Comments to the Board

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STATE CAPITOL
Room 4208
Sacramento, CA 95814
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ASSEMBLY
CALIFORNIA LEGISLATURE

DISTRICT OFFICE
4900 California Avenue, Suite 100-B
Bakersfield, CA 93309
(661) 395-2995
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SHANNON GROVE
ASSEMBLYWOMAN, THIRTY-FOURTH DISTRICT

April 15, 2014

Peter V. Lee, Executive Director
Covered California
P.O. Box 989725
West Sacramento, CA 95798-9725

Dear Mr. Lee:

Many of my constituents are struggling to obtain basic information regarding coverage of abortion through qualified health plans (QHPs) offered through Covered California.

I respectfully request that you please provide a list of QHPs that offer abortion as a covered benefit as well as a list of QHPs that exclude abortion as a covered benefit. For the QHPs that include abortion coverage, please indicate the scope and circumstances regarding such benefit, including the amount of abortion coverage surcharge described in 1303(b)(2)(i)(II) of the Affordable Care Act and how much of that is billed to consumers.

Finally, Section 1303(b)(3)(A) of the Affordable Care Act specifies that "[a] qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) [abortion in cases other than rape, incest or to save the life of the mother], shall provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage." Please describe how this notice is provided to individuals purchasing plans offered through Covered California.

Thank you for responding to my request.

Sincerely,

Shannon Grove

July 17, 2014

The Honorable Shannon Grove
California State Capitol
Room 4208
Sacramento, CA 95814

Dear Assemblymember Grove,

Thank you for your letter regarding abortion services through the Qualified Health Plans (QHPs) in Covered California's marketplace. I appreciate the importance of this issue and welcome the opportunity to provide you with an update.

In the QHP solicitation, Covered California required all issuers to be in good standing with their respective regulatory agency, either the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). Covered California on its own does not regulate nor require providers offered by participating health issuers to cover abortion services. We leave that to the plans and their regulatory agencies.

However, below is some information I am able to provide regarding abortion, relevant to this discussion:

- All of the QHPs in Covered California's marketplace cover elective abortion services, with one exception I note below.

- Under Federal law, plans must segregate federal funds including tax credits and cost-sharing subsidies from private premiums, and only private premiums may be used to pay for abortion services beyond those permitted by the federal Hyde Amendment. 45 C.F.R. § 156.280. Additionally, plans must estimate the basic per enrollee, per month cost of including abortion coverage for which federal funding is not allowed to no less than $1 per enrollee per month.

- Additionally, as a phased-in process, Covered California must provide two multi-state plans. The Multi-State Plan Program (MSPP) was created by the ACA to ensure that at least two health plans will be uniform across all of the states, improving consumer choice by including these high-quality insurance plans in every state's insurance marketplace. The MSPP is administered by the federal Office of Personnel Management. While the ACA does require one multi-state plan to not offer elective abortion services the multi-state plan program is being implemented nationally over a 4-year multi-phase approach. The phase-in

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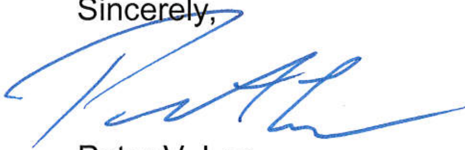
approach places the impetus on the individual health plan issuer to provide the health plan in 60% of states the first year, then 70%, then 85% and by the fourth year in all states.

To comply with state enforcement of federal law, regulators require QHPs to submit an annual Abortion Coverage Compliance Memorandum (ACCM) to their respective regulatory agency and Covered California requires all plans to follow compliance requirements set forth by those agencies. The ACCM is to be submitted to DHMC/CDI in advance of plan year to cycle with other plan filings. The ACCM shall include documentation of compliance with all requirements set forth therein, including description of abortion services covered and applicable rate information.

Finally, a Summary of Benefits and Coverage (SBC) and Evidence of Coverage and Health Services Agreement (EOC) is provided to consumers via mail after they have selected a QHP. These documents satisfy the requirements set forth by *ACA § 1303(b)(3)(A).* These documents may also be available on the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) website.

Please feel free to reach out to me for further questions.

Sincerely,



Peter V. Lee
Executive Director

Congress of the United States
Washington, DC 20515

June 2, 2014

Peter Lee
Director
Covered California
1601 Exposition Boulevard
Sacramento, CA 95815

Dear Director Lee:

As Covered California moves beyond its successful first open enrollment period, we write to encourage you to focus on the ultimate goal of ensuring adequate access to health care and health care services to Californians. We applaud you for your accomplishments to date; our state is clearly leading the nation and exceeding all expectations for overall enrollment and rollout of the new state-based exchanges.

The end of the open enrollment is only one milestone along the road toward truly reforming our nation's health care system and broadening access to care. Now that California has shown great success in expanding insurance coverage, it's time to focus on ensuring a meaningful and adequate network of health care providers.

We have heard concerns from individuals, physicians, and insurance agents about the adequacy of existing provider networks, and the accuracy of information provided about those networks. Many consumers are confused as to which primary care physicians and specialists are in their new plans. Through the significant advances of the Affordable Care Act, many people on the state exchange have access to health insurance for the first time. Concepts such as "out of network" or "in-network" are new and confusing to them, opening them up to the risk of expensive medical bills after they have received care. This confusion is natural and can be addressed with patience, but Covered California must continue the work of ensuring that beneficiaries have proper information on the plans they have signed up for. The next open enrollment period must also build on ensuring transparency regarding the plans on the exchange and their networks.

These concerns are particularly acute in rural areas of the state where people do not have the health insurance choices offered in more densely populated areas. Faced with significant challenges for travel to see specialists within their plans, a narrow network may fall short of the promise of health care access that the Affordable Care Act envisions. Establishing a new, state-based health care exchange, with a working website and proper outreach to all Californians, was a big task. But we are hearing all too often about consumers who are finding themselves surprised, confused, and unacceptably burdened by the lack of local providers covered by their plans. Clearly there is still work to be done on improving network adequacy, especially in rural communities.

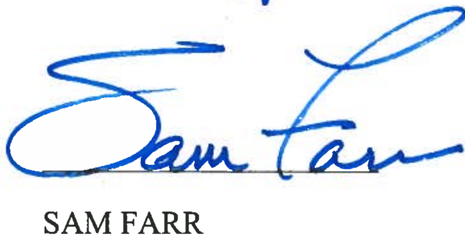
PRINTED ON RECYCLED PAPER

As Covered California's work moves forward, please share with us what is being done to monitor the health care access of new beneficiaries on the state exchanges, and what Covered California is doing to assess the adequacy and accuracy of networks moving forward. We look forward to your response.

Sincerely,

JARED HUFFMAN

MIKE THOMPSON



SAM FARR

LORETTA SANCHEZ

MARK TAKANO

JERRY MCNERNEY

CC: California Insurance Commissioner Dave Jones
CC: Department of Managed Health Care Director Shelley Rouillard

June 30, 2014

The Honorable Jared Huffman
The United States House of Representatives
1630 Longworth House Office Building
Washington, DC 20515

Dear Representative Huffman,

Thank you for your letter regarding network adequacy and timely access to care through the qualified health plans in Covered California's marketplace. I appreciate the importance of this issue and welcome the opportunity to provide you with an update.

Assuring access to quality health care is integral to the successful implementation of the Affordable Care Act. We recognize the challenges some of our consumers face in the new marketplace in finding doctors and providers that meet their needs and expectations. We are working closely with the state agencies that regulate the insurance marketplace to ensure that state standards for network adequacy are closely monitored and enforced. The information that you've shared helps the regulators identify specific patterns and geographic regions where additional scrutiny is warranted. We understand that these concerns are particularly acute in many rural areas of the state.

Recently, the California Department of Managed Health Care (DMHC) has launched a non-routine survey of health plans following repeated consumer reports of network inadequacy. While DMHC has done a preliminary review of these health plans, no results are available as of yet. At this point, all of our plans remain certified and all are able to participate in the Exchange. Covered California will coordinate with DMHC to review the survey findings when it is released in a few months. We hope that the results will better inform our oversight of plans.

In the meantime, we will continue working with regulators and participating health plan to improve the consumer experience. The following steps have been taken:

- Providing consumer option to switch health plans: Covered California has given consumers the option of switching health plans, even after open enrollment ended, if they have been legitimately misinformed. More information on how consumers can enroll or switch plans during our special enrollment period can be found here: https://www.coveredca.com/coverage-basics/special-enrollment/qualifying-life-events/index.shtml. Consumers can also discuss their situation with the Covered California Service Center at (800) 300-1506.

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- Working with health plans: Covered California has referred consumer issues on a case by case basis to our health plans for resolution. The Covered California Service Center has also developed an escalation unit to handle access related issues. Additionally, Covered California has engaged the Health Consumer Alliance as a partner to provide consumers with an additional resource.

- Working with California Regulators: Covered California continues to engage with the California Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) to help our consumers identify resources available to help resolve individual cases. DMHC and CDI actively engage consumers to resolve their issues in partnership with the health plans they regulate. Consumers can contact DMHC at 888.466.2219 or CDI at 800-927-4357.

- Expanding health plan network: As a part of the pre-programmed enhancement strategy that was in place should plans experience larger than predicted enrollment, Anthem Blue Cross, Blue Shield, and Health Net have substantially expanded their networks. We expect to see continued network expansion from our plans.

- Collaborating with providers: It is important that providers know whether or not they are in the network of Covered California health plan products and that offices message this accurately to consumers. To help, Covered California has issued joint welcome letters with Anthem, Blue Shield and Health Net to communicate network changes to providers in a clear fashion. Covered California and its plans have also issued joint communications to the California Medical Association and other provider associations.

- Health plan outreach and education to consumers: Plans have processes in place to reach new enrollees within 60 days of their effectuated enrollment to help pair them with a primary care provider. Plans are building additional programs for direct outreach, consumer education, risk assessment portals, and stronger analytics capability to monitor access to care.

Covered California is also acutely aware of the need for accurate website information, especially when telling consumers where they can receive covered services. While directories can be helpful, they are always changing-- which is why Covered California has always advised consumers to verify provider participation with their specific health plan. Following inaccuracies in the provider directory we deployed, Covered California ultimately decided the risk of confusion and inappropriate plan selection outweighed the

value of the consumer convenience, and the tool was eventually removed. Indeed, such service needed to have a high level of accuracy to be useful to consumers, requiring reliable and up-to-date information from our plans. Covered California continues to support consumers by providing links to each plan directory on our "Preview Plan" page of the website, and continues to collaborate with our plans to find a way to ensure accurate and reliable provider information.

Covered California is proud of its first open enrollment, but recognizes there is still work to be done. We project that as this new health system evolves, more providers will see the value in partnering with us to engage business where it has never existed before. Covered California is already seeing indications of this activity. In addition, markets will stabilize in future years as health plans will not need to construct, but merely maintain, larger and broader networks. Ensuring people are able to access and benefit from their new coverage is at the epicenter of Covered California's mission, and we will continue to be proactive on navigating this set of topics.

Please feel free to reach out to me for further questions or discussion.

Sincerely,

Peter V. Lee
Executive Director

Cc: The Honorable Sam Farr
The Honorable Mark Takano
The Honorable Mike Thompson
The Honorable Loretta Sanchez
The Honorable Jerry McNerney

Essential Community Providers ***Comment Received via E-mail***

Subject: ECP 2014: Feedback and Request for Additional Time

We are writing today to thank Covered CA for the notable improvements to the 2014 Essential Community Provider (ECP) List. As we have shared before we believe this list is critical for both encouraging plans to contact with ECPs in their region and for creating a robust and consumer-friendly provider directory for Covered CA enrollees. We agree with Covered CA's decision to consolidate information into two lists. Furthermore, we appreciate that the information being provided for each institution is more complete and includes site details for our member institutions. We also support your decision to exclude the Medi-Cal HI-TECH providers.

We, like you, recognize that this draft Consolidated ECP reference list is an evolving work in progress. With this in mind, and considering that most providers (including CPCA) did not know the draft list had been published until this morning's California Healthline Report, we ask that you respectively give CPCA more time to work with our member community clinics and health centers to identify any missing information. For example, while all AmplaHealth sites appear to be listed, we noticed that some sites are missing their OSHPD or MEDIACID ID numbers. Similarly, the CEO of Venice Family Clinic has shared that, while the listing for Venice Family Clinic is accurate, she believes the listing for Venice Health Center is not. CPCA will aim to have further feedback to you by COB 7/14.

Looking forward to continued dialog on this list and the provider directory.

Beth Malinowski
bmalinowski@cpca.org

Essential Community Providers *Comment Received via E-mail*

Subject: ECP 2014

Dear Sirs,

With nearly 10% of our population affected by diabetes (i.e, Type I, Type II, Gestational Diabetes) nationwide it is important to consider listing our county run clinics in low-income areas of California as essential community providers so that our data collection with Electronic Health Record System (EHRs) accurately reflects our progress in preventing chronic diseases in California—especially in the early and pre-term infant birth/death area and maternal health. Many of these county run clinics are listed under the California Department of Public Health but a list used by a program such as the Women Infant and Children's program (WIC) or SNAP-ed should also be included so that these potential collaborators can refer to clear mandates and already established community projects. The current list seems to be missing such clinics in such areas of San Joaquin (example: Delta Healthcare) and in Fresno (example: Fresno Economic Opportunities Commission). It will simply the process to consider adding a clear list that clearly shows which community clinics that serve the low-income medical eligible consumers served by providers using our biggest programs with a large number of nurses, nutritionists, social workers and certified health workers, so we can tie funding streams and maximize these resources.

Just a comment, there also exists a Registered Dietitian Provider List which is available. This list will help tie in those providers in private practice that are not as big as those presently being used, but who can provide valuable information that will add to our efforts here in California. The California Dietetic Association has such a list that I can provide if needed.

Sincerely,
Denise L. Chapel
chefrdmph@yahoo.com

HEMOPHILIA COUNCIL OF CALIFORNIA

July 10, 2014

Covered California
P.O. Box 989725
West Sacramento, CA 95798-9725

Dear Board and Staff of Covered California:

The Hemophilia Council of CA (HCC) respectfully requests that all qualified health plans in Covered CA include at least one Hemophilia Treatment Center as an essential community provider (ECP) in its network for the comprehensive diagnostic, medical and pharmacy services.

The Hemophilia Council of CA represents the nearly 4,000 people in CA with rare, genetic bleeding disorders. We support referral to the federal supported Hemophilia Treatment Centers as their expertise and experience improves patient health care, increases patient life expectancy, and reduces costs to the overall health care system.

We support the HTC's recommendation to update the draft ECP list to consistently identify the HTCs in the following manner:

1. Under "Sub-entity" Type list as: *Comprehensive Hemophilia Care Program* or *Hemophilia and Thrombosis Care.* Eliminate the currently listing which reads: Hemophilia Program, Hemophilia Treatment Center, Hemophilia and Thrombosis, Hemophilia Comprehensive Care Program.
2. Under "340B entity" Type list as: *Hemophilia Treatment Center Program.* Eliminate the currently listing which reads: "Hemophilia RX Center."

Thanks for your consideration.

Respectfully,

Terri Cowger Hill
Terri Cowger Hill, HCC Legislative Advocate
Sacramento

CC: HCC Board of Directors
National Hemophilia Foundation

Hemophilia Council of CA 4629 Whitney Ave., Suite 1 Sacramento, CA 95821 (916) 498-3780

July 16, 2014

Honorable Diana Dooley
Secretary of the California Health and Human Services Agency
Chair, California Health Benefits Exchange
1600 Ninth Street, Room 640
Sacramento, CA 95814

Dear Secretary:

One year has passed since we wrote to you expressing our concern about the narrow networks that the Qualified Health Plans are using to provide care for the mass influx of the newly enrolled patients in Covered California and Medi-Cal.

The class action lawsuit filed recently against two of your Qualified Health Plans helps to reinforce our position that the narrow networks severely limit access to care for patients.

We are asking you and your fellow board members to immediately work with health plans to broaden the networks to include all eligible Essential Community Providers. We remain deeply concerned that health care providers, many of whom have met federal Essential Community Provider requirements, as well as other stringent requirements under California's Medi-Cal Electronic Health Record (EHR) Incentive Program, have been excluded. The EHR Incentive Program is known as HI-TECH LA in Los Angeles.[1] With the assistance of this program, more than 2,500 primary care providers successfully achieved Meaningful Use[2]. As you know, this helps providers improve patient care, and became a requirement to participate with the Qualified Health Plans.

Unfortunately, due to HI-TECH LA's financial constraints, not all Essential Community Providers were given the opportunity to participate in this incentive program. This has led to spotty EHR adoption in California and in many other areas. Restricting health plan networks by only allowing providers who have adopted EHR systems will further increase access issues and lead to the additional loss of providers/facilities.

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[1] http://www.dhcs.ca.gov/provgovpart/Documents/OHIT/Information_for_Providers.pdf
[2] http://www.hitecla.org/news/2500-primary-care-providers-meaningful-use

It has been well established that there is a shortage of providers to care for the influx of newly insured patients. This impacts access to care at a time when most of the newly insured will be added to the Medi-Cal expansion program, which is expected to reach approximately 2 million. **Why then, would you not use all eligible providers?**

An article published by Healthline states that the provider workforce has decreased by 25% from spring 2013 to spring 2014. This primarily occurred because Medi-Cal reimbursement rates are among the lowest Medicaid payment rates in the country. These low rates cause providers to stop treating Medi-Cal patients because their overhead costs outstrip reimbursements.[3] The remaining providers continue to have grave concerns about not being correctly identified by the Qualified Health Plans on their participation status.

The Qualified Health Plans continue to restrict their networks. They have stated that this is needed to hold down costs while risk corridors and risk adjustments are being determined. However, this approach will cause a very real access to care issue.

The current system of using only a small selection of commercial groups for the Covered California insurance product, and Community Clinics for the Medi-Cal component, puts patients at a significant disadvantage with regard to access to care. Once this limited group of providers reaches its threshold for patients it can treat, Essential Community Providers will be needed to handle the excess demand. Unfortunately, if the current group of Essential Community Providers continues to shrink, many communities with the largest influx of newly insured patients will not have the providers available to treat these patients.

Despite the rapid changes that are being made in the community clinic system, a recent study conducted from UCLA shows only two LA health clinics are ready to accommodate newly insured ACA patients.[4] This is why it is imperative that California takes steps to make the practices of these Essential Community Providers economically viable. If an inclusive system is not implemented soon, certain low-income communities, especially within the HIPSAs, will be left vulnerable.

Again, we ask, why not use all eligible providers?

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[3] http://www.californiahealthline.org/articles/2014/7/15/number-of-medical-providers--down-by-25-in-spring-2014; http://www.californiahealthline.org/articles/2014/7/18/dhcs-overstated-number-of--medical-providers-in-2013

[4] http://www.latimes.com/local/lanow/la-me-ln-study-obamacare-20140521-story.html

In conclusion, it is imperative that these networks are opened as soon as possible, and that all Essential Community Providers be included in the new networks. Let's work together to ensure a healthy California population.

Sincerely,

The African-American Advisory Committee of LACMA,

and

Concerned Los Angeles Community Essential Providers

Richard Baker, M.D.
Solo-Private Physician

Phillip E. Hill, M.D.
Solo-Private Physician

Toni Johnson-Chavis, M.D., M.P.H.,
Solo-Private Physician

Lorna McFarland, M.D.
Solo-Private Physician

Lemmon McMillan, M.D.
Solo-Private Physician

Nathaniel Neal, M.D.
Solo-Private Physician

Harold T. Peart, M.D.
Solo-Private Physician

Paul Wallace, M.D.
Solo-Private Physician

July 16, 2014

Honorable Diana Dooley
Secretary of the California Health and Human Services Agency
Chair, California Health Benefits Exchange
1600 Ninth Street, Room 640
Sacramento, CA 95814

Dear Secretary Dooley:

We are deeply concerned that there remains a continued exclusion of many health care providers, who meet the Federal requirements, for being considered an Essential Community provider. Many of those same providers did meet the stringent requirements by the State of California to be eligible for the Medi-cal (EHR) Electronic Health Record Incentive Program. In Los Angeles this was known as HITECH LA.

More than 2,500 HITEC_LA primary providers successfully achieved Meaningful Use. This measure is felt to help improve patient care and became a requisite to participate in the Covered California product. Many studies have shown that E H R adoption is spotty in California and in many areas, using that criteria of restriction will further add to the access issues and loss of providers/facilities that we are already encountering.

http://www.hitecla.org/news/2500-primary-care-providers-meanngful-use

http://www.dhcs.ca.gov/provgovpart/Documents/OHIT/Information_for_Providers.pdf

Since that date there has continued to be extensive concerns that providers are:

1. Not represented correctly.
2. Decreasing Medi-Cal numbers in 2014

http://www.californiahealthline.org/articles/2014/7/15/number-of-medical-providers--down-by-25-in-spring-2014

It is known that we have decreasing providers to enroll patients in the new product lines (Covered California, expanded Medi-Cal, Duel Eligible's, etc, to meet federal guidelines.

We've had lawsuits filed alleging that the provider lists given by some Health Plans are not both restrictive and are not accurate. Most newly added patients in the state of California will be added to the expanded Medi-Cal line of business (LOB).

Why would we not use all eligible providers?

The commercial Covered California product has very tight networks adopted to hold down the cost while Risk corridors and risk adjustments are determined. The current system of using only high performing commercial groups for the commercial product and Community Clinics for the Medi-Cal component, further exacerbates and underfunded Two-tiered payment system. It does very little to equalize and promote a more cost effective, collaborative, care coordinated system of care.

http://www.hitecla.org/print/news/2500-primary-care-providers-meaningful-use

3. Increase disparities in certain Geographical regions., (especially the HIPSA's)
4. **http://www.latimes.com/local/lanow/la-me-ln-study-obamacare-20140521-story.html**
5. **Now, we are informed that these same High performing providers will be left out once again** http://www.californiahealthline.org/articles/2014/7/10/covered-calif-releases-draft-list--of-essential-community-providers

Inadequate state and federal payments continue to exacerbate the closure of both hospitals and primary care offices.

Thank you for your attention to this very important and urgent issue.

Sincerely,

LOS ANGELES COUNTY MEDICAL ASSOCIATION—AFRICAN AMERICAN ADVISORY COMMITTEE

MILLER-LAWRENCE MEDICAL SOCIETY

Cc: Kimberly Belshe
Paul Fearer
Robert Ross, M.D.
Susan Kennedy

NATIONAL HEMOPHILIA FOUNDATION
www.hemophilia.org

July 10, 2014

Covered California
P.O. Box 989725
West Sacramento, CA
95798-9725

RE: Request to have QHPs contract with at least one Hemophilia Treatment Center designated as Essential Community Providers pursuant to Covered California's "Draft Consolidated Essential Community Provider List"

Dear California Health Benefit Exchange/Covered California:

The National Hemophilia Foundation (NHF) is the nation's leading advocacy organization for individuals with bleeding disorders. Our mission is to ensure that individuals affected by hemophilia and other inherited bleeding disorders have timely access to quality medical care, therapies and services, regardless of financial circumstances or place of residence.

We appreciate the opportunity to provide the California Health Benefit Exchange/Covered California our comments on the above-referenced draft list. Our comments focus on the need to ensure that Covered California require all qualified health plans (QHPs) to include at least one Hemophilia Treatment Center (HTC) as an essential community providers (ECP) in its network.

Hemophilia is a rare, chronic disorder affecting more than 20,000 people in the United States and as many as 3,800 Californians. Individuals with hemophilia are treated with expensive, high-cost blood clotting factor therapies to replace missing blood proteins. These lifesaving treatments cost as much as $300,000 per year for individuals with severe hemophilia. If a patient develops and inhibitor (an immune response to treatment), complications such as HIV/AIDS, hepatitis and joint disease, or bleeding as a result of trauma or surgery, then annual costs for treatment can exceed $1 million.

Most individuals with hemophilia are treated at Hemophilia Treatment Centers (HTCs). HTCs provide comprehensive, patient-centered care for individuals with hemophilia and other inherited bleeding disorders through a multi-disciplinary, specialized team of providers, including hematologists, nurse specialists, surgeons, dentists, physical therapists, pharmacists and social workers. Studies have shown that mortality and hospitalization rates are 40% lower for people who use HTCs than in those who do not, despite that more severely affected patients are more likely to be seen in HTCs.

Currently there are 11 federally-funded HTCs in California, which are located at the following institutions/facilities:

- The Center for Comprehensive Care and Diagnosis of Inherited Blood Disorders (Orange, CA)
- Children's Hospital Oakland (Oakland, CA)
- Children's Hospital of Central California (Madera, CA)
- Children's Hospital Los Angeles (Los Angeles, CA)
- City of Hope National Medical Center (Duarte, CA)
- Orthopaedic Hospital of Los Angeles (Los Angeles, CA)
- Rady Children's Hospital (San Diego, CA)

NATIONAL HEMOPHILIA FOUNDATION
www.hemophilia.org

- Lucile Salter Packard Children's Hospital, Stanford University Medical Center (Palo Alto, CA)
- University of California at Davis (Sacramento, CA)
- University of California, San Diego (San Diego, CA)
- University of California, San Francisco (San Francisco, CA)

Covered California's "Draft Consolidated Essential Community Provider List" includes all 11 of the federally-funded HTCs in California. These HTCs provide both clinical and pharmacy services to their bleeding disorder patients. We ask that Covered California ensure that QHPs include the HTCs in their provider networks for both types of services.

Currently, there is at least one insurer offering QHPs in California that does not allow for its adult enrollees to be treated at HTCs, and limits pediatric enrollees to one HTC visit per year. This practice has already created significant concerns about access to necessary, quality care based on the first-hand experience of some in our community. HTCs are the experts in hemophilia and not all hematologists outside an HTC setting have such expertise. Should Covered California require that at least one HTC be in a QHPs network, this may alleviate this significant access issue and ensure patient safety.

Again, we appreciate the opportunity to submit our request and would be happy to provide any additional information that may necessary to assist you further in your consideration.

.

Sincerely,

Michelle M. Rice

Michelle Rice
Vice President Public Policy and Stakeholder Relations
mrice@hemophilia.org
(317) 517-3032

Network of Ethnic Physician Organizations

NEPO is a project of the California Medical Association Foundation, a 501 (c)(3) organization dedicated to improving health and expanding access to care.

Member Organizations

Amer. Assoc. of Cardiologists of Indian Origin
Amer. Assoc. Physicians of Indian Origin, Northern California
American Russian Medical Assoc.
Armenian Amer. Medical Society, California
Assoc. of Amer. Indian Physicians
Assoc. of Black Cardiologists
Assoc. of Black Women Physicians
Bangladesh Medical Assoc. N. Amer., West Region
California Latino Medical Assoc. Chapters: San Diego, Fresno
Chinese Amer. Physicians' Society
Chinese Community Health Care Assoc.
Ethnic Medical Organizations Ventura Co. Medical Assoc.
Golden State Medical Assoc. Chapters: Capital Medical Society, Charles Drew Medical Society, Daniel Hale Williams Medical Forum, James Wesley Vines Jr. MD, Sinkler-Miller Medical Assoc. Stockton Chapter
Hispanic Amer. Allergy, Asthma and Immunization Assoc.
Indian Medical Assoc., Chapters: Greater Los Angeles, Southern California
Korean Amer. Medical Assoc., Southern California
Latino Physicians of California
Miller-Lawrence Medical & Dental Society
Minority Health Institute
National Council of Asian Pacific Islander Physicians
National Medical Assoc. San Diego Society
North Amer. Taiwanese Medical Assoc., Southern California
Peruvian Amer. Medical Society, Southern California Chapter
Philippine Medical Assoc., Chapters: Northern California, Southern California
Sacramento Latino Medical Assoc.
San Diego Assoc. of Physicians of Indian Origin
South Asian Physician Network Assoc.
Vietnamese Physicians Assoc. Chapters: Northern California, San Diego, Southern California

July 17th, 2014

Honorable Diana Dooley
Secretary of the California Health and Human Services Agency
Chair, California Health Benefits Exchange
1600 Ninth Street, Room 640
Sacramento, CA 95814

Re: Position on Essential Community Providers under the Affordable Care Act (ACA) 2014

Dear Secretary:

In order to ensure adequate patient access, particularly for vulnerable patient populations and medically underserved communities, we request that the definition of Essential Community Provider reflect the full spectrum of physician providers who provide care within the health care safety net. This definition should include the provider experience with safety net patients (e.g. volume of safety net patients seen); the geographic community of practice (e.g. medically underserved or high proportion safety net patient communities): and duration of practice in safety net community.

Additionally, we request that you direct the health plans to analyze the report card data at their disposal to identify and invite additional 'essential community providers' that have not yet requested to be included as network providers. With your assistance, Covered CA can provide patients with the access to healthcare that they deserve.

Covered CA recently released its draft list of 'essential community providers.' Specifically, the draft list contains 227 hospitals and more than 2,000 community clinics and county-operated health care centers. Covered California added that Medi-Cal HI-TECH doctors are considered qualified as ECPs but were not included in the list "due to the quantity and lack of reliable address information" for such providers. [1]

The exclusion of many qualified safety-net solo and small group providers from the Covered CA health plan networks and reliance on a network of Federally Qualified Health Centers (FQHCs) for this population will not ensure continuity of care or adequate access to care. FQHC's are largely at capacity and have recruitment/retention issues, and as predicted, have been made worse with the ACA and the expansion of Medicaid.

National data consistently demonstrates that over **78% of safety-net (Medicaid or no insurance) primary care visits are provided by private physicians** This pattern continued for safety-net ethnic minority patients, with 63% of primary care visits occurring in private physician offices. The majority of these private practice physicians are in solo and small group practice. [2]

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Limiting networks under Covered CA deprives patients of their right to choose accessible care and disrupts the continuity of care between patients and their current physicians. Patients want to continue care with their traditional providers, and cite the desire to maintain this relationship as a chief concern when choosing an insurance plan. If that patient's doctor is not included as a network provider in a Covered CA health plan, the relationship between the patient and their current doctor is severely limited (or possibly even terminated). Severing the current doctor-patient relationship also impairs the medical home of the patient, which is especially problematic for patients with complex medical conditions.

Nearly 25% fewer doctors participated in Medi-Cal during spring of this year than in the spring of 2013.[3] Qualified Health Plans (QHP) offered by Covered CA should include many of these solo and small group providers in their networks as essential community providers in order to address the issues on continuity of care, adequate access to care, and maintaining capacity for the newly insured and safety-net communities and populations

Thank you for your attention to this matter.

Sincerely,
Dr. Margaret Juarez, MD
Chair
Network of Ethnic Physician Organizations (NEPO)

Cc:
Kimberly Belshe
Paul Fearer
Robert Ross, M.D.
Susan Kennedy

[1] *Covered CA Releases Draft List of Essential Community Providers,* California Healthline,7/10/14
http://www.californiahealthline.org/articles/2014/7/10/covered-calif-releases-draft-list--of-essential-community-providers, last accessed 7/15/14

[2] Forrest, C.B & Whelan, E (2000). Primary Care Safety Net Delivery Site in
The United States-A Comparison of Community health Centers, Hospital
Outpatient Departments and Physicians' Offices.
Journal of the American Medical Association 284 (16). 2077-2083

[3] *Number of Medi-Cal Providers Down By 25% in Spring 2014,* California Healthline, 7/15/14
http://www.californiahealthline.org/articles/2014/7/15/number-of-medical-providers--down-by-25-in-spring-2014

***Essential Community Provider* Comment Received via E-mail**

Subject: ECP 2014

Thank you for the opportunity to comment on Covered California's Essential Community Providers (ECPs) list. We have offered recommendations and resources to assist Covered California beneficiaries living with HIV to access Ryan White health care providers (HIV specialty providers) for continuity of care.

1. The California Department of Public Health, Center for Infectious Diseases, Office of AIDS (OA) recommends Covered California adopt the 2015 standards of the Center for Medicare and Medicaid Services (CMS), which states that qualified health plans (QHP) must include "At least one ECP in each ECP category (see Table 2.1) in each county in the service area, where an ECP in that category is available." This is in addition to each QHP having 30% ECPs in their network. The link and table are below.

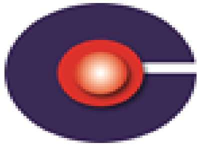
http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf - See Page 19

Table 2.1

Major ECP Category	ECP Provider Types
Federally Qualified Health Centers (FQHC)	FQHC and FQHC "Look-Alike" Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Program Providers
Family Planning Provider	Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics
Indian Health Providers	Indian Health Service (IHS providers), Indian Tribes, Tribal organizations, and urban Indian Organizations
Hospitals	Disproportionate Share Hospital (DSH) and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low-income, medically underserved individuals.

2. OA recommends Covered California include Ryan White clinics, as CMS does, as one of the categories of ECPs. As opposed to trying to figure out which Ryan White clinics are missing from Covered California's multiple lists. OA also recommends Covered California to add a link to the CMS Non-Exhaustive list and instruct QHPs to sort by California and Ryan White clinics. The CMS Non-Exhaustive list would include all Ryan White clinics. For convenience here is the link to the CMS list. http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/non-exhaustive-list-essential-community-providers-2015.xlsx

Theresa Harlan
Theresa.Harlan@cdph.ca.gov



WESTERN STATES REGIONAL HEMOPHILIA NETWORK
The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders
1310 West Stewart Drive Suite 606
Orange, CA 92868-4690 Phone: (714) 600-4712 Fax: (714) 600-4791

Diane J. Nugent, M.D.
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Judith Baker, DPH, MHSA
Public Health Director
judithbaker@mednet.ucla.edu

July 10, 2014

Covered California
P.O. Box 989725
West Sacramento, CA 95798-9725

RE: Request for all Qualified Health Plans to contract with at least one federally supported California Hemophilia Treatment Center for integrated diagnostic, medical, and pharmacy services as an Essential Community Providers pursuant to Covered California's "Draft Consolidated Essential Community Provider List"

Dear California Health Benefit Exchange/Covered California:

The Western State's Regional Hemophilia Network represents California's eleven federally supported Hemophilia Treatment Centers (HTC) which care for over 80% of the estimated 3,800 of our State's residents with rare, genetic, complex, and potentially fatal bleeding disorders. HTCs also care for several thousand Californians with rare genetic clotting disorders. HTCs provide the highest quality integrated diagnostic, prevention, treatment, surveillance, research, education, outreach, and 340B pharmacy services per national and State goals and guidelines. Our coordinated model of care improves overall health, quality of life, and satisfaction for our patients, leading to decreased absenteeism from work/school, decreased emergency room visits and ultimately reducing overall cost of care.

It is critical for Covered California to require <u>*all*</u> *qualified health plans (QHPs) to include at least one HTC as an essential community provider (ECP) in its network so that Californians can have access to nationally recognized Hemophilia Centers of Excellence*.

<u>Background</u>
Hemophilia is a rare, chronic disorder affecting more than 20,000 people in the US. Bleeding is internal, spontaneous in those with severe disorder, can be crippling and fatal. Community hematologists do not consistently care for a large enough volume of people with hemophilia to develop and maintain expertise. In contrast, HTCs care for an average of 200 such patients annually each year. Few community hematologists dedicate resources for the coagulation laboratories which ensure accurate diagnoses. Few community hematologists dedicate resources to maintain the federally and state required team of nurse coordinators, social workers, physical therapists, genetic counselors and other specialist consultants needed to address physical, educational, and psychosocial needs that affect patient and family. And few community hematologists support rare disorder data management to collect federal surveillance to monitor complications. HTCs do all this. Furthermore, all California HTCs offer federally discounted 340B drug prices, and integrate pharmacy care into HTC services.

Individuals with hemophilia are treated with expensive, high-cost blood clotting factor therapies to replace missing blood proteins. These lifesaving treatments cost as much as $300,000 per year for individuals with severe hemophilia. If a patient develops and an immune response to treatment, complications such as HIV/AIDS, hepatitis and joint disease, or bleeding following trauma or surgery, then annual costs for treatment can exceed $1 million.

HTCs foster HRSA and CDC goals, National Hemophilia Foundation recommendations, Healthy People 2020 objectives, and the new guidelines published in the National Guideline Clearinghouse. http://www.guideline.gov/content.aspx?id=39323&search=hemophilia. HTCs have a decade's long productive public/private partnership with California's Department of Healthcare Services, with Medi-Cal (Fee for service and managed), the Genetically Handicapped Persons Program, and California Children's Services.

California's 11 federally-funded HTCs are located at the following institutions/facilities:

- The Center for Comprehensive Care and Diagnosis of Inherited Blood Disorders (Orange, CA)
- Children's Hospital Oakland (Oakland, CA)
- Children's Hospital of Central California (Madera, CA)
- Children's Hospital Los Angeles (Los Angeles, CA)
- City of Hope National Medical Center (Duarte, CA)
- Orthopaedic Hospital of Los Angeles (Los Angeles, CA)
- Rady Children's Hospital (San Diego, CA)
- Lucile Salter Packard Children's Hospital, Stanford University Medical Center (Palo Alto, CA)
- University of California at Davis (Sacramento, CA)
- University of California, San Diego (San Diego, CA)
- University of California, San Francisco (San Francisco, CA)

Request to Update Covered California Essential Community Provider list

We offer the California Health Benefit Exchange/Covered California our input on the above-referenced draft list. The draft list currently identifies HTCs inconsistently under the "Sub-entity Type" and "340B entity" columns. This causes confusion, and may result in service barriers, compromising care and savings. **To remedy this, we recommend the draft ECP list be revised to consistently identify the HTCs** in these columns:

1. Under "Sub-entity" Type list as: *Comprehensive Hemophilia Care Program* or *Hemophilia and Thrombosis Care.* Eliminate the currently listing which reads: Hemophilia Program, Hemophilia Treatment Center, Hemophilia and Thrombosis, Hemophilia Comprehensive Care Program.
2. Under "340B entity" Type list as: *Hemophilia Treatment Center Program.* Eliminate the currently listing which reads: "Hemophilia RX Center."

In summary, we are pleased to see that Covered California's "Draft Consolidated Essential Community Provider List" includes all 11 of the federally-funded HTCs in California. **As HTCs provide both high quality, comprehensive clinical and pharmacy services to Californians with rare, genetic, catastrophic blood disorders, we ask that Covered California ensure that QHPs include the HTCs as an in-network provider for HTC clinical and pharmacy programs. Furthermore, clearly identifying HTCs with our recommended revisions to the "Draft Consolidated Essential Community Provider List" will help health plans to recognize HTC's on the list and benefit from our care.**

Thank you for the opportunity to comment. Please contact us at judithbaker@mednet.ucla.edu at 310 794 6264 if you have questions.

Sincerely,

Diane Nugent, MD *Judith Baker, DPH, MHSA*

Diane Nugent, MD
Regional Director

Judith Baker, DPH, MHSA
Public Health Director

On behalf of the Hemophilia Treatment Center Directors at: The Center for Inherited Blood Disorders, Children's Hospital Central California, Children's Hospital Los Angeles, Children's Hospital Oakland, Rady Children's Hospital San Diego, City of Hope, Orthopaedic Hospital, Stanford University, University of California Davis, University of California San Diego, and University of California San Francisco

July 8, 2014

Submitted via email: boardcomments@covered.ca.gov

To Ms. Belshe, Ms. Dooley, Mr. Fearer, Ms. Kennedy and Dr. Ross,

I have been trying to enroll with Covered California now for 9 months unsuccessfully. After attempting to enroll on October 2013, I was told to withdraw my application since my wife was due with our son in November 2013. We withdrew and re-applied after he was born. Then, I received a raise at work and wanted to change my plan. The new plan I selected had an effective date of March 1, 2014. I spent many hours waiting on hold during this whole process, but finally had things sorted out (or so I thought).

It is now July 8, 2014 – 4 months since that effective date – and Kaiser has no record of receiving any information from Covered California, except for the withdrawn plan from October 2013 (which somehow went through even though it was withdrawn immediately upon submission). I have called both Kaiser and Covered California numerous times, and even conferenced staff from both organizations together on a conference call since they could not call each other directly. Both Kaiser and Covered California have "escalated" my case. Unfortunately, none of this time and energy has helped me or my children get our health insurance coverage instated, or helped me get the security and peace of mind that comes with it.

My children have incurred routine medical expenses since March. Now, those expenses are at risk of being sent to collections by Kaiser as I wait for my coverage information to be sent to Kaiser with a March 1 back-date. The delay of information transfer form Covered California to Kaiser will negatively impact my credit, and I know of no recourse.

My writing this comment letter is to urge the Board to put accountability systems in place within the Covered California system. Covered California has not provided me with any way to take control of my own situation. I have repeatedly asked for contact information for the "escalation" team and it has been denied to me. I have no other point of contact with Covered California available or known to me. I have asked for any way to be able to track my own application, and have been told there is none. I have been told all I can do is sit by and call the help desk every couple weeks to check on status. I think this lack of transparency and accountability can only be dealt with systematically from the top of the organization, which is why I respectfully submit this comment letter to the Board for your consideration.

Thank you,

James Castelaz

jcastelaz@gmail.com

Sharon R. Ince ~ email: sharonince@gmail.com

July 19, 2014

TO: GOVERNMENT AGENCIES RE: ACA Administration (sent via fax and/or email.)

U.S. Senator Dianne Feinstein

U.S. Senator Barbara Boxer

Diana S. Dooley, Chair, Covered California

Re: Blue Shield Subscriber name: Sharon Ince

Dear Representatives:

You are my last hope in getting administration of my health insurance under the ACA straightened out, stream-lined, and regulated properly (and I've already tried with the Department of Managed Health Care, and their form response letters do nothing to problem solve). While I support this great new ideal of health insurance for all Americans, working within the Covered California Exchange and with Blue Shield has been the worst bureaucratic nightmare ever, and I am a retired litigation paralegal and master of paperwork systems. This is why I write to you today; **solve the inequity in ACA administration AND enforce compliance with ACA laws for administration in California, and stream line my health insurance.**

My desk has 4 files each holding 2" of paperwork for the "easy use" computer application of my health insurance. I have hopped over every hurdle, jumped through every hoop, researched the ACA law, sat up Christmas Eve and many other days and nights on the internet navigating the "easy" Covered California website, but I admit I surrender. My skill cannot streamline nor fix the myriad of problems which computers and "customer service" representatives have inflicted on me. All at a time when I am under medical care.

The issue: *rogue* change in my income wrought upon my Covered California application (for the umpteenth time) by an errant computer process, representative, or some x factor, since it wasn't me. While I realize possible reconciliation will be at tax time, the administration of my plan keeps changing through no fault of my own. Inflicting challenges on my health care. Let me explain the 7 month drama in less than two paragraphs.

I applied for health insurance through the exchange, choosing Anthem Blue Cross. My doctor, Robert Gonzales at Peachwood Medical Group in Fresno informed me they would not take Anthem, only Blue Shield. In February I terminated the Anthem plan, which cancelled my whole process, but I was persistent and consistent and so with fortitude I reapplied, selecting Blue Shield. Blue Shield put a rogue start date of 3/18/14. I did pay my premium to Blue Shield by priority mail on the same day I received their letter stating it was due. Covered

California admitted a computer mistake, terminated the 3/18 plan and started a new one with Blue Shield for 3/1. Blue Shield applied my premium to the terminated 3/18 plan and was about to cancel my 3/1 plan when I spent 2 hours on the phone with them to advert their suggestion "I just send in another premium and wait for a refund." My response: I would not fund an insurance company screw up. They finally migrated the premium to the correct plan (realizing their fiduciary duty, of course). My premiums have been paid for March, April, May and June. I awaited my autopay at blueshieldca.com to run for July, but it never did. Last week I learned my plan had been "terminated" because Covered California had a new determination on my income and migrated my billing to another plan. This is going on while I am sick, on pain meds, and trying to get this alligator-of-a-bureaucracy to stop biting me. After another 2 hour lengthy phone call last week, before my physical therapy (which I missed because the alligator had hold of my leg), I was told by Covered California my income had been updated in May and June 2014. I never updated it. I did upload my 2012 tax return in January 2014 on the Covered California website. I did received a letter in June 2014 stating my subsidy was $174 per month in premium assistance, which was reflected in my premiums already paid. But now a change and a termination?

Unreimbursed medical bills and deductibility: pondering what the heck some back office income analyst was doing to my application and therefore affecting my insurance plan (Blue Shield said it was terminated, but also confirmed it was not terminated. The billing was migrated to a new plan, and the language "terminated" was a bit harsh according to a supervisor [but that's what my account read]. Then Blue Shield emailed me a confirming letter my coverage is continuous and but took a new higher amount for the July payment. However, my blueshieldca.com account is still inoperable. An insight came: **ACA is not being administered properly by Covered California**. I am sure if you poll ANY of the over 3,000,000 applicants they would agree. But one (and only one) current issue: **the Covered California exchange website on the income and deduction screen does not allow for the deduction against AGI of unreimbursed medical bills. My research at the IRS.gov reveals there are some deductions (not necessarily the itemized deductions allowed on a tax return) allowed from the AGI which provides the MAGI for the income analysis on the exchange. Since the law allowed it, I reported un-reimbursed medical expenses at the Covered California website during my original enrollment in January/February 2014. Nothing has changed at present. Why now is my plan's assistance being changed? Did Covered California errantly delete them?**

AGI prejudice, another problem: an important issue [especially if one values their savings account]. Why is there age prejudice for Americans using the exchange system to obtain health insurance and their subsidies, creating financial inequality? Why does a married couple, similar age, applying for health insurance through the exchange get a tax subsidy which keeps their premium to less than 9.5% of their AGI income threshold for health insurance, and differs from a couple where the husband is on Medi-Care and the wife is insured through the exchange? The later couple ends up paying over 30% of their AGI in combined medicare and ACA-exchange premiums. Even without considering the Medi-Care premium, the wife, because she is now bearing the whole computation for household income for BOTH family members, she suffers an income and age prejudice. If she was single, then only her income is reported. Because it is not, her subsidy is lower. I am this lady. Had my husband been able to apply for health insurance on the California insurance exchange, we would not have this discriminatory problem with it's financial inequity for me and everyone whose is using it.

A simple math computation could be rendered with a stroke of a pen and some code into the computer: APPORTION AGI PER FAMILY MEMBER for subsidy calculations. The couple who is able to get equal ACA subsidy because they are the same age and applied through the exchange together and thus their AGI is apportioned gets one equal financial outcome, and my husband and I have an entirely different outcome, which

assesses premiums higher and subsidy lower, because of our age difference. I believe this is called age discrimination. Which is creating a financial burden, quite the opposite of the goal under premise of the ACA.

I rally your help. I raise the white flag and surrender at the point of the government tank called Covered California who rolls over California's citizenry and bleeds our wallets unequally, but do so in an effort to stop it. This letter is my last informal action item to rouse governmental intervention to solve the massive inequities and mistakes I alone cannot remedy. I've written and written, called and called, never receiving one call back from any representative or even a letter. Only rogue computer letters come. Hello, is anyone out there? Any government official manning the ACA Covered California Tank?

While my goal was to summarize the issues in two paragraphs but couldn't, at least you have a coherent summary letter, which is less than my own 4 file folders each over 2" thick filled with the "easy" paperwork process of applying for insurance through Covered California. Now that I am through the war-of-application process of applying for health insurance as required by law (which I am happy to have, yet beat-up and worn out over it's errant administration), the myriad of battles remain in order to maintain it, through no fault of my own, which now require governmental power. I cannot use the rest of my days until I receive Medi-Care (which is another 10) spending my life's currency on this bureaucratic mess called Covered California. Health care and health insurance is a very important basic human need, so I appreciate the ACA's fundamental premise, and as a new major change in health insurance, corrections and amendments are required.

All of you concerned have group health insurance through your government benefits arising from your employment. I too now have health insurance (previously being excluded for pre-existing causes, and when you are 54 everything is pre-existing) so I am now getting health care too. However, continued errant administration of the ACA through Covered California creates inequity, in addition to all the computer and customer service nightmares which do exist. This is causing extreme stress which impacts my health and finances.

Please intervene, because I've learned **a responsible, attentive, representative can solve a problem in an instant** a constituent has suffered because of improper administration and application of law. Please help.

/s/
Very truly yours, Sharon Ince

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August 13, 2014

Mr. Peter Lee
Executive Director
Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

VIA ELECTRONIC MAIL:
peter.lee@covered.ca.gov

Re: Proposition 45 Impact

Dear Mr. Lee:

The California Association of Health Plans ("CAHP") represents 42 public and private health care service plans that collectively provide coverage to over 21 million Californians. CAHP appreciates the opportunity to respond to questions posed by your staff regarding the impact of the Proposition 45 on Covered California's operations.

Health plans have accepted Covered California's invitation to provide health care coverage to millions of residents. This partnership is based on a simple bargain: health plans participate in Covered California and in return they accept Covered California's requirements to be Qualified Health Plans.

The requirements are many. The detailed QHP contract includes quality data reporting, customer service standards and data reporting, Essential Community Provider contracting, standard provider agreement terms and payment transparency, network management and delivery system standards, utilization review, language access, eValue8 reporting, detailed marketing and co-branding standards, and other reports and surveys to demonstrate access-to-care and compliance with the contract. There are eligibility and enrollment requirements, standard benefit designs, plan-based enrollment requirements, certification and re-certification requirements, and an appeals process.

Additionally, Covered California intends to revisit additional reporting and data collection requirements related to access, quality, and transparency that were delayed in the initial contract and to further increase standardization of the benefit designs in 2016.

At the end of this process, QHPs and Covered California negotiate premiums. As an active purchaser charged by state law with managing a competitive marketplace, Covered California approves plans and rates in each of the state's nineteen regions that give consumers options of provider networks at rates that are as affordable as possible while still sufficient to cover the cost of care.

Proposition 45 undermines this fundamental bargain between Covered California and Qualified Health Plans, as was originally envisioned by the State Legislature. By giving the Insurance Commissioner the power to change standardized benefit designs, reject or alter co-payment or co-insurance levels, and reject the negotiated premium amounts, this initiative greatly limits the ability of Covered California to control its own destiny.

The passage of Proposition 45 would mean that Covered California must seek permission from the Insurance Commissioner for nearly all its major decisions before they are made or risk a challenge by the Commissioner after negotiations have concluded. Even securing this permission from the commissioner is no guarantee that Covered California's decisions will stick. Special interest groups—as interveners-- can still challenge Covered California's rate and benefit decisions in an administrative or legal proceeding. How can Qualified Health Plans make commitments to Covered California to improve our health care system when there is no guarantee that premiums will be sufficient to pay for those efforts? Why would QHPs negotiate rates with Covered California when they know they will be challenged? Why would QHPs agree to charge a rate for a product when the design of that product can be changed later?

It is also important to note that some of the questions posed by the Covered California staff are hard to answer or perhaps can't be answered. When Proposition 103 was passed 1988, there was great confusion. Lawsuits proliferated in an effort to clarify the actual application of the new law. Eventually the California Supreme Court settled key issues. Regulations and legislation followed the Court's decisions. This same process will have to play out if Proposition 45 passes. Therefore many of the questions raised by your staff are unanswerable until they have been litigated. Covered California should be skeptical of any claims to the contrary.

In addition, health plans are troubled by recent arguments advanced by the California Department of Insurance that attempt to counter the Covered California staff analysis and the work of the Wakely report. Please see below for some of our responses to their assertions.

Timelines for Intervention, Hearings, and Open Enrollment

The proponents of Proposition 45 claim that the Insurance Commissioner can develop a new, expedited process for prior approval of Covered California offerings that will satisfy all the problems identified in the Covered California staff analysis and in the Wakely report. We disagree.

Proposition 45 deliberately and clearly links the regulation of health insurance rates to the requirements of Proposition 103. The Insurance Commissioner is bound by existing timelines for prior approval of automobile rates as outlined in Proposition 103 and as amended by the Legislature. These timelines include up to 180 days for public hearings

and extensions of that timeline if a judicial process ensues or if the applicant waives the 180 day timeline in the interest of avoiding having its rates rejected. The ability of outside groups to intervene and challenge decisions further complicates these timelines.

The Insurance Commissioner does not have the authority to waive a statute. Nor does he have the power to waive the provisions of the Administrative Procedures Act, which provides the public and interveners specific rights under California law.

The average time to complete a rate filing when there has been an intervener under Proposition 103 is 343 days. That is a problem.

Rate Review is NOT Prop. 45

The proponents of Proposition 45 point to the Department of Insurance's success in reviewing Covered California rates in time for open enrollment under current law as proof that this initiative will not lead to delays. This is a red herring. Rate review is not rate regulation—and rate review has no intervener process. The timelines and requirements for these filings are not the same. In addition, only one Qualified Health Plan is regulated by the Department of Insurance.

Interest Groups Will Intervene

The proponents of Proposition 45 claim that a very small number of rate filings under Prop. 103 attract an intervener therefore Covered California should assume that this will be a rare occurrence. We disagree.

The ACA has been a highly polarizing issue throughout the country. There is little reason to believe that rate filings for Covered California will somehow escape the notice of political advocacy groups.

Interveners and Hearings Not Limited to Rate Increases Above 7%

The proponents of Proposition 45 continue to imply that only premium increases greater than 7% will receive a lengthy hearing and therefore as long as premium increases are modest there will be no need for delays. This is misleading. While it is true that premium increases greater than 7% receive a mandatory hearing, nothing prohibits an intervener requesting a hearing and the Insurance Commissioner granting one for ANY rate filing – even a decrease. And nothing prevents an intervener from appealing a decision to the Superior Court.

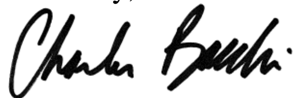
Summary

California's health plans foresee serious operational problems for Covered California should Proposition 45 pass. Your staff questions and the Wakely report point to the problems caused by the initiative. Contrary to the claims of proponents (who wrote the

text of Proposition 45 without a word about the Affordable Care Act or Covered California), these problems are not easily surmountable.

Covered California's role in fostering quality care, improving health status, and negotiating affordable coverage on behalf of Californians is jeopardized by Prop.45.

Sincerely,



Charles Bacchi
Executive Vice President

cc:
Secretary Diana Dooley
Kimberly Belshé
Paul Fearer
Susan Kennedy
Robert Ross

***Proposition 45* Comment Received via E-mail**

Subject: Rate regulation ballot measure

As I noted in my testimony, we have not taken a position on the ballot measure, but CALPIRG supports rate regulation in concept, and we have participated in the existing rate review process established in 2011 by submitting comments on rate filings to CDI. We recently completed an analysis of the current rate review process' benefits to consumers, as well as its deficiencies. The analysis is attached.

Here are the key findings from our analysis:

- Health insurance carriers have filed 369 proposed rate changes in the individual and small group markets.
- As a result of objections raised in the rate review process, carriers have voluntarily reduced or withdrawn 44 rate hikes.
- At least 14 times, health insurance carriers have moved forward with rate increases that regulators found unreasonable.
- Rate review has saved California consumers and small businesses $349 million in health insurance premiums since 2011, according to estimates by state regulators.
- An estimated 1.3 million Californians benefited from reduced or withdrawn rate increases on average in each of the first three full years of rate review.
- An estimated 923,237 Californians have been subject to rate hikes that were declared unreasonable but still went into effect.

We recognize that there are unanswered questions about how the ballot measure will affect the operations of Covered California. We encourage the staff and board at Covered California to do your best to not only ask the right questions and answer those questions, but also to come up with workable solutions, should voters approve the measure in November.

Emily Rusch
erusch@calpirg.org

CALPIRG
Standing Up
To Powerful Interests

California Health Insurance Rate Review

An analysis of implementation and results for consumers

Consumers and small businesses have seen lower health insurance rate hikes thanks to increased scrutiny and public transparency under California's new rate review process.

Rate review has saved Californians millions of dollars, with regulators pressing insurers to voluntarily reduce rate increases to reasonable levels. But in order to fully protect consumers and small businesses from unreasonable rate hikes, rate review must be strengthened.

Under California's rate review law established in 2011, health insurance carriers must publicly justify any proposed rate increase on individual or small group plans. Health insurance carriers must submit rate filings to state officials for review, and the public is able to access the filings online and comment on them.

Depending on the type of health insurance, filings are reviewed either by the California Department of Insurance (CDI) or the Department of Managed Health Care (DMHC). These agencies use their own actuarial staff to review each rate filing in the individual and small group market to determine if the proposed rate is reasonable.

Regulators also post rate filing documents and give the public the opportunity to review and comment. The regulators then meet with the carriers to clarify or challenge the assumptions driving projected cost increases, or request any missing information. They can request that the carriers modify or reduce rate increases if they find that they are unjustified but the insurance company can decide whether to comply with the request. If they do not, the regulator can make an official determination that the rate filing is "unreasonable."

In this brief, CALPIRG examines the implementation of rate review in California, and the results it has achieved for consumers and small employers across the state. Our analysis includes rate filings that were scheduled to go into effect between January 1, 2011 and April 1, 2014.

Key findings

- Health insurance carriers have filed 369 proposed rate changes in the individual and small group markets.[i]
- As a result of objections raised in the rate review process, carriers have voluntarily reduced or withdrawn 44 rate hikes.[ii]

- At least 14 times, health insurance carriers have moved forward with rate increases that regulators found unreasonable.[iii]
- Rate review has saved California consumers and small businesses $349 million in health insurance premiums since 2011, according to estimates by state regulators.[iv]
- An estimated 1.3 million Californians benefited from reduced or withdrawn rate increases on average in each of the first three full years of rate review.[v]
- An estimated 923,237 Californians have been subject to rate hikes that were declared unreasonable but still went into effect.[vi]

Table 1: Summary of Rate Review Results by Regulator

Agency	Total Number of Filings Reviewed	Number of Filings Reduced after Review	Number of Filings Declared "Unreasonable"	Consumer Savings Estimated by Agency Staff
CDI	160	33	13	$291,058,970
DMHC	209	11	3	$58,000,000
Total	**369**	**44**	**16**	**$349,058,970**

Table 2: Total Number of Californians Benefiting from Rate Reductions by Year[vii]

2011	1,978,911
2012	962,830
2013	1,161,607
Average:	**1,367,783**

Table 3: Rate Increases Reduced After Review

Agency	Company	Tracking #	Proposed Average Increase	Adopted Average Increase	Covered Lives	Proposed Effective Date
CDI	Anthem Blue Cross Life and Health Insurance Company	PF-2010-02061	9.8%	9.6%	Not provided	1/1/2011
CDI	Anthem Blue Cross Life and Health Insurance Company	PF-2010-02062	15.0%	Withdrawn	354	1/1/2011
CDI	Connecticut General Life Insurance Company	PF-2010-02230	10.0%	9.0%	186	1/1/2011
CDI	Blue Shield of California Life & Health Insurance Company	PF-2010-02083	27.8%	Withdrawn	252,983	3/1/2011
DMHC	Health Net of California, Inc.	HNLH-127062271	12.3%	9.6%	180,478	5/1/2011
CDI	Aetna Life Insurance Company	PF-2010-02396	21.0%	18.8%	21,000	7/1/2011
CDI	Aetna Life Insurance Company	PF-2011-00542	15.6%	10%	49,858	7/1/2011
CDI	Aetna Life Insurance Company	PF-2011-00827	16.8%	13.6%	93,246	7/1/2011
CDI	Anthem Blue Cross Life and Health Insurance Company	PF-2011-00002	9.8%	9.1%	638,631	7/1/2011
CDI	Anthem Blue Cross Life and Health Insurance Company	PF-2011-00660	7%	3%	17,505	7/1/2011
DMHC	Health Net of California, Inc.	HNLH-127139743	12.6%	10.1%	26,814	7/1/2011
DMHC	Kaiser Foundation Health Plan, Inc.	KHPI-127146976	12.0%	10.8%	1,081	7/1/2011
DMHC	Kaiser Foundation Health Plan, Inc.	KHPI-127146900	10.7%	9.5%	695,634	7/1/2011
CDI	Kaiser Permanente Insurance Company	PF-2011-00829	12%	10.8%	1,051	7/1/2011
CDI	American Heritage Life Insurance Company	PF-2011-00988	20%	10%	42	8/1/2011

Agency	Company	Tracking #	Proposed Average Increase	Adopted Average Increase	Covered Lives	Proposed Effective Date
CDI	American Heritage Life Insurance Company	PF-2011-01000	20%	10%	48	8/1/2011
CDI	Aetna Life Insurance Company	PF-2011-01551	10.9%	9.4%	83,198	10/1/2011
CDI	Aetna Life Insurance Company	PF-2011-01689	13.7%	9.3%	50,215	1/1/2012
CDI	UnitedHealthcare Insurance Company	PF-2011-01701	11%	10.5%	10,410	2/1/2012
DMHC	California Physicians' Service DBA: Blue Shield of California	BCCA-127793357	14.8%	8.9%	55,758	3/1/2012
CDI	Central United Life Insurance Company	PF-2011-02455	9%	Withdrawn	34	4/1/2012
CDI	Anthem Blue Cross Life and Health Insurance Company	PF-2011-02236	10.8%	8.3%	390,000	5/1/2012
CDI	Anthem Blue Cross Life and Health Insurance Company	PF-2011-02237	9.6%	8.1%	205,000	5/1/2012
CDI	Aetna Life Insurance Company	HAO-2012-0035	16.3%	13.5%	74,318	7/1/2012
CDI	Aetna Life Insurance Company	HAO-2012-0077	9.6%	4.7%	68,972	7/1/2012
CDI	Anthem Blue Cross Life and Health Insurance Company	HAO-2012-0050	5.9%	Withdrawn	51,691	7/1/2012
CDI	Blue Shield of California Life & Health Insurance Company	HAO-2012-0038	6%	4.4%	51,697	7/1/2012
CDI	Health Net Life Insurance Company	HAO-2012-0082	22.6%	16.1%	377	7/1/2012
CDI	Anthem Blue Cross Life and Health Insurance Company	HAO-2012-0162	6.9%	6.2%	51,422	10/1/2012
CDI	John Alden Life Insurance Company	HAO-2012-0008	9.9%	-5%	2,179	10/1/2012

Agency	Company	Tracking #	Proposed Average Increase	Adopted Average Increase	Covered Lives	Proposed Effective Date
CDI	Time Insurance Company	HAO-2012-0011	9.9%	-5%	2,179	10/1/2012
DMHC	Aetna Health of California, Inc.	AETN-128693505	12.8%	11.3%	75,819	1/1/2013
CDI	Aetna Life Insurance Company	HAO-2012-0182	8%	5.10%	38,446	1/1/2013
CDI	UnitedHealthcare Insurance Company	HAO-2012-0176	5.30%	2.80%	18,670	1/1/2013
CDI	Anthem Blue Cross Life and Health Insurance Company	HAO-2012-0189	24.60%	19.40%	296,059	2/1/2013
CDI	Anthem Blue Cross Life and Health Insurance Company	HAO-2012-0190	28.10%	25.60%	340,085	2/1/2013
DMHC	Blue Cross of California	AWLP-128772955	15%	12.50%	85,834	2/1/2013
DMHC	Blue Cross of California	AWLP-128773104	14.60%	12.10%	7,724	2/1/2013
CDI	Aetna Life Insurance Company	HAO-2012-0191	18.80%	12.40%	68,766	4/1/2013
DMHC	Blue Cross of California	AWLP-128797997	4%	3.70%	108,401	4/1/2013
CDI	Blue Shield of California Life & Health Insurance Company	HAO-2013-0031	10.90%	10%	179,188	7/1/2013
DMHC	UHC of California	AMMS-128937373	18.20%	Withdrawn	4,506	7/1/2013
DMHC	UHC of California	UHLC-129046703	8.30%	6.60%	4,643	8/1/2013
CDI	UnitedHealthcare Insurance Company	HAO-2013-0039	9.00%	Withdrawn	2,232	8/1/2013

Table 4: Rate Increases Declared Unreasonable[viii]

Agency	Company	Tracking #	Proposed Average Increase	Adopted Average Increase	Covered Lives	Proposed Effective Date
DMHC	Blue Cross of California	20102521	16.1%	16.1%	150,983	5/1/2011
CDI	Aetna Life Insurance Company	HAO-2012-0010	8.0%	8.0%	72,531	4/1/2012
DMHC	Aetna Health of California, Inc.	AETN-128693505	12.8%	11.3%	75,819	1/1/2013
CDI	Aetna Life Insurance Company	HAO-2013-0040^	8.0%	8.0%	25,592	7/1/2013
CDI	Anthem Blue Cross Life and Health Insurance Company	HAO-2012-0177	6.5%	6.5%	52,396	1/1/2013
CDI	Anthem Blue Cross Life and Health Insurance Company	HAO-2013-0013^	9.6%	9.6%	45,235	4/1/2013
CDI	Anthem Blue Cross Life and Health Insurance Company	HAO-2013-0045	17.6%	17.6%	37,352	7/1/2013
CDI	Blue Shield of California Life and Health Insurance Company	HAO-2012-0195^	11.7%	11.7%	268,653	3/1/2013
CDI	Blue Shield of California Life and Health Insurance Company	HAO-2013-0031^	10.9%	10.0%	179,188	7/1/2013
DMHC	California Physicians' Service DBA: Blue Shield of California	BCCA-128784554	11.8%	11.8%	27,283	3/1/2013

Agency	Company	Tracking #	Proposed Average Increase	Adopted Average Increase	Covered Lives	Proposed Effective Date
CDI	SeeChange Health Insurance Company	HAO-2013-0151^	40.0%	40.0%	3,135	11/1/2013
CDI	United HealthCare Insurance Company	HAO-2013-0028	7.7%	7.7%	12,234	5/1/2013
CDI	United HealthCare Insurance Company	HAO-2013-0088^	10.1%	10.1%	12,530	8/1/2013
CDI	Blue Shield of California Life and Health Insurance Company	HAO-2013-0160	22.6%	22.6%	81,015	1/1/2014
CDI	Blue Shield of California Life and Health Insurance Company	HAO-2013-0146	N/A	Withdrawn	unknown	1/1/2014
CDI	Blue Shield of California Life and Health Insurance Company	HAO-2013-0149	N/A	Withdrawn	unknown	1/1/2014
Total covered lives					**923,237**	

Policy Recommendations

Extend rate review to large groups. Rate review is a proven success. It has protected consumers from paying hundreds of millions of dollars in unreasonable rate increases. Large employers and their employees deserve the same protection. The adoption of SB 1182 (Leno), would extend the scope of rate review to the large group market, which is the next step in making sure that more Californians are protected by insurance regulators at the CDI and DMHC.

Give regulators the power to reject or modify rate increases. California consumers and businesses should not be subjected to unreasonable rate increases. Especially as we move into a framework with individual and employer mandates, regulators must have the authority to reject or modify rates to protect consumers and businesses from paying premiums that carriers have failed to justify.

Require rate increases to be based on reasonable administrative costs. Rate review should protect consumers from rates based on excessive or unjustified overhead expenses. Insurers should itemize their administrative expenses, and justify any increase exceeding the rate of inflation. We recommend that administrative costs be reported on a per member, per month basis.

Require Insurers to use their leverage to cut waste and improve care. In addition to cutting their own administrative waste, carriers have an important role to play in cutting waste and improving care in the health care delivery system. By encouraging providers in their networks to prioritize quality care that cuts cost – such as prevention, patient safety, coordination of care and effective disease management – and by negotiating lower prices, carriers can help slow the increase in medical costs and improve the health of their enrollees. Insurance companies should be required to report what strategies they are using to improve care and cut waste. With that information, California can use rate review as a tool to ensure insurers are doing everything they can to cut waste and improve care before they raise premiums.

Endnotes:

[i] The CDI database of rate filings is housed here: https://interactive.web.insurance.ca.gov/apex/f?p=102:4:0::NO
The DMHC database is housed here: http://wpso.dmhc.ca.gov/ratereview/Default.aspx
[ii] See tables 1 and 3. Based on rate requests that have been reduced after their initial filing, as reported in the CDI and DMHC databases.
[iii] See Table 4.
[iv] Estimates provided by actuarial staff of CDI and DMHC. CDI savings numbers were provided to CALPIRG in emails dated April 2, 2013 (for 2011 and 2012) and February 25, 2014 (for 2013). Total DMHC savings numbers were provided to CALPIRG in an email dated February 26, 2014.
[v] See tables 2 and 3.
[vi] See Table 4. This figure is the sum total of covered lives reported, excluding HAO-2013-0040, HAO-2013-0013, HAO-2013-0045, and HAO-2013-0088 because of the presumed population overlap with other filings on this list.
[vii] See Table 3. These figures are the sum totals of the covered lives reported, excluding PF-2011-01551, HAO-2012-0162, and HAO-2012-0191 because of the presumed population overlap with other filings on this list.
[viii] These filings were declared unreasonable on the DMHC and CDI interactive filing websites, with the exception of filings marked with a "^" by their filing number. These filings do not have statements on their rate filing websites, but agency staff confirmed with CALPIRG that they were declared unreasonable. Table 4's estimate of "Total Covered lives" was calculated using the sum total of the covered lives reported, excluding cases where there were multiple filings in one year for the same covered lives. These were excluded from the total in order to avoid presumed population overlap with other filings on the list.

This analysis was written by Zach Weinstein and Emily Rusch of CALPIRG.

The authors would like to thank the staff at the Department of Managed Health Care and the Department of Insurance for providing data at our request and responding to questions promptly. The authors would also like to thank Laura Etherton from U.S.PIRG, Betsy Imholz from Consumers Union, and Beth Capell for reviewing a draft of this analysis.

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Dfcdcg]h]cb'() Comment Received via E-mail

Subject: Insurance Rate Public Justification and Accountability Act

I am Christine Busch, a registered nurse and a member of the California Nurses Association/National nurses United, which has 85,000 California members. The Nurses Association endorsed this measure on November's ballot to regulate health insurance rates in California.

I SUPPORT Insurance Rate Public Justification and Accountability

chbrn1@gmail.com

Dfcdcg]h]cb ( ) Comment Received via E-mail

Subject: Imitative: Justify Rates...

I am Meg Ahirega-Amaichigh with California Nurses Association:

Kaiser nurses cannot stand by quietly while Kaiser is hiking rates, cutting care and accumulating vast reserves & using $7 million patient care dollars to defeat an initiative that begins to bring some accountability into high prices that insurers impose on patients + families. Remember, the $24.5 million raised against this health insurance rate regulation initiative comes, exclusively from a handful of health insurance companies.

They are spending that money because, they don't want to lower rates!
California & covered California should not be concerned about more transparency & accountability for health insurance companies...They should welcome it.

megngu@icloud.com

Dfcdcg]h]cb'() Comment Received via E-mail

Subject: Insurance Rate Public Justification and Accountability Initiative

I am a registered nurse and Chief Nurse Representative with the California Nurses Association/National Nurses United, which has 85,000 California members. The nurses association endorsed this measure on November's ballot to regulate health insurance rates in California, just as the State already regulates auto and home insurance rates.

I am not an accountant, I am a registered nurse, but it makes no sense that health plans like Kaiser can tuck away billions of dollars while charging patients more. That's the status quo. This health insurance rate regulation initiative will ensure oversight and empowerment to stop unreasonable rate hikes.

Consumers will save money under this ballot measure, and that should be the reason the board supports it.

Years ago, with the same employer, I paid premium rates for my dental insurance for three years in order to eventually have 100% coverage. Last December 2013, our two dental insurance plan choices were reduced to one. I recently received a bill from my dentist, for the amount not covered. I have been seeing my same dentist for over 20 years. I received a bill because my dentist's private practice cannot survive at the increased insurance rates. I cannot afford the balances for dental care for my family and will have to find a new dentist that can afford to stay in business with the only plan offered by my employer.

Thank you,

Michele Mueller
socalrnadvocate@gmail.com

Dfcdcg]h]cb'() Comment Received via E-mail

Subject: Potential operational implications of the insurance rate public justification and accountability act

I am, Patricia joubert , a registered nurse with California Nurses Association/National Nurses United which has 84.000 members. The California nurses association supports the insurance rate public justification and accountability.

Thank you very much
Patricia Joubert
pjoubert@mac.com