Douglas P. Brosnan, J.D., M.D. FACEP
Board of Trustees, California Medical Association
Director of Provider Relations, CEP America
Vice Chair, Sutter Roseville Emergency Department

Brett Johnson, J.D., M.P.H., M.S.
Associate Director, Center for Medical and Regulatory Policy
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
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

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Patient Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Silver Plan</strong></td>
<td><strong>Standard Bronze Plan</strong></td>
</tr>
<tr>
<td>Hospital Stay</td>
<td>$900 per day, up to 3-day limit</td>
</tr>
<tr>
<td></td>
<td>$1,200 per day, up to 3-day limit</td>
</tr>
<tr>
<td>ER Services</td>
<td>$250</td>
</tr>
<tr>
<td></td>
<td>$300</td>
</tr>
<tr>
<td>Prenatal and Postnatal Care</td>
<td>$45</td>
</tr>
<tr>
<td></td>
<td>$80</td>
</tr>
<tr>
<td>Delivery &amp; Related Inpatient Services</td>
<td>$900 per day, up to 3-day limit</td>
</tr>
<tr>
<td></td>
<td>$1,200 per day, up to 3-day limit</td>
</tr>
<tr>
<td>Inpatient Mental &amp; Behavioral Health</td>
<td>$900 per day, up to 3-day limit</td>
</tr>
<tr>
<td></td>
<td>$1,200 per day, up to 3-day limit</td>
</tr>
<tr>
<td>Skilled Nursing Care</td>
<td>$250</td>
</tr>
<tr>
<td></td>
<td>$300</td>
</tr>
<tr>
<td><strong>Deductibles</strong></td>
<td></td>
</tr>
<tr>
<td>Facility-related (institutional &amp; ER)</td>
<td>$1,400; brand drugs = $250; 70% coinsurance after</td>
</tr>
<tr>
<td></td>
<td>Medical &amp; drug integrated (inpatient, ER, drugs) = $4,500; 60% coinsurance after</td>
</tr>
</tbody>
</table>
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…

- **Specialist**
  - Medi-Cal: 42%
  - Other coverage: 24%

- **Primary care provider**
  - Medi-Cal: 26%
  - Other coverage: 15%
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
- Other coverage

- Fair or poor health: 55% (Medi-Cal), 25% (Other coverage)
- Excellent, very good, or good health: 34% (Medi-Cal), 14% (Other coverage)
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?