Comments to the Board - External

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May 21, 2015 Board Meeting

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CALIFORNIA

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United States Senate
HART SENATE OFFICE BUILDING
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April 9, 2015

Peter Lee
Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Dear Director Lee:

Since enactment of the Affordable Care Act in March of 2010, California has led the country by creating a successful health insurance exchange under your leadership. As you know, Covered California offers opportunities not just to individuals, but to small employers who have historically grappled with an expensive, fragmented insurance market prior to the enactment of the health reform law. I write to inquire about how Covered California plans to continue outreach to the small business community.

Not only should small businesses benefit from allowing their workers to be able to pick from multiple options available at Covered California, but very small businesses with fewer than 25 full-time employees at an average salary of $50,000 may be eligible for a new federal tax credit if they purchase insurance through the exchange. These tax credits could very well mean the difference between an employer deciding to offer coverage and leaving their workers to find coverage on their own.

Since there are new federal tax benefits available under the health reform law, marketing, education, and outreach is pivotal to letting employers know that there is assistance available to them. I would like to know more about how Covered California plans to continue to reach out to small businesses to encourage them to enroll, particularly minority entrepreneurs and small businesses in underserved communities. How successful has enrollment been to date, and what methods does Covered California plan to employ in the future to educate small businesses about new options available under the Affordable Care Act?

Implementation of health reform in California is dependent on a strong federal-state partnership. I look forward to continuing to work together and stand ready to act as your liaison to federal agencies so that we can continue to provide access to affordable, quality care to all individuals and families in our state.

Sincerely,

Barbara Boxer
United States Senator

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COVERED CALIFORNIA

May 8, 2015

The Honorable Barbara Boxer
United States Senate
Hart Senate Office Building, Suite 112
Washington, DC 20510-0505

Dear Senator Boxer:

Thank you for your letter regarding Covered California for Small Business, formally known as Small Business Health Options Program (SHOP). I appreciate the importance of this issue and welcome the opportunity to provide you with an update.

Since the inception of Covered California for Small Business, employers with 50 employees or less have the option to provide their employees with affordable, quality health insurance through Covered California. Many small businesses now have the opportunity to take advantage of small business tax credits and other benefits by enrolling in Covered California for Small Business. California offers small business employees and employers a choice of dual metal tier coverage in all available Qualified Health Plans (QHP). As of March 1, 2015, a total of 2,289 small businesses covering 15,644 employees, have enrolled in Covered California for Small Business.

To educate the small business community about the benefits of Covered California for Small Business, Covered California is committed to working with community partners. In June 2013, Covered California awarded $2.2 million in grant funding to three organizations to provide outreach and education to small businesses about the benefits of Covered California for Small Business. These grants were awarded to the California Asian Chamber of Commerce, the California Hispanic Chambers of Commerce and the Small Business Majority. These organizations continue to take part in ongoing discussions about the future of Covered California for Small Business.

As Covered California transitions from being funded by federal grant dollars to being funded by assessment revenue of QHPs, Covered California continues our focus on wise and targeted investments, operational excellence and marketing effectiveness. Strategy discussions are taking place with a range of marketing experts, health plans and with our Small Business Advisory Group, which is represented by various stakeholders, including agents, general agent firms, small business advocates, small business owners and insurance carriers.

While we continue to discuss the future of Covered California for Small Business with our stakeholders, Covered California is also engaging in the following activities:

- **Rebranding the SHOP Marketplace.** On April 20th, Covered California announced the rebranding of the SHOP marketplace to "Covered California for Small Business." This new name aligns SHOP with the established Covered California brand in the individual market. This rebranding includes updates to the Covered California for Small Business website in both English and Spanish as well as marketing in business publications across the state. The marketing campaign, which promotes the tax credit and employee choice, includes direct mail to businesses in Los Angeles, a region with one of the highest concentrations of small businesses in the state. Moving forward, we will continue to identify the right opportunities to promote Covered California for Small Business with our paid and earned media campaigns.

- **Navigator Grant Program.** At the April 2015 Board meeting, Covered California's Board voted to allocate up to 10 million dollars towards a new Navigator Grant Program. The Navigator Program is a partnership with community organizations across the state that have experience in reaching and assisting California's diverse populations, including Latinos, Asians and African Americans. As part of the new program, Certified Enrollment Counselors (CEC) will be trained on effective outreach and education efforts aimed at small businesses, including sole proprietors. Since only Certified Insurance Agents and Covered California can enroll small businesses in Covered California for Small Business, CEC's will provide education, outreach and connect small businesses to Covered California.

- **Partnerships.** Covered California will be funding strategic marketing and outreach efforts through partnerships with small business organizations again this year. These organizations will receive outreach tools and support to educate minority entrepreneurs and small businesses in underserved communities about the benefits of Covered California for Small Business and the opportunity to get financial assistance through the small business tax credit. The timing to implement these partnerships will line up with the third and fourth quarter of 2015 which is when most small businesses in California will be moving into Affordable Care Act compliant plans and when the entire state will be focused on Covered California and signing up for health insurance.

- **Agent Support.** Covered California has over 14,000 certified agents, of which 1,100 have sold plans through Covered California for Small Business. In California, 85% of currently insured small businesses work with an insurance agent. Our certified agents reach California's diverse populations and many speak multiple languages and focus their efforts in our underserved communities. Over 129 certified agents have set up certified Covered California Storefronts in their communities throughout the state to provide both small businesses and

individuals with in-person enrollment assistance. Focusing on agent development is both an opportunity and a priority, and one that is vital to reaching California's uninsured small businesses and Covered California for Small Business's continued success. Supporting certified agents development and sales are Covered California for Small Business internal sales force of 20 field sales representatives, our four contracted general agent firms and their sales teams with a combined total of 81 field sales representatives, and our QHP Issuers' sales teams with over 100 field sales representatives.

Also supporting agents is our new SHOPWorks marketing program, which provides agents with marketing products and services to identify small businesses interested in health insurance options through Covered California for Small Business. Since the implementation of SHOPWorks, agents have distributed 119,000 postcards and enrolled 123 small business, covering 1,223 employees.

- **Operations.** Covered California for Small Business currently enrolls 98% of new groups in 3 days or less, which meets the industry standard for small business enrollment. During the launch of the Covered California for Small Business, small business enrollment was challenged by a variety of technology issues. Covered California has migrated into a new enrollment system that will allow better invoicing to small businesses. It will also improve agent, general agent and QHP payment processing. Over the last year, Covered California developed a new electronic administrative system to enroll and renew groups, and pay agents, general agents and QHPs.

Covered California is committed to supporting and providing small businesses with the highest degree of service and affordable, quality coverage. Moving forward, Covered California will continue to solicit feedback and identify innovative solutions to improve Covered California for Small Business and increase access to health care for all California small businesses. I appreciate the opportunity to provide you with this update. Again, thank you for your continued support and leadership on the Affordable Care Act. Please feel free to reach out to me if I can provide you with additional information on this issue.

Sincerely,

Peter V. Lee
Executive Director

CC: Covered California Board of Directors

Congress of the United States
Washington, DC 20515

April 24, 2015

Mr. Peter V. Lee
Executive Director
Covered California
1601 Exposition Boulevard
Sacramento, California 95815

Dear Mr. Lee:

First of all, we commend your leadership in making Covered California a model for a success for the entire nation. We are writing in regards to Covered California's Small Business Health Options Program (SHOP), the marketplace that currently provides health insurance options for businesses with fewer than 50 employees. While Covered California has led the country in individual enrollment, reports indicate that less than 1% of estimated eligible businesses have enrolled in SHOP. In light of that information, we request an update on business enrollment, upcoming outreach plans, and ask that you continue to increase Covered California's commitment to fully developing SHOP.

The small business community in California is large and diverse representing more than 4.5 million employees and 97% of all private sector jobs. The health reform law made new benefits available to employers. However, significant outreach work remains to educate the small business community about healthcare options.

As you know, in addition to providing the opportunity for employees to pick from multiple plan options, SHOP offers federal tax credits to eligible businesses with fewer than 25 full-time employees. These tax credits are only available through SHOP and can be the determining factor in an employers' decision to offer coverage. As the small group health insurance market transitions to new plans throughout 2015 and the SHOP opens to businesses with 50-100 employees, there is a tremendous opportunity increase small business participation in SHOP.

Therefore, we urge Covered California to demonstrate its commitment to SHOP by investing in outreach and improvements through 2015. More specifically, we ask that you include organizations working to increase business enrollment, in addition to those focusing on individual enrollment, in upcoming requests for proposals. We thank you for your prompt attention and look forward to continuing to work with you to ensure all individuals and families have access to affordable, quality health care.

AMI BERA, M.D.
Member of Congress

ZOE LOFGREN
Member of Congress

TED LIEU
Member of Congress

MARK TAKANO
Member of Congress

DORIS MATSUI
Member of Congress

JUDY CHU, PhD
Member of Congress

MARK DESAULNIER
Member of Congress

RAUL RUIZ
Member of Congress

ERIC SWALWELL
Member of Congress

JIM COSTA
Member of Congress

NORMA TORRES
Member of Congress

JOHN GARAMENDI
Member of Congress

COVERED CALIFORNIA

May 8, 2015

The Honorable Ami Bera
United States House of Representatives
1535 Longworth House Office Building
Washington, DC 20515

Dear Congressman Bera:

Thank you for your letter regarding Covered California for Small Business, formally known as Small Business Health Options Program (SHOP). I appreciate the importance of this issue and welcome the opportunity to provide you with an update.

Since the inception of Covered California for Small Business, employers with 50 employees or less have the option to provide their employees with affordable, quality health insurance through Covered California. Many small businesses now have the opportunity to take advantage of small business tax credits and other benefits by enrolling in Covered California for Small Business. California offers small business employees and employers a choice of dual metal tier coverage in all available Qualified Health Plans (QHP). As of March 1, 2015, a total of 2,289 small businesses covering 15,644 employees, have enrolled in Covered California for Small Business.

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Covered California is committed to supporting and providing small businesses with the highest degree of service and affordable, quality coverage. Moving forward, Covered California will continue to solicit feedback and identify innovative solutions to improve Covered California for Small Business and increase access to health care for all California small businesses. I appreciate the opportunity to provide you with this update. Again, thank you for your continued support and leadership on the Affordable Care Act. Please feel free to reach out to me if I can provide you with additional information on this issue.

Sincerely,

Peter V. Lee
Executive Director

CC: Covered California Board of Directors
Zoe Lofgren, Member of Congress
Ted Lieu, Member of Congress
Mark Takano, Member of Congress

Doris Matsui, Member of Congress
Judy Chu, Member of Congress
Mark Desaulnier, Member of Congress
Raul Ruiz, Member of Congress
Eric Swalwell, Member of Congress
Jim Costa, Member of Congress
Norma Torres, Member of Congress
John Garamendi, Member of Congress

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California State Senate

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7800 ARROYO CIRCLE, SUITE A
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April 22, 2015

Peter V. Lee, Executive Director
Covered California Board of Directors
1601 Exposition Blvd.
Sacramento, CA 95816

Dear Director Lee:

This letter is to request that you and the Covered California Board of Directors use this year's Qualified Health Plan certification/recertification process to increase health care coverage options for constituents in the 17th Senate District, as well as in the entire state.

As you know, new health plans may apply for 2016 inclusion in the Covered California marketplace, if they offer coverage in regions with limited plan choice. This includes regions like Santa Cruz County where entire zip codes (95006 and 95017) have fewer than three plan choices, Monterey County where there is only one plan, and San Luis Obispo County where there are only two plan options.

Access to health care coverage varies throughout my district, from anywhere between three and one Covered California health plan options. Moreover, the fact that certain zip codes in Santa Cruz County are blacked out of purchasing the same health plan in a neighboring zip code creates unequal access to health care among residents.

As a principal co-author of Assembly Bill 1602 (Chapter 655, Statutes of 2010), legislation that established the California Health Benefit Exchange, I highly encourage you and the Board to do everything in your power to ensure that all Californians, including those living in the 17th Senate District, are able to fulfill the promise of the legislation and provide all consumers quality health care choices.

Thank you for your time and consideration.

Sincerely,

Thank you.

WILLIAM W. MONNING
Senator, 17th District

WWM:lv/rog

cc: Genoveva Islas, Covered California Board of Directors
Diana S. Dooley, Covered California Board of Directors
Paul E. Fearer, Covered California Board of Directors
Marty Morgenstern, Covered California Board of Directors

COVERED CALIFORNIA

Monday, May 18, 2015

The Honorable William Monning
Senator, 17th Senate District
State Capitol, Room 313
Sacramento, CA 95814

Dear Senator Monning,

Thank you for your letter regarding Qualified Health Plan certification and recertification in the Exchange. We appreciate your feedback, and share your commitment to improve access to affordable, quality health care in rural and semi-rural areas of the state—including key regions such as Santa Cruz and Monterey counties.

Covered California recognizes the importance of providing all Californians with a diverse array of health plan choices. To that end, the Exchange is currently undergoing a rigorous Qualified Health Plan certification and recertification process, by which new plans may join Covered California, and current networks may be expanded. The Exchange has made a number of changes to its "new entrant" policy, with the goal of expanding access and choice for members who may have less than three health plans available in their pricing region. This decision, approved at the Covered California January 2015 board meeting, will help increase plan choice in many areas of the state.

New health plans that offer coverage in regions with limited plan choice had the opportunity to apply for inclusion into the 2016 marketplace. As we review proposed applications, selection will be based on a plan's ability to expand coverage, capacity to increase provider networks, and other operational considerations. The final makeup of the 2016 marketplace will be announced in July this year.

As an active purchaser, Covered California will continue to engage health plans to determine how to increase coverage, network quality, and consumer choice, while keeping premiums affordable.

Thank you for your feedback, and your leadership in this issue.

Sincerely,

Peter V. Lee
Executive Director

DAVE JONES
Insurance Commissioner

April 14, 2015

Secretary Diana Dooley
Chair, Covered California and Board Members
1601 Exposition Blvd.
Sacramento, CA 95815

Re: Prescription Drug Formulary Cap Recommendations – Vote on Covered California's Standard Plan Design

Dear Chairperson Dooley and Covered California Board Members,

Your decision as to whether you will allow health insurers and health plans to place specialty drugs into a "high-cost tier" and if so, what out-of-pocket costs for policyholders must pay to obtain these drugs is critical to California consumers, as such a potentially discriminatory benefit plan design would place vital life-sustaining drugs out of reach for many Californians.

I have appreciated the opportunity for the Department of Insurance to work on this issue with Covered California, your staff, and the members of the Specialty Drug Work Group. During discussions leading to Covered California's staff recommendation, we have asked Covered California to establish a monthly cap of $200 on out-of-pocket costs for specialty tier drugs in order to spread the cost sharing amount over the coverage year. Unfortunately, however, your staff's recommendation to cap out-of-pocket expenses for specialty drugs at $500 per prescription per month falls short of what is needed. Capping out-of-pocket expenses at this level creates an affordability barrier for the average consumer, particularly those who struggle with chronic conditions that require multiple prescriptions. We urge Covered California instead to adopt a cap of $200 per prescription per month for specialty drugs, which we believe would provide considerable relief for those affected by the high costs of specialty drugs by spreading their costs over the plan year.

Discriminatory Benefit Design

Your proposed Standard Benefit Plan Design creates a 4-tier pharmacy benefit in which the fourth tier is, for most metal levels, treated differently than drugs on the other tiers. For example in the Silver plan (which is the plan with the highest number of policyholders in the individual market), the copay in tiers 2 ($50) and 3 ($70) are subject to a pharmacy deductible of $250 individual/$500 family, while tier 4 drugs are subject to a 20% coinsurance of up to $500 per

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prescription, which is applied over and above the pharmacy deductible. The Bronze (the plan with the second highest number of policyholders and the highest number of those who don't qualify for federal premium assistance) has a $500 maximum deductible per prescription for all tiers. In the Platinum plan, the first three tiers involve a copay, while the fourth tier involves a 10% coinsurance capped at $300 per script. In the Gold plan, a 20% coinsurance level for the fourth tier is capped at $500 per script.

The proposed Standard Benefit Plan Design sets criteria for Tier 4 drugs at footnote 19: one such criterion is the cost of the drug. Drugs with a cost in excess of $600 can be placed in Tier 4. This criterion can result in drugs vital to those with HIV/AIDS, multiple sclerosis, rheumatoid arthritis, Hepatitis C and other chronic or life-threatening conditions being placed in Tier 4, and thus subject to cost-sharing different from all other drug tiers. While footnote 20 provides that, in situations where there are at least 3 drugs in a drug class, at least one must not be in Tier 4, this provision does nothing to protect those with conditions for which there are less than three drugs.

Insurance Code §10753.05(h)(3) prohibits "...marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminate based on the individual's....health conditions." Cost-sharing requirements that place medically necessary care out of the reach of individuals with certain health conditions is discriminatory. In the last two years, as we have implemented the new Affordable Care Act (ACA) rules, the Department of Insurance has rejected some plan designs with co-insurance requirements on specialty drugs because of their discriminatory impact on those with certain medical conditions. We are concerned that the Standard Benefit Plan Design, as currently proposed, also implicates California anti-discrimination statutes because of its potentially disparate impact on the enrollment of those with significant health needs. In particular, the Silver plan, which imposes copays with a $250 maximum annual deductible in the first three tiers, imposes coinsurance with a cap of $500 per script.

It is also worth noting that in the preamble to the Federal Notice of Benefit and Payment Parameters for 2016 final rule, CMS sends a clear message about the types of benefit designs that would be prohibited under 45 CFR §156.125. This guidance is helpful to the Department of Insurance in highlighting areas where regulators may find discriminatory practices. It notes that "placing most or all drugs for a certain condition on a high cost tier without regard to the actual cost the issuer pays for the drug may often be discriminatory in application when looking at the totality of the circumstances, and therefor prohibited." (80 Federal Register 10823, Feb. 27, 2015)

The recommended cap does not ameliorate our concerns that significantly higher out-of-pocket costs borne by consumers using specialty drugs is, in fact, discriminatory.

Impact on Consumers

There is a significant body of research indicating that cost can significantly impact drug adherence for those with chronic conditions. We are therefore concerned that such a high cap will put important prescription drugs out of reach of many consumers, leading to decreased

treatment compliance and increased adverse health outcomes. For example, one research study found decreased treatment compliance when out-of-pocket expenses for certain multiple sclerosis treatments were greater than $200[1]. Most studies demonstrate that adherence drops off significantly when the cap is greater than $200.

A recently released report by the Kaiser Family Foundation (KFF) entitled, *Consumer Assets and Patient Cost Sharing*[2] made it clear that households are already struggling to meet their out-of-pocket expenses. According to the report, "Looking at the out-of-pocket limits, most households do not have sufficient liquid financial assets to meet either the lower or the higher limit. The percentage of households who have both low incomes and enough assets to meet either of the out-of-pocket limits is very low."[3] Further, they concluded that for families with incomes between 100% and 200% of Federal Poverty Level (FPL), "Only 32% of households with incomes between 100% and 250% of poverty can meet the lower deductible amounts, while one-in-five can meet the higher deductible amounts."[4]

It is not only lower income households who feel this squeeze. The report found that, "substantial shares of households with incomes between 250% and 400% of poverty would be unable to meet even the lower out-of-pocket limits with their current resources, and meaningful shares of households with incomes over 400% of poverty would have problems as well."[5]

The KFF report clearly demonstrates that many families of low and moderate incomes are struggling to meet their annual deductibles and therefore cannot afford to fill prescriptions for specialty drugs if their out-of-pocket cost is $500 per prescription per month.

Impact on Actuarial Value and Premium

I asked our actuaries to run options of capping the dollar amount per drug/per month through the 2016 Actuarial Value (AV) Calculator. They reported to me that capping Tier 4 coinsurance payments at $200 per prescription would have almost no impact on the AV. The plans would thus still comply with the required AV range for each metal level and significant changes in premium would not be justified. Even when your staff collected information from health carriers about what level of premium increase they would propose, the information you received from the health insurance carriers indicated that for some of them, capping the out-of-pocket cost for specialty drugs at $200 would have no impact on premium, and for others the maximum increase proposed was .77% for 2016 – the plan year for which you are setting the Standard Benefit Design. This proposed premium increase by the carriers of 0 -.77% associated with the $200 cap I am urging you to adopt is almost identical to the proposed price increase of 0 - .70 % for setting the cap at $500 as you propose.

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[1] Gleason, P. et al. (2009) Association of Prescription Abandonment with Cost Share for High-Cost Specialty Pharmacy Medications. Journal of Managed Care Pharmacy, 15(8):648-58.
[2] http://kff.org/health-costs/issue-brief/consumer-assets-and-patient-cost-sharing/
[3] Ibid, p6
[4] Ibid, p7
[5] Ibid, p13

In addition to our internal calculations, Milliman produced a recent report entitled, *Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations*, where they used California exchange data to model the impacts of per-prescription caps set between $100 and $200 and an annual prescription drug out-of-pocket (OOP) maximum set at 20% of the total OOP. The report concluded what our actuaries reported: "The average plan member would be expected to see very little change in their total expected healthcare spending (premiums plus out-of-pocket costs for medical and pharmacy services) upon implementation of any of the potential benefit design changes."[6]

Efforts in Other States to Prevent Specialty Drugs from Being Out of Reach for Policyholders

My recommendation for a $200 cap for specialty drugs is well in line with caps implemented by other states including Maryland, Florida, Delaware, Louisiana, and Montana. These states have caps between $100 and $250 per prescription per month. Colorado has a $500 cap, but they are by far the outlier. In 2010, New York went even further out of concern for policyholders with chronic conditions. Instead of implementing a cap, they prohibited specialty tiers altogether which, in effect, limits maximum cost-sharing to those of non-preferred brand name drugs.

Finally, my recommendation is consistent with ongoing legislative efforts in 5 states and the District of Columbia including Oregon, Kansas, Oklahoma, Illinois, and Connecticut. In fact, four of the five of those states are recommending caps of $100 per prescription per month. Given that Covered California is currently setting the Standard Benefit Design for California for both inside and outside the Exchange, we would urge that you set the $200 per prescription cap for specialty drugs.

Conclusion

If approved as recommended by your staff, the Covered California Standard Benefit Plan Design will put many Californians with chronic medical conditions in the position of being expected to pay thousands of dollars in the first few months of their policy year in order to receive life-saving prescription drugs. Of note, a $200 copay cap per prescription is consistent with the proposed benefit plan design for the Silver 100%-150% and 160%-200% FPL plans, showing such a cap can be achieved in the California context. We also know from California's $200 cap on the cost of oral cancer medications that this can be achieved.

The impacts of non-adherence to their prescription drug regime go beyond the health of the individual. Nationally, the annual cost of non-adherence resulting in emergency room visits and other preventable medical expenses was $290 billion or 13% of total health expenditures[7]. For people with chronic conditions that require specialty drugs, adopting a $200 cap is a prudent cost-saving measure for the system as a whole.

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[6] Milliman. Et al (2015). *Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations*. p3.

[7] New England Healthcare Institute. (2009). *Thinking outside the Pill Box: A System-Wide Approach to Improving Patient Medication Adherence for Chronic Disease*.

A cap of $200 on specialty drugs would have almost no impact on actuarial value while providing a positive impact on consumer affordability and adherence to complicated drug regimens. Further, other states have demonstrated that it can be done successfully; such a cap is also consistent with what many insurers already do in the large group market.

I urge you to modify your staff's recommendation and impose a $200 cap per prescription on the out-of-pocket costs for specialty drugs, for the benefit of consumers throughout California who have health conditions that necessitate access to these drugs.

Sincerely,

DAVE JONES
Insurance Commissioner

COVERED CALIFORNIA

Friday, May 15, 2015

The Honorable Dave Jones
300 Capitol Mall, Suite 1700
Sacramento, California 95814

Dear Commissioner Jones,

Thank you for your letter regarding caps on the consumer share of costs for specialty prescription drugs in the 2016 Covered California Standard Benefit Plan Design.

The Covered California board will be making its decision at its upcoming board meeting. Based on the board's guidance and after soliciting and reviewing a range of data and input from a range of stakeholder groups, staff have revised the recommendation for the board that would include lowering the caps on specially drugs for most enrollees to $250 (see attached for details). Covered California's priority remains to provide affordable options to all enrollees, now and in the long run, regardless of health status or economic condition. In that spirit, the board will be considering benefit design alternatives that will allow enrollees to spread out the cost of high-cost medication over the length of their coverage, while maintaining long-term affordable premium rates.

As we look into this issue we have been and will continue to be mindful of the potential cost to those using specialty drugs, and to all consumers who may face increased premiums. There have been a number of reports from health plans and actuaries on the potential rate impact projected by various cap scenarios, and the Exchange must consider the potential for rate increases beyond 2016. The increased introduction and utilization of high-cost specialty drugs means this issue requires close monitoring. Covered California will continue to work to find the right balance in its benefit design, taking into account affordability to all consumers, overall affordability of premiums, and a plan's ability to control drug cost.

The Covered California Specialty Drug Workgroup, which your office and the Department of Managed Health Care participated in, has provided valuable feedback on the issue. Covered California is taking a number of steps to assure transparency, access and accountability regarding high-cost drugs. These include:

- Requiring plans to publish an up-to-date, accurate and complete list of covered drugs, including drugs used to treat HIV/AIDS, Hepatitis C, Rheumatoid Arthritis, Multiple Sclerosis, Systemic Lupus Erythematosus, beyond the Top 50 or Highest Use Drugs, and include any tiering structure that is adopted;

- Requiring plan formularies to include at least one drug in Tiers 1 or 2 or 3 if all FDA-approved drugs in the same drug class would otherwise qualify for Tier 4 and at least 3 drugs in that class are available as FDA-approved drugs;

- Requiring plans to provide estimates for enrolled consumers of the range of out-of-pocket cost for specific drugs;

- Requiring plans to include a statement on the availability of drugs not listed on formularies and how to obtain them using an exception process;

- Creating a dedicated pharmacy customer service line for advocates, prospective, and current consumers to answer and clarify any questions on formularies.

Covered California is committed to find consumer-focused solutions, and help lower the financial burden for enrollees that need high-cost medication. Thank you again for your feedback.

Sincerely,

Peter V. Lee
Executive Director

Enclosure

CC: Covered California Board of Directors
Shelley Rouillard, Department of Managed Health Care

PLAN MANAGEMENT ADVISORY GROUP

May 14th, 2015

BENEFIT DESIGN UPDATES AND CONSUMER CLARITY

JAMES DEBENEDETTI, DEPUTY DIRECTOR
COVERED CALIFORNIA PLAN MANAGEMENT DIVISION

Update: Pharmacy changes to the 2016 Standard Benefit Plan Design

Covered California reassessed the cap dollar amounts on Tier 4 (specialty) drugs and requested data from QHPs on Tier 4 cost and utilization to inform the final recommendation to the Board.

- Covered California will recommend Tier 4 drugs to be capped at a maximum of $250 for Silver, Gold, and Platinum plans and $150 for Silver 87 and Silver 94 plans.
- A lower cap of $250 on all drug tiers in the Bronze plan does not meet the AV requirement. As such, we will be recommending all drug tiers have a member cost share of 100% coinsurance up to a $500 cap.
- Due to operational challenges raised by plans (inability to cap the cost-share for a service with a combined medical and pharmacy deductible), the Bronze plan now has a separate medical and pharmacy deductible.
- The maximum cap applies to a script of up to a 30-day supply.
- A member in a Bronze or Silver plan filling a high-cost drug will spend the pharmacy deductible, then pay a percentage of the cost of the drug up to the cap (maximum possible for a high-cost script).

Premium, Utilization and Cost of Tier 4 Drugs

To help determine the recommendation for the maximum cap to set for Tier 4 drugs, QHPs provided Covered California data related to projected premium impact, prior utilization and cost information. Using the information received, we determined that setting a lower maximum cap is in the best interest of the consumer for the 2016 plan year.

Premium

- Estimated range of premium impact in the first year is generally less than 1% for all metal levels
- Projected future 3 year premium impact varied widely by 0%-3%
- There is a high degree of uncertainty with the new introduction and pharmaceutical pricing of specialty drugs which makes projecting future year premium impacts difficult
- The annual evaluation of the pharmacy benefit is necessary to adjust benefits as needed

Proportion of membership filling Tier 4 scripts, by plan

- Bronze: 0-2% fill Tier 4 scripts
- Platinum: 5-9% fill Tier 4 scripts

Premium, Utilization and Cost of Tier 4 Drugs (continued)

Average number of Tier 4 fills among members filling Tier 4 scripts:

- On average, Bronze members fill fewer Tier 4 scripts than the other tiers.
- Platinum, Gold, and Silver members fill more Tier 4 scripts.
- Silver 94 and 87 members fill the fewest Tier 4 scripts.

Allowed Cost Per Tier 4 Script

- Plans provided utilization of Tier 4 drugs within a specified range of cost (e.g. <$1,000, Between $1,001 and $3,000, and > $3,000)
- There was wide variation by plan with the percent of consumers who utilized Tier 4 drugs within each dollar range
- As a result, Covered California was not able to determine accurately the change in percentage of consumers who would be impacted by a lower versus higher maximum cap

Proposed 2016 Action for Specialty Pharmacy

Implementation of a Maximum Coinsurance for Tier 4 Drugs

Covered California recommends modifying the 2016 Standard Benefit Plan Designs to put a maximum ceiling on the member cost-share for Tier 4 prescription fills.

Changes to the deductible and coinsurance are indicated in red.

- BRONZE: Coinsurance up to a maximum of **$500** per script* on Tiers 1-4 after deductible
  - Medical Deductible $6,000 / Pharmacy Deductible $500 / Coinsurance 100%
- SILVER 70 AND 73: Coinsurance up to a maximum of **$250** per script for Tier 4 after deductible
- SILVER 87 AND 94: Coinsurance up to a maximum of **$150** per script for Tier 4 after deductible
- GOLD: Coinsurance up to a maximum of **$250** per script for Tier 4
- PLATINUM: Coinsurance up to a maximum of **$250** per script for Tier 4
- SHOP SILVER: Coinsurance up to a maximum of **$250** per script for Tier 4 after deductible
  - Medical Deductible $1,500 / Pharmacy Deductible $250

* Up to a 30-day supply per script. This applies to all metal levels.

2016 Standard Benefit Plan Design: Summary of Member Cost Shares for Drugs

Plan	Tier	2016 Member Rx Cost Share After Pharmacy Deductible	2016 Pharmacy Deductible	2016 MOOP	2016 Maximum Member Cost Share Per Script (after RX deductible is satisfied)	Maximum Member Cost Share for a Tier 4 Script (deductible plus cap)	AV WITH PROPOSED CHANGES
Bronze	1	100%	$500	$6,500	$500	$1,000	61.87
	2	100%	$500	$6,500	$500	$1,000	
	3	100%	$500	$6,500	$500	$1,000	
	4	100%	$500	$6,500	$500	$1,000	
Silver	4	20%	$250	$6,250	$250	$500	70.45
Silver 94 100-150	4	10%	$0	$2,250	$150	$150	93.84
Silver 87 150-200	4	15%	$50	$2,250	$150	$200	86.85
Silver 73 200-250	4	20%	$250	$5,450	$250	$500	72.83
SHOP Silver Coins	4	20%	$250	$6,500	$250	$500	71.57
SHOP Silver Copay	4	20%	$250	$6,500	$250	$500	71.26
Gold Coinsurance	4	20%	$0	$6,200	$250	$250	80.24
Gold Copay	4	20%	$0	$6,200	$250	$250	81.08
Platinum Coinsurance	4	10%	$0	$4,000	$250	$250	88.50
Platinum Copay	4	10%	$0	$4,000	$250	$250	89.45

DAVE JONES
Insurance Commissioner

May 20, 2015

Secretary Diana Dooley
Chair, Covered California
and Board Members
1601 Exposition Blvd
Sacramento, CA 95815

Dear Chairperson Dooley and Covered California Board Members:

At your Board meeting tomorrow (Thursday, May 21st) you will revisit the Board decision made in January 2015 relating to cost-sharing for specialty drugs in the Covered California 2016 Standard Benefit Plan Design that all health plans and health insurers in California are required to sell in the individual and small group markets, whether or not that company sells through the Exchange.

The 2016 Standard Plan Design adopted in January had no cap on cost sharing for specialty drugs other than the $6500 annual maximum out of pocket limit for the policies. Prior to the Covered California Board's adoption of the 2016 Standard Plan Design in January and during the months that followed, the Department of Insurance has been working with your staff and stakeholders to ask that Covered California adopt a monthly cap of $200 for each specialty drug for all metal levels.

In advance of your April 2015 Board meeting, the Covered California staff recommendation to the Board was a monthly $500 cap for each specialty drug. I wrote to you at that time, as did consumer organizations, asking that you lower the cap so that specialty drugs are affordable to consumers. You then postponed your decision until the May Board meeting. Like you, I continue to hear from consumers who want to see you adopt a monthly cap on the cost of specialty drugs that ensures that Californians have access to the drugs they need to treat their chronic and often life-threatening medical conditions.

The current Covered California staff recommendation is a cap of $250 per month for each specialty drug for the Silver, Gold and Platinum Plans. For the Silver Plan this $250 monthly cap for each specialty drug is after a $250 pharmacy deductible is met.

The Covered California staff recommendation for the Bronze Plan, however, still allows health insurers and plans to charge up $500 a month for each specialty drug after a $500 pharmacy deducible is met. This means that for a person taking just one specialty drug, the cost in the first month would be $1000 for someone with a Bronze plan. The Bronze plans are the most popular choice among Californians who do not receive premium assistance and who must pay

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the full cost of the monthly premium themselves. For someone who chooses the Bronze plan because that is the premium level they can afford to pay, it is difficult to imagine that they will be able to pay $1000 to get their first month's supply of a specialty drug, or $1500 in the first month if they need two specialty drugs. Californians with a Bronze plan simply may not be able to afford to get their medically necessary prescriptions filled if you approve the staff recommendation to set the cap for Bronze plans at $500 per drug per month after a $500 deductible.

Department of Insurance staff provided Covered California staff with a number of options that would meet the Actuarial Value (AV) requirements for Bronze plans, but allow for capping the monthly cost of specialty drugs in the Bronze Plan at $200, $250 or $300. The option for a cap for the Bronze plan most in line with the current Covered California staff recommendation for Silver, Gold and Platinum plans is a $300 monthly cap on specialty and lower tier drugs for Bronze, after the pharmacy deductible is met. This option meets the AV requirement, while making specialty drugs more affordable and accessible than they would be under the latest Covered California staff recommended proposal.

There are a number of states that have caps between $100 and $250 for specialty drugs. And there are states, including our own, in which legislation is under consideration to cap specialty drugs at less than $300 per month. To the extent that you are concerned with consistency from one year to the next, a $300 cap on the Bronze plan is more in line with pending California legislation than the $500 cap your staff propose. And all the information collected by my Department, your staff and other parties that we have seen to date shows that even a $250 cap will not result in premium increases in 2016.

A great deal of work has been done by your staff, my staff at the Department of Insurance, consumer organizations and other stakeholders to look at these issues over the last six months. The current Covered California staff proposal is better for consumers who purchase Silver, Gold or Platinum plans than the January and April proposals, but it leaves Bronze plan consumers facing unaffordable drug costs. You can and should lower the staff recommended $500 cap on drug costs in the Bronze plan to at least as low as $300 a month per drug, in order to provide those with the Bronze plan affordable access to the medically necessary prescriptions they need.

I ask that you amend the staff proposal for the Bronze plan to lower the cap before you vote to adopt the Standard Benefit Design that all California health plans and health insurers will use for 2016. Thank you for your consideration of this important issue.

Sincerely,

Dave Jones

DAVE JONES
Insurance Commissioner

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May 18,2015

To: The Covered California Board of Directors and Executive Director Peter Lee

Re: Comments regarding the tiered network rule proposed at the Covered Ca Board Meeting on April 16, 2015.

Regulatory oversight of network sufficiency is especially important as it applies to new approaches to health carrier network designs, such as tiered networks. Given that tiered networks may be designed in different ways such that not all covered services are provided in every tier, it is critical that consumers be made aware of what services are included, or not included, at the point of sale.

While LLS supports Covered California's efforts to develop regulations regarding tiered networks, LLS recommends that the following requirements also be included in order to ensure proper notification and disclosure to consumers.

- Carriers must explicitly disclose which providers are in each tier of the plan's provider directory.
    - The tier and patient out-of-pocket cost associated with each provider must be listed in the provider directory.
    - When using a carrier's online provider directory search tool, consumers must be able to filter or display providers according to tier.
- A carrier must explicitly disclose that a plan's lowest cost tier (Tier 1) must satisfy state network adequacy and timely access standards, without regard to the providers and facilities included in the plan's Tier 2 network.
- If a carrier's Tier 1 network does not include a provider of the required specialty with the required professional training and expertise, a consumer must be permitted to seek care outside the Tier 1 network and, in these cases, the carrier must limit cost-sharing to the amount required for a Tier 1 network provider.

The Leukemia & Lymphoma Society (LLS) is the world's largest voluntary health agency dedicated to the needs of blood cancer patients. Each year, over 140,000 Americans are newly diagnosed with blood cancers, accounting for nearly 10 percent of all newly diagnosed cancers in the United States. The mission of LLS is to find cures for leukemia, lymphoma, and multiple myeloma and to ensure that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare. LLS funds lifesaving blood cancer research around the world, provides free information and support services, and advocates for public policies that address the needs of patients with blood cancer. Since our founding 65 years ago, LLS has invested over $1 billon into research for cures and LLS-funded research has been part of nearly all of the FDA-approved therapies for blood cancer.

If you have any further questions regarding these comments, please contact:

Thea Zajac, MSW, Director of Government Affairs
Phone: 415-625-1105 Email: thea.zajac@lls.org

May 20, 2015

Attn: Peter Lee
Covered California
1601 Exposition Boulevard
Sacramento, CA 95814

Re: Covered California 2014-15 Navigator Program & 2015-16 Navigator Program Recommendations

Dear Mr. Lee and Covered California Board:

Asian Americans Advancing Justice – Los Angeles (Advancing Justice-LA) is writing on behalf of the undersigned organizations, including Covered California Outreach and Education and Navigator grantees, many of whom are Health Justice Network (HJN) grantees serving Asian American, Native Hawaiian, and Pacific Islander communities, and others who have provided valuable in-person assistance to hard-to-reach communities during the last two years. All of the undersigned Covered California grantees are committed to reaching out to, educating, enrolling and assisting consumers so they are able to enjoy the benefits of Covered California, as well as the new health care options created by the Patient Protection and Affordable Care Act. As grantees of Covered California's Outreach and Education and Navigator Programs, we seek to increase access to affordable, high quality, and culturally and linguistically competent health care for eligible community members across the state.

We have on the ground experiences as certified health educators and certified enrollment counselors whose outreach, education, enrollment and post-enrollment work has proven highly successful yet also challenging. Many grantees and HJN partners have provided culturally and linguistically appropriate services in over 36 languages to the very hard-to-reach communities that truly require in-person assistance. As we have done in the Regional debriefs and past Board meetings, we would like to share some of the greatest challenges we faced and to provide recommendations based on the lessons learned to improve the existing 2014/15 Navigator Program and to ensure the success of the proposed 2015/16 Navigator Program.

A. Accomplishments

During the first open enrollment period, with the assistance of many partners under its Outreach and Education grant program, Covered California exceeded its enrollment goals. For example, Advancing Justice-LA's collaborative worked tirelessly to reach over 130,000 individuals through in-language outreach, education and enrollment assistance. Building on the momentum and experiences outreaching, educating, and enrolling during the first open enrollment period, many Navigator grantees have continued their work through the second open enrollment period. For this last open enrollment period, Covered California has come close to meeting its enrollment and retention goals, once again with the help of the Navigator Program partners. As each year passes, it will be harder and harder to find uninsured, eligible Covered California consumers. Therefore, it will become increasingly more important to have Navigator partners who are the "trusted messengers" of health information to whom community members turn when they need help or have questions and possess the cultural and linguistic competency to serve the "hardest-to-reach" communities.

B. Challenges with Current 2014/15 Navigator Grant Program

Despite our Navigator partners' best efforts to conduct in-language outreach, education, and enrollment assistance, and extensive post-enrollment conversations and troubleshooting, we encountered serious challenges. Some of the most significant ones described below greatly impeded our ability to fully execute our collaborative work plan in the timeline provided.

1. **Substantial Increase in the Time Needed to Assist and to Enroll Consumers** – For this open enrollment period, it has been much more difficult to find eligible consumers and generate interest compared to the first open enrollment period. This time around, the path to completing applications has been a complicated and arduous journey for many and required much more time than expected. Based on many of our experiences conducting the range of navigator activities, from outreach, education, enrollment, renewals, post-enrollment, utilization and other technical assistance, we found that certified enrollment counselors (CECs) were averaging 8-11 hours for every successful enrollment.

   More often than not, it took multiple appointments and phone calls to help consumers get enrolled. Moreover, there were at least three to four times as many Medi-Cal enrollees as those eligible for Covered California. Nonetheless, Navigator grantees took the necessary time to give each consumer the attention and provide the technical assistance and support needed to help consumers make educated decisions based on their personal circumstances.

2. **Surge or Troubleshooting Efforts** – As noted above, many grantee staff spent much of their time troubleshooting issues for consumers, many of whom had coverage from the first open enrollment period but received assistance from another entity or an insurance agent unable or unwilling to assist them during this enrollment period. For many of these organizations with limited staff capacity, having to spend time waiting upwards of 45 minutes to an hour to talk to a CEC helpline representative reduced their ability to assist new consumers with enrolling into coverage.

3. **CEC Certification Progress Challenges** – Many grantees experienced technical difficulties with the certification process, which resulted in unnecessary, protracted delays and a late start for many. For example, one HJN partner in Sacramento, which trained all of their twenty staff members to become

CECs, lost many hours due to the inability to progress past each learning module. The collaborative was unaware that LMS was going through a transition/upgrade during that period, which created this problem. Although a "workaround" was eventually found to get past this frustrating situation, much time had already been wasted and many grantees were not made aware of the "workaround." Additionally, CECs had to take the exam multiple times because the exam was not checked off as "passed" even though over 80% of the questions were answered correctly. Furthermore, the long processing time for background checks delayed the CEC certification process and CECs were not notified if a background check did not go through or could not be processed. It would have been useful for CECs and lead organization to have been updated when a CEC's certification process had been delayed for an extended period of time. In addition, Covered California should also have provided CECs with access to re-review training modules, even after passing exams.

4. **Customer Hotline Service Challenges** – Although the extension in hours for the CEC Dedicated Help line was extremely helpful, during surge periods, our Navigator CECs continued to have long waits and were often on hold for over an hour at a time. Furthermore, it was frustrating to wait for an interpreter when language assistance was required, only to learn that there was no representative or interpreter available for interpreter services. When having to assist clients at enrollment events or when only a dedicated amount of time is given for appointments, waiting almost an hour takes away time from actual consumer assistance and generally increases consumer frustration with Covered California. We recommend that Covered California extend its dedicated CEC Helpline hours into later in the evenings during the week and longer weekend hours, including Sunday, when the most help is needed for working individuals. The long wait times for the CEC Helpline could also be decreased if there were additional staff transferred from the Consumer Helpline to the CEC Helpline, which currently only has 11 staff.

5. **Challenges with Insurance Agent Community** – While we understand the need for, and respect the role of, the insurance agent community in enrolling consumers, many grantees encountered consumers who needed assistance and help troubleshooting their application due to problems with insurance agents. Some consumers had enrolled with agents but when returning to the agents for follow-up assistance, the insurance agents were unwilling or unable to provide help and/or provide the consumer their account log-in credentials, which proved time consuming for CECs to provide assistance. Since many of the grantee organizations have limited staff capacity, the time spent helping consumers with resolving these problems ultimately took away time to enroll new consumers.

6. **More Frequent Progress Reports from Covered California** – While we appreciate that Covered California staff has consistently improved the reports sent to Navigator grantees, it is imperative that we receive more timely progress reports to be able to strategically adjust our work plans. Many grantees were not able to receive timely reports to monitor progress towards our enrollment goals. For example, we did not receive our first report until 1/30/15 covering the period through 12/31/14. While it is useful to get monthly Covered California figures, grantees did not receive their reports until the end of the following month. Therefore, the late reports made it difficult to definitively know the collaborative's official performance standing without timely, up-to-date reports.

7. **Continued Need for Simple, Understandable, In-Language Materials and Translated Notices and Letters for the Consumers** – Having understandable, in-language materials has always been a critical need for limited-English proficient (LEP) consumers in order for community partners to provide

effective outreach, education, and enrollment assistance to LEP individuals and for LEP consumers to understand their health care options. Although many Navigator grantees provide in-language oral assistance in over 37 languages, the lack of translated materials for many LEP communities, such as Thai, South Asian, Native Hawaiian, Pacific Islander, and other Southeast Asian groups, has made navigator efforts challenging. For the past two enrollment cycles, the lack of properly translated materials, including letters and notices with critical consumer information, has made reaching, educating, enrolling and assisting the "hardest to reach" populations, such as immigrants and LEP community members very difficult. Even for the materials that were translated, sometimes the translations needed to be changed to correct inaccurate information, to capture cultural nuances, and to match the literacy level of certain populations. Because there were not enough translated materials provided to underserved groups, some grantees had to create or translate materials on their own. For example, after requesting information in additional languages, Advancing Justice-LA finally used its own resources to translate Covered California's "Welcome Tri-fold" into 13 additional Asian and Pacific Islander languages, which was a time intensive process and required extensive financial and staff resources to complete.

C. Recommendations for Current 2014-15 Navigator Program

We recognize that the budget for the 2014-2015 Navigator Program was set at $16.9 million ($14.65 + $2.25 million in bonus payments.) but that amount is unlikely to be spent for the program because most of the grantees will not be able to receive more than their second payment for the full range of Navigator activities that they have conducted under this grant. We also understand that Covered California acknowledged that there needed to be changes to the current Navigator Program, as well as the 2015-2016 Navigator Program. Although we appreciate the changes that have been made to the 2014-15 Navigator Program because of the recognition of indispensable contributions made by grantees despite the many of the challenges identified above, we believe that there should be some additional adjustments made to the current Navigator Program to allow grantees to continue their work, especially since the budget has already been allocated and much of the work has been completed. Therefore, we respectfully request the board to consider the following recommendations:

1. **Revise the Navigator Program Payment Policy**: In recognition of the "critical work that [Covered California] Navigator Grantees are doing to support [Covered California's] culturally and linguistically diverse communities" and the "unanticipated efforts to support retention" needed to ensure the overall success of Covered California, the Board agreed to the staff's recommendation to change the definition of "effectuated enrollment" to count "assisted applications through plan selection towards enrollment goals instead of effectuations" and to process the second payment upon satisfactory demonstration of their readiness and efforts to implement their campaign strategy for those grantees that did not meet 25% of their enrollment goal.

   A) Similar to the recognition that renewals are critical to retention efforts for the 2015-2016 Navigator Program, we request that renewal numbers be counted towards total grantee enrollment goals. We believe that some grantees will be able to achieve 75-100% of their enrollment goals if renewals are counted.
   B) For those grantees who do reach 75% of their enrollment goals (including renewals), we request that Covered California consider a third payment for those grantees who reach 50% of their enrollment goals (including renewals). As for the second payment, we would submit a narrative

report demonstrating the satisfactory implementation of our campaign strategy. This would allow many of the current grantees to continue their critical work for the next open enrollment period rather than losing many trained, experienced, and certified pool of enrollers.

C) Finally, for those grantees who reach 90% of their enrollment goals (including renewals), the fourth payment since these grantees have come so close to reaching their enrollment goals and would easily meet the goals of the 2015-2016 Navigator Program goals.

2. **Disbursement of Remaining Outreach and Education Grant Program Funds to Navigator Grantees**: Prior to transitioning to the Navigator Grant Program, many Outreach and Education (O/E) grantees had to quickly weigh difficult factors that would affect our transition from the O/E program to the Navigator program. One major consideration was what effect the transition would have on the remaining funding in the Outreach and Education grant, for which many grantee partners relied on to maintain staffing for Covered California navigator activities.

   Although O/E grantees appreciated that Covered California did take away all of the remaining O/E funding as originally proposed, many also expressed our serious concern with allowing the remaining O/E grant to be rolled into the proposed Navigator Program and the disadvantages it would create for our collaborative partners. However, because of our desire to continue the vital in-person assistance that is needed to reach and enroll hard-to-reach populations, as well as to continue an official partnership with Covered California, many O/E grantees made the difficult decision to allow the rollover of the remaining O/E grant in order to pursue a Navigator grant. Now many current Navigator grantees will be penalized as predicted because we will not receive the full allocation of the O/E grants, despite meeting our O/E goals. For example. Advancing Justice-LA's collaborative far exceeded the terms of providing in person outreach and education to well over our target of 130,000 individuals. Similarly, all of the other O/E grantees have met, if not exceeded, all of their grant deliverables. Therefore, we strongly urge Covered California to disburse the final allocation of funding under the prior O/E grant owed to the former O/E grantees that transitioned to the Navigator program.

D. Recommendations for 2015-16 Navigator Program

We fully support the improvements made to the new 2015-16 Navigator Program, including the use of block grants and the recognition of the full range of navigator activities, including the lowered enrollment projections. However, based on our prior experience working on outreach, education, enrollment, renewal and retention, utilization, and post-enrollment assistance to consumers on a wide range of problems, we would appreciate the board's consideration of the following recommendations:

1. **Increase the Proposed Navigator Total Budget of $10 Million:** We appreciate Covered California's continued commitment to community based entities targeting hard to reach populations. However, as we noted at the last Covered California Board meeting, we are concerned that the proposed budget allocation of $10 million for the 2015/16 Navigator program is the maximum being considered. We certainly believe that this should be considered the minimum needed to support in-person assistance to eligible, uninsured and hard-to-reach consumers. In fact, we believe the budget is too little, especially in light of the decrease from previous years. For example, the budget for the O/E program during the First Open Enrollment Period totaled $43 million and for the 2014-15 Navigator program, the amount was decreased to about $16.9 million. The $10 million currently allocated to the Navigator Program is only 3% of the total 2015-2016 budget and only 8% of the total Outreach and Sales, Marketing budget.

We would argue that the money spent for the Navigator Program is much more cost effective than funding for other programs. For example, in the 2014-2015 budget year, when comparing the resources allocated to the Service Center ($99 million) to that for the Navigator Program ($16.9 million), it appears that Navigator grantees are much more cost-efficient, accounting for about 9% of the enrollees compared to the 9% enrolled by the Service Center during the last enrollment period. Given this discrepancy in allocation of funding, we believe that additional funding should be allocated for the next Navigator grant program. Another source of additional funding could be the Marketing budget.

With every passing year, with those who needed health coverage already enrolled, i.e., the "low hanging fruit," it will be more difficult to identify and to enroll consumers, especially those from hard-to-reach, immigrant and limited-English proficient communities. It would be a terrible loss to Covered California to lose all of the experience and knowledge developed by the more than 6,000 Certified Enrollment Counselors it has already invested to provide critically necessary in-person, in-language assistance for thousands of consumers.

Therefore, we strongly feel that both increased and continued funding for in-person, in-language assistance from community-based Navigator grantees are critical to Covered California's strategy not only to retain consumers but to target the most vulnerable and hard to reach populations who are eligible for the marketplace. At a minimum, the Navigator budget should be at least $10 million.

2. **Allocate Specific Funding for Ethnic Media Buys in Navigator Program:** We would suggest that a portion of the $71 million allocated to the Marketing budget be apportioned to the Navigator grantees, which may provide more efficient and effective ethnic media outreach. Regardless of where the funding is found, we would request that Covered California consider allocating distinct funding through the Navigator program specifically for grantees to work with targeted ethnic media outlets, many of whom our partners have long established relationships with, to reach LEP and mixed immigration status populations and other hard to reach communities. We have found that when our organizations placed media buys with our existing ethnic media partnerships, consumer interest increased greatly not only because the buys were in-language but because of consumer recognition and familiarity with our organizations as "trusted messengers" who provide numerous community services year round.

3. **Provide Timely Disaggregated Ethnic and Language Enrollment Data:** Data is power; disaggregated consumer enrollment data by race, ethnicity and language from the first and second open enrollment periods would provide a clearer picture of those consumers not being reached and what gaps still need to be filled. As Navigator grantees plan for future outreach efforts to the hardest-to-reach, and the "low hanging fruit" population begins to dwindle even more, updated disaggregated enrollment data by language, race and ethnicity will be even more important when analyzing and executing enrollment strategies.

4. **Ensure Administrative and Reporting Requirements are Simple and Not Overly Burdensome:** We hope Covered California will create an efficient reporting system to monitor the Navigator grant program. While the current Navigator Program was too dependent on one performance metric ("effectuated enrollments"), it greatly reduced the administrative reporting requirements and was a great improvement from the O/E Program.

5. **Expand Staff to Achieve Covered California's Mission to Reduce Health Disparities**: We were extremely excited when Covered California hired its first Health Equity and Diversity Officer, Jonathan Tran. As California's population continues to grow in racial, ethnic, cultural, and language diversity, and given the overwhelming task for one staff to address this huge area of need, we would recommend that Covered California expand its staff devoted to reducing health disparities among vulnerable populations and to ensuring health equity in the state's emerging health care system. Doing so will increase Covered California's ability to respond to the needs of the range of affected populations and issues, including monitoring activities such as racial and ethnic media marketing, language assistance services, both interpreter and translation services, development of culturally and linguistically competent consumer materials, such as applications, renewals and notices, and other relevant activities. We trust that Covered California will make it a priority for Jonathan and other relevant staff to meet regularly with community stakeholders and urge Covered California to produce written reports about the suggestions that staff receive and provide updates on these issues. We believe that expanding staff and increasing dialogue with community stakeholders will improve the enrollment process.

The O/E and Navigator grantees believe that our partnership with Covered California has contributed to its overwhelming success for the last two years. We look forward to our continued partnership with Covered California and leading the efforts in reaching vulnerable, hard-to-reach consumers. Thank you for your consideration. If you any questions or need further information, please contact Doreena Wong at (213) 241-0271.

Sincerely,

Doreena Wong, Project Director, Health Access Project
Asian Americans Advancing Justice – Los Angeles

Eileen Ma, Executive Director
API Equality-LA

Richard Konda, Executive Director
Asian Law Alliance

Stephanie Nguyen, Executive Director
Asian Resources, Inc.

Peter Ng, Executive Director
Chinatown Service Center

Sonya Vasquez, MSW, Health Care Coverage Policy Director
Community Health Councils

Tana Lepule, Executive Director
Empowering Pacific Islander Communities

Lillian Lew, Executive Director
Families in Good Health

Yey Coronel, Executive Director
Filipino American Service Group, Inc.

Sarah Gonzalez, Executive Director
Filipino Youth Coalition and Community Development Services of Santa Clara County

Lola Santos, Executive Director
Guam Communications Network

Candice Adam-Medefind, Executive Director
Healthy House Within a Match Coalition

Michael Villaire, MSLM, CEO
Institute for Healthcare Advancement

Quyen Vuong , Executive Director
International Childrens Assistance Network

June Lee, Executive Director
Korean Community Center of the East Bay

Jongran Kim, Health Access Project Director
Korean Resource Center

Kawen Young, Executive Director,
Native Hawaiian & Pacific Islander Alliance

Ye Lee, Program Manager
Orange County Asian and Pacific Islander Community Alliance

Charlene Kazner, Project Manager
Pacific Islander Health Partnership

Bill Skeen, MD, Executive Director
Physicians for a National Health Program - California

Patsy Tito, Executive Director
Samoan Community Development Center

Joel F. Jacinto, Executive Director
Search to Involve Pilipino Americans

Manjusha P. Kulkarni, Esq., Executive Director
South Asian Network

Leafa Taumoepeau, Executive Director
Taulama for Tongans

Chancee Martorell, Executive Director
Thai Community Development Center

Nongyao Varanond, Executive Director
Thai Health And Information Services

Margaret Iwanaga-Penrose, President & CEO
Union of Pan Asian Communities

Susana Sngiem, Executive Director
United Cambodian Community

Cat T. Nguyen, Director
Vietnamese Voluntary Foundation, Inc.

Maria Lemus, Executive Director
Vision Y Compromiso

Stella Kim, Executive Director
Young Nak Outreach and Transformation Foundation

NATIONAL HEALTH LAW PROGRAM

Elizabeth G. Taylor
Executive Director

May 13, 2015

Diana Dooley, Chair
Peter Lee, Executive Director
Covered California
1601 Exposition Road
Sacramento, CA 95815

Re: 2016 Benefit Designs: Cost Sharing for Prescription Drugs & Tiered Network Designs

Dear Ms. Dooley and Mr. Lee,

The National Health Law Program, joined by the Western Center on Law & Poverty, writes to offer recommendations concerning the changes the Board will contemplate at its Board meeting this month regarding the 2016 standard benefit designs. The National Health Law Program protects and advances the health rights of low income and underserved individuals. Specifically, our comments address the proposed regulations that were before the Board in April that would have capped cost-sharing for prescription drugs, and added a footnote to explicitly allow plans to offer a two-tiered benefit design. We understand that the Board will again consider these proposed regulations at its meeting on May 21.

Cost-sharing on Prescription Drugs

We applaud Covered California for recognizing the financial burden on consumers posed by high cost drugs; the proposed regulations take a hugely important first step to limit the amount of cost-sharing consumers are exposed to for high cost drugs. We remain concerned, however, that the cap amounts proposed in April are still quite high—starting at $200 per prescription per month for individuals at 139% FPL (about $1,355 per month for a single individual), and will place a disproportionate financial burden on individuals with chronic diseases who take multiple specialty drugs each month. A person at 139% FPL who has just three

specialty prescriptions will be spending nearly half of her income on drug costs. As described in more detail below, costs this high are extremely likely to result in adverse health outcomes for Covered California enrollees. We urge the Board to lower the cap amounts and to consider an overall monthly cap in order to ensure that prescription drug costs affordable, especially for the lowest-income and highest need enrollees.

Higher cost sharing significantly reduces medication adherence, particularly for lower income individuals.[1] For people who require expensive medications, marketplace deductibles and extremely high cost sharing for specialty drugs can present an enormous one-time cost that makes it nearly impossible to afford the care they need. Such practices concentrate out-of-pocket expenses in a single month or quarter before the enrollee exceeds their aggregate cap. This is somewhat analogous to High Deductible Health Plans (HDHPs), which also frontload out-of-pocket expenses by requiring individuals to pay the full cost for nearly all services prior to meeting their deductible. Studies of employer-sponsored HDHPs suggest they disproportionately reduce pharmaceutical use (on both high and low priority medications) and increase noncompliance.[2] Other studies show, unsurprisingly, that lower income individuals are relatively more likely to forgo or delay care in HDHP plans.[3] California's proposal to cap monthly pharmaceutical costs represents an important first step to lessen the financial burden of cost sharing for expensive drugs by distributing those costs across the year and making these drugs relatively more accessible.

We recognize that even with the proposed caps, the high financial burden on individuals with multiple prescriptions or in lower income brackets will persist. Studies of Medicaid programs have shown that copay increases of just a few dollars can significantly reduce medication adherence.[4] The consequences of forgoing needed medication are magnified for people with chronic conditions.[5] One exhaustive literature review declares the evidence "unambiguous" that higher cost sharing is associated with more frequent

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[1] Becky A. Briesacher et al., *Patients At-Risk for Cost-Related Medication Nonadherence: A Review of the Literature*, 22 J. GEN. INTERNAL MED. 864 (2007); Michael T. Eaddy et al., *How Patient Cost-Sharing Trends Affect Adherence and Outcomes: A Literature Review*, 37 PHARMACY & THERAPEUTICS 45 (2012).
[2] M. Kate Bundorf, *Consumer-Directed Health Plans: Do They Deliver?* (2012), http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf402405; Song Chen et al., *Medication Adherence and Enrollment in a Consumer-Driven Health Plan*, 16 AM. J. MANAGED CARE e43 (2010).
[3] Jeffrey Kullgren et al., *Health Care Use and Decision Making Among Lower-Income Families in High-Deductible Health Plans*, 170 ARCHIVE INTERNAL MED. 1918 (2010).
[4] Joel F. Farley, *Medicaid Prescription Cost Containment and Schizophrenia: A Retrospective Examination*, 48 MED. CARE 440 (2010); Leighton Ku et al., CTR. ON BUDGET & POLICY PRIORITIES, *The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program* (2004), www.cbpp.org/files/11-2-04health.pdf.
[5] Amitabh Chandra et al., *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 AM. ECON. REV. 193 (2010).

hospitalizations and emergency department visits for people with chronic conditions.[6] Numerous studies, including the gold standard RAND Health Insurance Experiment in the 1980s, demonstrate that when faced with higher cost sharing people forego higher and lower priority care in roughly equal proportions.[7] Aside from the human impacts of these negative outcomes, the added costs from expensive ED visits and hospitalizations substantially or even completely offset savings from reduced utilization of medications.[8] Other studies have shown that reducing copays for common medications for chronic conditions can improve health outcomes without significantly impacting overall costs.[9] These findings highlight the inefficacy of cost-sharing as a tool to improve the efficiency of the health care system. We urge Covered California to lower the cap amounts and to implement an overall monthly cap on drug costs (rather than a cap per prescription) to contain the high costs of expensive but vital medications for these populations without simply shifting those costs onto enrollees.

Tiered Benefit Design

We appreciate that as long as QHPs are permitted to use tiered networks, the proposed regulations will clarify how Covered California will assess the plans' compliance with consumer protections. We recommend that the Board further revise proposed footnote 23 to add clarity. It should specify that, in addition to meeting state network adequacy and timeliness rules in its lowest cost tier, plans must comply with ECP requirements with respect to the lowest cost tier, and may not impose additional cost-sharing on emergency services provided by a provider associated with the second tier.

We are also heartened that the staff has articulated intent to closely scrutinize tiered network plans in 2016. We are concerned that, despite Covered California's attempt to ensure that these plans offer protections and benefits to consumers, in reality, their design is incredibly confusing to consumers, and too often results in consumers' paying additional cost-sharing for which they should not be liable. For example, consumers who are choosing a plan often do not understand the distinction between different tiers. They may try to do the right thing by choosing a plan that contracts with all of their current providers, only to discover, after receiving care from one of those providers, that the cost of using a "second tier" provider is substantial, and that those costs do not even count toward their plan's deductible or out-of-pocket maximum. In addition, consumers

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[6] Dana P. Goldman et al., *Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health*, 298 JAMA 61, 64 (2007).
[7] Judith H. Hibbard et al., *Does Enrollment in a CDHP Stimulate Cost-Effective Utilization?*, 65 MED. CARE RES. REV. 437 (2008); Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MED. PRACTICE MANAGEMENT 317 (1992), http://www.rand.org/pubs/reprints/RP1114.html.
[8] John Hsu et al., *Unintended Consequences of Caps on Medicare Drug Benefits*, 354 NEJM 2349 (2006); Amitabh Chandra et al., *supra* note 5;
[9] Joy L. Lee et al., *Value-Based Insurance Design: Quality Improvement but No Cost Savings*, 32 HEALTH AFFS. 1251 (2013).

and regulators may have more difficulty monitoring tiered network plans' compliance with existing protections. For example, while consumers should always pay "primary tier" cost-sharing for emergency services, if they use a hospital on a secondary tier and are charged the higher cost-sharing associated with that tier, consumers may not know to complain, and regulators may not know that the plan is evading its duty.

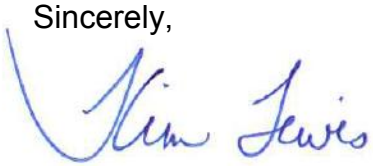
Because tiered designs are so confusing to consumers, and seem to provide little added benefit, we strongly urge Covered California staff to closely monitor plans with tiered networks over the next year. This monitoring work should be done in close partnership with the California Departments of Managed Health Care and Insurance. We urge the Board to set a deadline by which staff must report back to the Board on their findings related to tiered network plans in the following areas:

(1) How clear are the descriptions of the tiered-network and its implications for consumers in marketing materials and the provider directory;
(2) How many consumers are enrolled in tiered-network plans;
(3) What is the rate of grievances and appeals in tiered network plans relative to non-tiered plans;
(4) What is the subject matter of these grievances and appeals;
(5) Has another regulator (such as DMHC or CDI) required a tiered-network plan to take corrective action in the last year, and if so on what basis;
(6) What additional benefits do these tiered-network plans offer to consumers relative to other, non-tiered plans; and
(7) What additional benefits do these tiered-network plans offer to providers relative to other, non-tiered plans.

We encourage the Board to re-evaluate at a Board meeting next year whether allowing tiered-network designs to continue in Covered California is consistent with the Covered California's mission, based on this information and other including stakeholder input.

Thank you again for the opportunity to give input on these issues. If you have any questions or need any further information, please contact Abbi Coursolle (coursolle@healthlaw.org; 310-736-1652), at the National Health Law Program.

Sincerely,



Kim Lewis
Managing Attorney

Abbi Coursolle
Staff Attorney

And on behalf of the Western Center on Law & Poverty

NHeLP
NATIONAL HEALTH LAW PROGRAM

May 20, 2015

Peter Lee, Executive Director
Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

Dear Mr. Lee,

Covered California is not ready to declare "Mission Accomplished" on voter registration.

According to the Secretary of State, since Covered California started mailing registration cards to all enrollees in March 2104 and enabling online registration, just 48,024 voters were registered through April 20, 2015. This total includes a paltry 8,175 who registered to vote online. This is just 1 percent of an estimated 4 million people who have signed up for insurance at Covered California. Assuming 75 percent of those are already registered to vote, which tracks the general population registered, that would still mean 1 million are not registered voters. If the exchange had as poor of a record converting health insurance applicants to enrollees as it does registering voters, Obamacare would have crumbled before it got off the ground.

Disturbingly, instead of acknowledging this ongoing problem, your proposed 2015-16 budget cites "oversight and legal support for the creation and implementation of the voter registration compliance program" as one of the key accomplishments of the Office of Legal Affairs, and the Policy, Evaluation and Research Division has reduced a $1.1 million allocation for voter registration in its 2013-14 budget to $0 for 2015-16.

We are deeply troubled by Covered California's failure to effectively implement its mandate to facilitate voter registration for the millions of Californians it serves.

Covered California started to comply with its voter registration duties a year ago only after voting rights groups were forced to threaten legal action to spur movement. Under the "Motor Voter Law," each applicant for any of Covered California services, renewal of its services, or address changes must be provided with a voter registration form or a declination form as well as assistance in completing the form and forwarding the completed application to the appropriate state or local election official.

The major contact point for people signing up is the online portal. Rather than keeping people on the Covered California site and streamlining voter registration into the enrollment process, the website forces enrollees to leave CoveredCa.com and go the Secretary of State's website when they indicate they want to register. Click-away registration doesn't work and this outdated system should not be the model for Covered California. Instead, Covered California should update the system to auto-fill

the voter form with the personal information needed to register. Such a simple change would make it much easier for Californians to register to vote.

Many eligible voters fail to register due to lack of access and opportunity. According to the Secretary of State, nearly seven million eligible voters have not registered. Nearly 60 percent of those are Latinos. A greater proportion of Latino eligible voters is younger, poorer and has less education than other groups. Nearly 68 percent of those California Latino eligible voters speak a language other than English in the home. In addition, Covered California has targeted millennials in its marketing for health insurance. Young people are twice as likely to register online compared to older people.

Covered California would seem to be in a unique position as a new public entity, with up-to-date analysis, to entice motivated unregistered residents to register. Residents who log on to its site are looking for help and guidance. They should also be receptive to become civically engaged by navigators and agents.

The budget cites one of the key accomplishments of the information technology department was a successful redesign of CoveredCA.com to reflect content and design standards to provide improved consumer experience. As far as we can tell, the voter registration portal was not included in this design because it hasn't been improved at all. The proposed budget includes $5 million for IT infrastructure upgrades and projects necessary for organizational IT operations, security and efficiencies. This should include a budget item to enhance the voter registration process.

Covered California can create a new generation of registered voters. By simplifying the system and keeping potential voters on your site, you can become the gold standard for all other public agencies. We look forward to working with you to make sure all eligible voters are encouraged to register to vote and become civically engaged.

Sincerely,

Carmen Balber
Executive Director

Cc:
Covered California Board members
Sarah Vu, voter registration coordinator