THE HEALTH CONSUMER ALLIANCE

The Health Consumer Alliance

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14 January 2013

California Health Benefit Exchange Board
Attn: David Panush, Director, Government Relations

Re: Bridge Plan: Affordability and Continuity of Care Options for QHPs

Dear Members of the California Health Benefit Exchange Board,

These comments on the Bridge Plan: Affordability and Continuity of Care Options for QHPs revised January 10, 2013 are submitted on behalf of the Health Consumer Alliance (HCA), a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, which includes: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Greater Bakersfield Legal Assistance, Legal Aid Society of Orange County, Legal Aid Society of San Diego, Legal Aid Society of San Mateo, Legal Services of Northern California, the National Health Law Program, Neighborhood Legal Services of Los Angeles County, and the Western Center on Law and Poverty.

We support the stated goals of these recommendations to increase affordability, maintain continuity of care for lower income populations in the Exchange and maintain a safety net system of care. We wholeheartedly agree that premiums for those below 200% of the federal poverty level (FPL) will have a significant effect on the ability and willingness of low-income consumers to purchase coverage in the Exchange. For example, for individuals trying to get by on $1,862 per month in California (200% FPL), having to pay a premium of $117 per month is prohibitive. Many low-income individuals at this income level are already struggling to make ends meet so paying a lower premium will make the difference between having health coverage and being uninsured.

That said, our support of allowing Medi-Cal plans to be bridge plans in the Exchange to provide more affordable coverage for lower-income Exchange eligible persons, should not be construed as undermining our support for adoption of the Basic Health Program (BHP) in California as the

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Orange County	Orange County Health Consumer Action Center	Legal Aid Society of Orange County
Sacramento area	LSNC – Health	Legal Services of Northern California
San Diego County	Consumer Ctr. for Health Education & Advocacy	Legal Aid Society of San Diego
San Francisco & Alameda Counties	Community Health Advocacy Project	Bay Area Legal Aid
San Mateo County	Health Consumer Center of San Mateo County	Legal Aid Society of San Mateo
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best option. Studies show that a BHP could provide better affordability both in premiums and in cost sharing for Californians with incomes below 200% FPL as opposed to this option which only achieves lower premiums. Moreover, the premium affordability in BHP could be lower than in this option by as much as three times ($20 projected in BHP v. $58 to $94 projected in the Exchange with a premium of $400 per month). However, given the uncertainty regarding whether a BHP will be adopted in California, we think it prudent to explore all options to improve affordability and support continuity of care.

We also agree that strategies to promote continuity of care are critical to help consumers retain their health plan and provider network and thus allow uninterrupted access to services when a consumer moves between Medi-Cal and Exchange coverage.

Discussion of the Recommendations

Recommendation 1: Covered California Should Contract with "Bridge" Plans for Transitional Medi-Cal Eligibles and Parents of Medi-Cal/CHIP Children

We support the staff recommendation to adopt the federal option of allowing Medi-Cal plans to qualify as Exchange Bridge Plans if it meets the goals without negative unintended consequences. We support this effort if it will enable people transitioning from Medi-Cal or CHIP to the Exchange and parents of children on Medi-Cal or CHIP to stay with the same Medi-Cal plan or enroll in the plan their child is in. This will offer improved continuity of care and hopefully more affordable coverage as well as supporting the safety net providers with whom the Medi-Cal plans contract.

Affordability. This recommendation assumes that if the Exchange contracts with a Medi-Cal health plan with premiums set enough below the next lowest cost silver plan then there would be little to no premium cost for the lowest cost plan. This recommendation assumes that plans will have an incentive to offer lower premiums to attract those eligible for the bridge plan.

We have questions about how this necessary difference in premiums will be achieved besides relying on the Medi-Cal plans to set lower premiums. Specifically, we are concerned that issuers may seek extensive flexibilities to offer low premium plans. Also, we wonder whether the price differential, if achieved initially, will be maintained in the following years. For example, if the second lowest plan (upon which the premium tax credit is based) lowers its premium, the premium affordability for the lowest plan may no longer be guaranteed. How would that be protected against?

We urge the Board to authorize the full use of selective contracting to achieve a 15% price differential. Even with a 14% price differential consumers at 200% FPL would pay a premium of $44 to $58 per month according to Tables 3 and 4 of the Board Recommendation Brief, 1/10/13.

If the premium difference is indeed achieved, this would provide important relief on the premium cost for the lowest income Exchange enrollees, but would not provide them with any greater affordability of cost sharing. The current standard benefit designs have consumers with income between 150% and 200% FPL paying significant co-pays which are unaffordable, including $20 for a doctor visit, $100 for imaging and $600 per day for hospital inpatient care up to three days. While we understand the Exchange has limited options to increase affordability of cost sharing and better premium affordability is still important, this is one of the reasons we support adoption of a Basic Health Program.

Continuity of Care: Continuity of care for those moving between Medi-Cal and Exchange plans is an important benefit. A critical feature of continuity of care remains access to the enrollee's existing primary and specialty care providers. Therefore, the Exchange should require that participating Medi-Cal Bridge Plans provide at least the same provider network that they offer Medi-Cal beneficiaries.

Eligible Population / Timeline for Enrollment. The staff recommendation is that consumers would have to enroll in the Bridge Plan within 90 days of their Medi-Cal coverage being terminated. We urge the Board not to impose such a stringent timeline. We often work with consumers who do not know for several months that their Medi-Cal coverage was terminated because they did not receive their notice. The goals of the bridge program are met by allowing those who have had Medi-Cal or CHIP within the last 12 months to enroll in the Bridge Plan. This is also in keeping with the goal of equity expressed under Recommendation 2.

Recommendation 2: Bridge Plans Should Cover 138% to 200% FPL Population.
We support seeking the necessary changes in law to expand the Bridge Plans to cover all low-income people – not only those moving from Medi-Cal or those with children in Medi-Cal/CHIP. As stated in the Board Brief, this is an important matter of equity to allow all eligible consumers below a certain income level to have access to the more affordable premiums. We also believe it would be simpler to administer and that the affordability benefits are equally critical for all beneficiaries in this income range.

Affordability. We wholeheartedly agree with the goal of a more affordable premium to increase enrollment but have the same questions for this recommendation as we did for Recommendation 1 in terms of how the necessary price differential would be assured both initially and over time. We urge the Board to support changes in state law that would allow everyone up to a certain income level to have access to the Bridge Plans and we urge the Board to use its selective contracting authority to achieve a 15% premium differential.

Consumer Eligibility. We urge the Board, if it does adopt Recommendation 2, to set eligibility up to 250% FPL instead of 200% in order to offer the more affordable coverage to more low-income Californians and to align with the CHIP eligibility level of 250%.

Consumer Choice: As outlined in the Board Recommendations Brief, we support giving eligible consumers the choice whether to choose the lowest cost plan.

Recommendation 3: Potential Streamlining Approaches for Covered California to Encourage Participation of Medi-Cal Managed Care Plans.

Recommendation 3 identifies potential approaches to streamline plan enrollment in order to foster maximum participation of Medi-Cal Managed Care plans in Covered California to improve continuity of care and support the community safety-net. Some of the potential areas identified in this option by the Covered California staff to revise the solicitation process include to:

- Allow Medi-Cal Managed Care plans to respond only to those elements of the solicitation that are applicable to a non-commercial health plan (e.g. waive their completing eValue8 elements in 2014).
- Deem Medi-Cal Managed Care plans to have satisfied the Essential Community Provider network requirements by virtue of the composition of their typical networks.
- Accept state Medi-Cal quality and performance requirements as satisfying Exchange quality requirements for year one (2014) certification as a Qualified Health Plan.
- Coordinate with Department of Managed Health Care to streamline regulatory approval that may be required.

While we appreciate the steps the Board and staff have already taken to encourage participation by Medi-Cal plans in the Exchange and to support additional efforts to streamline the process for Medi-Cal plans participation, we urge the Board not to undermine important standards and consumer protections in doing so. To that end, we would like additional information about what elements of the solicitation would be waived for these plans and the potential impact of such a waiver. Additionally, we would not want to deem Medi-Cal Managed Care plans to have satisfied the Essential Community Provider network requirements by virtue of the composition of their typical networks. This is a concern we have previously raised in our comments regarding the QHP requirements as many providers (e.g. Family PACT and Ryan White Aids/HIV providers) may not currently be a part of those existing networks. That said, we can accept Medi-Cal quality and performance requirements as satisfying Exchange requirements and not requiring NCQA or URAC accreditation initially.

Thank you for your consideration of our comments and your work to provide quality affordable coverage to low-income Californians through Covered California.

Sincerely,

Elizabeth A. Landsberg
Western Center on Law & Poverty and the Health Consumer Alliance