Health Care Reform, Year One: Where We Stand Now

Anne McLeod
Senior Vice President, Health Policy
California Hospital Association
- Health insurance coverage for ~35 million additional people
- Insurance market regulation and reorganization
- Complicated financing challenges for both state and federal governments

Providers will have to adjust
Medi-Cal expansion for families at or below 133% FPL (~$29k family of 4)
2 million new Medi-Cal enrollees in CA
One in three Californians will be on the Medi-Cal program
Coverage begins 2014
Medi-Cal currently underpays hospitals roughly $686 per year per enrollee
• “Bridge to Reform” Medi-Cal Waiver
• County-based coverage from now until 2014 “Low Income Health Program”
• County expense becomes “CPE” and draws federal matching funds
• All counties have applied, except Stanislaus (city of Pasadena and Rural Indian Health Board also applied)
• CMSP application in process – rural county indigent care program
Key Elements:

- Expand coverage up to 200% FPL
- Improve care coordination
- Prepare for enrollment into Medi-Cal or the Exchange in 2014
- Up to 133 FPL is “MCE”
- 134 up to 200 FPL is “HCCI”
- If county participates, MCE required, HCCI optional
How the CMSP Spending Pencils Out

- County indigent care for up to 133 FPL: $210 million
- County indigent care for up to 200 FPL: $20 million
- County care for undocumented: $10 million

Total: $240 million

Federal Financial Participation LIHP: $115 million

Expand HCCI, invest in delivery systems/requirements, build reserves, increase access through improved provider rates?
2014

MCE up to 133% FPL → Medi-Cal

HCCI 134-200% FPL → Exchange

What is an Exchange?
Three Designs for an Exchange:

<table>
<thead>
<tr>
<th>Passive/Distribution</th>
<th>Manage/Coordinate</th>
<th>Active Market Mgmt</th>
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</thead>
<tbody>
<tr>
<td>• No control beyond ACA requirements</td>
<td>• Beyond ACA requirements but no aggressive plan negotiation</td>
<td>• Manages the insurance market</td>
</tr>
<tr>
<td>• “Billboard”</td>
<td>• Minimum bens and product rules</td>
<td>• Negotiates with plans and has strict QHP/certification</td>
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<tr>
<td>• No certs, QHP, minimum benefits or off-exchange rules</td>
<td>• Off-exchange rules similar to On</td>
<td>for plans</td>
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<td></td>
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<td>• Requirements in addition to ACA</td>
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California Health Benefit Exchange

- Third (hybrid) approach – Exchange operates in tandem with outside markets – achieves goals through selective contracting
  - Eligibility determination, selection, and enrollment
  - Reduce administrative costs for small-group and individual
  - Promote value, quality, transparency
  - Reduce potential for adverse selection
  - Solid governance and financing structure

- Exchange creates clear rules for participation

- Exchange is NOT a third regulator (DMHC/DOI)
California Health Benefit Exchange

- Essential health benefits package (in and out) *All Plans*
- *All Plans* must offer the four “precious metal” plans
  - Bronze = 60% actuarial value
  - Silver = 70%
  - Gold = 80%
  - Platinum = 90%
- Catastrophic plan for >30 or affordability exemption
- Premiums “in” must equal premiums “out”
Five member board

- Two gubernatorial appointees
- One appointee of Senate Rules committee
- One appointee of the Speaker of the Assembly
- Ex-officio member – Secretary HHS
- CA residents
- Demonstrated expertise in at least two areas:
  - Individual coverage
  - Small employer coverage
  - Plan administration
  - Health care finance
  - Administering public or private health care delivery system
  - Purchasing health plan coverage
Four Representatives to the California Exchange Board have already been appointed

### California Exchange Board Appointments

<table>
<thead>
<tr>
<th>Susan Kennedy</th>
<th>Kimberly Belshé</th>
<th>Diana Dooley</th>
<th>Paul Fearer</th>
<th>TBD</th>
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<tbody>
<tr>
<td><img src="image1" alt="Susan Kennedy" /></td>
<td><img src="image2" alt="Kimberly Belshé" /></td>
<td><img src="image3" alt="Diana Dooley" /></td>
<td><img src="image4" alt="Paul Fearer" /></td>
<td><img src="image5" alt="TBD" /></td>
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</tbody>
</table>

**Susan Kennedy**
- **Political Affiliation:** Democrat
- **Past Positions:**
  - Chief of Staff to Gov. Schwarzenegger
  - Member of the California Public Utilities Commission
  - Cabinet Secretary and Deputy Chief of Staff for Gov. Davis

**Kimberly Belshé**
- **Political Affiliation:** Republican
- **Past Positions:**
  - Secretary of the California HHS Agency
  - Program Director for the James Irvine Foundation

**Diana Dooley**
- **Current Position:** Secretary of the CA HHS Agency
- **Past Positions:**
  - CEO of the California Children’s Hospital Association
  - General Counsel and Vice President for the Children’s Hospital Central California

**Paul Fearer**
- **Appointed:** March 3, 2011
- **Appointed by:**
  - Assembly Speaker
  - Sr Exec Vice President Union Bank
  - Deputy Director Human Resources at Stanford
  - Chair Pacific Bus Group on Health

**TBD**
- **Appointed:**
  - Expected Feb 2011
  - Senate Rules Cmte
California Health Benefit Exchange

- **Raises some concerns:**
  - Market “outside” Exchange could be vulnerable
  - Could lead to “adverse selection”
  - Exchange success requires a robust risk pool
  - Consumers may be at risk
  - Exchange should not be involved in rate setting for providers
  - Rates below cost could result in further cost shift
Annual ratio of hospital profit to costs by payor category

Reductions in Medicare and Medi-Cal reimbursement have required hospitals to increase charges to private payors to maintain overall profitability.

1 Profit-to-cost ratio calculated by payor category in each year using the formula: \((\text{Net Patient Revenue} - \text{Hospital Costs}) / \text{Hospital Costs}\)

SOURCE: OSHPD Quarterly Data Files, 2000-09
ACA implementation will pose further challenges for California:

- Already high levels of cost-shifting, given low Medi-Cal payment rates and high uninsured population.
- High level of Medicare Advantage penetration, where dramatic cuts will take place near-term.
- Insurance Exchange where many changes (rate compression, outside activity) will take effect and may cause disruption.
- $17 billion in cuts to hospital Medicare FFS payments through 2019.
- Severe State budget crisis and high levels of unemployment continue in California.
### The potential dangerous cycle that could be triggered

#### 1. Federal and state governments further reduce Medicare and Medi-Cal reimbursement rates

#### 2. Cost shifts from public to private payors, significantly increasing commercial premiums

#### 3. High premiums cause further employer “dropping” and rise in subsidized individual coverage and uninsured, further burdening federal and state government budgets

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**Medical costs**
- Medicaid/Medicare
- Private payors

 Leads to significant risk pool deterioration in insurance market and destabilization of overall payment and delivery system
Several strengths in California’s healthcare system that we can and should build on:

**Some defining attributes**

- Extensive use of accountable and coordinated care structures, with shared risk among health plans and providers
  - >35 yrs of Knox-Keene regulation
  - >10 M lives in delegated model
  - >½ of residents now covered by HMOs

- Innovative payment and delivery systems tailored to serve California’s diverse population – *not “one size fits all”*

- Employers and State institutions that have pioneered value-based purchasing and benefit designs to reward healthy behaviors

**Results**

- Health care costs are below the national average, and growing more slowly – despite:
  - >Much higher cost of living and of doing business in CA
  - >High levels of cost-shifting inherent in the system, with Medi-Cal costs among the lowest in the nation

A major driver of our relative cost advantage is our much better ability to manage utilization, especially in the private sector
California per capita costs historically below many other states, 12% below the U.S. average, and growing at slower rate.

Per capita health expenditures, 2004

Dollars

<table>
<thead>
<tr>
<th>State</th>
<th>CA</th>
<th>UT</th>
<th>NV</th>
<th>WA</th>
<th>U.S. average</th>
<th>IL</th>
<th>FL</th>
<th>NJ</th>
<th>NY</th>
<th>MA</th>
</tr>
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<tbody>
<tr>
<td>Value</td>
<td>4,638</td>
<td>3,972</td>
<td>4,569</td>
<td>5,092</td>
<td>5,283</td>
<td>5,293</td>
<td>5,483</td>
<td>5,807</td>
<td>6,535</td>
<td>6,683</td>
</tr>
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CA growth of 5.9% CAGR vs. 6.7% CAGR for U.S. overall from 1994-2004.

SOURCE: National Health Expenditure Accounts
Utilization rates in 2008¹
Number of encounters/days per 1000 population

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of encounters/days per 1000 population</th>
<th>CA utilization as percent of U.S. average Percent</th>
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<tbody>
<tr>
<td>Admissions</td>
<td>95, 117</td>
<td>81</td>
</tr>
<tr>
<td>Inpatient days</td>
<td>493, 644</td>
<td>77</td>
</tr>
<tr>
<td>ER visits</td>
<td>275, 404</td>
<td>68</td>
</tr>
<tr>
<td>Hospital-based</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP visits</td>
<td>1,336, 2,050</td>
<td>65</td>
</tr>
<tr>
<td>Total outpatient visits</td>
<td>2,806, 3,579</td>
<td>78</td>
</tr>
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¹ Data are for total population of community hospitals (85% of all hospitals). Federal hospitals, LTC hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals are not included.

SOURCE: Kaiser State Health Facts
Prospects for the Future:

• PPACA will lead to insurance coverage for millions

• Providers will face the prospect of rate cuts from all payers:
  – Medicare cuts
  – Medicaid rates will remain low, even as the covered population expands
  – Limited ability to “pass on” losses from public sources with higher rates for privately insured

• We must focus on the cost drivers and preserve California’s low-cost and low-utilization levels
So What Should We Do?

- EHR implementation
- Physician Integration
- Sustainable health care delivery models
- Improve quality, efficiency and reduce readmissions
- Lead
- Meet the challenges
- Work together
- Effective care transition, better coordination/outcomes
- Build trust with the medical staff
So What Should We Do?

• Medicare payment bonus – ten percent to primary care practitioners in a HPSA – may apply to surgeons also
• Low cost counties - $200 million over two years for hospitals in lowest quartile of Medicare beneficiary spending
• Are you a CAH?? CAHs paid at 101 percent of costs
• Lab reasonable cost payment for qualifying rural hospitals
• CMSP – LIHP for MCE and HCCI
• Keep CHA on speed dial
Thank you so much for inviting me.

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