



Comments to the Board – External

Table of Contents

January 26, 2017 Board Meeting

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Correspondence with Elected Officials

- None

Correspondence with Stakeholders

- Joint Letter: Consumers Union, California Pan-Ethnic Health Network, Health Access California, National Health Law Program, Project Inform, Western Center for Law and Poverty , December 20, 2016
- Joint Letter: Asian Americans Advancing Justice – Los Angeles, California Pan-Ethnic Health Network, Community Health Councils, Consumers Union, Health Access, National Health Law Program, Western Center on Law & Poverty, January 26, 2017

Section 1332 Waiver

- Covered California, January 18, 2017
- Department of Health & Human Services, Centers for Medicare & Medicaid, January 19, 2017



December 20, 2016

James DeBenedetti, Director Plan Management Division
Lance Lang, MD, Medical Director
Covered California
1600 Exposition Blvd
Sacramento, CA 95815

Dear Mr. DeBenedetti:

The undersigned consumer advocacy organizations, participants of the Plan Management Advisory Committee and/or Benefit Design Work Group, write to oppose Covered California staff's proposed recommendation to allow pharmacy tiering as part of the 2018 Covered California benefit design. Additionally we write to urge continued pressure on Qualified Health Plans by Covered California to gather and timely submit racial and ethnic disparities data as required in the 2017 contract.

Pharmacy tiering

Over the past two years, hospital tiering as a part of Anthem's benefit design was an issue before staff and the Board. We had expressed concerns about its potential to create confusion for consumers—already struggling to understand their policies, including network composition of individual providers no less whether they had privileges at various hospitals. We understand the countervailing argument about consumer choice and promoting value-based options, but weighing that against consumer confusion and potential surprise out-of-network bills for consumers concluded that the scales tipped against allowing such tiers as a part of Covered California's laudable standardized benefit designs.

We have similar concerns about the proposal by Anthem and Blue Shield of California for tiered pharmacies and must oppose it. We reject the allowance of tiered pharmacies as the right solution to our shared concerns about the ever-escalating prices of prescription drugs and their effect on premiums. The data presented by the plans on geographic impacts was informative, but does not reassure us that such a design - offered as a plan option - would be in consumers' best interest.

First, the generic data on geographic access masks the impact on particular segments of consumers. For example, those with limited English proficiency, those living in rural locations, lower-income consumers without cars and reliant on public transportation, and those with particular conditions such as HIV with complex drug regimens all present situations for which relationships with particular pharmacies may be important. For example, we know that Limited English Proficient (LEP) seniors in Orange County will often choose to travel to pharmacies in Los Angeles' Koreatown to get their prescriptions filled just so they can speak with a pharmacist in their native language. Tiering runs counter to the pooling of risk and non-discrimination that should be foundational to health insurance, and instead would result in a disproportionate burden on these segments of the population. The plans clearly acknowledge that certain consumers will still need to use higher-tier pharmacies and will face higher cost sharing as a result. This acknowledgement came out as the plans explained that the savings they estimate from such tiering would come from the additional amounts that consumers using the higher-tier networks would pay.

Thus, cost would be shifted to those who must continue to rely on the more expensive pharmacies due to geographic, social or economic barriers to accessing these pharmacies such as lack of transportation, language access, or other issues. We have no reason to believe people are loyal to their pharmacies for abstract reasons of reputation or family history - as they may be for hospitals or doctors - but rather that there are practical, concrete reasons that they need certain pharmacies. Thus, the financial hit they would take is "involuntary", rather than a matter of true free choice. Given Covered California's 90% subsidy-eligible population, there is reason to believe reliance on public transit and other financial impacts are more significant for this population than for the general insured population.

Secondly, tiering runs counter to the standardization of products that has been a hallmark of Covered California. While the two largest plans presented the proposal, it does not appear that all plans want to pursue it. Health insurance literacy is very low, and your standardization—and relative stability of designs from year to year - gives Covered California a leg-up from the traditional insurance market, making insurance product comparisons easier. Also, even if Covered California embarked on a public education campaign to explain this variation in designs, given how much of the Covered California population turns over annually, we question whether you or the plans can sufficiently educate people about pharmacy tiers in order to avoid consumer confusion and bad surprises in terms of cost sharing.

Transparency of prescription drug pricing is more likely to yield positive results for consumers and other purchasers than adding consumer confusion through tiering of pharmacy availability.

Disparities reduction

Additionally, we write to express our disappointment at the slow progress made thus far in collecting from health plans the data needed to accomplish the critical and laudable goal of disparities reduction adopted by Covered California with our strong support and urging. California law is clear on the responsibility of health plans to collect data on the race, ethnicity, and language of their members in order to adequately address health inequities and eliminate barriers to care for limited English proficient (LEP) members. Plans have been required by state law to collect this data for many years prior to Covered California's 2017 QHP contract. Therefore, we are astounded to hear that not all QHPs are meeting your data submission deadlines in a timely fashion.

We are supportive of Covered California facilitating a sharing of best practices for supplementing *self-identified* race, ethnicity data, but we also urge you to require QHPs to provide what data they do have, even if imperfect, to the exchange today. We would urge you to move forward with efforts to hold health plans accountable for year-over-year improvement in disparities reduction based on the data Covered California currently has from the QHPs that have appropriately reported this data in compliance with the requirements of the 2017 Covered California QHP contract. Plans that fail to comply with data collection requirements that have been in place for many years should be treated as failing to comply with contract requirements regarding disparities and should also be reported to the relevant regulator for further action by the regulator.

Sincerely,

Consumers Union

California Pan-Ethnic Health Network

Health Access California

National Health Law Program

Project Inform

Western Center for Law and Poverty



January 24, 2017

Diana Dooley, Chair
Covered California Board

Peter Lee, Director
Covered California
1601 Exposition Way
Sacramento, CA, 95815
Via Electronic Submission

Re: Proposed Amendments to Plan Based Enroller Regulations

Dear Ms. Dooley and Mr. Lee,

Our organizations, which include Certified Enrollment Entities (CEEs) and consumer advocacy groups, write in support of staff's proposed amendments to Covered California's Plan Based Enroller Regulations. These amendments will protect consumers against steering and conflicts of interest by reaffirming the prohibition on Plan Based Enrollment Entities (PBEE) and Plan Based Enrollers (PBE) from affiliating with, receiving any compensation from, or entering into a partnership with a certified Navigator Grantee or a Certified Application Entity or Counselor.

Background:

Over 1.4 million Californians are enrolled in coverage through Covered California. Covered California enrollees receive enrollment assistance through several channels including insurance agents, certified enrollment counselors and county human services agencies:

- *Certified Enrollment Counselors (CECs) and Certified Enrollment Entities* are individuals and entities that are eligible to be trained and registered to provide in-person assistance to Covered California consumers. These individuals and organizations are required to be unbiased. Their services are free to consumers. The majority of these organizations which include non-profits, faith based organizations, labor unions, community clinics and school districts, were selected to be CEEs and CECs because of the trusted relationships they have established with their communities from many years of

service. Consumers who enroll in health coverage through these entities assume the enrollment information they are given is impartial and unbiased. This is especially important as health care premiums and insurance offerings can change on a year to year basis.

- *The Plan Based Enroller program* was created to allow consumers the option to enroll directly through a Qualified Health Plan (QHP) into a Covered California plan with tax credit subsidies. The PBE program provides an important function, ensuring there is a no-wrong-door approach for consumers interested in enrolling in subsidized health care coverage. PBEs assisting enrollees are required to disclose that the “PBE is employed or contracted by a QHP Issuer” so as to inform consumers that the individual handling the sale is affiliated with one particular plan, rather than a neutral party.

Covered California’s proposed amendments strengthen consumer protections by managing potential conflicts of interests between PBEs and other Covered California enrollment programs. The regulations prohibit dual affiliation and co-location with any other Covered California enrollment program by clarifying that PBEs and their Contractors and Employees that are PBEs shall “not employ, be employed by, be in partnership with, or receive any remuneration arising out of the functions performed under this Article, from any individual or entity certified through Article 8 or Article 11 of this chapter.”¹ This additional language is important as it will help to distinguish the roles of CEEs and CECs with that of PBEs and PBEs while clearing up any confusion about the legality of these types of potential arrangements.

As statewide consumer organizations, CEEs and CECs, we strongly support this proposed amendment and thank Covered California for ensuring its consumers receive the type of fair and impartial assistance they are entitled to when choosing a Covered California plan.

Sincerely,

Asian Americans Advancing Justice – Los Angeles
California Pan-Ethnic Health Network
Community Health Councils
Consumers Union
Health Access
National Health Law Program
Western Center on Law & Poverty

¹ Article 8 and Article 11 refer to the Enrollment Assistance Program and the Certified Application Counselor Program respectively.



January 18, 2017

Mr. Kevin J. Counihan
Director and Marketplace Executive Officer
Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue, SW
Washington, DC 20201

RE: California's State Innovation Waiver Application

Dear Mr. Counihan:

Thank you for your letter dated January 17, 2017, advising Covered California that the Department of Health & Human Services and the Department of Treasury have completed their preliminary review of California's December 19, 2016 application for a State Innovation Waiver under Section 1332 of the Affordable Care Act. This letter marks the beginning of the Federal public notice process and the 180-day Federal decision-making period.

At the request of Senator Ricardo Lara, author of California Senate Bill 10 (Lara, Chapter 22, Statutes of 2016) which authorized Covered California to submit California's application, and with the concurrence of the Governor of California, Edmund G. Brown Jr., California hereby withdraws its December 19, 2016 application and is no longer seeking a State Innovation Waiver at this time. In withdrawing this application, California reserves its right to resubmit this application and its right to submit future State Innovation Waivers under Section 1332 of the Affordable Care Act.

We appreciate the time and attention that has been put into the review of this application and look forward to working with you on future submittals.

Sincerely,

A handwritten signature in blue ink, reading "Peter V. Lee".

Peter V. Lee
Executive Director

cc: Secretary of the California Health and Human Services Agency, Diana S. Dooley
California State Senator, Ricardo Lara
Assistant Secretary for Tax Policy, U.S. Department of the Treasury, Mark J. Mazur
CCIIO/HHS Deputy Director for Policy, Jeff Wu

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201



January 19, 2017

VIA ELECTRONIC MAIL: Peter.Lee@covered.ca.gov
Mr. Peter V. Lee
Executive Director, Covered California
1601 Exposition Boulevard
Sacramento, California 95815

Dear Mr. Lee,

Thank you for your letter on January 18, 2017 withdrawing California's application for a State Innovation Waiver under Section 1332 of the Affordable Care Act (ACA) which was submitted on December 19, 2016. As the state is withdrawing the application the Department of Health & Human Services (HHS) and the Department of the Treasury (the Departments) will not proceed with the Federal public notice process and 180-day Federal decision making period.

Please do not hesitate to contact us if you have any questions.

Sincerely,


Kevin J. Gounthar
Chief Executive Officer, Health Insurance Marketplaces
Director, Center for Consumer Information & Insurance Oversight

Cc: Mark J. Mazur, Assistant Secretary for Tax Policy, U.S. Department of the Treasury