November 10, 2015

To: Anne Price, Director, Plan Management, Covered California
James DeBendetti, Plan Management, Covered California

From: Beth Capell, on behalf of Health Access
Betsy Imholz, Special Projects Director, Consumers Union
Cary Sanders, Director of Policy Analysis, California Pan-Ethnic Health Network

Re: 2017 Benefits and Networks Subcommittee: Staff recommendations

Our organizations write to offer comment on the November 4, 2015 meeting of the 2017 Benefits and Networks Subcommittee

1. Value-Based Insurance Design

We come to the Value-Based Insurance Design (VBID) discussion of two minds. We are supportive of innovative efforts to guide consumers to better health outcomes and its potential to contain overall system costs. We also are mindful of the challenges consumers (and providers) face in understanding complex benefit designs. We also recognize that lowering copays or coinsurance for higher prevalence conditions may have an impact on actuarial value if projected cost savings in other benefits (hospitalizations, ER visits, complications) are not realized, recognized by carriers in their rate projections, or cannot be scored in the AV calculator.

As the staff noted, the standard benefit designs developed by Covered California already incorporate many elements of VBID such as lower cost sharing for primary care compared to specialty care and lower cost sharing for generic drugs. We strongly supported these carefully calibrated designs, and also appreciate the detailed discussion and analysis you have begun on additional potential VBID designs that put consumers first.

- *Hips/knees:* While CalPERS has had success with this, CalPERS has both an older population (early retirees and over-age 65 retirees, greater stability in its enrollees and greater geographic concentration than the Covered California enrollment. It is

also worth noting that CalPERS had difficulty replicating its success with other procedures.

- *Ambulatory Surgery Centers:* sadly in California, ambulatory surgery centers are not regulated in the same manner and to the same degree as hospitals. Ambulatory surgery centers are not subject to the nurse ratios, are not required to report health-acquired infections or other preventable conditions that cause consumer harm, are not subject to fines for unsafe care, and are regulated primarily through industry self-accreditation. This lack of oversight has resulted in scandals such as the Lap-Band scandal in Southern California. For these reasons, we do not support steering consumers to ambulatory surgery centers without very considerable consumer protections that are beyond the scope of Covered California as a purchaser rather than a regulator.
- *Diabetes:* Based on survey data and various studies, we would anticipate a diabetes prevalence of 8%, plus or minus 2%. This is much higher than the plans report—which makes us question whether the plans have sufficient information on their enrollees. We are supportive of lowering copays for diabetes medicines and equipment (test strips, glucose meters) as well as diabetes education (if this is not already covered as a preventive benefit). We understand that such care should be stratified based on risk. We look forward to hearing from the plans what each of them does with respect to diabetes care under the current benefit designs and to your analysis of the actuarial and cost-sharing impacts. We also emphasize that intensified disease management programs and focused education on the new benefit design for all plan staff, consumers, and providers should be complements to any such strategy

2. Potential Benefit Design Changes

We recognize that trending forward of the AV calculator may require increased cost sharing, particularly for the bronze plan. We remind ourselves that the State of California has the statutory authority to operate its own AV calculator: this statutory authority was granted because the Legislature (and Governor) recognized the dominance of managed care in California and the likelihood that California would make different policy choices in implementing the Affordable Care Act than other states. If more comprehensive data becomes available in the future—through Covered California's efforts with Truven or a potential All-Payer Database the State may undertake in the future—we urge reconsideration of developing our own AV calculator (and risk-adjustment system) that recognizes California's unique characteristics.

Below we outline comments on specific adjustments proposed and also look forward to Covered California's analysis of the financial trade-offs from the various combinations of adjustments under consideration.

- *Change to Drug Tier 1 Copay for All Plans:* We support replacing co-insurance for generic drugs for the bronze plan with a copay. We also recognize that most generic

drugs cost less than $20 and that the 50% rule on drug cost sharing as well as the impact on actuarial value must be taken into account.

- *Urgent Care Cost Sharing:* We support elimination of a differential copay for urgent care both because of the inability of plans to administer the differential copay from primary care and because doing so will keep urgent care services affordable and while still incentivizing consumers to avoid unnecessary emergency room services.

- *Remove physician/surgeon fees:* We support removing the separate physician/surgeon fees from facility care. We would also support converting this to a copay at appropriate levels for each metal tier.

- *Remove emergency room deductible:* The application of the deductible to emergency room care for the silver tier has created a "gotcha" situation for consumers: consumers think the copay for the ER is $250 and then a few weeks later get a bill for the deductible of as much as $2250. Consumers who make less than 400%FPL literally do not have $2,500 in liquid assets to use to pay for an ER visit, yet that is what the current silver benefit design imposes on them.

  The ER copay is already much higher than the copay for primary care or specialist care, so consumers are steered toward the doctor's office. Consumers are not clinicians: California law does not expect consumers to be able to diagnose themselves. ER visits must be covered, even if out-of-network, unless the plan can demonstrate that the care was not provided or that the consumer did not reasonably believe they needed emergency care.

- *Lower copays for Silver plan:* We support lower copays! We also recognize that there are constraints in terms of actuarial value.

- *Lower copays for primary care and specialist:* Again, we support lower copays. We also recognize that there are constraints in terms of actuarial value.

Increase Consumer Cost Share

- *MOOP:* Very few consumers, thank goodness, hit the annual maximum out of pocket limit or MOOP. But for those who do, this protects them from bankruptcy. On a list of bad choices, we accept that a potential increase in maximum out of pocket limit is one of the most impactful in terms of AV.
- *Deductible:* Rising deductibles in the health insurance marketplace are one of the biggest hindrances to consumers seeking and receiving necessary care. While increasing the deductible for the bronze plan may make sense, increasing the silver deductible by $500 seems too big a jump. If the deductible needs to be increased to meet AV, then we would ask that the Covered California staff look at increasing the medical deductible for the silver product to $2,500 rather than $2,750.
- *Inpatient Fee:* The proposed increase in co-insurance from 20% to 25% is a big jump: how many more consumers will hit the MOOP because of this?

- *Specialist Visit for bronze:* We are reluctant to increase the copay from $90 to $110, but understand the constraints of the AV calculation. We note that including specialists within the 3 pre-deductible visits helps mitigate the cost sharing burden for consumers with Bronze plans.

3. Consistent Cost Sharing for Less Utilized Benefits

We support consistent cost sharing for less utilized benefits while recognizing the constraints of the mental health parity law. We look forward to reviewing specifics as the plans provide greater detail.

We also support moving to a standardized evidence of coverage for the standard benefit designs, but recognize that this is a longer term project.

4. Staff Recommendations to Date

- *Non-standard benefits/non-EHBs:* We support the staff recommendation to NOT adopt non-standard benefits/non-EHBs. We support more comprehensive benefits but we recognize that in many instances, non-standard benefits may lead to adverse selection.

- *ER Services*: We strongly support removing the deductible for ER services and would accept a slightly higher copay to minimize impact on AV calculation.

- *Mental health parity:* We recognize that the federal mental health parity law is not easy to reconcile with standard benefit designs.

- *Alternative Benefit Designs:* We have not yet heard a compelling reason to allow alternative benefit designs. We strongly support standard benefit designs which are designed collaboratively among the Covered California staff, the plans and consumer advocates, within the constraints of state and federal law.

- *Tiered networks:* We remain unpersuaded of the virtues of tiered networks. We continue to have concerns about consumer confusion. We are worried that there is a lack of alignment between admitting privileges and hospitals in the lowest cost sharing tier. Notice is helpful but not sufficient to address these concerns.

- Diabetes education: We appreciate further consideration of diabetes education as a preventive service as we would guess that different plans are handling and defining this important service differently. Since Covered California is considering VBID models focused on diabetes health improvement, it makes sense to ensure this service is treated uniformly and encourages participation. Given the prevalence of diabetes among communities of color, it is particularly important that diabetes education be both culturally competent and in the language spoken by the enrollee.