Comments to the Board - External

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January 21, 2016 Board Meeting

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The Voice of Accountable Physician Groups

January 13, 2016

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

Re: QHP Model Contract – Attachment 7

Dear Peter:

We greatly appreciated the meeting with you, Lance and Ann on December 9th. In follow-up to your invitation to provide comment on the proposed changes to Attachment 7 of the 2017 QHP renewal, we are providing several suggestions and observations.

At the outset, I do want to convey the sentiment to you and the Board that the language in the latest version of Attachment 7 shared with us does not go nearly far enough to ensure that there is a significant transition away from the disaggregation of fee-for-service payment to providers in QHPs in the Exchange toward delivery systems that are integrated, accountable and paid under a risk-based model.

As we read the draft the repeated usage of "may" instead of "shall" for many if not most of the requirements stands out, creating ambiguous soft targets that can be ignored with impunity. The current language "encourages" plans to do things, or to report what they are doing, or to provide inventories of data. Few of these deliverables are couched in mandatory language. To be meaningful and for the Exchange to serve as a change agent from volume to value, these deliverables must be couched in mandatory works, like "shall" and not "may."

The Exchange will have been in operation for three coverage years before the new Attachment 7 is implemented, and this document will govern the next three years

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through the end of the decade. Attachment 7 must immediately set hard targets that would drive a meaningful transition toward the kind of accountable, value-oriented delivery system necessary to comply with the objectives recently established by federal HHS under the Learning Action Network[1], "Let's Get Healthy California,"[2] and the Berkeley Forum[3].

In the Forum Report of 2013, Stephen Shortell aptly summarized the chief objective for California health care:

> "*Specifically, the Forum endorses two major goals for California to achieve by 2022: 1) Reducing the share of healthcare expenditures paid for via fee for service from the current 78% to 50%; and 2) Doubling, from 29% to 60%, the share of the state's population receiving care via fully- or highly- integrated care systems."*

The Berkeley Forum Report reflects an important consensus within California that includes the CEOs of six of California's leading health systems, three health insurers and two large physician organizations, along with the California Secretary of Health and Human Services (your Board Chair), the U.S. Department of Health and Human Services Region IX Director and California insurance regulators. The Forum report, published in 2013, complements the "Let's Get Healthy California" report of 2012, providing extensive analysis of several key areas of the California health care market and reflects "the collective work of all involved." It provides seven specific initiatives aimed at bending the cost curve, two initiatives to improve the health of Californians, one involving physical activity and the last expanding palliative care:

> "*To have their maximum impact, the initiatives will require sustained leadership from the healthcare delivery, public health, education, housing, labor, transportation, social services and related sectors, all working together."*[4]

We believe that clearer, simpler priorities should be established that demonstrate alignment with Medicare and CalSim objectives. Three chief measurable objectives come to mind:

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[1] Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. CMS. January 26, 2015.
[2] Let's Get Health California Task Force Final Report. December, 2012.
[3] http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/A-New-Vision-for-California%E2%80%99s-Healthcare-System.pdf.
[4] The Forum Report, at http://berkeleyhealthcareforum.berkeley.edu/about/.

- Requiring a measureable transition away from disaggregated, fee for service networks toward clinically integrated, accountable delivery systems
- Requiring a measureable transition away from pure fee for service compensation to value-based payment models that are predominantly risk-based.
- Requiring a measureable transition toward statewide cost, quality and performance transparency systems

Measurable Transitions: When we say "requiring a measurable transition" we mean that significant metrics are established (like those suggested below and in the Forum Report), progress targets are mandated by the Exchange under the contract and progress or failure is reported and made transparent to the public. This approach is very similar to the one used under the Integrated Healthcare Association's Pay for Performance program and we note that at least 9 of the 12 QHPs participating in the 2016 enrollment year are long-term participants in the IHA program. Those plans are intimately familiar with the IHA process. When the Berkeley Forum issued its watershed report in February, 2013, there was little time to incorporate the findings, objectives and metrics established under that process prior to the opening of the Covered California marketplace. Now, as we look ahead to the next three years it is imperative that the Exchange incorporate as much of the Forum's goals and metrics as possible.

The three proposed priorities are further described as follows:

1. **Clinically Integrated, Accountable Delivery Systems:** The current version of Attachment 7 adopts the CalPERS Integrated Health Model (IHM). This would be sufficient in the Midwest where virtually no integration exists, but in a market like California that has the level of sophistication, integration and accountability, the definition is poor and the metrics are nearly useless. The far-better approach is to adopt the definitions and standards of the Berkeley Forum.[5] The Forum was a collaborative effort between established QHPs and providers and thus represents an agreed-upon framework for change that recognizes the existing level of integration within the current California market.[6] The Forum Report set a target, doubling, from 29% to 60%, the share of the state's population receiving care via fully-or highly-integrated care systems by 2022.[7] Such systems were described as follows:

   "The Forum believes that healthcare must be delivered via systems that coordinate care for patients across conditions, providers, settings and time, and

[5] A New Vision for California's Healthcare System: Integrated Care with Aligned Financial Incentives. The Berkeley Forum for Healthcare. February 2013 (hereinafter, "the Forum Report").
[6] "The Forum includes the CEOs of six of California's leading health systems, three health insurers and two large physician organizations, along with the California Secretary of Health and Human Services, the U.S. Department of Health and Human Services Region IX Director and California insurance regulators"
[7] The Forum Report, at page 14.

are paid to deliver good outcomes, quality and patient satisfaction at an affordable cost."

More recently, the Berkeley Forum has issued an updated report on the progress of California's several Accountable Care Organizations, offering six characteristics of such delivery systems: [8]

- Achieving sufficient size to spread costs,
- Developing new models of caring for high complex/high risk patients,
- Expanding the use of electronic health records,
- Developing effective partnerships with post-acute care providers and specialists,
- Motivating patients and families to become more engaged in their care, and
- Using standardized and transparent quality of care data for the purposes of public reporting and internal quality improvement.

The Forum Report earlier characterized integrated care systems in the following manner:

"The Forum believes that integrated care systems composed of sufficiently scaled medical groups and hospital and health systems can provide the platform for effective stewardship of both the health and financial risk of a population. As part of this Vision, individual or small physician practices, free-standing hospitals, nursing homes, rehabilitation centers and other components of the care continuum would be brought together in new organizations that could be held accountable for the overall health and care of patients. It is crucial that these new organizations have patient populations large enough to properly support investments in areas such as information technology, new care practices, outcomes data collection and evidence-based initiatives."[9]

We note that very few of the QHP networks other than Kaiser Permanente or Sharp Health Plan incorporate such delivery systems as described by the Berkeley Forum, even though Anthem, Blue Shield and HealthNet were the three major QHP participants in the Forum. Together, these three QHPs hold approximately 71 percent (nearly three-quarters) of the 2015 Covered California enrollment.[10]

[8] See: http://berkeleyhealthcareforum.berkeley.edu/2015/02/accountable-care-organizations-ca/.
[9] The Forum Report, at page 15.
[10] Based on QHP enrollment data reported on the Covered California website, accessed December 30, 2015.

In our opinion, it should be the Exchange's chief priority to mandate substantial and rapid progress toward the Forum goal by these three plans over the next three years. We recommend that the existing 2016 networks for each QHP are benchmarked and that each participant is thereafter required to increase its share of "integrated care systems" annually during the term of the agreement. The contract requirement would reference the Forum definition of "fully or highly-integrated care system" and specifically state that each QHP would demonstrate an increased share of such systems annually as follows:

- 35% adoption by 2017 contract year (2018 PY)
- 50% adoption by 2018 contract year (2019 PY)
- 75% adoption by 2019 contract year (2020 PY)

We further note that Section 5.02 does not list such entities as are described in the Forum Report other than a single reference to Accountable Care Organizations among 12 "Use of Care Models." The section should be revised to incorporate "integrated care systems" and the emerging "alternative payment models" that are contemplated under MACRA, since those entities are intended to function in a multipayer environment as were ACOs.

2. **Value-Based Payment Models that are Predominantly Risk-Based:** The other of the two major goals of the Forum Report also included reducing the share of healthcare expenditures paid for via fee for service from the current 78% to 50% by 2022.[11] This was a mutually-agreeable target conceived through the collaborative efforts of the participating QHPs and provider organizations that participated in the Forum. The chief recommendation stated:

   "Specifically, the Forum recommends significant payment reform that aligns financial and clinical incentives. The act of tying providers to a risk-adjusted global budget that encompasses the full spectrum of a population's healthcare needs is the single most important step that can be taken to achieve the twin goals of better health and better healthcare."[12]

   Article 7, Section 7.02 currently defines "value based reimbursement methodologies" as models that *"include those payments to hospitals and physicians that are linked to quality metrics, performance, costs and/or value measures."* While the section then references "integrated care models that receive such value based reimbursements" as those "referenced in Section 5.02" we have previously

[11] The Forum Report, at page 14.
[12] The Forum Report, at page 14.

commented that Section 5.02 does not reference any integrated care system beyond an ACO among the 12 categories described within. Thus, the two sections, 7.02 and 5.02 should be revised to more clearly require a transition to integrated care systems that are aligned with alternative payment models under value-based reimbursement mechanisms.

As seen in Secretary Burwell's announcement of the Learning and Action Network framework earlier in January, 2015, specific, measurable goals must be established in order "[to] help drive the health care system towards greater value-based purchasing…"[13] In that instance, HHS first defined value based payments and then set measurable goals toward the transition away from fee for service reimbursement:

> *"HHS has adopted a framework that categorizes health care payment according to how providers receive payment to provide care.*
>
> - *category 1—fee-for-service with no link of payment to quality*
> - *category 2—fee-for-service with a link of payment to quality*
> - *category 3—alternative payment models built on fee-for-service architecture*
> - *category 4—population-based payment*
>
> **for more detail and examples, see "Payment Taxonomy Framework"*
>
> *Value-based purchasing includes payments made in categories 2 through 4. Moving from category 1 to category 4 involves two shifts: (1) increasing accountability for both quality and total cost of care and (2) a greater focus on population health management as opposed to payment for specific services."*
>
> *…*
>
> *"HHS has set a goal to have 30 percent of Medicare payments in alternative payment models (categories 3 and 4) by the end of 2016 and 50 percent in categories 3 and 4 by the end of 2018. This will be achieved through investment in alternative payment models such as Accountable Care Organizations (ACOs), advanced primary care medical home models, new models of bundling payments for episodes of care, and integrated care demonstrations for beneficiaries that are Medicare-Medicaid enrollees. Overall, HHS seeks to have 85 percent of*

[13] Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. CMS. January 26, 2015.

Medicare fee-for-service payments in value-based purchasing categories 2 through 4 by 2016 and 90 percent by 2018."

This definition of value-based payment and the timelines for adoption should be incorporated into Attachment 7 as mandatory requirements. California and most of the major QHPs have already signed-on to the Burwell value based payment transition timeline, and so the adoption of those requirements over the next few years should become mandatory under Attachment 7 requirements.

3. **Requiring a measureable transition toward statewide cost, quality and performance transparency systems:** We understand that you intend to include new initiatives as listed in Lance Lang's email of December 10, 2015, including additions to Articles 6 and 7. Specifically, your chief additions include:

    a. A requirement that all plans with narrow networks select those networks by criteria including quality and be transparent about their criteria
    b. That all plans track and trend quality (starting with Diabetes, Hypertension, Asthma and Depression) by ethnic, racial and gender groups and with documented reduction of disparities. The tentative target is a 10% relative reduction to be negotiated after baselines are established
    c. Provide price (allowable charges) transparency to support provider selection, and that quality will be added over time

    We agree with these three objectives, and each of these can be incorporated more meaningfully into attachment 7 without ambiguity through the adoption of existing Learning Action Network, IHA Value Based Program and Berkeley Forum transition metrics and targets that we have previously proposed.

    It is important to remember that in order to accomplish meaningful reporting and transparency of cost, quality and performance measures all of this information has to be collected in a timely and accurate manner. Several issues have prevented the ability of the State to stand-up an All Payer Claims Database, but chief among them is the disaggregation of data that is reported and collected through several sources. Uniformity, standardization and a common, open platform is needed to accomplish these initiatives that you have proposed.[14] CAPG has advocated that California take advantage of the one-time opportunity that exists in the pending health plan "mega mergers" through the DMHC's ability to require undertakings of the merging entities. We have proposed that the State require the creation of a pool of funds

[14] The IHA describes the encounter data reporting solution as "an industry-wide end-to-end process" in its Issue Brief titled, Encounter Data: Issues and Implications for California's Capitated Delegated Market. IHA Sept. 2015.

from which to create a common, uniform system for encounter data reporting, a patient deductible accumulator and a provider directory reporting portal. Greater accuracy and timeliness of claims, encounter and provider identification are critical to build a meaningful transparency system. We urge the Covered California Board to join in our request to the DMHC concerning the undertakings. The Exchange should further join with the DMHC and require the same effort from each of its contracting QHPs. Rather than require each Plan to build separate siloed infrastructure, the Exchange should incorporate the statewide effort outlined in the DMHC's undertaking order on the Blue Shield – Care First merger.

In 2015, the Integrated Healthcare Association (IHA) summarized quality of care and resource utilization for Healthcare Effectiveness Data and Information Set (HEDIS) data in various geographies throughout California[15]. They looked at six clinical quality measures (breast cancer screening; colorectal cancer screening; blood sugar control for people with diabetes; blood sugar screening for people with diabetes; kidney disease monitoring for people with diabetes; and medication management for people with asthma) and three resource use measures (all-cause readmissions; emergency department visits; and inpatient bed days). These performance standards are aligned with national benchmarks within the Core Measurement Collaborative, a multi-stakeholder group of consumers, employers, providers and public and private payers who have come together to set a model for future work on measure selection and performance measurement alignment. The Collaborative has reached consensus on core measures that promote evidence-based medicine and generate valuable information for quality improvement, decision-making and value-based payment and purchasing. Eleven Plans participated in the IHA study, supplying their own data. They each agreed to the 9 core measures to be analyzed. Most of the 11 Plans are present in the Exchange, and the results now create a benchmark against which QHPs can be measured. The Exchange should adopt these core measures and require each of its QHPs to perform to at least the existing commercial market standards reported by the IHA.

Conclusion

We would like to thank you for requesting our comments on the pending Attachment 7. Covered California's continued role as a transformative change agent is critical to the continued evolution and development of the commercial coverage market in California. In many ways, the Exchange is on the right track. You have engaged the Catalyst for Payment Reform organization to track the progress of each QHP toward a value-based purchasing model. We strongly recommend that you engage the Berkeley Forum to help further refine the goals for delivery system transformation and develop a transformation progress dashboard for Article 5 compliance. Finally we think that using

[15] Issue Brief: Healthcare Hot Spotting: Variation in Quality and Resource Use in California. IHA (July 2015).

the existing IHA Value Based Care metrics under Articles 6 and 7 will leverage a broad, existing data collection and reporting infrastructure already in use by several of your existing QHPs. IHA can and should be used to track and monitor compliance under these two Articles. We are preparing further specific comments on each subsection of Attachment 7 and will share those within the workgroup.

We look forward to further engagement with you on these important topics.

Sincerely,

_____

Donald H. Crane
President and CEO, CAPG

CC: Covered California Board

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

December 18, 2015

California Health Benefit Exchange Board
Covered California
1601 Exposition Blvd
Sacramento, CA 95815

Dear California Health Benefit Exchange Board Members,

I am writing today on behalf of the California Rural Indian Health Board (CRIHB) regarding Covered California's implementation of the American Indian/Alaska Native (AI/AN) provisions of the Affordable Care Act and the specific issues that must be resolved to ensure health care access for AI/ANs in California. Specifically, CRIHB requests that the California Health Benefit Exchange Board Members prioritize the resolution of several challenging issues that are creating obstacles to enrollment and preventing correct implementation of the Affordable Care Act's (ACA) special provisions for AI/ANs. These issues include but are not limited to the mixed tribal family glitch and incorrect implementation of zero and limited cost sharing protections.

The mixed tribal family "glitch" has arisen because the CalHEERS system is unable to accommodate the enrollment of a household that includes AI/ANs who are members of federally recognized tribes and family members who are not on the same application without tribal members losing their special ACA benefits. These special benefits include higher federal poverty level thresholds for premium tax credits and zero and limited cost sharing protections. Although Covered California leadership and staff have repeatedly assured tribal leaders that this issue would be resolved, including statements made during tribal consultations throughout 2013 and 2014, we have seen no progress throughout 2015 and this issue appears to be entirely unresolved as we near 2016.

In addition, although Covered California has informed tribal leaders that there is a manual workaround the call center staff can do for AI/AN consumers, it is clear from the volume of calls we have received from AI/ANs who have been told that there is no workaround that the call center staff are either not receiving adequate training on the mixed tribal family glitch workaround or not communicating accurately about it to AI/AN consumers. This is unfortunate, as this mixed tribal family glitch has resulted in AI/AN consumers spending hours of time on the phone with the Covered California call center without any resolution and receiving conflicting information about whether mixed tribal family enrollment is even possible. At least one AI/AN consumer was advised by a call center employee that there was no workaround and that he needed to appeal that determination. While he won his appeal, he lost hundreds of hours of time in calls and preparation, time he could have spent on his job or with his family. Information about that consumer's case was relayed to Covered California in early 2015.

AI/AN consumers have also experienced incorrect implementation of zero and limited cost-sharing benefits. Qualified Health Plans are not correctly coding AI/AN consumers in the system or understanding the AI/AN special benefits. While the Covered California system states that there is zero-cost sharing for an AI/AN member of a federally recognized tribe under 300% FPL, the consumer's insurance card incorrectly states a deductible. This is a barrier to AI/ANs seeking care because it creates confusion when they present the card to health care providers who believe, quite reasonably, that they can rely on the accuracy of the information printed on the insurance card. AI/ANs need insurance cards that reflect their actual benefits or they and their tribal clinics will continue to be asked to pay cost-sharing from which the AI/AN consumers are statutorily exempted. AI/AN consumers have also reported inadequate or incorrect implementation of limited cost sharing, which applies to any contract health service/purchased referred care referral for outside services made by a tribal clinic regardless of the AI/AN consumer's income. In some cases the referring tribal clinic has been told by Covered California that they are required to pay the cost sharing charges, which they have been forced to cover with their extremely limited purchased/referred care funding.

We understand that Covered California staff is tasked with many difficult tasks and competing priorities, but AI/ANs in California have been waiting far too long for resolution of these fairly basic issues, which the federally facilitated marketplace resolved several years ago. While CRIHB staff continues to consult Covered California staff with individual AI/AN concerns, the better solution would be to resolve these topics so that all AI/AN consumers are served appropriately with the protections they are entitled to without delay.

We appreciate the efforts of the External Affairs Department, staff is always willing to assist AI/AN consumers resolve issues. At this time, however, we ask the California Health Benefit Exchange Board to ensure that adequate resources are committed to these issues to fix them for AI/ANs permanently. Any other outcome will continue to shift the burden of resolution to members of underserved communities who already experience the worst health inequity and health disparities of any population. It will also block their access to health care, surely not a result the Board would want. I am available to discuss this topic with you at your earliest convenience should you wish to do so.

Sincerely,

Mark LeBeau, PhD, MS
Chief Executive Officer

cc: Waynee Lucero, Covered California, via email
Peter Lee, Covered California, via email

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December 31, 2015

Joel White
President, Council for Affordable Health Coverage
and Clear Choices Campaign
1101 14th St. NW Suite 700
Washington, DC 20005

Re: Request for Update and Correction of Clear Choices Report

Dear Mr. White,

I am writing to ask you to correct inaccurate information about Covered California in your December report titled "2016 Health Insurance Exchanges: The Good, the Bad, and the Ugly." On the whole, we applaud the report and Clear Choices raising many important issues about the need for health insurance marketplaces to provide consumer tools and price transparency, and providing a useful road map for policy makers and marketplaces.

Among other areas we applaud is your encouragement for marketplaces to offer a consolidated provider directory. Covered California offered such a feature at our initial launch, but switched to relying on separate links to each plan's directory when we faced problems with the underlying data. We don't disagree with your assessment of our provider directory, though do think that more emphasis could and should be given to the accuracy of the underlying data of provider information – separate but more accurate provider directories are better tools than is a combined but unreliable directory.

However, in one important area your report is flat-out inaccurate. Contrary to your report, which gave Covered California an "F" for lacking a "tool to provide consumers with a customized estimate of total annual out-of-pocket costs," *Covered California was the first exchange in the nation to offer this tool*. It seems your reviewers looked at the Shop & Compare Tool rather than the "Preview Plans" tool, which is accessible *both before and after* sign in – no more than three clicks away from the homepage by multiple pathways that research has told us most accurately reflect consumers' state of mind as they commence their online shopping.

Furthermore, Covered California's out-of-pocket cost tool goes beyond the function of a typical calculator. Covered California's health plan display is customized in response to the information that the consumer enters into the calculator -- the tool provides consumers with the metal tiers and cost-sharing that likely will be the highest value for that specific consumer.

Secondly, we are especially concerned that you did not acknowledge Standard Benefit Design as one of the single most important features of exchange offerings to assist consumers in making smart shopping decisions. Requiring plans to offer standard benefit designs enables consumers to compare the *same product* side-by-side from one insurer to the next knowing they are comparing apples-to-apples rather than trying to compare among dozens of different products with dizzyingly-complex benefits, deductibles, co-pays and co-insurance features.

In fact, Standard Benefit Design was so beneficial for consumers that Covered California was recognized by Consumer Reports as one of a handful of entities distinguishing itself as having adopted policies that advance the interest of consumers. A link to the Consumer Reports "Naughty and Nice" list can be found here.

Since 2014, more than 2 million Californians have enrolled in Covered California, and the exchange is a leader in the nation in innovation and improvement, with exceptionally strong partnerships with consumer advocates. We attribute much of our success to our consumer choice tools and the consumer-friendly approaches we have taken. For this reason, we are extremely disappointed by Clear Choices' incomplete review of our website.

I know we share the same goal of assisting consumers in having the most comprehensive and complete information available when shopping for insurance and ensuring that policy makers are informed about how best to achieve that goal. For this reason, I respectfully request that you update your report to correct the description of the use of our out-of-pocket calculator.

In the future, please do not hesitate to reach out to my team when you are finalizing any report that casts our exchange – or any exchange – in such a negative light. We would be eager to have an opportunity to review a draft and offer "course correction" along the way to avoid the embarrassment of a report going out with mistakes that do such a disservice to the conversation about how best to improve the nation's health exchanges for consumers.

If you have any further questions, please contact me.

Sincerely,

Peter V. Lee
Executive Director

cc: David Lansky, Ph.D., CEO, Pacific Business Group on Health
Dr. Troy Brennan, SVP, Chief Medical Officer, CVS Health
Paul Markovich, CEO, Blue Shield of California

January 19, 2016

Anne Price
Plan Management
Covered California
1601 Exposition Blvd.
Sacramento, CA

Re: Proposed 2017 Benefit Design

Dear Ms. Price,

Our organizations, advocating on behalf of consumers, offer comments on the proposed 2017 benefit design presented at the Plan Management Advisory Committee meeting on January 14, 2016. Each of our organizations has participated in the benefit design workgroup, the Plan Management Advisory Committee or both.

Covered California has led the nation in standardizing benefit designs, including both cost sharing and the description of the benefits. Covered California has done this in a public, collaborative process that involved consumer advocates as well as health plans and other stakeholders. In standardizing benefit designs, Covered California has prioritized primary care, been sensitive to the needs of those with chronic conditions and capped drug cost sharing, particularly for the most expensive specialty drugs. The proposed 2017 benefit designs reflect modest adjustments that build on this strong foundation.

We acknowledge the constraints imposed by the metal tiers and the de minimus variation in actuarial value for each tier. We recognize that the trending forward of the actuarial value calculation imposes greater cost sharing on consumers when cost sharing was already very high, particularly given the income levels of most Covered California enrollees.

Emergency Room Cost Sharing: Improvements

We appreciate and support the elimination of two "gotchas" in the current benefit design for emergency room care: the application of the deductible and the emergency room physician fee. Emergency room copays are substantially higher than physician office visits: for 2016 silver, the emergency room copay was $250 while a primary care office visit is $45. But under the current benefit design, a consumer also faces a deductible of $2250 and an ER physician fee of $50. For most consumers in 2016, an emergency room visit cost $2,250, not $250. The proposed 2017 benefit design eliminates the application of the deductible to emergency room visits and merges the ER physician fee into the ER visit copay. The result is a lower overall cost for an emergency room visit and higher, but more transparent copay of $350 for silver. This is an improvement we sought in order to minimize consumer confusion.

Deductibles, Out of Pocket Maximums: Higher Costs for Consumers

We recognize that the trending forward of the actuarial value calculator means increased costs for consumers. We also recognize that the out of pocket maximum and the deductible have the biggest impact on the actuarial value calculation, far greater than copays for specific services. We appreciate the effort to adjust the deductible as modestly as possible, but a deductible of $2,500 is a lot of money for someone on silver and the same is true of a $6,300 deductible for bronze. While very few consumers hit their out of pocket maximum, those that do are almost always facing significant medical costs as well as loss of time at work and other financial strains. We recognize that increasing the maximum out of pocket limit and the deductible minimizes the increases in other cost sharing, particularly for primary care but to the extent that the increase in deductible and out of pocket maximum can be minimized, we appreciate that effort. To the extent that the increases in deductibles and out-of-pocket maximums could be further minimized when the final actuarial value calculator is released in February, we would appreciate movement in that direction.

Primary Care/Specialist Copays

Laudably the Covered California staff has proposed reducing primary care office visit copays. This is a good thing. It also has the pleasant effect of bringing Covered California more into line with the primary care office visits in other exchanges.

However, the decrease in primary care visit copays is coupled with an increase in copays for specialists that seems to us somewhat out of balance. While we support encouraging reliance on primary care, there are instances in which it is appropriate to

see a specialist—and some consumers, particularly those with chronic conditions or more complex needs, may rely on specialists even for primary care. For 2016 silver, the copays were $45 primary care and $70 specialist: for 2017, the copays are proposed to be $35 primary care and $75 specialty care. We do not want consumers to avoid specialty care when that is appropriate care. We ask that the staff relook at the proposed specialty care copays across all of the metal tiers (except platinum which is unchanged).

End-Note: Diabetes Education and Diabetes Self-Management

The proposed end-notes reflect two policy changes with respect to diabetes care: zero cost sharing for diabetes education and diabetes self-management and equally important, a move toward standardizing what constitutes diabetes education and diabetes self-management. In our discussion of potential Value Based Insurance Design for diabetes, we learned that plans and providers vary considerably in what is provided to which consumers with diabetes or pre-diabetes. We support zero cost sharing for diabetes education and self-management and greater standardization of what constitutes education and self-management for diabetes. We appreciate the inclusion of standardized definitions of diabetes self-management and diabetes in the end-notes. This will help to provide further clarity to consumers, and providers, as to which services are provided at zero cost sharing and which are not.

Standardized Benefit Designs: Alternative Benefit Design, Non-Essential Health Benefits, and Co-Insurance

We strongly support standardization of benefit design, so we appreciate the rejection of alternative benefit designs as an option for plans for the 2017 plan year. We were unable to determine what added value alternative benefit designs would have for consumers—and the danger of risk selection was considerable. In the same vein, we also appreciate the rejection of the ability of plans to offer benefits other than essential health benefits or to allow plans to pick and choose what non-essential health benefits to offer. Even seemingly innocuous additions such as gym memberships have the effect of risk selection. This is different than the offering of adult dental, a non-essential health benefit that is offered across all plans and products and that we hope someday will be an essential health benefit.

While we would prefer to eliminate the remaining co-insurance products because of the consumer confusion engendered by co-insurance, the relatively small enrollment in these products lessened our concern.

Value-Based Insurance Design, Reference Pricing

In the benefit workgroup, we spent a considerable amount of time looking at options for Valued-Based Insurance Design (VBID) as well as reviewing the literature and exploring potential approaches. We support the staff's recommendation not to proceed with VBID at this time, and question whether VBID will ever be appropriate for Covered California

within the constraints imposed by federal law. VBID benefit designs tend to be offered by employers that offer higher actuarial value coverage than the bronze and silver products that dominate the Covered California market. In the context of de minimus variation, at the silver level, a VBID design for a specific condition would mean increasing already high cost sharing for consumers with other conditions. We appreciate the extensive exploration of a VBID based on diabetes management, and found the overview illuminating.

Plans, and providers, seemed to vary considerably in what was considered diabetes self-management and which patients merited it. To some extent, this variation reflected a different understanding of the science but in other instances, plans had tried various interventions specifically for diabetes and found a lack of improvement in outcomes. And to the extent that diabetes education or self-management meant an extra ten minutes with the doctor and a brochure to take home, we were dubious that would be sufficient to change behaviors associated with diet, exercise, and other diabetes self-management behaviors. Trading off higher cost sharing for everyone else to get such modest improvements in diabetes cost sharing, education and self-management did not make much sense to us, especially given the cost sharing already imposed at the silver level.

We also looked at reference pricing. CalPERS has had good success with reference pricing for joint surgery and a more mixed record with respect to colonoscopies. But PERS has richer benefits, an older population heavy with retirees and early retirees for which joint replacement is a more frequent need, and geographic concentration of membership which allowed the changes in PERS benefits to drive change in provider pricing. In contrast, Covered California has a market dominated by silver and bronze coverage, with few over age 65 and a smaller proportion ages 50-64, and a geographically dispersed enrollment that makes it more challenging to affect provider pricing. For these reasons, we support staff's recommendation to defer action on reference pricing.

Tiered Networks

We remain profoundly unenthusiastic about tiered networks and would support a staff recommendation to disallow tiered networks in 2017. Consumers, particularly those with PPO coverage, have enough difficulty sorting out what care is in-network and out-of-network: adding another level, a tier with higher cost sharing, just adds more confusion. This is worsened if there is a lack of alignment of admitting privileges for clinicians and hospitals in different tiers. Allowing a plan, or a clinician, to claim that a hospital is in-network when it is at a tier with higher cost sharing multiplies consumer confusion. Allowing some carriers to offer tiering while others do not calls into question the fundamental Covered California principle of offering standardized benefit designs and makes comparison among plans more challenging. Recent federal regulations prohibit the use of tiered networks for the federal Marketplace.

Clarifications of Benefits

The effort to standardize benefits has uncovered considerable variation in definitions of what is covered by what benefit. This has been problematic for the regulators just as it has been problematic for consumers for many years. Consumer confusion about what is covered, and what is not, in terms of specific benefits is so commonplace as to be unremarkable. We very much appreciate the ongoing efforts of Covered California to clarify and standardize benefits.

Sincerely,

Health Access California
California Pan-Ethnic Health Network
Consumers Union
Project Inform
Western Center on Law and Poverty

January 19, 2016

Anne Price
Plan Management
Covered California
1601 Exposition Blvd.
Sacramento, CA

Re: Proposed 2017 Quality Initiatives

Dear Ms. Price,

Our organizations, advocating on behalf of consumers, offer comments on the proposed quality initiatives for the 2017 plan year presented at the Plan Management Advisory Committee meeting on January 14, 2016. Each of our organizations has participated in the quality workgroup, the Plan Management Advisory Committee or both.

We are generally supportive of the quality initiatives proposed for the 2017 contract. Covered California staff has explored a variety of options: those that are recommended will move Covered California forward from collecting information to requiring contracting health plans to improve quality and reduce health disparities. Moving forward on the quadruple aim of lower costs, better care, better health and reduced disparities will require ongoing efforts over a number of years: what Covered California proposes for 2017 is to require actual improvements in quality in a number of areas. We strongly support the underlying principle which governs most, though not all of the quality initiatives, that is for all contracting plans to make progress on the same set of quality initiatives, rather than allowing plans to cherry pick quality initiatives in the same way

they used to cherry pick enrollees. The Affordable Care Act is about system transformation to support the quadruple aim as well as extending coverage to millions.

Networks: Quality, Satisfaction, Cost Efficiency

Covered California is taking the first steps toward requiring provider networks based on quality as well as cost. As it does so, we urge that the quality measures take into account the demographics of those served so that this effort does not inadvertently worsen disparities.

Participation of the Covered California plans in the existing California maternity initiative as well as the efforts on drug overuse will extend and strengthen these collaborative efforts.

Quality Data

Our organizations support further data collection, including claims and clinical data as well as regional survey data for the quality rating system. Los Angeles County alone, with ten million people, has more people than 43 of the states and we know that there is considerable regional variation within California which is masked by the current practice of surveying at the state level. We look forward to working with Covered California staff on further quadruple aim efforts that reflect the actual enrollment of Covered California.

Health Disparities

From the beginning, Covered California has had a stated commitment to reducing health disparities. By extending coverage to over two million Californians, most of them people of color, over the last two years, it has taken the first step toward reducing disparities in access to care. For the 2017 contract year, the staff proposes to reduce disparities in health outcomes by requiring plans to report baseline data on race/ethnicity and gender, and to be able to show in the 2018 contract application, year over year improvement during the 2017 contract year. Since 2003, California law has required health plans to collect data on race, ethnicity and language of their enrollees. It is a rather modest step to require all contracting plans to report that data to Covered California as part of health disparities reduction efforts.

We appreciate the focus on reducing disparities for diabetes, hypertension, asthma and depression that will be reflected in the 2017 and 2018 contract requirements: these are the high prevalence, high impact conditions that affect communities of color, particularly adults. Making progress in steps toward control of these conditions a priority is essential to improving the health of communities of color, the majority of Californians and exchange enrollees.

Primary Care, Accountable Care Organizations

As consumer advocates, we have supported standardized benefit designs that minimize enrollee cost sharing for primary care while providing appropriate access for specialty care and emergency room services. We support requiring all Covered California enrollees having a primary care physician so long as the proposal recognizes that many Covered California enrollees, and more in the future, will have had prior coverage and should have a primary care physician already. While there is no standard definition of a patient-centered medical home, our preference is for a definition that starts from the consumer perspective rather than the convenience of the physician or physician reimbursement.

With respect to Accountable Care Organizations, we support better integration of care and a focus on the quadruple aim. Payment reform which fails to take into account existing health disparities and the social determinants of health risks worsening disparities in pursuit of lower costs or better outcomes for those consumers for whom social determinants of health work in their favor rather than against them. For instance, an over-reliance on readmissions penalties without taking into account well-established disparities affecting lower income communities of color would not well serve moderate income consumers or Covered California's goals.

Hospital Quality and Safety

As consumer advocates, some of us have fought for decades to require better reporting of Hospital Avoidable Complications and adverse events. We strongly support requiring reporting of hospital avoidable complications, including the six conditions listed. As we understand the literature, these complications should not be adjusted for disparities: sepsis, adverse drug events, and hospital acquired infections should not vary based on race/ethnicity, gender or income. Going to the hospital should make people better, not sicker.

With respect to appropriate use of C-sections, we support Covered California's participation in the effort to reduce inappropriate C-sections. We commend the joint efforts of the Department of Health Care Services, the California Department of Public Health, CalPERS, Covered California and the California Health and Human Services Agency to encourage hospital participation in this collaborative: taken together, these public entities pay for a majority of the births in California as well as licensing California hospitals.

Population Health

Tobacco cessation, obesity management, and preventive care as well as identification of at-risk enrollees at the point of transition are important elements of population health. In addressing each of these, disparities should be taken into account. While California does better than the nation on many of these measures, that is not true of all Californians, and particularly not true of moderate income Californians from communities of color which are the overwhelming majority of Covered California enrollment.

Cost and Quality Transparency, Choosing Wisely

As consumer advocates, we support transparency of enrollee costs and quality data. We acknowledge how much Covered California has already done to support transparency for enrollees, from standard benefit designs to Shop and Compare to condition-specific fact sheets. We also acknowledge that from Day One, consumers shopping for a plan through Covered California were given plan Quality Ratings alongside premiums. While there is certainly more to do on transparency of cost and quality, consumers in the individual market are no longer shopping blind for an expensive but necessary product that provides both coverage and care.

We also support use of the Choosing Wisely decision aids. More care is not necessarily better care or even appropriate care. Sometimes the simplest care is the best: rest and liquids for the common cold, mild exercise for a sore back, and nursing care during labor and delivery rather than a surgical intervention. Choosing Wisely is intended to help consumers converse with their providers and become active players finding the appropriate care for their individual situation.

Summary

Staff explored a number of initiatives with consumer advocates as well as plans and providers. Some possible initiatives were not a good fit for the Covered California population or lacked sufficient grounding or had operational barriers to implementation. The quality initiatives that remain will make Covered California a leader in system transformation with a focus on the quadruple aim of lower costs, better care, better health and reduced disparities. We have noted in our comments a number of initiatives that would be strengthened by including a focus on disparities as well as cost and quality. We are generally supportive of Covered California's proposed quality initiatives.

Sincerely,

Health Access California
California Pan-Ethnic Health Network
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