***Bridge Plan* Comment Received via E-mail**

Subject: Bridge Plan: Continuity of Care and Affordability Brief

Good afternoon,

Health Net offers the following comments about the Bridge Plan: Continuity of Care and Affordability Brief (hereafter Bridge Plan).

Health Net is the largest health plan covering Medi-Cal and Healthy Family enrollees in California, with close to one million enrollees in thirteen counties, including two-plan and GMC counties, and as a subcontractor to
Cal Optima. We think a well conceived and implemented Bridge Plan
proposal is needed to provide continuity of care and more affordable coverage for low income Californians between 139% and 200% of the FPL, both for children who were recently in Medi-Cal and their parents and for the others who are also between 139-200% of FPL, but were not enrolled in Medi-Cal within the last 90 days. Thus, Health Net agrees that the Board should seek the necessary authorization to create the Program. Given the short time to work with other state and federal agencies, as well as make any necessary changes to state law, the determination of a number of important questions quickly is of utmost importance.

We agree that those leaving Medi-Cal recently should be a key priority population for implementation of the Bridge in 2014. In making this comment, we do not diminish the importance of serving others in this income group. We recognize that both populations will face the same problem in paying premiums. But we are concerned about the impact of the disorientation that some will face who are moving from Medicaid to the Exchange.

We reiterate our concerns about the impact of Risk Adjustment (RA) on the capitated, delegated model. The data problems we have discussed with the HBEX are even more acute with MCOs, where capitation is far more dominant
than in the commercial market. Many medical groups that have significant
enrollment in state health programs have the least developed capacity to
provide robust encounter data. Therefore, we continue to support
substituting pharmacy data for professional encounter data in and out of the Bridge Plan.

We also recommend that RA in the Bridge Plan be limited to data obtained
for enrollees in the Bridge. We expect substantial movement in and out of
this pool. This will make it more difficult to obtain robust encounter data for comparison with the data that can be obtained from more stable populations outside of the Bride Plan pool. We also agree with the Local Health Plans and other plans that serve low-income populations around the country that RA does not fully take into account the risk of low-income populations. Conducting RA for this population separate from the commercial market will provide an apples-to-apples comparison of risk.
Another approach would be to request from HHS that there be no RA for this pool. If RA cannot be limited to the Bridge pool, it could affect plans'
ability to provide the low rates that both the Exchange and they want to offer to low-income enrollees.

Should HBEX adopt alternate methods of certifying QHPs for the Bridge, these plans should at a minimum meet CA licensing requirements, but we strongly recommend that those same plans be required to meet all QHP requirements to participate in the HBEX outside of the Bridge Plan.

We sincerely appreciate your consideration of our comments and would welcome an opportunity to discuss these issues with you.

--Linda

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