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HEALTH ACCESS

WCLP WESTERN CENTER ON LAW & POVERTY

November 9, 2012

Peter Lee, Executive Director
Andrea Rosen, Acting QHP director
California Health Benefits Exchange
560 J Street, Suite 290
Sacramento, CA 95814

Re: Benefit Designs released October 30, 2012

Dear Mr. Lee and Ms. Rosen,

Consumers Union and Health Access California offer comments on the benefit designs released October 30, 2012:

http://www.healthexchange.ca.gov/BoardMeetings/Documents/October30_2012/VII-D_HBEX_StandardBenefitDesignSpreadsheet_103012.pdf

We appreciate that staff is attempting to reconcile many conflicting imperatives. However, we remain deeply troubled that the Exchange will fail to achieve its goal of being a trusted source of information if it adopts the proposed benefit designs. In our view and based on our research as well as our experience working with consumers, the proposed benefit designs will be experienced by consumers as full of fine print "gotchas", incomprehensible terminology that leads to high costs when consumers actually need to use their coverage.

We also note that what currently exists in the individual and small group market in terms of cost-sharing should not guide the Exchange any more than the existing inadequate benefits guided the development of the essential health benefit standard.

1. ***Standardize Application of Deductible Between Co-insurance And Co-pay Products In the Same Metal Tier***

As we noted in our prior letter, consumers are often confused by deductibles and whether other cost-sharing counts toward the deductible.

To use the Bronze tier as an example, having the same dollar deductible in-network ($2,000) in both the co-insurance and co-pay products, but having it apply to different services is needlessly confusing. Deductibles should be treated consistently across all products in a tier. We understand that the delegated model PPOs have difficulty in

applying a deductible to services provided in a medical office (including not only office visits, but some diagnostic tests). We suggest that the appropriate solution to this problem from a consumer perspective is to apply the deductible to facility-related charges for both the co-pay and the co-insurance products. This has other implications for the reduced cost-sharing, particularly at the lowest income as noted below. Other cost-sharing may be adjusted as needed to achieve the indicated actuarial value.

2. Reduce or Eliminate Use of Co-insurance for In-Network Providers

Co-insurance is not needed to achieve a designated actuarial value threshold. Any form of patient cost-sharing (for example, co-pays and deductibles) can be used to ensure that the correct portion of overall medical spending by a standard population falls on the enrollees (10%, 20% etc).

The "co-insurance" designs make heavy use of the co-insurance cost-sharing approach. This is the most difficult cost-sharing approach for consumers to understand and to estimate their out-of-pocket risk.[1] There are myriad reasons. Many consumers have poor numeracy skills and struggle to manipulate percentages.[2] In the health insurance context specifically, many are uncertain whom the percentage applies to (the patient or the plan), particularly if the percentage is 0% or 100%.[3] And no consumer can understand what co-insurance means for their final out-of-pocket expense, because the "allowed amount" --what the co-insurance percentage is applied to-- is almost always unknowable to the consumer. Bottom line: co-insurance leaves consumers unarmed to function as an informed, health services consumer.

Actuarial Value models vary in their approach to estimation.[4] Some models may be limited in terms of the inputs that the model can accept, thus making it appear that co-insurance is needed. But this is not a real world limitation. If the current model suffers from this limitation, we urge a second opinion using a robust model that accepts a wide variety of cost-sharing specificity and is built on a very large claims dataset.[5]

Co-insurance is not an appropriate tool for encouraging more price conscious shopping by consumers. As previously noted, consumers cannot know their bottom line cost when co-insurance is used. The "allowed" amount is the negotiated payment level

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[1] Early Consumer Testing of New Health Insurance Disclosure Forms (December 2010). http://yourhealthsecurity.org/wordpress/wp-content/uploads/2011/09/CU_Consumer_Testing_Report_Dec_20101.pdf

[2] Based on the National Adult Literacy Survey, almost half of the general population has difficulty with relatively simple numeric tasks such as calculating (using a calculator) the difference between a regular price and a sales price or estimating the cost per ounce of a grocery item. For more on numeracy in the health care context, see: http://content.healthaffairs.org/content/26/3/741.full

[3] A finding from three consumer testing studies, summarized in L. Quincy. *What's Behind the Door: Consumers' Difficulties Selecting Health Plans*, Consumers Union, January 2012.

[4] This analysis shows how differences in the underlying model can produce vast differences in estimates, despite calibrating all models to the same starting point. http://www.kff.org/healthreform/upload/8177.pdf

[5] R. McDevitt and R. Lore, *Actuarial Valuation with the Consumer in Mind*, Consumers Union, June 2012. http://www.consumersunion.org/pdf/Plan_Valuation_with_the_Consumer_in_Mind.pdf

agreed to between the carrier and the provider and it is this amount that is used to determine the patient's financial liability.[6] The "allowed" amounts for services differ by carrier, provider and even different products for the same carrier. It is not uncommon for two different insurance carriers to negotiate a substantially different price for the same service delivered by a provider, or for an insurance carrier to negotiate different payment amounts for the same service when offered in different types of plans, such as indemnity or managed care. In almost all cases, these provider contacts are considered privileged business information, not accessible to consumers or even regulators.[7]

3. *Standardize Patient Maternity Cost in a Manner That Consumers Can Comprehend*

Maternity care by in-network hospitals should be a completely predictable expense, negotiated at either an episodic or capitated rate. This financial certainty should be passed along to consumers. The benefit designs should be redone so that maternity expenses feature a fixed co-pay amount, not co-insurance. We find buried in the footnotes a note that "total pregnancy related pre-natal and post natal visit co-payments are limited to a total of $250". But this appears to apply only to co-payments and only to office visits, not to the entire package of pregnancy-related care. Once a woman is pregnant, pregnancy costs are one of the most predictable of health care needs: families should be able to budget. Co-insurance deprives families of the chance to budget for what should be a knowable expense.

4. *Co-Insurance for Non-Participating Providers is Not a Substitute for Timely Access to an Adequate Network*

We appreciate that Exchange staff is attempting to mitigate the financial exposure that results from benefit designs that rely on co-insurance for out of network providers. We acknowledge that the Exchange staff has proposed use of FAIR Health as the basis for out-of-network of network provider rates. We also acknowledge that in the proposed benefit designs the Exchange staff proposes maximum out of pockets for out-of-network providers, something that neither state nor federal law requires. Differences in basis of provider rates have a large impact on the consumers' cost for out-of-network care.[8]

Access to out-of-network of network providers is not a substitute for timely access to an adequate network, including access to specialty care or even tertiary care if medically necessary. The failure of the Department of Insurance to adopt timely access

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[6] http://www.nhbar.org/publications/archives/display-journal-issue.asp?id=353

[7] In Massachusetts it took legal action by the state attorney general to examine these provider contracts. AG Coakley's examination found that "[t]he market players – whether insurers, providers, or the businesses and consumers who pay for health insurance – *had not effectively controlled costs, in part, because the prices negotiated between insurers and providers were not designed to encourage or reward provider efficiency*." (emphasis added) Instead, these rates reflected the relative market power of the providers. http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf

[8] This report from the NY State Department of Financial Services details consumer problems with out-of-network care – one of the most common reasons for consumer complaints: http://www.governor.ny.gov/assets/documents/DFS%20Report.pdf

standards, to conduct medical surveys to determine network adequacy, and to fine insurers who fail to arrange for an adequate network exposes consumers with CDI products to considerable financial risk. While most Californians understand the concept of being in-network versus out-of-network, the presentation by Exchange staff makes it appear as if the co-insurance products provide a benefit not provided by the co-payment products when in fact the reverse is the case: the co-insurance products regulated by the Department of Insurance expose consumers to financial costs for a regulatory failure. Perhaps consumers above 500%FPL (over $100,000 a year for a single person) consider this a benefit but for someone making $12 or $15 an hour, it is an illusory one. To the best of our knowledge, DMHC-licensed PPOs do NOT currently permit co-insurance for out-of-network providers.

5. Reduced Cost-Sharing Plans in the Silver Metal Tier

Co-insurance is confusing, unpredictable and unnecessary to achieve actuarial values. For a person below 250%FPL, it is even worse. Co-insurance for a hospital stay means spending next month's rent money on the first day in the hospital: it is literally a recipe for homelessness. An annual limit of $1833 may seem manageable to someone making six figures, but for those eligible for cost- sharing reductions, it is a month's wages. The answer that an individual will hit their out of pocket maximum on the first day in the hospital is no answer to somebody who spent their income for a month on a day in the hospital.

An individual who has a hospital stay of one day with $200 hospital co-pay will not hit their annual maximum, but an individual with even 5% co-insurance is likely to hit the maximum annual out of pocket limit. Even an individual who has a second hospital stay or an outpatient surgery may not hit their annual maximum in a co-pay plan.

Emergency room visit: $250 for someone at 200%-250%FPL is unaffordable. Even $100 for someone at 150%FPL-200%FPL (who may make as little as $1400 a month) is problematic. A differential emergency room co-pay is appropriate: a co-pay that is so prohibitive that consumers avoid appropriate emergency room use is not.

In comparing the products for those 150%FPL-200%FPL with those for the next step up in income, the jump in co-pays and co-insurance seems big for someone who is only making slightly more. This is true not only of emergency visits but outpatient surgery, specialty drugs, urgent care, mental health, and physician fee for hospital stay. Another round of review seems in order here.

The actuarial value estimates for the Gold-Coinsurance plan vs. Silver Coins 200%-250% plan are only 2 percentage points different – 81% vs. 79%. However, the actual cost-sharing amounts suggest a much bigger spread: $500 versus $1,000 deductible; 20% versus 30% co-insurance; $10 versus $30 co-pays. Is there an error in the estimates for one or both of these plans?

6. Health Savings Accounts: Tax Shelters for the Affluent

We recognize that health savings accounts are permitted under existing state and federal law. We also recognize that their primary use is as a tax avoidance device for the affluent. We ask that no health savings account compatible products be offered for subsidy-eligible products. If people over 400%FPL wish to use these tax devices, so long as state and federal law permit health savings accounts, the Exchange might choose to offer these to relatively affluent individual purchasers.
For the SHOP Exchange, we note that many small employers fund health savings accounts in order to minimize the harm to their employees caused by the prevalence of high deductible products promoted by carriers. We ask whether the Exchange should allow health saving account compatible products in the small group market only if employers contribute to the health savings account of their employees.

7. Bronze Plans

It is not necessary to use co-insurance to achieve the cost-sharing required for the bronze plans.

Because consumers may forego the cost-sharing subsidy in return for the lower premium of the bronze plan, the bronze plan should be sufficiently distinct from the silver plan so as to alert consumers that the bronze plan is based on very different cost-sharing with much higher cost exposure.

8. Determination of Actuarial Value: Proprietary Models Lead to Public Errors

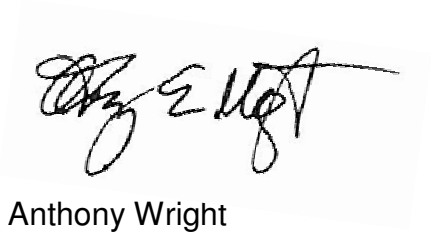
We recognize that the staff, as well as many other stakeholders, eagerly await the release of federal guidance on actuarial value and the actuarial value calculator and that proposed benefit designs will be adjusted in accordance with federal guidance.

We have sought information about the modeling methodology used by the Exchange in developing the proposed standard benefit designs. It is impossible to provide fully informed comments on the benefit designs without knowing the underlying actuarial assumptions that form the basis for the recommendations staff has made. The methodologies, or at least meaningful descriptions of the assumptions, should be open to the public so that we and others may make constructive, precise suggestions about the resulting benefit design recommendations. If your contractual relationship with the actuaries prohibits this, we urge Exchange staff, working with actuaries at sister agencies CDI and DMHC, to press for the detailed assumptions and claims data sources so that the Exchange and regulators collectively have a deep understanding of the variables and can push for possible adjustments. For example, Kaiser Family Foundation found three very different results using three different actuaries, each of which used a different population bases for its actuarial value calculation: one even included the Medicare population which has a rather different claims profile than a commercial population: http://www.kff.org/healthreform/upload/8177.pdf

The proposed Exchange benefit design decisions have critical, on the ground implications for consumers both inside and outside the Exchange. Nothing less than a fully featured, robust model that uses an appropriate and very large claims data set should be used for this exercise – indeed used for all actuarial estimation exercises that affect consumers.[9] In fact, we urge that the proposed benefit designs be subjected to a second opinion using a very robust model with all assumptions disclosed.

Sincerely,

Elizabeth Imholz
Consumers Union of the United States



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[9] R. McDevitt and R. Lore, op cit.