Status of Delegated Model
Physician Groups

Bill Barcellona - Sr. VP, CAPG
FSSB Meeting, Sacramento
June 18, 2014
The Environment

Delegated Model groups historically operate in three main areas:

- Medicare Advantage HMO
- Commercial HMO
- Medi-Cal Managed Care

Enrollment by payer source is tracked on www.cattaneostroud.com.
Trends

- Some group consolidation, especially in the north
- Competition between groups, especially in the south, and even new groups formed
- Formation of foundation-model integration with hospitals has been significant
- Financial status has been stable generally, but less so where high percentage of MMC lives
Forecast

- ACA calls for integration, coordinated care, supporting delegated model base
- ACO experiment – tough sledding
- Overshadowed by MA enrollment growth
- Revenue cuts with loss of cross-subsidization between product lines
- Uncertain policy in Covered California
- Need for evolution of model
Medicare Advantage
Medicare Advantage

- Historically the best-paying capitated payment source
- Groups with high MA enrollment among the most solvent
- MA DSNP enrollment preserved in state budget deal for 2015 – will stabilize groups
- MA enrollment has funded care management infrastructure in delegated model groups
Medicare Advantage Final Rate Notice

- Average 7 percent cuts, but varies by region across California, for 2015
- Add on 2.5% ACA premium tax passed through by MA plan to capitated provider
- 8-10% cut in capitated revenue
- Can it be offset by continued steady growth in the MA population?
- Enrollment percentage grew from 10% to 51% in 2013 among all newly eligible seniors
The New Reality of MA

- ACA calls for parity with Medicare FFS resulting in cuts to program funding, but seniors are choosing MA more frequently
- STARS plan rankings are key to stability
  - 3 star plans will face more cuts in 2015
  - 4 star or higher will receive bonuses
  - MA plans narrow networks to high performing groups to maintain effective STAR rankings
- Groups in 4 star plans will prosper, others less so
Cal Medi-Connect

- DSNP enrollment in existing non-CMC plans is preserved for 2015 – will stabilize groups
- Plans in CMC that are 3 stars may face probation, and will lose bonuses
- New Duals population will be difficult to handle under reduced capitation rates
- Groups in higher-ranking plans that have percentage of premium revenue will be more stable than groups in lower-ranked plans
In Sum…

• Medicare Advantage revenue is leaning out
• Plans will utilize higher-performing, narrower networks to maintain high STAR rankings
• This will increase the divide between the “have” and “have not” physician groups
• While enrollment is increasing, volume may not make up for decreased revenue
• MA will no longer be as much of a stabilizing force in the delegated model
Commercial Payers
Impacts in Commercial Model

• Continued erosion of employer-sponsored HMO enrollment
• Covered California appears to be a directly-contracted PPO market, will not feature delegated model networks – no growth there
• November 2014 Rate Review Ballot Measure threatens cross-subsidization of MMC by commercial payer sources
• Future growth tied to expansion into ERISA employer plans
Commercial & MMC Enrollment

Non-Kaiser Permanente Delegated Model Enrollment in 2013

Source: Gil Riojas report, August 31, 2013 FSSB Meeting
Preliminary HMO membership estimates for 2014 show a 7.9 percent growth (1.4 million member increase) over 2013 – the strongest growth in over a decade.

* Medi-Cal includes Health Families enrollment

## Covered California March 2014
### Enrollment Growth by Plan

<table>
<thead>
<tr>
<th>Plan</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem Blue Cross of California</td>
<td>223,630</td>
<td>268,204</td>
<td><strong>425,058</strong></td>
</tr>
<tr>
<td>Blue Shield of California</td>
<td>213,646</td>
<td>245,632</td>
<td><strong>381,457</strong></td>
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<tr>
<td>Chinese Community Health Plan</td>
<td>7,657</td>
<td>9,720</td>
<td>14,306</td>
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<tr>
<td>Contra Costa Health Plan</td>
<td>668</td>
<td>774</td>
<td>1,091</td>
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<tr>
<td>Health Net</td>
<td>125,550</td>
<td>154,414</td>
<td><strong>264,079</strong></td>
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<tr>
<td>Kaiser Permanente</td>
<td>131,434</td>
<td>158,372</td>
<td>241,098</td>
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<td>L.A. Care Health Plan</td>
<td>12,439</td>
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<td>38,124</td>
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<td>Molina Healthcare</td>
<td>4,482</td>
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<td>11,731</td>
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<td>Sharp Health Plan</td>
<td>5,998</td>
<td>7,476</td>
<td>13,087</td>
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<tr>
<td>Valley Health Plan</td>
<td>815</td>
<td>1,017</td>
<td>1,891</td>
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<tr>
<td>Western Health Advantage</td>
<td>1,697</td>
<td>2,159</td>
<td>4,007</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>728,016</strong></td>
<td><strong>868,590</strong></td>
<td><strong>1,395,929</strong></td>
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</tbody>
</table>

*Data include individuals who finished their applications and selected plans through April 15, 2014.*

Exchange Plan Enrollment

- KP: 241,000
- Others: 83,000
- Anthem, Shield & Health Net: 1.3 M
## Comparison of Physician Overlap between Plans in California

### Covered California-2014

<table>
<thead>
<tr>
<th>Plan</th>
<th>Blue Shield</th>
<th>Anthem</th>
<th>Health Net</th>
<th>Kaiser</th>
<th>All Other CC Plans</th>
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<tr>
<td>Blue Shield</td>
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<tr>
<td>Anthem</td>
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<tr>
<td>Health Net</td>
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<td>3,781</td>
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<td>13,420</td>
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<tr>
<td>Kaiser</td>
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<td>All Other CC Plans</td>
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### Timely Access Reporting-2013

<table>
<thead>
<tr>
<th>Plan</th>
<th>Blue Shield</th>
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<th>Health Net</th>
<th>Kaiser</th>
<th>All Other CC Plans</th>
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<td>Blue Shield</td>
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<td>Anthem</td>
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<td>Health Net</td>
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<td>1,968</td>
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<td>16,107</td>
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Narrower Networks in Exchange

- Anthem has 425,000 lives in Covered California but is using 37,000 physicians rather than its full panel of 60,000.
- Blue Shield has 381,000 lives and is using 47,000 out of 58,000 physicians.
- Health Net gained 264,000 lives but reported only 4,697 doctors in Covered California out of its full panel of 45,000.
## Group and Physician Participation by Plan Product

<table>
<thead>
<tr>
<th>Provider</th>
<th>CAPG Groups</th>
<th>Groups</th>
<th>Physicians</th>
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</thead>
<tbody>
<tr>
<td><strong>Blue Shield</strong></td>
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<tr>
<td>Blue Shield-EPO (Exclusive) (Individual)</td>
<td>95</td>
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<td>Blue Shield-HMO (Exclusive) (SHOP)</td>
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<td>Blue Shield-HMO (Full) (SHOP)</td>
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<td>650</td>
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<td>Blue Shield-PPO (Exclusive) (Individual)</td>
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<td>Blue Shield-PPO (Exclusive) (SHOP)</td>
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<td>5,265</td>
<td>29,745</td>
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<tr>
<td><strong>Anthem</strong></td>
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<tr>
<td>Anthem-EPO</td>
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<td>140</td>
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<tr>
<td>Anthem-EPO (Individual)</td>
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<td>Anthem-EPO&amp;HMO</td>
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<td>1,332</td>
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<td>Anthem-HMO (Individual)</td>
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<td>12,670</td>
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<td>Anthem-HMO&amp;PPO</td>
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<td>3,406</td>
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<tr>
<td>Anthem-PPO</td>
<td>39</td>
<td>797</td>
<td>7,963</td>
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<tr>
<td>Anthem-PPO (Individual)</td>
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<td>2,209</td>
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<tr>
<td><strong>Health Net-HMO (Individual)</strong></td>
<td></td>
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<td>4,697</td>
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<tr>
<td><strong>Kaiser-HMO (Individual &amp; SHOP)</strong></td>
<td>2</td>
<td>2</td>
<td>13,420</td>
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<tr>
<td>Chinese Community-HMO (Individual &amp; SHOP)</td>
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<td>Contra Costa Health Plan-HMO (Individual)</td>
<td>6</td>
<td>119</td>
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<td>L.A. Care-HMO (Individual)</td>
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<tr>
<td>Molina-HMO (Individual)</td>
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<td>5,190</td>
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<tr>
<td><strong>Sharp</strong></td>
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<td>Sharp Health-HMO (Performance) (Individual &amp; SHOP)</td>
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<td>1,907</td>
<td>1,340</td>
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<td>Sharp Health-HMO (Premier) (Individual &amp; SHOP)</td>
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<td><strong>Valley Health-HMO (Individual)</strong></td>
<td>5</td>
<td>19</td>
<td>1,780</td>
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<tr>
<td>Western Health-HMO (Individual &amp; SHOP)</td>
<td>19</td>
<td>1,907</td>
<td>1,780</td>
</tr>
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Medi-Cal Managed Care
Commercial & MMC Enrollment

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MMC Enrollment Growth

- Lowest cost structure of all three major payer sources, but fastest growth
- Milliman analysis for CAPG of Cal Medi-Connect capitation rate showed underpayment similar to the prior SPD experience
- Percentage of Premium (SB 208) implemented at 23% of cap dollar – opposite of MA Plans
- MLR is uncertain in some plans - investigate
MMC Medical Loss Ratio

• Federal law exempts MMC plans from MLR regulation
• DHCS is the “enforcement” entity – imposes MLR by contract with MMC plan
• DMHC can only monitor
• Indication that some plans are paying combined physician and hospital cap in the 55-60% range. Add 10-15% for drugs, still fails to add up to 85 percent.
Shared Risk Pools

• MMC plans use shared risk pools between delegated physician groups and hospitals, require partnering to obtain capitated lives

• Pools are underfunded and dry up. Hospitals demand backfill from group or threaten to pull out, causing group to lose assigned lives

• Backfilling a deficient risk pool for hospital costs is akin to taking institutional risk w/o a Knox Keene license
Potential Solutions

Physician Group Solvency
What is a Restricted License?

- The DMHC and its predecessor agency, the Dept. of Corporations, have licensed several “limited” and “restricted” entities over the years.
- Such licenses allow the licensee to accept both institutional and professional risk-based payments as subcontractors to full-service plans.
- These licenses do not allow the entity to market coverage directly to enrollees, like a full-service Knox Keene Health Plan.
History of Licensure

• Generally, the Department has required restricted licensees to file all of the sections of the application except the marketing sections.
• The Knox Keene Act does not define a limited or restricted licensee, although the DMHC does acknowledge their existence under its health plan list.
• No formal guidance or regulation has ever been issued and it could be argued that this practice amounts to an underground regulation since the filing requirements have varied over time
Purpose of the Regulation

• To “codify” a long-standing process at DMHC
• To encourage licensure, and the increased financial oversight that ensues from it
• To differentiate from “health insurance issuers” under the ACA
• To recognize emerging functions of full-risk entities, like ACOs, direct relationships with self-funded employer plans and to provide an alternative to shared-risk pools
Accountable Care Organizations

• The Pioneers had licenses or acquired them in advance of downside risk in year 3
• There is a rapidly developing federal policy on “ACO 2.0” that includes “global payments” to such entities. This will require state licensure.
• California has led in other areas of the ACA implementation – this is another opportunity
• The proposed rule supports a “Multipayer” strategy for such entities
Proposed Submittals

• CAPG has drafted a regulation and statement of reasons
• Per previous discussions with the Department, a section following the main application was selected as the best placement
• A regulation was chosen over legislation, because of the 30 year practice of granting such licenses, and the evolution from “limited” to “restricted” for Medicare Advantage, without prior legislation
Structure

• The regulation identifies a “restricted” license
• Calls out that it is not a “health insurance issuer” and cannot market coverage
• Must meet all financial requirements of a full-service plan – including periodic monitoring
• It can subcontract with a fully-licensed plan, directly contract with a government payer (Pioneer) or self-funded employer plan
Grandfathering

- Recognizes prior “limited” and “restricted” licensees in good standing on the effective date of the new rule.
- Allows for new contracts based on amendment filings rather than material modifications, where acceptable – obviously not in cases of service area expansions, etc.
- Creates a recognized category of full-risk bearing entity between a full-service plan and an RBO.
Protections

- Greater oversight of financial conditions that currently exists for RBOS that are part of a shared-risk pool arrangement
- Resolves the ACO-licensing discussion
- Reporting and monitoring of the whole entity unlike current RBO situations
- Additional risk requires the same capitalization of reserves as a full-service plan
Request

- CAPG asks DMHC to consider issuing such a regulation in 2014 and to convene a stakeholder process to discuss the economic, regulatory and policy reasons for such a regulation at this juncture in California coverage expansion.

- Dovetailed effort with Wyden “Better Care Act” in the Congress.