



October 6, 2016

Secretary Burwell
Attention: CMS-9934-P
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Covered California comments on Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters (NBPP) for 2018; CMS-9934-P (RIN 0938-AS95) – **Standardized Options Approach for 2018 (Section 156.20) and Differential Display of Standardized Options (Section 156.265)**

Dear Secretary Burwell,

Covered California is submitting comments in response to the proposed regulations CMS-9934. The comments in this letter refer to the proposal to standardize health plan options (Section 156.20) and require differential display of standardized options (Section 156.265). Covered California has also submitted comments on the following additional areas: [FFE user fee](#), [innovation in Qualified Health Plans](#), [direct enrollment and web-based entities](#), and [proposals affecting the Small Business Health Options Program](#).

Regarding proposals for standardization of health benefits, Covered California echoes many of the comments it submitted for the 2017 NBPP. Covered California currently offers “patient-centered” benefit designs that are standardized across health plans and only allows alternate, non-standard plans in the individual marketplace upon specific request to Covered California – which has not been sought by the eleven health plans serving California. With input from consumer and health condition advocates, health plans and policy experts, Covered California’s patient-centered plan designs mean insurers compete with one another based on premium, network, quality, consumer tools, and service. Covered California’s standard plan designs for 2017 are available [here](#) for reference. The benefits of the common patient-centered benefit designs are significant, including:

- Californians seeking coverage through the marketplace can easily compare health plans knowing that every health plan has the same cost-sharing levels and benefits – this means that more important factors for differentiation are clearly used by consumers in making plan selection which is first and foremost price, that should include total price of both premium and likely out-of-pocket exposure and other factors (e.g., provider networks, plan quality);

- The patient-centered plan designs are constructed to minimize financial barriers to access for consumers, reduce confusion and to have designs that actively reinforce efforts to promote higher value care delivery, such as better use of primary care. Elements that reflect these goals include not applying the deductible to most out-patient care; designs limiting the out-of-pocket costs for high cost prescription drugs; minimizing coinsurance; and having copayments for higher value care and services as low as possible given the actuarial value constraints (e.g., for primary care visits and generic medications);
- Standardization simplifies both the “sales” and the enrollment process to boost enrollment and the delivery of services in clinician offices. The simplification is especially important to previously uninsured individuals or those who are otherwise new to the purchase of individual coverage. In addition, we believe simplified and standard designs means that consumers are more likely to select “higher value” products, in particular lower income consumers who are eligible for the cost-sharing subsidy are more apt to understand the relative value of their Silver Cost-Share Reduction plan in contrast to the Bronze alternative; and
- Promoting better value at the point consumers select a health plan should promote retention and have positive effects on the risk pool.

With regard to the HHS proposal, Covered California has comments in four areas: (1) the structure of the Proposed 2018 Standardized Options; (2) how the standardized cost-sharing plans are differentially displayed to consumers compared to non-standardized plans; (3) future standardization; and (4) the need for ongoing analysis of the implications of plan design for consumer access to care.

1. Proposed Standard Benefits Structure

Covered California believes that HHS has done a good job presenting a structure for the elements of the Proposed 2018 Standardized Options and providing alternatives for states with cost-sharing laws. The exemption of routine services, including primary, specialty, and generic drugs, from the deductible for standardized plans reduces barriers to needed care and aligns with efforts to encourage effective coordination and integration of care building on the foundation of effective primary care. Building on this good work, Covered California offers the following technical assistance:

- Consider how to further minimize the application of co-insurance due to consumer confusion that often arises from cost-sharing that is based on a percentage of a cost that is generally unknown to the consumer. We recognize that the wide variation in costs nationally and the need to apply the national actuarial value standards makes eliminating co-insurance very difficult, but we would encourage HHS to review the elements where Covered California has moved from co-insurance to copayment designs. Because California is a large state that also has wide variation of costs across that state, our experience should be instructive as to what is possible nationally.
- Consider making Emergency Room Services not subject to the Deductible. While we support a member cost share for emergency room visits that is substantially higher than

that applied to either out-patient physician visits or urgent care – to discourage inappropriate use of the emergency room – not exempting Emergency Room Services from the deductible makes a copayment meaningless, since the consumer will almost invariably need to meet the full deductible. Note that Covered California made this change for its 2017 platinum, gold and silver benefit designs.

2. Differential Display of Standardized plans and Non-Standardized plans

Covered California strongly supports the differential display of standardized patient-centered plan options on the FFM enrollment website so that consumers can make better informed choices. Covered California also acknowledges the technical limitations that prevent the FFM from differential display of State-designed standardized plan options.

Covered California reiterates its concerns communicated in the comments submitted for the 2017 NBPP regarding the FFM's use of bold text or some other easy to recognize feature for standard plans. While these labels are necessary and important, Covered California believes they do not go far enough to prevent confusion and allow consumers to make an informed plan selection.

We recommend that standardized patient-centered plans be displayed *preferentially* to the non-standardized plans. Placing all standardized plans at the top of the list on the website, as a primary “sorting criteria” to be applied in conjunction with others, would allow consumers to easily identify standardized options. For instance, if the standard display criteria is to “rank” plans by the premium – all standardized plans would be displayed first and then non-standardized plans would be displayed, with premium used as the “secondary” method to sort plans for display. In the absence of such a display policy, non-standardized products – that may, for example, have deductibles applied to all services – may come up before standardized products and superficially look like a “better deal.” Preferential display of standardized plan options must be accompanied with adequate explanation of the benefits of standardized plans for consumers—and a description of the major factors that differ between products—network, quality and premium price.

Mere labeling of products as “standard” is not sufficient and runs the risk of consumers making uninformed and less than optimal decisions. Similarly, by publicly noting a policy of displaying standardized plans first, Qualified Health Plan issuers would have a strong incentive to offer standardized plans.

HHS should also limit the number of Qualified Health Plans a carrier may offer and should apply a screen as to what benefit designs it allows based on promoting consumer understanding and access to needed care. Implementing this for 2018 will result in consumers choosing health plans that have the best value for the enrollees.

3. Promoting Innovation and Meaningful Competition

In California, we believe our efforts to promote true consumer competition, in which shelf-space is devoted to a limited number of products in each tier, is a substantial benefit to consumers. At the same time, we recognize the need for innovation and evolution of product design over time. We believe that the proposed HHS model of some standardized options in each tier with clear designation and preferential display is a good first step. We encourage HHS to continue to

consider additional methods in the future to ensure consumers make fully informed decisions about their health plans.

4. Need for Ongoing Analysis

The continuing improvement of benefit designs should be based on evidence of the implications of respective designs with regard to consumer understanding, access to services, cost and other factors. HHS should describe its plans to evaluate the impact of different benefit designs and design features and how those impacts may differ by the characteristics of the consumers using them (e.g., income level, subsidy level, education, language, and race/ethnicity).

Thank you and please contact me if you have any questions.

Sincerely,



Peter V. Lee
Executive Director

cc: Covered California Board of Directors