



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

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

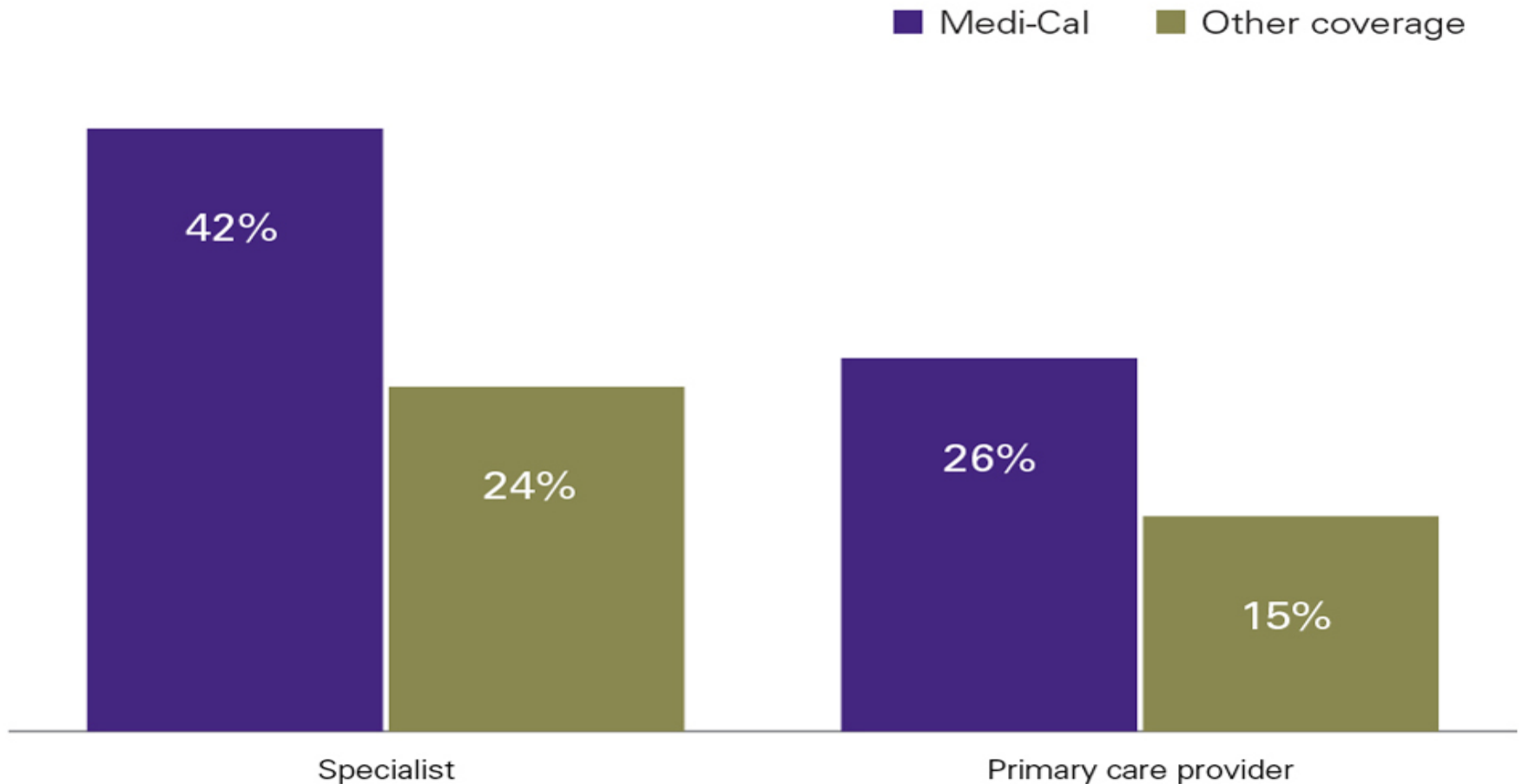
- ACA adds more than 100 new patients for every primary care doctor in CA
 - Uneven distribution of physicians in CA (e.g., shortages in Inland Empire, rural communities)
- 31% of the newly insured do not speak English as their primary language, compared with 12% of the currently insured.
- 29% of practicing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

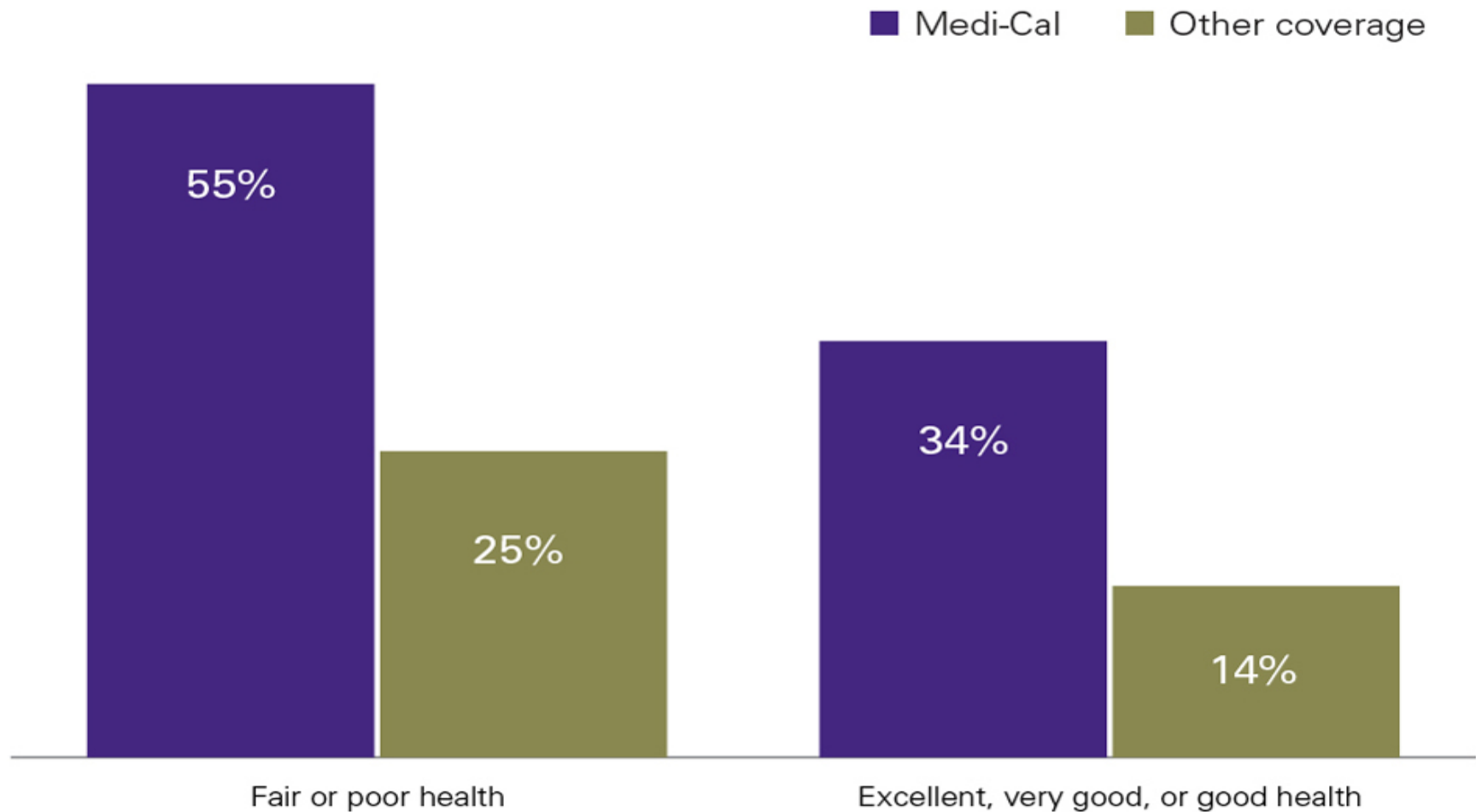
Percentage of covered adults reporting difficulty getting an appointment with a...



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?