California Medical Association

Physicians dedicated to the health of Californians

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New Managed Care Landscape in 2014 and Beyond

- Medi-Cal Managed Care expansion
- California's Health Benefit Exchange, also known as Covered California
  - Including Bridge Plans
- Numerous Centers for Medicare & Medicaid Services (CMS) programs hitting their stride
- Uncertainties regarding the newly insured population

Potential Impact: California vs. Massachusetts

The Uninsured:

- CA = around 7.1 mil uninsured – approx. 20% of state's population
  - If the uninsured in CA were a state, they would represent the 13th largest state in the U.S.
- MA = uninsured rate declined from 10.9% to 4%
  - Assuming a similar decline in CA would mean around 4 mil newly insured

CHCF Center for Health Care Reporting June 29, 2012

The Path to Insurance

- Children on parents' plans (450,000 covered lives)
  - Children may remain on parents' plans until age 26
- Insurance Exchange (2-3 million)
  - Some estimates have 4.4 million enrolling in the Exchange by the end of 2016
- Medicaid (Medi-Cal) Expansion (1.5 - 2 million)
- Total New Insureds: 4 - 5.5 million
  - 2 – 3 million uninsured remaining (approx. 6 - 8% of Californians)

Potential Impact of the Exchange in CA

- 90-day grace period that leaves providers on the hook for 60 days may create fiscal uncertainty
  - Will plans cap deduct?
- High patient cost-sharing (up to $6,400 for individual, $12,800 family)
- Estimated 30% annual turnover of Exchange popul.
- Half of the under 200% FPL population may experience a change in coverage status
- Currently, Exchange would allow unfettered changes in plan choice in enrollee's first 60 days

Exchange's RBO-Focused HMO Co-Pay Plans

Service Category	Patient Co-Pay	
	Standard Silver Plan	**Standard Bronze Plan**
Hospital Stay	$900 per day, up to 3-day limit	$1200 per day, up to 3-day limit
ER Services	$250	$300
Prenatal and Postnatal Care	$45	$80
Delivery & Related Inpatient Services	$900 per day, up to 3-day limit	$1200 per day, up to 3-day limit
Inpatient Mental & Behavioral Health	$900 per day, up to 3-day limit	$1200 per day, up to 3-day limit
Skilled Nursing Care	$250	$300
Deductibles	Facility-related (institutional & ER) = $1,400; brand drugs = $250; 70% coinsurance after	Medical & drug integrated (inpatient, ER, drugs) = $4,500; 60% coinsurance after

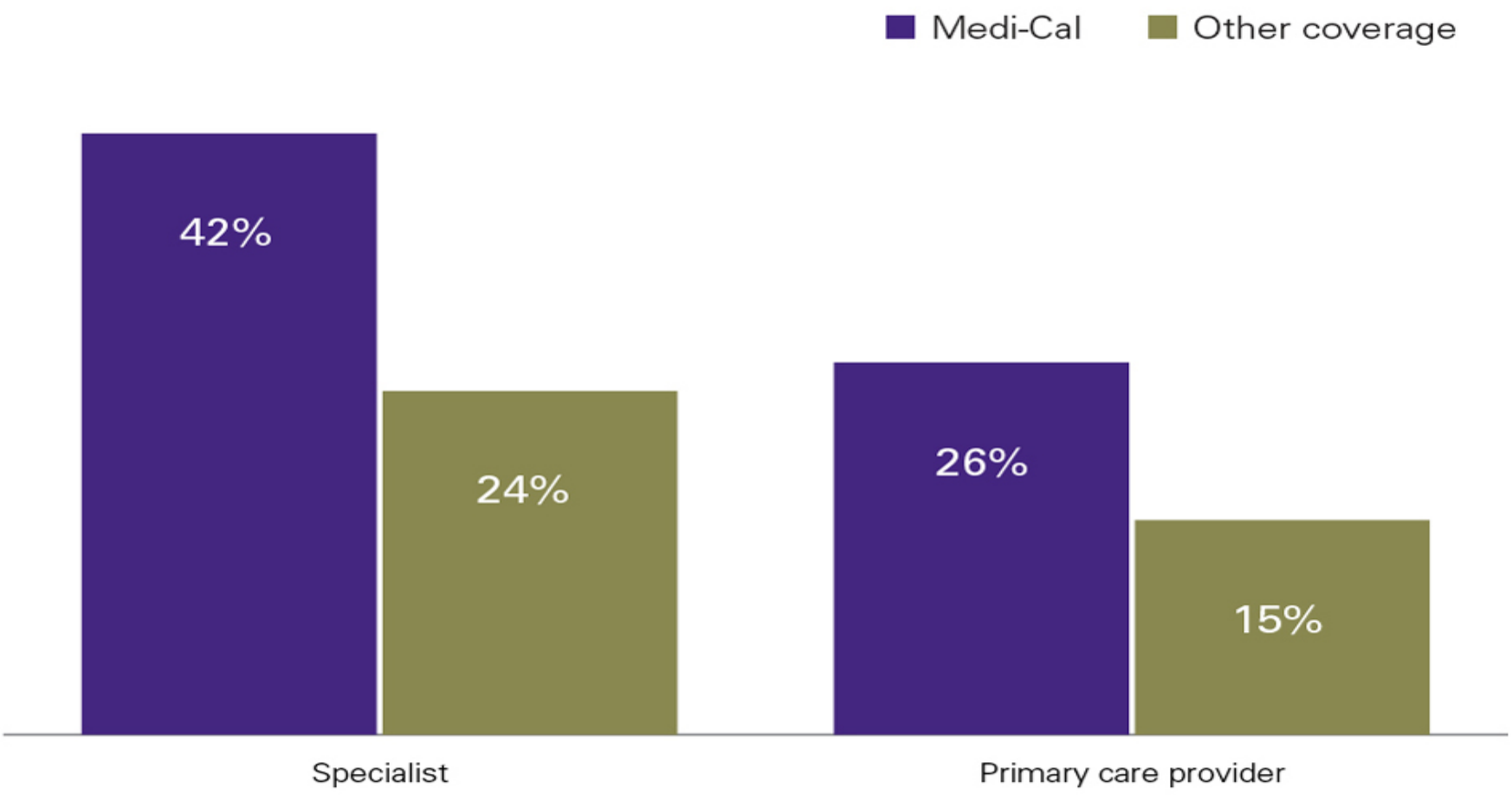
Workforce Pressures Affecting Access

- ACA adds more than 100 new patients for every primary care doctor in CA
  - Uneven distribution of physicians in CA (e.g., shortages in Inland Empire, rural communities)
- 31% of the newly insured do not speak English as their primary language, compared with 12% of the currently insured.
- 29% of practicing doctors in CA are over age 60
  - More doctors retiring in CA than entering practice

Access to Appointments with Providers,
Medi-Cal vs. Other Coverage*

BASE: ADULTS WHO NEEDED TO SEE A SPECIALIST (Medi-Cal, n = 201; other, n = 641) OR PCP (Medi-Cal, n = 301; other, n = 870)

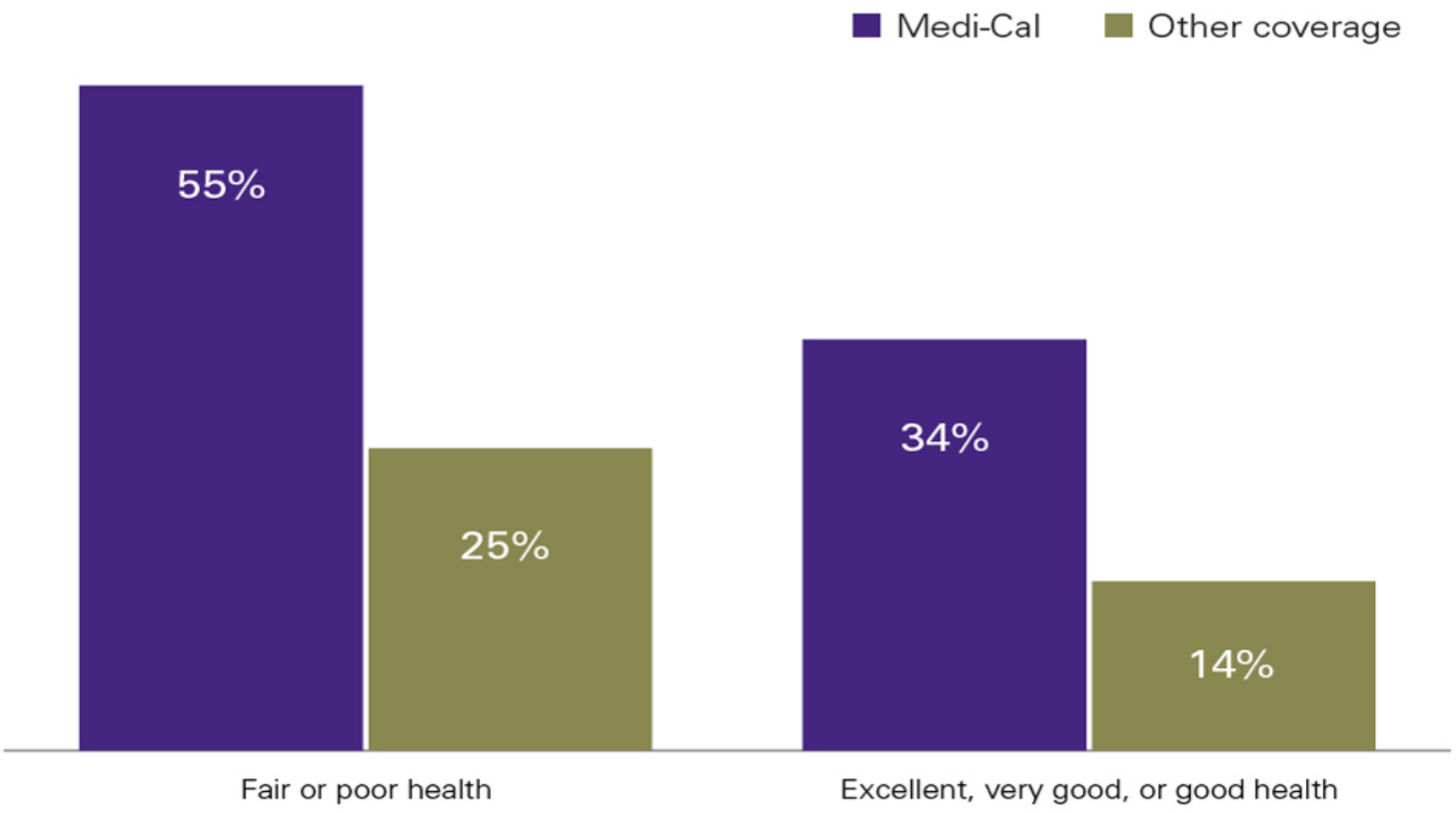
Percentage of covered adults reporting difficulty getting an appointment with a…



Emergency Room Visits, by Health Status,
Medi-Cal vs. Other Coverage*

BASE: ADULTS WITH MEDI-CAL (n=331); ADULTS WITH OTHER TYPES OF HEALTH CARE INSURANCE (n=1,020)

Percentage of covered adults who have visited the emergency room in the past 12 months



Medi-Cal:
Access Post-ACA Implementation

- Less access and, due to the numbers of new enrollees, greater risk of insolvency due to low rates:
  - Less than 60% of physicians accept new Medi-Cal patients.
    - CA reimburses <38¢ on the commercial dollar, which is LESS than the cost of rendering care (prior to the pending 10% payment reduction)
    - Federal PCP payment “bump” is temporary
  - Commercial market expanding, competing for those physicians with capacity to see new patients
  - Physician supply is stagnant

Delegated Plans to Experience Increasing Financial Risk

- Climbing Utilization
  - Assumption of Medi-Medi population
  - Increasing Enrollees with Stagnant Physician supply
    - ➔ Delays in Care
    - ➔ Increasing Utilization of Emergency Departments
      - ➔ED visits increased 8% in MA the first year after health reform
- 90-day unpaid-premium grace period
  - RBO/ physicians potentially left with unpaid claims

How DMHC Can Help: Augment Solvency Requirements

- Health plans must provide adequate capitalization of RBOs' mounting risk in this new coverage landscape
  - RBOs must pay rates that encourage physicians to contract
    - *Network adequacy & timely access requirements*
  - Rates must account for any unpaid "grace period" claims

Special Circumstance: The EMTALA Provider

- EMTALA obviates need for RBO to contract with mandated providers
- Non-payment/underpayment frays the safety-net:
  - Discourages participation on Call Panels
  - Increases transactional costs (disputes, lawsuits)
  - Adds financial strain to Hospitals (ER closures)
- Canary in the coal mine
  - Indicator of liquidity/ solvency issues
- Inadequate fines from DMHC fail to discourage bad behavior

Recommendations: Oversight & Enforcement

- Enhance & efficiently use DMHC resources
- Network adequacy requirements
  - Require participation of a reasonable percentage of EMTALA providers within service region
- Timely Access Requirements

Recommendations: Meaningful Penalties

- Punish egregious violations (e.g., non-payment of claims, holding “issued” checks, down-coding majority of claims)
- Revocation of Knox-Keene license (and re-assignment)
- Monetary fines (above restitution in cases of underpayment)
- Freeze new patient enrollments

Recommendations: Transparency

- Clearly define regulatory responsibilities and coordinate with the Exchange
  - MSOs, MCMC plans, sub-delegated payors
  - Require PDR denials to contain contact info of the entity responsible for oversight
- Encourage both physician and patient reporting of potential violations and clearly communicate what complaints should be filed where and how

Questions?