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Re: Proposed 2017 Benefit Design

The National Health Law Program (NHeLP) appreciates the opportunity to provide written comments in response to the recommended 2017 Benefit Designs presented at the January 21, 2016 Covered California Board meeting. NHeLP advocates, litigates, and educates at the federal and state levels to protect and advance the health rights of low-income and underserved individuals.

We participated in the Benefits and Networks Subcommittee of the Covered CA Plan Management Advisory Group where benefit designs were discussed at length over a four month period. We greatly appreciate the opportunity to have been involved in that process, and support the subcommittee goals of addressing benefit design priority areas that will reduce financial barriers and improve consumers' access to needed care, while also identifying benefit design areas that should be improved for consumer understanding of coverage and ease of plan comparison. Below are our comments on the benefit design recommendations made by Covered CA staff to the Board.

1. Primary Care, Mental Health and Rehabilitative Services Copays Reduced

We fully support the recommendation to reduce primary care, mental health and rehabilitative services copays by $5-10 in every metal tier (except bronze due to actuarial value limitations.) Making primary care visits affordable is an important step to better manage overall health and can lead to improved health outcomes. In addition, oftentimes, primary care serves as the portal for accessing other services. Copays can deter individuals from receiving the care that they need. Lowering the primary care

copay reduces this financial barrier and is a step in the right direction for improving access to care.

Equally important, is a reduction in mental health and rehabilitative services copays. In compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), the copays for mental health and substance use outpatient services have been reduced since there is a proposed reduction to primary care copays. There has also been a reduction of copays for rehabilitative speech, occupational, and physical therapy. For individuals that need to access rehabilitative services, their treatment plan may require numerous visits, and having a reduced copay will help ensure they can afford this care, which may be critical for a full recovery.

We also appreciate that these copays were reduced without increasing specialty care copays, as originally proposed. Individuals with chronic conditions may need to access all, or most, of their care through a specialist, and an increased copay would serve as a barrier to accessing needed care.

2. Urgent Care Copays Reduced

We support the recommendation to reduce urgent care copays to the same cost-sharing as primary care in every metal level. Urgent care is an important health care option. Enrollees may need immediate care, but cannot get an appointment with their physician or their work schedule may only allow them to access after-hours care. Reducing the urgent care copay to the same amount as the primary care copay ensures that enrollees who need to access urgent care are not being penalized with higher copays for what oftentimes are circumstances out of their control, and it may also deter unnecessary Emergency Department use.

3. Emergency Department Services

We support the restructured Emergency Department (ED) fees, which include the elimination of the deductible for ED visits, and merging the ED physician copay into the ED facility copay in order to avoid separate copays for the same visit. These changes will significantly improve consumers' understanding of the cost involved with an ED visit, and for those who need to access this service, it will make it more affordable by not having the deductible apply.

4. Increased Cost-Sharing (Deductibles, Out-of-Pocket Maximums, and Copays)

Increased cost-sharing reduces access to care, particularly among low-income populations. In order to meet the Target Actuarial Value (AV), the Covered CA staff proposal includes: 1) increases to the deductible by $100-300 for silver and bronze, 2) increases in the out-of-pocket maximum by $550 for silver and gold, $300 for bronze, and $100-250 for enhanced silver, and 3) increases in copays for x-rays and diagnostic imaging. These increases may serve as a barrier to care.

We understand that there are constraints placed by the AV requirements, yet we know it is important to make accessing care affordable. Since the proposed computations were done using the 2017 *proposed* AV calculator, we request that once the *final* AV calculator is released (later this month), that Covered CA staff re-evaluate whether these cost-sharing increases are necessary, and that every effort is made to keep cost-sharing as low as possible.

5. Diabetes Education and Self-Management

We appreciate the clarification made in endnotes 25 and 26 of the 2017 Standard Benefit Plan Designs where Covered CA staff has indicated that cost-sharing may not be applied to diabetes education and self-management, and has defined what is covered under each of those services. This will help ensure that all health plans and issuers have a clear understanding of what they are expected to cover, and that enrollees are able to access this critical care at no cost to them.

6. Value-Based Insurance Design

We support the recommendation not to proceed with a value-based insurance design (VBID) at this time. In the Benefits and Networks Subcommittee meetings there was extensive discussion about a diabetes management VBID. With the number of individuals with diabetes on the rise, we know that diabetes treatment and management is important, but many questions remain unanswered in terms of the effectiveness of a diabetes management VBID, and whether it would lead to improved health outcomes and reduced costs. For this reason, we agree with Covered CA staff that further research and data is needed in order to determine if this is a good option for the Marketplace.

7. Tiered Networks

We support the recommendation to disallow tiered networks in 2017. Tiered designs can be incredibly confusing to consumers and often result in consumers paying additional cost-sharing for which they should not be liable. Therefore removing network tiering will improve consumer understanding of coverage and ease of plan comparison.

Thank you again for the opportunity to submit these comments. We look forward to our continued work together. If you have any questions regarding these comments, please contact Michelle Lilienfeld at (310) 736-1648 or lilienfeld@healthlaw.org.

Sincerely,

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