

HEALTHCARE BY DESIGN:

Consumer-Centric Benefits for California's Individual Market

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Of course, the underlying work described in the paper was the result of a team of consumer advocacy organizations, including Consumers Union, which doggedly worked over a period of years with Covered California staff to create, and continually improve, the benefits offered in the individual market in California. The organizations are listed in this paper, but special recognition is owed to the individual colleagues from those organizations who worked most intensively on benefit design: Beth Capell for Health Access California, Cary Sanders for the California Pan-Ethnic Health Network (CPEHN), and Jen Flory for Western Center on Law and Poverty.

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Elizabeth M. Imholz, Consumers Union, Editor

FOREWARD

A decade ago, before the enactment of the Affordable Care Act, California artist Susan Braig faced huge medical bills despite having coverage sold to her as health insurance. When she was diagnosed with breast cancer, she found, to her surprise, that her policy only covered hospital care—not the lumpectomy, chemotherapy, mammograms, or other care she so desperately needed. Ms. Braig ended up with tens of thousands of dollars in medical bills. And, in the pre-Affordable Care Act world without protections for those with pre-existing conditions, she had no ability to buy any other coverage.

Ms. Braig shared her story with Health Access California and Consumers Union in support of our fight for California legislation to standardize benefits, create tiers to facilitate plan comparisons, and set a floor on benefits—similar to what later became the essential health benefits and other standards required under the Affordable Care Act. While these state efforts did not succeed, Ms. Braig went on to become a tenacious advocate for these policies in the ACA to prevent others from facing her same fate.

Once the ACA became the law of the land in 2010, California was primed to implement and improve the law quickly since policymakers, consumer advocates, and other health care stakeholders in California had already been through several debates on state health reform. From these prior deliberations, policymakers and the health policy community already had envisioned an exchange for the individual insurance market to offer health plans, actively negotiate with health insurers on cost and quality, and require standardized benefit designs. The state had experience using its bargaining power in purchasing health benefits for state employees through CALPERS, for children through its S-CHIP program, and in its Medicaid program.

Implementing the ACA, California set strong market rules and gave its Health Benefits Exchange, now called Covered California, selective contracting authority, including the ability to require standardized benefit designs for coverage it sold as well as for coverage sold off-exchange. Now these consumer-centric benefit designs dominate the individual market in the state.

This comprehensive paper shows how this authority can be used to improve the market and the experience for healthcare consumers. Our vision as consumer advocates was that Covered California would function like a human resources department for those in the individual market— bargaining with insurers and helping create understandable products that could be compared using apples-to-apples comparisons, spurring greater price competition, and providing patients greater peace of mind. The goal was to prevent unpleasant surprises for consumers like Susan Braig. Covered California, a state agency subject to the open meetings law, now takes crucial benefit design issues out of a private corporate boardroom and into a public stakeholder forum where consumer advocates can have a say. We hope the experience of California can help policymakers and advocates in other states improve the market and experience for all consumers seeking health coverage.

Beth Capell and Anthony Wright, Health Access California

INTRODUCTION

Shopping for health insurance is a high stakes, stressful undertaking for consumers.¹ The market-based health insurance system in the United States has long encouraged a proliferation of products with cost-sharing levels and covered services that vary enormously. The resulting complexity makes it difficult for consumers to understand their options and make choices in their best financial interest. Thus, in short, consumers—particularly those who rely on the individual market—dread shopping for health insurance.

California, the first state in the nation to create its own Exchange, has taken many steps to mitigate that dread. In the 2010 statute creating the Exchange,² Covered California, state legislators made a key decision. They gave Covered California the option to create standardized products³ that would ease consumers' ability to compare plans and make wise choices. Covered California seized that opportunity from the outset, offering only products with consumer-friendly benefit designs and standardized cost-sharing—that is, what consumers pay in addition to monthly premiums, including deductibles, copayments, and coinsurance. The state law creating the Exchange also required carriers in Covered California that sell individual market products outside the Exchange to offer “mirror products” with the same benefits, networks, and premiums as in the Exchange. Thus, all California consumers seeking individual plans can directly compare them, both inside and outside Covered California, via standardized cost-sharing.⁴

These policy decisions, enshrining consumer-centered standardized cost-sharing in the individual market, have led to better

outcomes—in terms of coverage, cost, consumer comprehensibility, and market stability—than many other states have experienced. The close collaboration of several strong consumer advocacy organizations (see sidebar) contributed crucially to California's progress and momentum. This paper describes Covered California's iterative cost-sharing design process and choices; consumer advocates' involvement in that journey; and the positive impact on consumer and market outcomes. Finally, it offers implications for other states and for federal decision-makers.

ELEVATING CONSUMER CONCERNS: A TEAM EFFORT

Many factors influenced California's ACA implementation, but central to the adoption of benefit standardization and other consumer-friendly benefit features was sustained attention from a core group of consumer advocacy organizations. Four organizations regularly participated in Covered California work groups and its Plan Management and Delivery System Reform Advisory Committee, drilling down on the details of benefit design: Consumers Union, Health Access California, California Pan-Ethnic Health Network, and Western Center on Law and Poverty. Each of these organizations brought a unique perspective and skillset to the effort, with a shared mission to advocate for consumer interests, a special emphasis on vulnerable populations, and a commitment to successful implementation of health reform in California. Their long history of collaboration offered a formidable coalition of voices on behalf of California healthcare consumers.

¹ Lynn Quincy, *What's Behind the Door: Consumers' Difficulty Selecting Health Plans*, Consumers Union (Jan. 2012), available at https://consumersunion.org/wp-content/uploads/2013/03/Consumer_Difficulties_Selecting_Health_Plans_Jan2012.pdf.

² While the California Exchange sells both individual market and small business products, this paper focuses solely on the individual market designs, process and outcomes.

³ California Government Code 100504(c)(1).

⁴ California Health & Safety Code 1366.6(c); Insurance Code 10112.3(c). Outside of Covered California, non-standardized products are permitted, but very few are offered.

⁵ For more information about each organization, visit consumersunion.org, health-access.org, cpehn.org, and wclp.org.

The Foundation: Keeping Consumer Needs at the Forefront

California's decisions about how to successfully implement and build upon the Affordable Care Act (ACA) rest on a firm foundation: prioritizing consumer needs.

Making Choices Manageable

In shopping for health coverage, consumers want to be able to quickly and confidently choose a plan to fit their needs. The adage is that consumers like lots of choice. The theory is that more options help consumers by increasing the likelihood that they will find an option that meets their specific needs. However, particularly for complicated products and high-stakes decisions such as choosing a health insurance plan, a broad body of evidence suggests otherwise. In many contexts—from selecting a 401(k) fund to a Medicare drug plan—too many options discourage action, or lead to sub-optimal choices.⁶ While consumers generally do value having more than one option, being presented with too many choices can lead to less satisfaction, more anxiety, greater disengagement, and poorer decision-making.⁷

Consumers struggle mightily to understand health insurance jargon. Cost-sharing concepts—coinsurance, copayments and deductibles, including how such features interact within a given product—are especially confusing to

consumers.⁸ While consumers have a strong desire to understand what they are getting for their premium dollar, they also find it difficult to synthesize the various health plan provisions to arrive at a comparative sense of plans' overall value.⁹ Each cost-sharing feature in isolation is difficult enough to comprehend, but combining concepts and understanding their interaction is an insurmountable challenge. For example, the deductible must be satisfied first, but are there exceptions? Do copays apply to the deductible? Numeracy skills may limit consumers' ability to estimate the financial impact of different cost-sharing features even if they understand, in theory, what terms mean.¹⁰ These factors argued for Covered California circumscribing both the number of products available and for standardizing cost-sharing within those product choices.

Beyond narrowing the number of plan choices to a manageable universe, the Exchange needed to consider how else its benefit designs could meet consumers' financial and health needs. Affordability concerns were paramount—obviously in premiums, but also as to other out-of-pocket costs. When cost-sharing curtails use, consumers are as likely to cut necessary as unnecessary services. Reduced health care use due to cost-sharing is greatest for patients who are poor, particularly those with chronic health conditions.¹¹ Increased cost-sharing for people with chronic conditions can lead to increased expenditures

⁶ Lynn Quincy and Julie Silas, *The Evidence is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making*, Consumers Union (Nov. 2012), available at http://consumersunion.org/pdf/Too_Much_Choice_Nov_2012.pdf.

⁷ Ellen Peters et al., More Is Not Always Better: Intuitions About Effective Public Policy Can Lead to Unintended Consequences, *Social Issues Policy Review* (Jan. 2013), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3758756/#>.

⁸ Mira Norton et al., *Assessing Americans' Familiarity with Health Insurance Terms and Concepts*, Kaiser Family Foundation (Nov. 2014), available at <http://www.kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/>.

⁹ Early Consumer Testing of Actuarial Value Concepts, Kleiman Communication Group and Consumers Union (Sept. 2011), p. 26, available at http://consumersunion.org/wp-content/uploads/2013/04/prescriptionforchange.org_testing_actuarial_value_concepts1.pdf; George Loewenstein et al., Consumers' Misunderstanding of Health Insurance, *Journal of Health Economics* (Feb. 2013), pp. 850-862, available at <https://sites.hks.harvard.edu/fs/bmadria/Documents/Madrian%20Papers/Consumers%20Misunderstanding%20of%20Health%20Insurance.pdf>

¹⁰ Sharon Long et al., Low Levels of Self-Reported Literacy and Numeracy Create Barriers to Obtaining and Using Health Insurance Coverage, Urban Institute Health Policy Center (Oct. 2014), available at <http://hrms.urban.org/briefs/Low-Levels-of-Self-Reported-Literacy-and-Numeracy.html>.

¹¹ Melinda Beeuwkes Buntin et al., "Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans," RAND (Feb. 2011), available at http://www.rand.org/pubs/external_publications/EP20110048.html. See also, Robert H. Brooke et al., "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate," RAND (Dec. 2006), available at https://www.rand.org/pubs/research_briefs/RB9174.html.

ACTUARIAL VALUE: DEFINITION AND APPLICATION

Actuarial Value (AV)¹³ is a summary measure that estimates the generosity of coverage provided under a particular health plan, taking into account covered benefits and cost-sharing arrangements. AV measures the percentage of medical expenses paid by a health plan for a standard population (for example, the population enrolled in the individual market). For the group of people enrolled in a Silver (70% AV) plan, plan payments would average 70% of total medical expenses and enrollee payments would average 30%. But each individual enrolled in that silver plan might pay a very different proportion, depending on what health care services s/he actually used.

Under the ACA, the federal Center for Medicare and Medicaid Services updates its Actuarial Value Calculator annually.¹⁴ AV is tightly defined and can be a tough taskmaster. Covered California continually learns from consumer needs, concerns and preferences and gauges product trends. Each year, Covered California considers market factors and adjusts cost-sharing to stay within the calculator's and the statutory bounds.

on hospitalizations.¹² Thus, product design needed to aim for cost-sharing arrangements that would incentivize access to appropriate health-sustaining services.

Making the Consumer, Not the Health Plan, “The Decider”

Prior to the ACA, insurers generally developed individual market products based on risk avoidance, creating products to attract customers

with fewer healthcare needs and lower costs. The ACA, however, upended that paradigm, establishing a framework for putting consumers in the driver's seat by encouraging health plans to compete not on risk selection, but on more consumer-centric ends such as price, quality, provider networks, and customer service—in short, on value. The ACA thus:

- Required coverage of ten categories of “essential health benefits (EHBs)”;
- Prohibited annual dollar limits and lifetime limits for EHBs;
- Required that carriers pay a minimum percentage of premium dollars toward actual medical care (also known as medical-loss ratios);
- Established a standardized display of each policy's coverage, the “Summary of Benefits and Coverage”; and
- Required that products be grouped into “metal tiers” that meet broad standards for cost-sharing generosity for an average population, as measured by actuarial value (AV): Bronze (60%); Silver (70%); Gold (80%); Platinum (90%).

Together, these requirements were aimed at averting “adverse selection”—when a disproportionate share of high-risk and high-utilizing individuals purchase within a pool. If Exchanges experienced adverse selection, their costs would rise at an unsustainable pace and, at the extreme, make it impossible to offer affordable products, leading to the market collapsing.

These ACA parameters, however, went only so far. They neither required that products be simplified nor limited the number of products that health

¹² Sarah Goodell and Katherine Swartz, “Cost-sharing: Effects on spending and outcomes,” Robert Wood Johnson Foundation Synthesis Project (Dec. 2010), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103.

¹³ Actuarial Value Under the Affordable Care Act, American Academy of Actuaries (July 2011), available at https://www.actuary.org/pdf/health/Actuarial_Value_Issue_Brief_072211.pdf.

¹⁴ Final 2017 Actuarial Value Calculator Methodology, Center for Medicare and Medicaid Services (Jan. 2016), available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-AVC-Methodology-012016.pdf>.

insurance carriers could offer. Instead, the ACA maintained a good deal of state flexibility and preserved the central role of state regulators in approving health insurance products. In its authorizing legislation, California added requirements to exceed these federal floors,¹⁵ including a requirement that the Exchange selectively contract with carriers, rather than “take all comers.”¹⁶ In addition, carriers participating in the Exchange must offer a product at every metal level, whereas federal law simply requires plans to offer at least two tiers on an Exchange.¹⁷ Finally, carriers that participate in the Exchange, if they also sell off-Exchange, must offer all their Covered California products as “mirror products” off-Exchange, whereas federal law requires participating plans to simply offer two “mirror plans” off-Exchange.¹⁸

Notwithstanding these extensive requirements within the ACA and in California’s implementing legislation that were intended to level the playing field and minimize adverse selection, Covered California and consumer stakeholders sought further protections since old habits—including health plan tendencies to use benefit designs to attract or deter consumers based on risk—die hard. The National Association of Insurance Commissioners observed that, “the more choices a market provides, the greater the opportunity for adverse selection, either directly or indirectly.”¹⁹ Consumer advocacy groups, as well as some other stakeholders, noted that challenges with complexity, affordability, and risk selection could persist despite mitigating features of federal and state law if Covered California permitted a variety of product designs. They urged Covered

California to exercise an important option provided by the authorizing state statute: for the Exchange to standardize its cost-sharing designs.²⁰

As detailed below, Covered California from the outset determined to follow that course. It thus prioritized consumer needs by ensuring an easier way to compare plans, encouraging informed choices, and offering consumers incentives to get the right care.

Guiding Principles

The threshold decision for Covered California to exercise the option to require standardized benefit designs was adopted in August 2012 and was not controversial. Several principles guided that decision and the steps that followed it. Chief among them was having a fully transparent policymaking process with public hearings from the outset. As staff who worked on the authorizing legislation noted, “...we tried to put in the most solid foundation that we possibly could, with transparency and openness that one expects of government.”²¹ That foundational precept of Covered California’s establishment as an independent state entity—subject to open meeting requirements—carried through to its administrative processes, including on benefit design. Through public Board meetings, notices, and Plan Management and Delivery System Reform Advisory Committee meetings, starting in the first year and continually thereafter, the decisions about the cost-sharing designs—a technical but critical topic—have been fully vetted, probed, and decided in full public view. The public

¹⁵ See Kelch Policy Group, Benefit and Coverage Rules Under the ACA: California vs. Federal Provisions, California Health Care Foundation (March 2014), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20A/PDF%20ACAbenefitRules.pdf>.

¹⁶ CA Government Code 100503(c)

¹⁷ CA Government Code 100503(e)

¹⁸ CA Government Code 100503(f)

¹⁹ Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act, National Association of Insurance Commissioners (2011), p. 5, available at <http://www.naic.org/store/free/ASE-OP.pdf>.

²⁰ CA Government Code 100504(c)(1). See also 100503(i) directing the Exchange to set cost-sharing for qualified health plans, though not requiring it be standardized amongst them.

²¹ See, California’s Insurance Exchange: Experts Tackle the Big Questions, California Health Care Foundation (Dec. 2010), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CAInsuranceExchangeExpertsTackleBigQuestions.pdf> (quoting Sumi Sousa).

process supported robust debate and sound decisions grounded in principles of consumer choice, investments in health, and competition amongst carriers based on value.

Support informed consumer choice

When Covered California first articulated its core values, “consumer-focus” was at the top of the list. Both Covered California staff and consumer advocates prioritized a benefit structure that assured consumers could compare and choose options to reflect their financial interests and preferences.

Advocates encouraged Covered California to allow for apples-to-apples comparisons among products, keeping the designs as transparent, intuitive, relevant, and stable as possible. They urged standardized cost-sharing designs²² that were:

- **Transparent:** Present key cost-sharing features as plainly as possible, so that consumers do not encounter big surprises when they access services. Use co-pays rather than coinsurance wherever possible since consumers overwhelmingly prefer the certainty of fixed dollar cost-sharing. Avoid cost-sharing features that are subject to exceptions or special circumstances.
- **Intuitive:** Assure that benefits and premiums are arrayed in logical “stair steps.” Do not

let cost-sharing vary in opposition to what actuarial value differentials suggest: copays should increase and premiums decrease as metal level decreases from platinum to bronze. Consumers should not have to make sense of counter-intuitive features.

- **Relevant:** Offer consumers something of value across a range of circumstances and metal levels, so that all consumers—including those of very limited means and those in excellent health—can see reasons to enroll.
- **Appropriate:** Consider how consumers’ out-of-pocket costs relate to their available financial resources (for example, compare potential out-of-pocket costs to monthly salary). Provide clear signals to encourage consumers who qualify for cost-sharing subsidies²³ to enroll in Silver plans and obtain those cost-sharing subsidies.
- **Stable:** Make sound foundational design decisions in early years and keep year-to-year changes incremental. With a relatively stable benefit structure, consumers’ efforts to understand and compare coverage options would be rewarded over time as features became increasingly familiar. In contrast, frequent or dramatic changes in products or features would confuse consumers and undermine their ability to choose wisely.

²² Letter to Peter Lee and Andrea Rosen of Covered California, Consumers Union, Health Access, Western Center on Law & Poverty (Oct. 2012), available at http://consumersunion.org/california-health/2012_10_Jt-comments-standard-benefit-design_JS.pdf.

²³ Enrollees earning between 100% and 250% of the federal poverty guideline (FPL) are eligible for additional cost-sharing assistance if they enroll in Silver plans. That cost-sharing assistance elevates the actuarial value from Silver’s basic 70% AV, to 73% AV for those 200-250% FPL; 87% AV for those 151-200% FPL; and 94% AV for consumers between 100 and 150% FPL.

Encourage getting the right care, at the right time

One purpose of health insurance is to provide protection from financial catastrophe; another, which Covered California chose to emphasize, is to provide access to care that supports good health outcomes. The ACA requires private health insurance plans to cover certain preventive services without any cost-sharing.²⁴ Income-eligible consumers may qualify for cost-sharing subsidies under the ACA—but only if they choose a Silver plan offering in an ACA Exchange. So that consumers would be less likely to delay basic care due to cost concerns, California consumer advocates urged decision-makers to:

- Make payments for primary care and generic drugs manageable for consumers, prioritizing lowering copayments as much as possible.
- Make payments for primary care and related services predictable. Consumers may avoid diagnostic tests that involve coinsurance if they have no idea how much they will owe. Delayed diagnosis may lead to adverse health outcomes and higher total costs down the road.
- Exempt primary care services from application of the deductible. While deductibles keep premiums lower and help actuarial values stay in line with ACA requirements, they discourage consumers from obtaining timely basic care.²⁵ Advocates encouraged Covered California to think creatively about when and how to administer deductibles—and how to describe them.

Encourage appropriate competition among plans

In an ideal world, consumers would select among health plans that represent “the optimal combination of choice, value, quality and service.”²⁶ Value is a complex concept and means different things to different people; at the same time, the structure of products and benefits can make it simpler or harder for consumers to consider tradeoffs and assess value. If every product differs along many unique dimensions, consumers will find it difficult if not impossible to estimate their total cost (premiums plus out-of-pocket costs). In contrast, products with identical cost-sharing categories are easier for consumers to compare and thus exercise their market power, rewarding plans that excel in quality, efficiency and service. To assure consumers would be able to make informed choices, consumer advocates encouraged Covered California to:

- Standardize benefit designs so that consumers could compare options on an “apples-to-apples” basis. Presented with standardized benefits, consumers could focus instead on areas of relevant variation, most notably premium, provider network, and quality.
- Impose quality requirements via plan contract negotiations, assuring that any plan offered through Covered California met threshold quality standards.
- Prioritize timely provision of information to the public about provider networks, participating hospitals, and plan quality including customer service.

²⁴ Preventive Services Covered by Private Health Plans under the Affordable Care Act, Kaiser Family Foundation (Aug. 2015), available at <http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/>.

²⁵ Zarec Brot-Goldberg et al., What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics, Harvard Kennedy School Faculty Research Working Paper (Oct. 2015), available at <https://research.hks.harvard.edu/publications/getFile.aspx?id=1265>.

²⁶ See, AB 1602 (Perez), available at http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100930_chaptered.html (Covered California enacting legislation).

Decisions Reflected Consumer Interests

Consumer advocates actively participated in the Exchange's Plan Management and Delivery System Reform Advisory Committee, specific benefit design work groups that sprung from the Advisory Committee, and Board meetings, thus making substantial contributions to many of Covered California's plan decisions. Many stakeholders came into ACA implementation assuming that the existing product constructs would form the basis for Covered California products. Given the challenges consumers faced in understanding and choosing health plans, however—as well as new goals for improving health outcomes and care coordination—consumer advocates urged Covered California to take a fresh look at products and benefit design. The following examples illustrate how steady attention to what was and wasn't working well for consumers helped upend some of the conventional wisdom, making Covered California's products and benefits more and more consumer-friendly over time.

Coinsurance vs Copayments

Prior to the ACA, the majority of enrollees in California's individual health insurance market were covered through PPOs for which coinsurance was a common cost-sharing arrangement.²⁷ Continued reliance on familiar designs seemed natural; envisioning a shift to greater reliance on copayments was not a given.

From the outset, however, consumer advocates questioned continued extensive reliance on coinsurance, explaining that coinsurance created great confusion and insecurity for consumers. Research on consumer numeracy skills confirms what common sense tells us: that people overwhelmingly prefer fixed dollar share-of-cost amounts to coinsurance percentages.²⁸ And they do so for several reasons. Ascertaining which coinsurance portion the plan pays and which the customer is responsible for can be confusing to consumers. Coinsurance final costs are unknowable since consumers don't know either initial costs or allowed amounts. Even if underlying costs were known, evidence suggests that many consumers have difficulty comparing fixed dollar payments to percentages.²⁹ In contrast, actual dollar amounts are concrete and do not require the numeracy skills and assumptions required for percentage calculations.

Advocates' first ask was to eliminate coinsurance cost-sharing altogether. Modeling by Covered California actuaries showed the challenge of eliminating coinsurance altogether within the constraints of the actuarial levels, while keeping premiums manageable. However, on deeper exploration, Covered California staff did find

²⁷ Katherine B. Wilson, *California's Individual and Small Group Markets on the Eve of Reform*, California Health Care Foundation, (April 2011), available at <http://www.chcf.org/publications/2011/04/ca-individual-small-group-eve-reform>.

²⁸ See, *Early Consumer Testing of Actuarial Value Concepts*, Kleiman Communication Group and Consumers Union (Sept. 2011), p. 12, available at http://consumersunion.org/wp-content/uploads/2013/04/prescriptionforchange.org_testing_actuarial_value_concepts1.pdf (In focus groups and intensive interviews testing consumer understanding of insurance concepts, when presented with side-by-side comparisons of dollar amounts and percentages (e.g. Platinum: \$40 vs. Gold: 20%), participants noted an overwhelming preference for actual dollar amounts which are considered concrete, plus it was clearer to participants that copays were their responsibility. Percentages, such as coinsurance, were harder to decipher because the final cost depends on the initial total cost, which is unknown.).

²⁹ Lynn Quincy, *What's Behind the Door: Consumers' Difficulty Selecting Health Plans*, Consumers Union (Jan. 2012), available at https://consumersunion.org/wp-content/uploads/2013/03/Consumer_Difficulties_Selecting_Health_Plans_Jan2012.pdf.

opportunities to reduce the use of coinsurance significantly. The most critically important example was regarding Silver plans—which nearly 60% of Covered California enrollees choose. Advocates illustrated through detailed charts based on the proposed designs the very minimal differences between cost-sharing features in the 2014 and 2015 Silver plans labeled “Copay Plan” versus those labeled “Coinsurance Plan”—each of which were based primarily on copayments. They argued that the confusion created by this distinction-without-much-difference was detrimental to consumer understanding. In response, after extensive input from all stakeholders which yielded agreement, the Exchange merged the two into a single Silver design for 2016 that relied primarily on copay cost-sharing.

Over time, through ongoing review of plan designs and consumer product choices, as well as the updates to the actuarial value calculator required by the federal government, Covered California designs have shifted where possible from use of coinsurance in other metal levels as well. For example, in the Bronze plan, whereas laboratory tests had been subject to a 30% coinsurance in 2015, in 2016 a \$40 copay applied.

Deductibles

Deductibles—the upfront amount for which a consumer is responsible before insurer payments kick in—have a powerful effect in keeping premiums down and meeting actuarial value requirements, yet can be a barrier to necessary care.³⁰ They can also be a sharp financial pain point for consumers, and one that adds complexity as consumers often struggle to understand to what services and when deductibles apply.

Consumer advocates worked with Covered California to explore whether deductibles were necessary and, if so, how they might

best be applied to keep coverage affordable and avoid surprises for consumers when they seek, or consider seeking, care. From the beginning, Platinum and Gold plans included no deductibles. However, to meet Silver and Bronze actuarial value requirements and keep premiums affordable, it was necessary to impose deductibles in those tiers. Given this reality, advocates sought to avoid consumer confusion and limit the extent to which deductibles discouraged consumers from using needed care. A particular concern was that consumers, especially low-income consumers, be able to weigh a known out-of-pocket cost against medical need. Consumers should not be confused or unduly discouraged by cost-sharing, nor surprised by higher-than-expected bills after getting care.

While California HMO products typically waived the deductible for office visits even prior to Covered California’s establishment, removing office visits from the deductible was not initially proposed for all Covered California products. Following exploration and actuarial modeling, these services were removed from the deductible in Silver plans starting in 2014. In Bronze plans—which have a very high deductible—three visits (plus the free preventive visit annually) provided were not subject to the deductible.³¹ Consumers who chose these least generous and lowest premium plans thus gained flexibility and immediate value because most outpatient services (primary care or specialist office visits) were subject only to a simple copay.

Over time, to make benefits as understandable and affordable as possible, the span of services to which the deductible applied evolved. Consumer groups advocated, for example, to remove emergency room (ER) services from the deductible so as not to hit consumers with outsize bills, beyond their copay, when they had not met their deductible. The aim was to neither surprise enrollees with unexpectedly large bills, nor to discourage those who truly need emergency

³⁰ Zarec Brot-Goldberg et al., What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics, Harvard Kennedy School Faculty Research Working Paper (Oct. 2015), available at <https://research.hks.harvard.edu/publications/getFile.aspx?id=1265>.

³¹ In addition, in the 2014 and 2015 plan year, in Bronze (as well as Silver) plans, prenatal care and preconception visits had no cost-sharing.

treatment from seeking it. Thus, for 2017 individual market plans Covered California removed ER facility and ER physician fees from the deductible in Silver products.

Today, almost all outpatient services for Covered California individual market products receive “first-dollar coverage”—that is, coverage excluded from deductibles. Rather than having the deductible apply to relatively common professional services—and thus requiring the consumer to bear all the cost if the deductible has not been otherwise met—the deductible applies primarily to high-cost, infrequent services such as care in hospitals, skilled nursing facilities, and other inpatient services. In addition, to assist consumers in comparing products on a head-to-head basis, deductibles apply to facility-related charges for copay products as well as coinsurance products.

A final issue related to deductibles is whether, if deductibles are necessary for a given product, having a separate deductible for medical care and one for prescription drugs is in consumers’ interest. During the work group process on benefit design, advocates were initially skeptical, concerned that having two deductibles would add complexity and generate confusion about what services and products were subject to which deductible. However, actuarial calculator modeling demonstrated that a relatively low prescription drug deductible—say \$100—could help keep premiums down and get a consumer to first dollar coverage for drugs more quickly than requiring them to satisfy the much larger medical deductible in full. Once consumer groups reached the (initially counter-intuitive) conclusion that two separate deductibles could be consumer-friendly, they advocated for clear labeling, displays, and messaging to clarify how deductibles would work.

Prescription drug benefit design

About half of all Americans regularly take a prescription drug, and more than one in ten takes

five or more.³² For many years, prescription drug costs have accounted for a growing share of health care spending and of insurance premiums. Over the past decade or more, prescription drug benefits have grown very complex. For example, many products have separate prescription drug out-of-pocket limits and deductibles; most sort drugs into several tiers (generic, preferred, non-preferred, specialty) that are subject to different copays or coinsurance levels. To forecast needs and estimate costs under such complex schemes poses significant cognitive challenges for consumers.

Recognizing the importance of prescription drug coverage as both consumer benefit and cost driver, the structure of prescription drug benefits was subject to ongoing review by Covered California and its Plan Management Advisory Group, on which consumer advocates served. By early 2015, consumer cost burden associated with specialty drugs was attracting heightened concern. Covered California convened an intensive group process over several months that included several consumer advocates, health plan representatives, and representatives of California’s Department of Managed Health Care and Department of Insurance. As a result of extensive study, educational sessions with pharmaceutical experts, and workgroup recommendations, the Board approved 2016 standard benefits designs that imposed caps on consumer out-of-pocket costs for specialty drugs.³³ A maximum charge of \$250 for Platinum, Gold, Silver and Silver 73 plans; \$150 for Silver 87 and Silver 94 plans; and \$500 for Bronze plans applied for a 30-day supply. In contrast to earlier benefit designs with open-ended coinsurance for specialty drugs, these changes made consumer out-of-pocket prescription drug costs more predictable. It also spread the maximum out-of-pocket amount over the course of a year, in an effort to allow consumers some month-to-month relief.

³² National Center for Health Statistics Fast Stats, Center for Disease Control and Prevention, available at <https://www.cdc.gov/nchs/fastats/drug-use-therapeutic.htm>.

³³ See, James DeBenedetti, Benefit Design Updates and Consumer Clarity, Covered California Plan Management Advisory Group (May 2015), available at http://hbex.coveredca.com/stakeholders/plan-management/PDFs/Plan%20Management%20Advisory%20Group_Slide%20Deck_%20May_14_2015.pdf.

CONSIDERED BUT DEFERRED: ALTERNATIVE VALUE-BASED INSURANCE DESIGN

Since its early days, Covered California has demonstrated a deep commitment to delivery system reform, innovation, and value. In that vein, Covered California considered incorporating value-based insurance design (VBID) in some of its products. The goal of VBID is to structure consumer cost-sharing so that enrollees are guided toward services known to improve health outcomes and away from services of limited or uncertain value.³⁴ For example, waiving cost-sharing for diabetes monitoring or treatment may make sense if cost-sharing is a barrier to maintaining normal blood glucose levels and leads to serious health complications.

Advocates acknowledged that consumer cost-sharing can impede access to care and affect health outcomes. Diabetes management is a particular concern to millions of Americans and disproportionately affects communities of color. So the Plan Management and Delivery System Reform Advisory Committee decided to explore whether a VBID for diabetes was feasible. Advocates urged that VBID proposals be considered from the viewpoint of consumers. Cost-sharing arrangements that vary by health condition can be difficult for consumers to understand. Allowing different plans to test multiple VBID variations could undermine the simple comparison shopping made possible by standardized benefits.³⁵

During 2015, Covered California staff led a thorough exploration of a potential VBID focused on diabetes for potential implementation in the 2017 plan year.³⁶ However, lacking solid evidence of value, advocates determined—as did Covered California—that at this stage consistency was more important than offering unproven innovation with possible unintended consequences. Potential benefits were outweighed by two concerns: additional confusion and complexity for consumers and health care providers; and increased premiums for those not targeted by the effort.

³⁴ Lance Lang et al., "Moving the Needle on Primary Care: Covered California's Strategy to Lower Costs and Improve Quality," Health Affairs blog (June 2017), available at <http://healthaffairs.org/blog/2017/06/14/moving-the-needle-on-primary-care-covered-californias-strategy-to-lower-costs-and-improve-quality/>.

³⁵ Letter to Peter Lee and Andrea Rosen of Covered California, Value-Based Insurance Design Options, Consumers Union and Health Access (Sept. 2012) (on file with author); Consumer Criteria for Value-Based Insurance Designs, Consumers Union (Jan. 2013), available at https://consumersunion.org/wp-content/uploads/2013/01/Consumer_Criteria_1_13.pdf.

³⁶ Lance Lang et al., Memo to 2017 Benefits & Networks Subcommittee: Consideration Issues for Implementing Value-Based Insurance Design (VBID) for Diabetes (Dec. 2015) (on file with author).

On a parallel path, Health Access California, drawing from learnings from the work group process at Covered California, sponsored legislation, AB 339, to cap outpatient prescription drug costs across the entire commercial insurance market in California. AB 339 was signed into law by Governor Brown and took effect in January 2017.

Focusing on Consumers Yields Win-Win Outcomes

Gauged along many dimensions—and in comparison to many other states—California has proven how the Affordable Care Act can truly work for consumers.³⁷ California adopted the ACA's optional Medicaid expansion, declined to allow continuation of plans that do not comply with ACA requirements, and pursued many other policies that fostered the ACA's successful implementation. As a result, California's uninsured rate has dropped by nearly half³⁸ and Covered California has attracted robust participation by plans and a healthy mix of consumers. California's consumer orientation has been a critical contributor to that success. Further details on the positive impacts of that orientation are set forth below.

Premiums and out-of-pocket costs

Covered California's weighted average premium increase was 4.2% in 2015, 4.0% in 2016, and 13.2% in 2017. According to experts,³⁹ the 2017 increase included a one-time bump due to the end

of the temporary federal risk mitigation programs (reinsurance and risk corridors)⁴⁰ intended to cushion the expenses of high-cost patients. While any premium increase is a burden on consumers, taken together these rates of increase compare very favorably to the median annual increase in California's individual market prior to ACA implementation: 9.8% from 2011 to 2014.⁴¹ California's premiums also compared favorably to those in other states.⁴² Premiums reflect many factors: competition among plans and providers, use of health care services, labor costs. But there is a case to be made that Covered California's benefit structure has encouraged plan competition and exercised a check on premiums.

Standardizing benefits, in addition to making shopping easier for consumers, also streamlined evaluation of health plan bids by Covered California staff.⁴³ When all plans offer comparable benefits, it makes reviewing complex rate filings simpler and provides greater opportunity to clarify what drives premium differences.

Significantly, California consumers also fared well in terms of out-of-pocket costs, compared to consumers in states that did not standardize cost-sharing nor engage in active purchasing. According to a Covered California analysis, consumers enrolled in similarly priced products in Denver and Miami, for example, had higher deductibles and more exposure to cost-sharing than those in Los Angeles with Covered California products.⁴⁴

³⁷ Jonathan Cohn, Trump Says Obamacare Is 'Imploding.' That's News To California, Huffington Post (June 2017), available at http://www.huffingtonpost.com/entry/covered-california-obamacare_us_5936cf84e4b013c4816b639f.

³⁸ Paul Fronstin, California's Uninsured: As Coverage Grows, Millions Go Without, California Health Care Foundation (Dec. 2016), available at <http://www.chcf.org/publications/2016/12/californias-uninsured>.

³⁹ Drivers of 2017 Health Insurance Premium Changes, American Academy of Actuaries (June 2016), available at <http://www.actuary.org/content/drivers-2017-health-insurance-premium-changes-0>.

⁴⁰ Cynthia Cox et al., "Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors, Kaiser Family Foundation (Aug. 2016), available at <http://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/>.

⁴¹ Katherine Wilson, Premium Rates in California's Individual Market, 2011–2014, California Health Care Foundation (July 2014), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20P/PDF%20PremiumRatesIndivMarket.pdf>.

⁴² Cynthia Cox et al., 2017 Premium Changes and Insurer Participation in the ACA's Health Insurer Marketplaces, Kaiser Family Foundation (Oct. 2016), available at <http://www.kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/>.

⁴³ Open Enrollment 2013-14: Lessons Learned, Covered California (Oct. 2014), p. 21, available at <https://www.coveredca.com/PDFs/10-14-2014-Lessons-Learned-final.pdf>.

Enrollment

In 2016, Covered California had enrolled 48% of its estimated potential Marketplace population, more than the 40% share enrolled in the federally-facilitated Exchange and a greater share than in most other state-based Exchanges.⁴⁵ California's robust individual market enrollment under the ACA may be due in part to California's previous high rate of uninsurance and an unregulated pre-ACA individual market, but also can be attributed to strong outreach efforts by the Exchange. Also, by making it easier to compare and understand products, benefit standardization may have helped California attract enrollees.

Moreover, enrollees in Covered California plans seem to be choosing the right plans for their health needs. An analysis of medical risk profiles for enrollees in Covered CA for 2016 and 2017 showed that mean "risk scores" are higher for plans with higher actuarial value.⁴⁶ In other words, those consumers expected to use more care are selecting a plan in a metal tier that provides more comprehensive coverage, in line with their financial interests. While further research is needed,⁴⁷ it may well be that standardized benefit designs, combined with Covered California's well designed web-based search tools, have helped consumers find plans that fit their health status.

Consumer satisfaction within Covered California has been strong. From 2015 to 2016, 88% of renewing consumers maintained their carriers and benefit levels, suggesting that they were satisfied with the combination of price, access, quality, and service they were receiving.⁴⁸ The

ability to compare standardized options likely increased consumer confidence in their choices and contributed to enrollment stability.

Effective Process Grounded in Transparency

Covered California has a deep commitment to mission. Its early articulation of core values, developed with input from stakeholders, served to rally diverse stakeholders.⁴⁹ Decisions and implementation actions taken by the Covered California Board, its executive leadership, and its staff were guided by a steady commitment to consumers. In addition to achieving outcomes that served consumers well, that commitment helped solidify consensus among stakeholders and supported an efficient process for airing and resolving differences when they did arise.

Extending upon its identity as an open government entity, Covered California has built a culture that elicits and attempts to respond to stakeholder concerns. Consumer advocates regularly voice their questions, concerns, and suggestions at Covered California Board meetings. In early 2013, Covered California established a Plan Management and Delivery System Reform Advisory Group, which continues to meet regularly, to inform initial Covered California benefit design decisions. Participants include health plans, health care providers, independent health experts, and several consumer advocates. Throughout health plan design deliberations, Covered California staff provided analysis, modeled different cost-sharing options, and demystified actuarial tools to help

⁴⁴ Delivering on the Promise of the Affordable Care Act, Covered California (July 2015), p. 15, available at <http://nashp.org/wp-content/uploads/2015/07/7-17-15-CoveredCA-Delivering-on-the-Promise-of-the-ACA.pdf>.

⁴⁵ Marketplace Enrollment as a Share of the Potential Marketplace Population, Kaiser Family Foundation (March 2016), available at <http://www.kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22desc%22%7D>.

⁴⁶ Covered California Continues to Attract Sufficient Enrollment and a Good Risk Mix Necessary for Marketplace Sustainability, Covered California (May 2017), available at http://hbex.coveredca.com/data-research/library/CoveredCA_Sufficient_Enrollment_Good_Risk_Mix.pdf.

⁴⁷ See also, Vicki Fung et al., Nearly One-Third of Enrollees in California's Individual Market Missed Opportunities to Receive Financial Assistance, Health Affairs (Jan. 2017), available at <http://content.healthaffairs.org/content/36/1/21.abstract> (The jury is out with respect to consumers optimizing access to premium subsidies and cost-sharing reduction.)

⁴⁸ New Data Show How Covered California Spurs Competition Among Health Insurance Companies, Covered California (Feb. 2016), available at <http://news.coveredca.com/2016/02/new-data-show-how-covered-california.html>.

⁴⁹ See, About Us: California's Health Benefit Exchange, Covered California, available at <http://hbex.coveredca.com/about/> (Covered California describes its values in the following domains: Consumer-Focused; Affordability; Catalyst; Integrity; Partnership; Results).

advocates and other stakeholders grapple with tradeoffs and understand actuarial implications or various cost-sharing adaptations.

From the start, a commitment to consumers' experience and their ability to understand options led Covered California to consider both short- term choices and long- term implications. Balancing the desire to innovate with a desire for stability, Covered California defined a structure for standardized benefits in its first year, but then revisited each year—tweaking where needed, but avoiding sweeping changes that would have been disruptive for consumers, as well as health plans.

As a result, Covered California's implementation path on cost-sharing was smooth, yet also allowed for continuous improvement. There were no dramatic retrenchments or reconsiderations in benefit policy or product design. Covered California's clear vision and stable priorities—anchored in consumer needs—supported long-term planning by health plans and health care providers. All parties were able to invest resources in steady improvement rather than revisiting major past decisions or operating under uncertainty.

Implications

California established a well-functioning health benefit Exchange and consumer-friendly, standardized cost-sharing products under the ACA. California's consumer-centric approach paid dividends for those enrolled through Covered California. More broadly, it improved choices and supported comparison shopping for all Californians who rely on the individual market. California's experience offers insights for coverage policy and implementation decisions in other states and at the federal level.

Many consumer challenges—and ways to address them—are universal:

- Consumers wrestle with tradeoffs between affordability and access to care. Tools and presentations that illustrate tradeoffs help consumers make wise and durable choices. Standardizing benefit designs removes one source of variability and uncertainty.
- Having too many choices impairs decision-making and may prevent consumers from acting at all. Simplified benefit designs streamline decisions and improve consumer confidence. Offering a limited number of products makes it easier for consumers to choose.
- Consumers want to minimize time spent shopping, yet avoid buyer's remorse. Streamlined structures to compare options and clear messaging encourage enrollment and increase satisfaction.

In implementing the ACA in California, prioritizing consumer concerns has paid off both directly and indirectly. Within Covered California, enrollment levels, health of the risk pool, premiums, consumer participation and satisfaction compare favorably to those features in California non-Exchange markets and in other state Exchanges. Within the broader California market, innovative standardized cost-sharing benefit designs and expanded consumer protections have begun to take hold—some through legislation, as in the case of caps on out-of-pocket costs for specialty drugs; some through other policy decisions, as in the requirement for standardized products, offered both inside and

outside Covered California so that consumers can compare all options.

California's experience can inform deliberations at the federal level and within other states. One sign that the federal government has learned from California's approach came when the Center for Medicare and Medicaid Services adopted standardized cost-sharing as one option within the federal Exchange.⁵⁰ Consumers Union vigorously encouraged this step and offered concrete suggestions drawn from the California experience about how to maximize its usefulness for consumers.⁵¹ Those suggestions remain relevant as long as Exchanges play a role in presenting individual market products to consumers. In 2016, Avalere analyzed the federal proposal, including its proposed reliance on first-dollar coverage for outpatient services, and noted the potential appeal to healthier consumers of benefit designs such as Covered California's.⁵²

At the state level, advocates and policymakers may want to consider opting for consumer-friendly standardized cost-sharing designs. In addition to easing the burden on consumers in comparing plans and fostering access to valuable services, such as primary care, this approach may also have the benefit of reducing regulatory burden for the states. Some states are already on that path, also allowing carriers to offer non-standardized plans in addition to requiring standardized plans. Researchers have suggested that offering both presents a difficult balancing act to ensuring consumer understanding, however, making improved web-based consumer choice tools especially important.⁵³

Consumers' need for coverage that is understandable and reliable—devoid of hidden exclusions and other unwelcome surprises—is undeniable. As advocates and leaders within the public and private sectors work to protect and assure health coverage—either under the ACA or within a new policy context—they would do well to emulate California's strong commitment to transparency and to consider adopting standardized, consumer-friendly benefits that encourage primary and high-value care.⁵⁴

50 HHS Notice of Benefit and Payment Parameters for 2017, Federal Register (March 2016), available at <https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf>.

51 Consumers Union, Comments to HHS Secretary Burwell Re: CMS-9937-P: Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2017 (December 21, 2015).

52 Caroline F. Pearson and Elizabeth Carpenter, Proposed Exchange Standardized Benefit Designs Expand First-Dollar Coverage for Services and Drugs, Avalere (Jan. 2016), available at <http://avalere.com/expertise/life-sciences/insights/proposed-exchange-standardized-benefit-designs-expand-first-dollar-coverage>.

53 Sabrina Corlette et al., Missed Opportunities: State-Based Marketplaces Fail to Meet Stated Policy Goals of Standardized Benefits Designs, Robert Wood Johnson Foundation and Urban Institute (July 2016), available at <http://www.urban.org/sites/default/files/publication/82611/2000862-Missed-Opportunities-State-Based-Marketplaces-Fail-to-Meet-Stated-Policy-Goals-of-Standardized-Benefit-Designs.pdf>.

54 Elliott S. Fisher and Peter V. Lee, Toward Lower Costs and Better Care—Averting a Collision between Consumer- and Provider-Focused Reforms, *New England Journal of Medicine* (March 2016), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1514921>.

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