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.

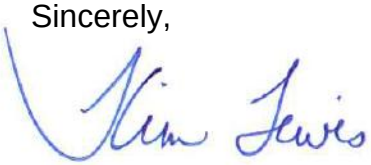
Because tiered designs are so confusing to consumers, and seem to provide little added benefit, we strongly urge Covered California staff to closely monitor plans with tiered networks over the next year. This monitoring work should be done in close partnership with the California Departments of Managed 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
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And on behalf of the Western Center on Law & Poverty

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