December 12, 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 December 11, 2012

Dear Mr. Lee and Ms. Rosen,

California Pan-Ethnic Health Network, Consumers Union, Health Access California, the National Health Law Program, and the Western Center on Law and Poverty offer comments on the benefit designs released December 11, 2012.

1. Evidence-Based?

Has the Exchange had the opportunity to test any of the proposed benefit designs with focus groups or other opinion research to determine whether consumers comprehend the differences between the products? As consumer advocates, we are doing our best to provide input, based on opinion research done by our organizations as well as other policy work.

Based on our direct experience, polling does not allow researchers to determine consumer response to proposed benefit designs: the entire concept is too confusing for consumers who cannot readily separate covered benefits from premium from cost sharing. Also, multiple consumer testing groups convened by Consumers Union indicates that consumers are confused by deductibles, challenged by percentages, and more comfortable with copays than coinsurance. These types of challenges will be even more pronounced for those with low health literacy, which disproportionately affects more vulnerable populations, including persons with disabilities, people with lower socioeconomic status, ethnic minorities, those with limited English proficiency and people with limited education, the very populations that stand to benefit the most from successful implementation of the Affordable Care Act.

If the Exchange has not yet had the opportunity to conduct opinion research with a diverse set of consumers on benefit design, will it do so in the future? Also, we urge the Exchange monitor complaints that it receives and ask the regulators to do so as well about aspects of the benefit design that may be problematic from a consumer perspective.

2. Pre-Reform Market

In the pre-reform California market, the majority of consumers get their coverage through employment. In California, employment-based coverage is overwhelmingly what the Exchange staff refers to as "copayment" policy. Our opinion research indicates that what Californians regard as basic benefits is what large employers provide and in California, that means copayments, not coinsurance.

The pre-existing individual market in California was badly broken from a consumer perspective, with coinsurance products not covering maternity benefits, not having a standard for network adequacy, allowing lifetime and annual maximums, not assuring essential health benefits, and allowing deductibles of $20,000 or more, an amount that exceeded the annual income of many Californians who will enroll in the Exchange. Products regulated by the Department of Managed Health Care were not as defective as those regulated under the Insurance Code. The point of the Affordable Care Act, and the additional improvements enacted in California law, is to fix a broken insurance market, not to mimic it.

3. Deductible: Unjustified Insistence on Different Application of Deductible for Different Products

We continue to oppose the proposed benefit design platforms in which deductibles that apply to different things for "coinsurance" products and "co-payment" products. We have not been provided any justification for this confusing practice that will prevent consumers from making apples to apples comparisons of apparently similar products. Is it impossible for issuers that rely on "co-insurance" products to apply the deductible in the same manner as those that offer "co-payment" products? This seems unlikely given that many carriers that offer "co-insurance" products apparently intend to offer "co-payment" products as well. Given that 2 million of the 2.2 million covered lives regulated by the Department of Insurance are covered by carriers that are also regulated by the Department of Managed Health Care and that of the remaining 200,000 lives, most of those are in products banned under the Affordable Care Act, we do not see any justification for treating deductibles differently for so-called "co-insurance" products and "co-pay" products?

From a consumer perspective, deductibles are difficult to comprehend. The "co-payment" products apply the deductibles to "institutional" services, including hospital care, emergency room, ambulatory surgery and imaging but the "co-insurance" products apply the deductible to all services, including physician visits. This is sufficiently

confusing that even the Exchange staff stumbled over it in the webinar. Certainly no real person can comprehend it from the summary chart, let alone someone who is limited English proficient. And it leads to a very misleading element of the silver plan: it appears that the silver co-insurance is more affordable than the silver copay plan because the deductible is lower when in fact, in the real life experience of most consumers, the deductible will apply more frequently. The bronze plans are similarly misleading.

If the justification for treating deductibles differently for different product platforms is the preference of actuaries, this is not a sufficient policy reason for proposing this benefit design feature. If this is how the current market operates, this is exactly the sort of unnecessarily confusing carrier practice that health reform was intended to eliminate. We see no reason why carriers that bid on the co-insurance plans cannot limit deductibles to institutional services given that many or all of the same carriers will be bidding on copayment plans. If there is a practical reason, we have not yet heard it. We do not understand why this difference persists.

4. Greater Reliance on Copayments in Proposed Benefit Design

We appreciate and commend the greater reliance on copayments in the proposed benefit designs than in those issued on November 9. This is a step in the right direction. It remains our view that the use of co-insurance is unnecessary and a relic of the pre-existing broken insurance market. We applaud the greater use of copayment in both "co-insurance" and "co-payment" products.

a. Use of Copayment for Hospital Stays: Support

We support the use of copayments for hospital stays even though the proposed copayments for the silver and bronze plan are quite high ($900 per day and $1200 per day for the first three days respectively). Copayments allow consumers to plan and budget for the cost of a hospital stay and to know the limit of their cost. Co-insurance does not allow this. Though the dollar amounts are high, Consumers Union found in its consumer testing (mentioned previously) that initial "sticker shock" is generally blunted when consumers are presented with the cost of a full "episode of care" such as for breast cancer.

We would support the use of co-insurance for hospital stays only if it guaranteed consumers that in the overwhelming majority of cases co-insurance for a hospital stay would be less than the co-payment. Given the limits of the variation in actuarial value, this does not seem possible. Also, we would question as a matter of evidence whether the Exchange has looked at the range of payment rates to hospitals by insurers and determined whether 30% co-insurance is less than $900.

The presentation of co-insurance will be critical since many consumers are challenged by computing percentages and none can predict 30% of what. This observation applies not only to inpatient stays but to all other instances of co-insurance.

b. Imaging: Copayment

We support setting a dollar copayment for imaging rather than co-insurance. Would this apply to both the co-insurance and the copay products? That would be our preference for the reasons stated above and previously. We note that the "proposed integrated delivery copay plan" includes copays for imaging ranging from $100 for platinum to $300 for bronze so plainly copayments are possible for imaging.

c. Maternity Cost Sharing

We are unable to determine from the materials provided whether cost sharing for all aspects of maternity care, including office visits, related lab tests, and hospital stays, is treated as a single package of pregnancy-related care with a single out of pocket maximum. Some of us heard Exchange staff describe an intended out of pocket maximum: some of us did not and the materials do not include this information. Once a woman is pregnant, pregnancy costs are among most predictable of health care events and the one that allows planning for associated costs. We strongly urge that pregnancy-related care be treated as a single package with a cap on costs.

5. Bronze Plans

We appreciate the greater use of copayments for the bronze plan.

If the only thing a consumer compared for the bronze plan was the premium and the deductible, they would be badly misled about which product offered more affordable coverage. The as yet unjustified insistence on treating deductibles differently for co-insurance and co-payment products results in an apparent discrepancy: the co-insurance product offers a lower deductible that appears more affordable when in practice consumers will start shelling out sooner and more frequently because the deductible applies to all services, not just institutional services.

6. Reduced Cost Sharing Plans in Silver Metal Tier

We do not have materials from the Exchange for reduced cost sharing plans in the silver metal tier except for the "proposed integrated delivery copay plan" and those offered on November 9 which we understand to be no longer relevant.

Our comments thus reflect the "proposed integrated delivery copay plan": we reserve the right to modify these comments on seeing the "copay" plan and the "co-insurance" plan for reduced cost sharing levels.

Hospital stays: we appreciate the reliance on copays for hospital stays. As we noted in commenting on the prior proposal, 5% co-insurance even with $1833 maximum out of pocket could easily result in homelessness at these income levels because $1833 is a month's income so how could someone at these income levels pay next month's rent?

This is not an idle example. Before the expansion of Medi-Cal and the creation of the CHIP program, emergency room costs were the most common single cause of homelessness among families according to the Los Angeles Homeless Coalition. Happily that is no longer true: the Exchange benefit design should learn from this example. While $600 per day up to three days and $300 per day up to three days is problematic from an affordability perspective, it is much preferable to co-insurance for the reasons stated above and previously.

Emergency room visits: $150 per visit and $100 per visit is significantly higher than most employer-based coverage. While we know that there is a prevalent theory that a differential for emergency room use discourages inappropriate use of emergency rooms, consumers are not clinicians and are frequently advised by clinicians to seek emergency room care, even in instances which turn out not to be emergencies. We also note that in many instances, urgent care is not available on an in-network basis. We request that the reduced cost sharing plans to reduce the emergency room and emergency transportation copayments further. Please remember that $100 emergency room copay applies to someone making $10 an hour. Will someone make the wrong choice and not go to the emergency room when they should have because $100 is too much? Someone who can afford platinum coverage is very differently situated than someone relying on the cost sharing reductions under 150%FPL yet the copays for emergency care are the same. This seems wrong to us.

7. Specialty Drugs

We note that in all of the proposed benefit designs, specialty drugs are subject to co-insurance. Two questions: first, does the out of pocket maximum include cost sharing for specialty drugs? We assume it does. Second, does the drug deductible apply to specialty drugs? We assume it does.

While we recognize that co-insurance for specialty drugs has become commonplace in the existing insurance market, that fact does not commend the practice in our view.

8. Third design? Integrated Delivery System Proposal

We are troubled at the notion of yet another standard benefit design. In reviewing the document titled “integrated copay recommended proposed copay standard plans version 121012”, even our sharp eyes have difficulty in determining what alterations are proposed for the integrated delivery system. Our understanding is that the difference is limited to whether physician care during inpatient stays and for ambulatory surgery has cost sharing separate from the facility costs.

A few points that we consider in evaluating this proposal:

- Our general preference is that the cost sharing for an episode of care result in a single bill to the consumer. It is really confusing to get separate bills from not only the facility but multiple bills from multiple physicians for a single hospital stay or a single ambulatory surgery. While this may be common practice, it makes no sense

from a consumer perspective. We would encourage the Exchange to see if this practice, a relic of uncoordinated care, can be phased out over time. This would reduce the need for a third standard benefit design.

- We support encouraging better integration of care that results in coordinated management of care across the inpatient and outpatient settings. To the extent that this proposal facilitates that, it moves in the right direction. We ask whether other carriers should be encouraged to consider moving in this direction in the future.
- The Exchange has permitted alternative benefit designs. We continue to be worried about the proliferation of alternatives and the dizzying array of plans that consumers will be expected to asses. We would view this proposal differently if the number of alternative benefit designs were limited or scrutinized more intensely as a result.

At this time, we do not support or oppose the proposed third alternative benefit design. We are troubled both by what it reveals about the fine print in the other standard benefit designs and by the proliferation of benefit designs.

9. QHP bidders to submit different standardized benefit plan platforms: Oppose

We understand why carriers regulated by both regulators might wish to forum shop in terms of which products are regulated by which regulator. We can see no public policy reason to encourage such behavior. We are certain it will worsen consumer confusion. For example, a consumer likes Anthem or Blue Shield and thinks all the products from a single carrier are comparable but buried in the fine print is the reality that a Blue Shield Exchange product for the silver tier has a different cost sharing structure than the Blue Shield Exchange product for the platinum tier. This defeats the purpose of apples to apples comparison within a single carrier's products. It is exactly the kind of fine print "gotcha" that we oppose.

We would also note that the legal requirement that carriers offer products in each tier is a requirement for products offered under the Health and Safety Code as well as products offered under the Insurance Code. In re-reviewing Health and Safety Code Section 1366.6, it appears to us a violation of that section of law to allow an issuer to offer a product in the bronze tier regulated by CDI while offering a product in the platinum tier regulated by DMHC. Instead, the health care service plan must offer a DMHC-regulated product in each metal tier:

> "Health care service plans participating in the Exchange shall fairly and affirmatively offer, market and sell in the Exchange at least one product within each of the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal act."

This does not permit health care service plans to offer a product in one tier that is regulated by DMHC and a product in another tier that is regulated by CDI. We note that Insurance Code Section 10112.3 applies the same restrictions to products regulated under the Insurance Code. If the proposal is to allow a DMHC-regulated "co-insurance" product in the bronze tier while also including a DMHC-regulated "co-pay" product in the platinum tier, that would not violate H&S Code Section 1366.6 though it may run afoul of other requirements.

We know that most carriers opposed these provisions of law and we suspect that some carriers continue to encourage the Exchange to overlook or undermine these provisions of law. From a consumer perspective, we strongly supported these requirements and continue to do so. The intent was to minimize adverse selection between the Exchange and the outside market as well as to provide greater transparency for consumers, including apples to apples comparison of products.

10. Copayments, deductibles, out of pocket maximums and other confusing features of health insurance

Do all copayments and co-insurance count toward the deductible? If not, why not?

Does all spending toward the deductible count toward the out of pocket maximum? If not, why not?

A recent study found that some consumers did not seek preventive care even though cost sharing had been eliminated because the elimination of cost sharing was not well understood by consumers. (Health Affairs, December 2012).

In working on the policy question of standardizing benefit design, we have found a wide variety of practices among carriers about what counts toward what. If it is the intent of the Exchange in standardizing benefits that cost sharing be handled in the same manner across all products, that standard needs to be stated. This appears to be an assumption underpinning the proposed benefit designs. Given the variability in behavior of carriers and the reality of two regulators, clarity is important.

We very strongly support uniform policies regarding what counts toward deductibles and out of pocket limits. We support counting all copayments and co-insurance toward the deductible for the relevant service. We support counting all spending for cost sharing toward the maximum out of pocket cost.

11. Increased Cost Sharing due to use of federal calculator: California-specific database?

We are disappointed that the use of the federal calculator has resulted in greater cost sharing for Californians than prior estimates. We would be most interested in understanding how a California-specific database might provide better affordability for Californians.

Sincerely,

Cary Sanders, California Pan-Ethnic Health Network
Betsy Imholz, Consumers Union
Anthony Wright, Health Access California
Byron Gross, National Health Law Program
Elizabeth Landsberg, Western Center on Law and Poverty