Date of Hearing: June 11, 2013

ASSEMBLY COMMITTEE ON HEALTH
Richard Pan, Chair
SB 3 X1 (Ed Hernandez) – As Amended: May 28, 2013

SENATE VOTE: 37-0

SUBJECT: Health care coverage: bridge plan.

SUMMARY: Requires the California Health Benefits Exchange (Exchange), by means of selective contracting, to make a bridge plan product, as defined, available to specified eligible individuals, as a qualified health plan (QHP). Exempts the bridge plan product from certain requirements that apply to QHPs relating to making the product available, marketing, and selling to all individuals equally (guaranteed issue), to making the product available outside the Exchange and selling products at other levels of coverage. Requires the Department of Health Care Services (DHCS) to include provisions relating to bridge plan products in its contracts with Medi-Cal managed care plans (MCPs). Specifically, this bill:

1) Defines bridge plan product as an individual health benefit plan that meets the standards for licensure by the Department of Managed Health Care (DMHC) under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) or as a health insurer licensed under the Insurance Code that contracts with the Exchange.

2) Authorizes health care service plans and health insurers offering a bridge plan product to limit the product to a specified group of individuals and exempts the bridge plans from being subject to the requirement to sell products within each of the five levels of coverage available in the Exchange, and the requirement known as guaranteed issue, inside and outside the Exchange.

3) Requires, to the extent federal approval has been obtained and for the purpose of allowing, to the greatest extent possible, a person to remain with the same plan when a person must move from Medi-Cal to a QHP in the Exchange, the Exchange to make bridge plan products available using its selective contracting authority.

4) Provides that to be qualified as bridge plan product, the plan must:
   a) Be a health care service plan or health insurer that contracts with DHCS to provide MCP services;
   b) Meet the Exchange requirements to contract as a QHP;
   c) Meet a medical loss ratio (MLR) of 85%;
   d) Limit enrollment to specified eligible individuals; and,
   e) Demonstrate that the provider network is substantially similar to the Medi-Cal managed care plan offered by the health care service plan or health insurer.

5) Requires, until December 31, 2014, a health care service plan that contracts with the Exchange to offer a qualified bridge plan product to do all of the following:

   a) File a material modification with DMHC to expand its license if it has not been approved to offer individual coverage as of the effective date of this bill; or,

b) File an amendment to expand its license with DMHC if it has been approved to offer individual health benefit plans.

6) Specifies that the plan is deemed to be in compliance with licensure requirements during the pendency of the material modification or license amendment request.

7) Requires, if a health insurance policy has not been filed with the Insurance Commissioner (IC) on or after the effective date of this bill, a health insurer that contracts with the Exchange to offer a qualified bridge plan product to file the policy form with the IC.

8) Requires a health care service plan or a health insurer selling a bridge plan product to maintain a MLR of 85% for the bridge plan product and requires the methodology for calculating the MLR to be, to the extent possible, the same as is utilized by other health care service plans and insurers under applicable licensure and Exchange requirements and requires the plan to report its MLR to DMHC and the insurer to report to California Department of Insurance (CDI).

9) Provides that a health care service plan or a health insurer selling a bridge plan product is not required to offer, market, and sell the bridge plan product to any individual, except to individuals eligible pursuant to a contract entered into by DHCS and DMHC.

10) Requires a health care service plan or an insurer selling a bridge plan product to provide an initial open enrollment period of six months, an annual enrollment period, and a special enrollment period consistent with the annual enrollment and special enrollment periods of the Exchange.

11) Requires the Exchange to provide information on all available Exchange-qualified health plans in the area, including, but not limited to, bridge plan product options for selection by individuals eligible to enroll in a bridge plan product.

12) Adds to the annual report that the Exchange is currently required to produce, data relating to bridge plan products regarding the extent of overlap between MCP health care provider and facility networks and those contracting for services in the bridge plan.

13) Authorizes the Exchange to adopt regulations to implement the provisions of this bill after consultation with stakeholders, as specified in current law, and exempts the process for adoption from the requirements for the Administrative Procedures Act, until January 1, 2016.

14) Requires DHCS to ensure that contracts with health care service plans or insurers to provide Medi-Cal managed care coverage meet all of the following requirements:

a) Limits enrollment in the bridge plan product to the following individuals:
   i) An individual who is eligible for the Exchange and can demonstrate their Medi-Cal or Healthy Families program (HFP) coverage was terminated;
   ii) Other members of a household that are counted as part of the Modified Adjusted Gross Income (MAGI) unit; and,
   iii) An individual who is eligible for the Exchange and has a household of not more than 200% of the federal poverty limit (FPL), conditioned upon federal approval and if consistent with the Patient Protection and Affordable Care Act (ACA);

b) Further limits enrollment to a plan through which the individual or a member of the household was enrolled prior to eligibility for the bridge plan product either as a Medi-Cal enrollee or a HFP enrollee.

15) Requires the Exchange to seek federal approval to allow individuals described in 14) a) and b) above to enroll in a different bridge plan product if the individual's primary care provider is included in the contracted network of a different bridge plan and the bridge plan the individual would otherwise be eligible for is not offered in the individual's service area or the product is not selected as bridge plan product by the Exchange.

16) Provides that the MCP is to only offer a bridge plan product if the premium contribution amount in the silver category for the eligible individual is equal to or less than the premium contribution amount for the lowest cost plan in the silver category that would have been available to the individual without the bridge plan product.

17) Authorizes DHCS to enter into a contract with the Exchange to delegate the implementation of any part of these provisions to the Exchange.

18) States the intent of the Legislature that the Exchange provides a more affordable coverage option for low-income individuals, improves continuity of care for individuals moving from Medi-Cal to the Exchange, and reduces the need for individuals enrolled in a MCP to change plans due to changes in household income.

EXISTING LAW:

1) Requires, under the ACA, as amended by the Health Care Education and Reconciliation Act of 2010 each state, by January 1, 2014, to establish an Exchange that makes QHPs available to qualified individuals and qualified employers. If a state does not establish an Exchange, the federal government is required to administer the Exchange. The ACA establishes requirements for the Exchange and for QHPs participating in the Exchange, and defines who is eligible to purchase coverage in the Exchange.

2) Allows, under the ACA and effective January 1, 2014, eligible individual taxpayers, whose household income is between 100% and 400% of the FPL inclusive, an advance payment of premium tax credits based on the individual's income for coverage under a QHP offered in the Exchange. The ACA also requires a reduction in cost-sharing for individuals with incomes below 250% of the FPL, and a lower maximum limit on out-of-pocket expenses for individuals whose incomes are between 100% and 400% of the FPL.

3) Establishes the Exchange in state government (known as Covered California), and specifies the duties and authority of Covered California. Requires Covered California to be governed by a Board of Directors that includes the Secretary of the California Health and Human Services Agency (CHHSA) and four members with specified expertise who are appointed by the Governor and the Legislature.

4) Requires, under the ACA, health plans offering coverage in the individual or group market to accept every employer and individual that applies for coverage. Permits a health plan to restrict enrollment to open or special enrollment periods. Permits health plans to deny coverage to individuals if the health plan has demonstrated, if required, to the applicable state

authority that it will not have the capacity to deliver services adequately to any additional individuals because of its obligations to existing group contract holders and enrollees, and it is applying this provision to all individuals without regard to the claims experience of those individuals, employers, and their employees (and their dependents) or any health-status related factor.

5) Establishes DMHC to regulate health plans under Knox-Keene in the Health and Safety Code and CDI to regulate health insurers under the Insurance Code.

6) Establishes, under state and federal law, the Medicaid program (Medi-Cal in California) as a joint federal and state program offering a variety of health and long-term care services to low-income women and children, low-income residents of long-term care facilities, and seniors and people with disabilities. Authorizes DHCS to enter into contracts with MCPs to provide services to Medi-Cal enrollees.

FISCAL EFFECT: According to the Senate Appropriations Committee, based on a prior version:

1) Administrative costs to establish bridge plans. The costs to DHCS and Covered California to establish bridge plans are likely to be minor as they have already begun the process of developing this option.

2) Information Technology (IT) costs. Adding bridge plans to the existing IT system under development to support Covered California (California Healthcare Eligibility, Enrollment and Retention System (CalHEERS)) may increase project costs. At this time, Covered California is planning to incorporate bridge plans into CalHEERS. However, it is not clear yet whether adding bridge plan support functions can be accomplished within the project's current development budget of about $183 million (mostly federal funds). If there are additional IT costs, those costs may be covered within the project's five-year operations and maintenance cost of $176 million (mostly federal funds) or by fees charged by Covered California on participating health plans.

3) Ongoing administrative costs for Covered California. The administrative costs of operating Covered California will be paid by fees on participating QHPs based on the number of people enrolled through Covered California (generally 3% of the average premium per member per month). It is important to note that this bill does not expand eligibility for Covered California. However, it is likely that some Exchange-eligible consumers would not apply for coverage without a bridge plan option (for example, because switching health plans and/or having to find a new primary care doctor would discourage healthy consumers who have lost Medi-Cal coverage from applying for coverage).

   The marginal impact on Covered California enrollment due to the bridge plan option is not known at this time. However, projections made by the Urban Institute and the UC Labor Center for enrollment in a proposed Basic Health Plan (which would serve a similar population) indicate that potentially around 100,000 additional consumers would enroll in a Basic Health Plan, if available. Using these projections as a proxy for the marginal enrollment in Covered California due to the availability of a bridge plan option, administrative costs (and fee revenues) for Covered California are likely to be about $15 million per year.

4) Enrollment impacts on Medi-Cal. The availability of a bridge plan option will likely increase enrollment in Medi-Cal. There are two elements of the bridge plan option that are likely to increase overall Medi-Cal enrollment. First, a low-cost bridge plan option is likely to keep low-income consumers enrolled in Covered California and connected to the health care system. A bridge plan participant who experiences a reduction in income may be more likely to apply for Medi-Cal than a person who would have dropped coverage in the absence of a bridge plan option. Second, the fact that bridge plans will mirror MCPs means that a bridge plan participant would not experience disruptions of coverage or need to change primary care providers if he or she shifted from a bridge plan to Medi-Cal managed care. This is likely to encourage bridge plan participants who experience a reduction in income to apply for Medi-Cal. The magnitude of this impact, and its fiscal implications to Medi-Cal, is unknown at this time.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill would establish a bridge health insurance plan for low-income individuals, the parents of Medi-Cal and HFP-eligible individuals, and individuals moving from Medi-Cal coverage to subsidized coverage through Covered California. The author states that a bridge plan is a Covered California product that promotes continuity of care, provides an additional coverage choice to hard-working Californians, and reduces the negative effects of "churning" back and forth between systems of coverage where individuals are required to shift health plans and health coverage programs because of changes in their household income. By allowing individuals to remain within their current health plan when they shift health subsidy programs, this bill will prevent disruptions in individuals' provider networks and improve continuity of care. In addition, the author argues this bill would make it more likely that Covered California-eligible parents of Medi-Cal enrolled children would be covered by a single health plan with the same provider network. The author states there are a number of life experiences that affect an individual's income eligibility for health subsidy programs (through Medi-Cal and Covered California), such as the birth of a child, marriage or divorce, getting or losing a job or receiving a pay raise or pay reduction, and the aging out of a child from coverage.

   The author also states that in addition to promoting continuity of care, this bill is needed to potentially provide a more affordable health plan choice, which will increase the number of individuals signing up for coverage (particularly individuals moving from no-cost Medi-Cal to paying premiums in Covered California), and therefore expand enrollment within Covered California. Finally, the author also argues that this bill will provide protection for the safety net. Specifically, the author states that even after full implementation of health care reform, and under a best case scenario, an estimated three to four million individuals will remain uninsured in California. The Bridge plan can help core safety net providers like public hospital systems continue to serve the remaining uninsured, by contributing to a diverse payor mix with Covered California enrollees.

2) BACKGROUND. On March 23, 2010, President Obama signed the ACA into law. The ACA will greatly expand access to public and private health insurance coverage in California. Beginning in 2014, millions of low-income Californians will gain access to coverage under the expansion of Medicaid, and lower to middle income Californians will be eligible for premium and cost-sharing subsidies offered through the Exchange.

Beginning in 2014, individuals purchasing coverage through Covered California with incomes up to 400% of the FPL (approximately $45,690 for an individual in 2013) are eligible for premium tax credits. The value of the tax credit is based on the premium for the second lowest cost silver plan in Covered California in the area where the person is eligible to purchase coverage. The premium tax credit caps the amount a person is required to spend on premiums for the second lowest cost silver plan. For example, individuals with incomes between 150% and 200% of the FPL would pay no more than 4% to 6.3%, respectively, of their income on premiums (approximately $57 to $121 per month) for the second lowest cost silver plan. The ACA also provides cost-sharing subsidies for enrollees with incomes less than 250% of the FPL who are enrolled in silver plans. These subsidies reduce the out-of-pocket costs (co-payments and deductibles) an eligible Covered California enrollee pays when receiving health care services.

According to the author, despite the premium and cost-sharing subsidies available through Covered California, there is a concern that low-income individuals will have difficulty affording even subsidized premiums, which will adversely affect enrollment in Covered California. Additionally, significant churning between Medi-Cal and Covered California income eligibility and low Medi-Cal health plan participation in Covered California will require individuals experiencing a change in income to switch health plans and potentially health care provider networks. In a February 2011 *Health Affairs* article, researchers analyzed projected churning between Medicaid and Exchange coverage for the newly eligible. They estimated that more than 35% of adults with family incomes below 200% of the FPL will experience a change in eligibility within six months, and 50% will experience a change within one year. In addition, 24% will churn at least twice within a year, and 39% will experience churning within two years.

3) BRIDGE PLAN OPTION**.** On December 10, 2012, the Centers for Medicare and Medicaid Services (CMS) issued a letter, "Frequently Asked Questions (FAQ) on Exchanges, Market Reforms, and Medicaid" that outlined the bridge plan option. CMS indicated that a state could allow a Medicaid health plan to offer QHPs in the Exchange on a limited-enrollment basis to certain populations. The letter also stated that additional guidance will be issued soon, but has not as yet, been released. In the December FAQ, CMS stated this approach is intended to promote continuity of coverage between Medicaid or HFP and the Exchange, allowing individuals transitioning from Medicaid or HFP coverage to the Exchange to stay with the same issuer and provider network, and for family members to be covered by a single issuer with the same provider network. CMS stated an Exchange may allow an issuer with a state Medicaid managed care organization contract to offer a QHP as a Medicaid bridge plan under the following terms:

   a) The state must ensure that the health plan complies with applicable laws, and in particular with a provision of the ACA that requires health plans to provide guarantee issue coverage, but provides an exception to the guarantee issue requirement to a health plan whose provider network reaches capacity. CMS states such a health plan may deny new enrollment generally while continuing to permit limited enrollment of certain individuals in order to fulfill obligations to existing group contract holders and enrollees. If the health plan demonstrates that the provider network serving the Medicaid managed care organization and bridge plan has sufficient capacity only to provide adequate services to bridge plan-eligible individuals and existing Medicaid and/or HFP-eligible enrollees, the bridge plan could generally be closed to other new enrollment. However, in order to

permit additional enrollment to be limited to bridge plan eligible individuals, the state must ensure there is a legally binding contractual obligation in place requiring the Medicaid managed care plan to provide coverage to these individuals.

b) The Exchange must ensure that a bridge plan offered by a Medicaid managed care organization meets the QHP certification requirements, and that having the Medicaid managed care organization offer the bridge plan is in the interest of consumers.

c) The Exchange must ensure that bridge plan eligible individuals are not disadvantaged in terms of the buying power of their premium tax credits as part of considering whether to certify a bridge plan as a QHP.

d) The Exchange must accurately identify bridge plan-eligible consumers, and convey to the consumer his or her QHP coverage options.

e) The Exchange must provide information on bridge plan-eligible individuals to the federal government, as it will for any other individuals who are eligible for QHP in the Exchange, to support the administration of advance payments of premium tax credits.

4) FEDERAL EXCHANGE PREMIUM SUBSIDIES. Federal premium subsidies in Covered California are based on the individual's income, and cap the amount an individual has to spend on the second lowest cost silver plan. The difference between what the individual pays for the second lowest cost silver plan and the actual cost of the premium is paid by the federal premium subsidy. Individuals can use the dollar amount of the federal premium subsidy to buy another plan (in the platinum, gold, silver, or bronze tiers) but must pay the difference between the federal premium subsidy amount and the actual premium. In addition to the federal premium subsidies, individuals with incomes at or below 250% of the FPL receive cost-sharing subsidies (that lower the average amount an individual would pay out-of-pocket for co-payments, co-insurance and deductibles). However, individuals only receive cost-sharing subsidies in the silver benefit tier, so individuals are likely to buy coverage in this benefit tier. In response to questions to the Center for Consumer Information & Insurance Oversight (CCIIO) at CMS, CCIIO staff stated that as part of considering when to certify a bridge plan as a QHP, the Exchange must ensure that bridge plan eligible individuals are not disadvantaged in terms of the buying power of their advance payments of premium tax credits.

5) BRIDGE PLAN'S EFFECT ON AFFORDABILITY. On May 23, 2013, Covered California released a booklet outlining health plans and rates for 2014. Contrary to predictions of high premiums in the Exchange (the Congressional Budget Office predicted monthly rates of $433, and a report by Milliman predicted monthly rates of $450), the rates released by Covered California included a statewide average for the second-cheapest silver plan of $325 per month, or $3,900 per year (average across all rating regions and age groups).

Introducing a bridge plan will reduce the federal subsidy for bridge-eligible individuals. This is because the bridge plan is required to be the least expensive silver plan on the market, which makes the plan that was previously the cheapest the benchmark plan for calculation of the premium subsidy (see 4) above). Assuming an even distribution of bridge-eligible individuals across rating regions, the federal subsidy for bridge-eligible individuals would be reduced by an average of $21, the difference between the averages for the two lowest-priced

silver plans. (Because the introduction of a bridge plan is optional under this bill, this average will depend on how many bridge plans are actually offered and where they are offered.)

In order to satisfy this bill's requirement that an individual's premium contribution amount for the bridge plan be equal to or less than the premium contribution for the cheapest silver plan that would otherwise be available, the average bridge plan premium would be capped at $293 (again, depending on how many bridge plans are offered). This bill requires the Exchange to use its selective contracting authority when certifying bridge plans, with the intent that negotiated premium rates would result in a patient premium contribution that is lower than this cap. This could result in the availability of a bridge plan that is more affordable than the lowest-cost silver plan would have otherwise been.

At the same time, the reduction in the federal subsidy translates into an increase in the patient share of premiums for commercial products offered to bridge-eligible individuals through the Exchange. In Figure 1 below, the patient share of premiums for the lowest-priced silver plan in the absence of a bridge option is compared to the patient share of premiums for the same plan if a bridge plan is available. For example, for individuals at 150% of FPL, the average patient share increases from $36 to $57.

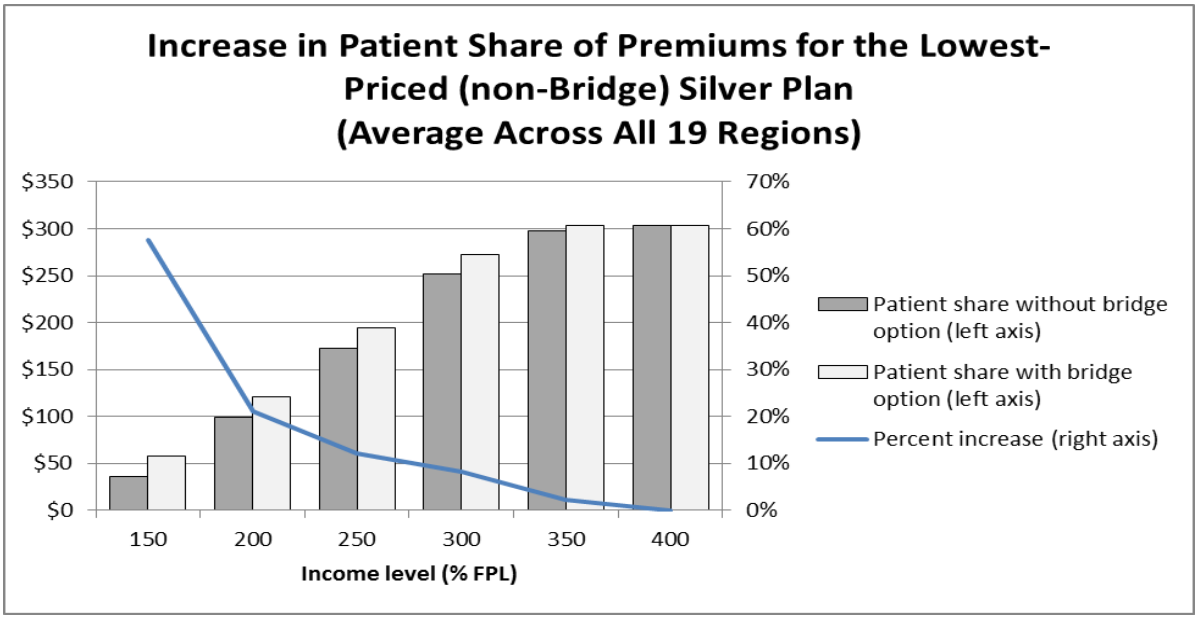


**Figure 1**

For a more detailed example, consider the rates published in the Covered California booklet for Rating Region 15 (north Los Angeles). The lowest-priced silver plan for a 40-year-old single individual is the Health Net HMO Plan, with a premium of $222, and the second lowest-priced silver plan is the Blue Shield PPO, with a premium of $252. The federal subsidy caps the individual's share of the premium for the second lowest-cost plan (in this case, the Blue Shield plan) at a certain percent of the individual's income. For an individual at 150% of the FPL, this cap is about $57, leading to a subsidy of $195. If that individual applies that subsidy to the Health Net plan, their share of the premium for that plan would be just $27.

However, if a bridge plan option is offered to that individual, this bill would require that plan's premium contribution amount to be less than or equal to the lowest cost silver plan that would have been otherwise available to that individual—in this case, the Health Net HMO plan at $27. Because the bridge plan is required to be the lowest-cost silver plan offered, the Health Net plan would now become the second lowest-cost plan, and federal subsidies would be calculated based on the Health Net plan rather than the Blue Shield plan, reducing the federal subsidy by $30. This, in turn, would increase the patient's share of premiums for each of these two plans by $30. Finally, the total premium amount of the bridge plan would have to be at least $30 less than the Health Net plan's premium (i.e., at most $192) to keep the patient's share under $27. See Figure 2 below for patient premiums and federal subsidies compared side-by-side.

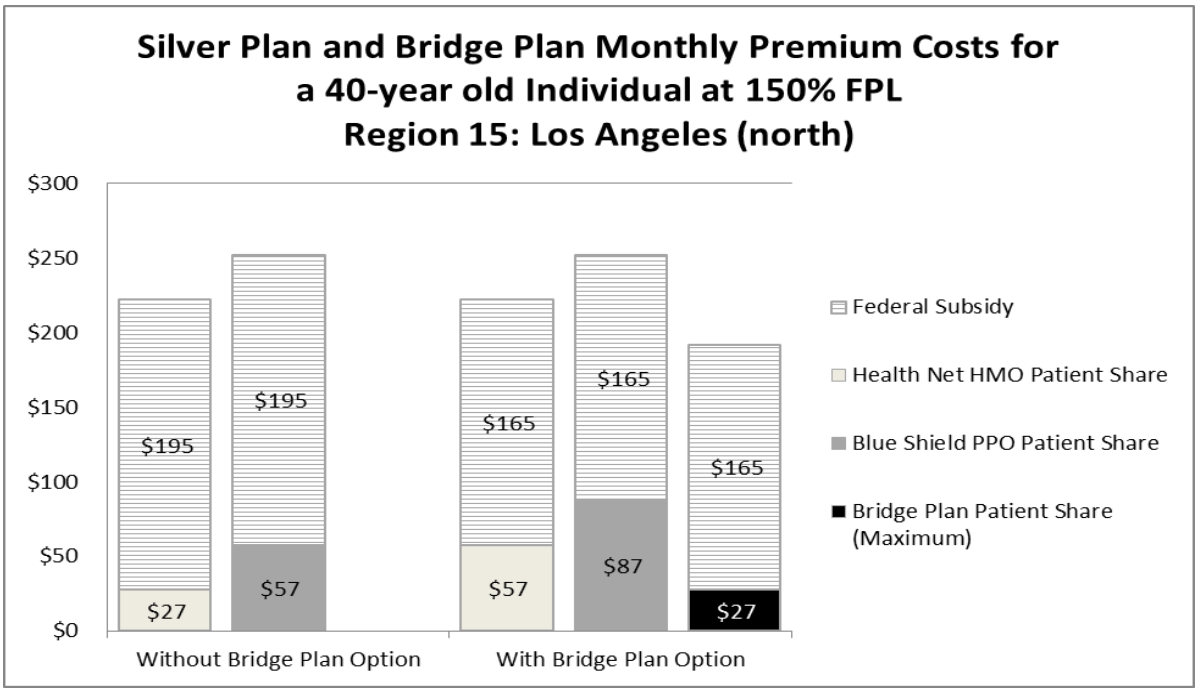


**Figure 2**

Depending on how many individuals are eligible for a bridge plan, the amount of federal premium support subsidies that are received in the state could be significantly reduced. The Covered California booklet estimates that 2.6 million individuals will be eligible for federal subsidies. Data from the UC Berkeley Labor Center indicate that the number of potential bridge plan-eligible individuals in 2014 would be between 670,000 and 840,000, assuming an April 2014 effective date. If the federal subsidy for each of these individuals is decreased by $21, based on the average premiums listed in the Covered California booklet, this would translate to a total reduction in federal subsidies received of $14 million to $17.6 million. This reduction would be less to the extent that some individuals receive a federal subsidy of less than $21 and to the extent that not all bridge-eligible individuals are offered a bridge plan.

6) SUPPORT WITH AMENDMENTS. The Western Center on Law and Poverty (Western Center) supports this bill's limitation on the premiums charged for bridge plans to ensure that consumers' premium contribution is the same or less than what they would pay in the lowest cost silver plan without the bridge. The Western Center argues that this ensures that

beneficiaries eligible for the bridge will not have the purchasing power of their tax credits undermined. However, Western Center argues that this provision does nothing to ensure greater affordability for the bridge plan than the lowest cost silver plan. Western Center urges that this bill be amended to set a specific threshold of premium differential to achieve the stated goal of better premium affordability and that Covered California use its selective contracting authority to only approve bridge plans that have at least a 15% price differential with the second lowest cost silver plan. Even with a 14% price differential, Western Center writes, consumers at 200% FPL would pay a premium of $44 to $58 per month, still a cost-prohibitive amount for some consumers at this income level. Western Center also requests an amendment to allow consumers to seamlessly transition from Medi-Cal to a bridge plan through CalHEERS, without requiring the consumer to demonstrate a loss of Medi-Cal coverage, as that information is already in the CalHEERS system. Anthem Blue Cross believes the 85% MLR requirement should be eliminated, given that plans will already need to comply with eh 80% federal MLR requirement and further states that the proposed 85% standard does not account for the additional requirements affecting plans offered on the Exchange.

7) SUPPORT. The American Cancer Society Cancer Action Network writes that continuity of coverage is essential in order to achieve positive health outcomes for all individuals, but even more so for individuals with a history of complex health issues, including cancer, and that this bill will keep low-income consumers enrolled in Covered California and connected to the health care system. Also in support, the California Association of Public Hospitals and Health Systems (CAPH) writes that the bridge plan will help ensure that many low-income individuals and families will be able to afford plans offered through Covered California. CAPH argues that the bridge-eligible population has minimal room in their monthly budget for health care premiums, and that developing a more affordable option for these low-income families will make a big difference in whether or not they enroll. In addition, CAPH writes that the bridge plan will help core safety net providers like public hospital systems continue to serve the state's remaining uninsured (estimated at three to four million individuals) by contributing to a diverse payor mix with Covered California enrollees.

8) OPPOSE UNLESS AMENDED. The Bay Area Council states that in the current form, this bill goes beyond the stated goals of affordability and continuity of care, tilts the state towards substantially more public rather than private coverage, contrary to the goals of the ACA, and would prefer a more narrowly tailored bridge plan with reasonable duration and income limitations. The Bay Area Council further states that as we work to provide affordable options for working and middle class consumers that allow them to preserve continuity of coverage, we must be mindful of not creating barriers for people to move up into higher-quality commercial coverage that pays providers adequate rates. The Medicaid Bridge Plan – in either its "broad" or "narrow" forms – provides a substantial disincentive for Californians to move up into private coverage. This is the case because access to a lower-cost Bridge Plan lowers consumers' subsidies and hence their purchasing power relative to the other products in the Exchange.

9) RELATED LEGISLATION.

   a) AB 2 X1 (Pan), Chapter 1, Statutes of 2013-14 First Extraordinary Session and SB 2 X1 (Ed Hernandez), Chapter 2, Statutes of 2013-14 First Extraordinary Session enact substantially similar provisions in each bill to implement the ACA insurance provisions

related to health insurance regulated under the Insurance Code and the Health and Safety Code, respectively.

b) AB 1 X1 (John A. Pérez) and SB 1 X1 (Ed Hernandez) implement various provisions of the ACA regarding Medi-Cal eligibility and program simplification including the use of MAGI and expansion of eligibility in the Medi-Cal program.

c) SB 18 (Ed Hernandez) requests the California Health Benefits Review Program (CHBRP) assess, in addition to the health, medical, and financial impacts, the impact that health coverage mandates will have on essential health benefits (EHB), as specified, and the Covered California.

d) SB 28 (Ed Hernandez and Steinberg) implements various provisions of the ACA regarding Medi-Cal eligibility and program simplification including the use of the MAGI and expansion of eligibility in the Medi-Cal program.

10) PREVIOUS LEGISLATION.

a) SB 900 (Alquist), Chapter 659, Statutes of 2010, establishes Covered California as an independent public entity within state government, and requires Covered California to be governed by a board composed of the CHHSA Secretary, or his or her designee, and four other members appointed by the Governor and the Legislature who meet specified criteria.

b) AB 1602 (John A. Pérez), Chapter 655, Statutes of 2010, specifies the powers and duties of Covered California relative to determining eligibility for enrollment in the Covered California and arranging for coverage under QHPs, requires Covered California to provide health plan products in all five of the federal benefit levels (platinum, gold, silver, bronze, and catastrophic), requires health plans participating in Covered California to sell at least one product in all five benefit levels in Covered California, requires health plans participating in Covered California to sell their Covered California products outside of Covered California, and requires health plans that do not participate in Covered California to sell at least one standardized product designated by Covered California in each of the five levels of coverage, if Covered California elects to standardize products.

c) SB 703 (Ed Hernandez) of 2011 would have implemented the Basic Health Program state option contained in the ACA to provide health care coverage to individuals under 200% of FPL who do not qualify for Medi-Cal in lieu of these individuals receiving coverage in Covered California. SB 703 was held on the Assembly Appropriations suspense file.

11) POLICY COMMENTS.

a) Benefit of a Bridge Plan Product. Establishing a bridge plan product lowers the benchmark for establishing a person's subsidy. For example, if the second lowest silver is priced at $252 for a 40 year old with income at 150% of FPL, the subsidy is set at $195 and the person can purchase the product for a premium of $57. If there is a bridge plan, the subsidy would be decreased to be equal to the subsidy for the lowest silver and the individual would have to pay more for the second lowest cost silver. The policy question that the Legislature must decide is whether this lowered subsidy (in effect, possibly

making the second lowest cost silver plan unaffordable for this person) is a worthwhile trade-off for providing continuity of care by being able to stay with one's Medi-Cal plan. At this point, the final provider networks are not public. Is there enough information to make an informed decision? A judgment will have to be made on behalf of those affected.

b) Affordability. Supporters argue that the fact that the cost of the second lowest cost silver plan would be increased is irrelevant to those with the lowest income (150% of FPL). They argue that in this income range, these individuals will choose to remain uninsured or purchase the lowest cost silver. These supporters argue that granting the Exchange the power to do selective contracting will result in low enough priced bridge products to make the bridge plan product more affordable. If this is the case, a ceiling could be required to ensure the trade-off of a reduced subsidy is worthwhile.

c) Income Limits. The presence of a bridge plan product lowers the subsidy for those eligible and the amount of federal dollars available to pay providers. This may be a reasonable trade-off if the person is still very low-income, for instance 150% or 200% of FPL, and would otherwise not be able to purchase any QHP. However, as this freezes the person in at a lower subsidy, it could disadvantage someone with income above 200% of FPL. To remedy this there could be an upper income limit for eligibility. According to CCIIO, this is an open question. Does the committee wish to amend this bill to provide an upper income limit subject to federal approval?

d) Continuity of Care as Rationale. The author's stated purpose is to promote continuity of care which usually means allowing a person to continue to receive services from an existing provider. However, a parent of a child who is in HFP or Medi-Cal has no relationship as an enrollee of the plan or a patient of the provider. Further attenuated is the situation if a person has not been on Medi-Cal in the recent past. Does the committee wish to amend this bill to limit eligibility to a person who lost Medi-Cal in the prior six months?

e) Broad Bridge. The so-called "broad bridge" opens up the bridge plan product to anyone under 200% of FPL. It is just as likely that this person will have no relationship with a provider in the plan and therefore it would actually be counter-productive. In fact the CCIIO staff that has provided guidance on this issue has stated that it is very unlikely that this category will be approved. The author may wish to explain why a provision that is unlikely to be approved would be included at this stage? Does the committee wish to delete the broad bridge and reconsider in future legislation when/if federal rules allow?

f) Sunset and Evaluation. The Legislature may want to be able to re-consider the bridge plan concept after some of these questions are answered. Adding a sunset and some additional reporting requirements would allow this. These could include:

   i) A comparison of premium, subsidy, and cost to consumers of bridge plans to see if it is actually more affordable;
   ii) Whether there are identifiable changes in provider behavior to detect if providers are willing to participate;
   iii) Whether the impact is eroding the Exchange pool to the detriment of other QHPs; and,

iv) Whether continuity of care is actually achieved.
v) Consumer surveys of whether individuals want to retain their Medi-Cal plan or would purchase a second level silver if there was no bridge plan product.

g) MLR. Under the ACA, consumers will receive more value for their premium dollar because insurance companies are required to spend 80% in the individual and small group markets or 85% in the large group market of premium dollars on medical care and health care quality improvement, rather than on administrative costs, starting in 2011. If they don't, the insurance companies must provide a rebate to their customers starting in 2012. The author may want to explain the rationale for choosing the 85% for the Bridge plan product, whereas the competing QHP plans are only required to meet 80%.

h) Technical Drafting.
i) On page 15, line 8, Section 1399.864 (b)(3) should be subdivision (c); on line 12, Section 1399.864 (b)(4) should be subdivision (d); on line 25, subdivision (5) should be subdivision (e); on line 33, Subdivision (6) should be subdivision (f).

ii) Section 14005.70 (a)(1) and (a)(2) of the Welfare and Institutions Code seem to be redundant.

REGISTERED SUPPORT / OPPOSITION:

Support
California Health and Human Services Agency, sponsor
American Cancer Society, Cancer Action Network
California Association of Public Hospitals & Health Systems
California Hospital Association
California Mental Health Directors Association
California Primary Care Association
California State Association of Counties
County Health Executives Association of California
Health Access California
L.A. Care Health Plan
Local Health Plans of California
Los Angeles Board of Supervisors
March of Dimes, CA Chapter
Organization of SMUD Employees (prior version)
Planned Parenthood Affiliates of California
Private Essential Access Community Hospitals
San Bernardino Public Employees Association (prior version)
San Luis Obispo County Employees Association (prior version)
Santa Clara County Board of Supervisors (prior version)
Santa Rosa City Employees Association (prior version)
SEIU California
The Glendale City Employees Association (prior version)

Oppose Unless Amended
Bay Area Council
Analysis Prepared by: Marjorie Swartz / Benjamin Russell HEALTH / (916) 319-2097