Improving the Health of Californians through Greater Accessible, Quality & Equitable Care

California Pan-Ethnic Health Network
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Chief Medical Officer
Covered California’s Promise

**Vision:**
To improve the health of all Californians by assuring their access to affordable, high-quality care.

**Mission:**
To increase the number of insured Californians, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

Better Care • Healthier People • Lower Cost
How Covered California Makes the Promise Real

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<tr>
<th>CREATING COMPETITIVE MARKETS</th>
<th>OFFERING AFFORDABLE PRODUCTS</th>
<th>EFFECTIVELY REACHING AND ENROLLING CONSUMERS</th>
<th>ENCOURAGING THE RIGHT CARE AT THE RIGHT TIME</th>
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<td>• Plan competition for enrollment (seek at least three plans)</td>
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<td>• Provider-level competition and distinction between plans</td>
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<td>• Benefit designs foster informed consumers</td>
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<td>• High enrollment of subsidy eligible to assure good risk mix</td>
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<td>• Long term affordability through delivery system changes</td>
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<td>• Robust and ongoing marketing</td>
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<td>• Cost effective enrollment support</td>
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<td>• Benefit design promoting appropriate access</td>
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<td>• Requirements for plans to promote effective delivery of coordinated care</td>
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Nationwide: The Affordable Care Act is Expanding Coverage

Uninsured Rate Among the Nonelderly Population, 1972-2015

Source: CDC/NCHS, National Health Interview Survey

KFF.org
Affordable Care Act, National Data

FIGURE 1
More coverage, less spending
Fiscal year 2016 federal health spending, in billions of dollars

Projected 2016 spending in January 2009, pre-ACA
- Medicare 802
- Medicaid 361
- Total 1168

Current 2016 estimate
- Medicare 695
- Medicaid 371
- Total 1128

The Affordable Care Act has dramatically changed the health insurance landscape in California with the expansion of Medicaid, Covered California and new protections for all Californians.

As of March 2015, Covered California had approximately 1.3 million members who have active health insurance. California has also enrolled nearly 3 million more into Medi-Cal of whom over 2 million are newly eligible.

All Californians now benefit from insurance policy changes.

From 2013 to 2015, the number of uninsured Californians has been reduced by almost half.

Consumers in the individual market (off-exchange) can get identical price and benefits as Covered California enrollees.


Note: Medicare recipients and other publicly funded insured are not included in the graph.
Covered California is Big and Having Big Impacts
It is now one of the largest purchasers of health insurance in California and the nation.

1.4 MILLION consumers have active health insurance as of March 2016

Covered California is now the second largest purchaser of health insurance in the state for those under age 65.

$6.4 BILLION estimate of funds collected from premiums in 2015

Covered California’s size gives it the clout to shape the health insurance market.

2.5 MILLION consumers served since Covered California began offering coverage on Jan. 1, 2014 (as of March 2016)

More than 1.1 million Californians have benefitted from coverage through Covered California. Many of them now have either employer-based coverage or Medi-Cal.

9 out of 10 consumers enrolled in coverage receive financial help to pay their premiums
More Than Two Million Consumers Served

The majority of those served have continuous coverage and of those who have left Covered California, the vast majority (85 percent) continue to have health insurance.

- Prior to 2014, Covered California forecasted that about one-third of enrollees would leave coverage on an annual basis.
- In the period from January 2014 through September 2015, more than two million Californians have had coverage for some period of time with approximately 700,000 of those no longer active in June 2015.
- As of June 2015, the actual rate of disenrollment is about 33 percent.
- Based on a recently completed Covered California survey of members who left (“disenrolled”), the vast majority (85 percent) left for employer-based, Medi-Cal, Medicare, or other coverage.

Estimated from Covered California enrollment data and 2015 member survey (n=3,373)
Covered California is Successfully Enrolling the Full Diversity of Those Eligible for Subsidies

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<tbody>
<tr>
<td>Asian</td>
<td>21%</td>
<td>23%</td>
<td>18%</td>
<td>20%</td>
</tr>
<tr>
<td>African-American</td>
<td>5%</td>
<td>3%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Latino</td>
<td>38%</td>
<td>31%</td>
<td>37%</td>
<td>36%</td>
</tr>
<tr>
<td>White</td>
<td>34%</td>
<td>35%</td>
<td>34%</td>
<td>34%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>8%</td>
<td>6%</td>
<td>7%</td>
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Covered California’s Third Open Enrollment succeeded in enrolling **439,000** individuals.

An independent study conducted by the Kaiser Family Foundation² confirmed Covered California’s success at enrolling Latinos.

Covered California enrollees are more racially diverse than Californians with private coverage — 60 percent identify as a race/ethnicity other than white and Latinos make up 36 percent of the total.

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¹ CalSIM version 1.91 Statewide Data Book 2015-2019
http://bit.ly/1Que1NV

Health Plan Offerings for 2017: Broad Choice and Multiple Local Options

For full details on plans and rates, see Health Insurance Companies and Plan Rates for 2017: http://bit.ly/2c6AS9U
Evolution of Attachment 7: Agenda for Delivery System Reform

• For contract years 2014-16, Covered California said “tell us” what you do. Current health plans provided data and detail about operations and enrollee focused care.

• For 2016 and beyond, Covered California asks plans and their contracted providers to “work with us” to fulfill the quality vision.
  ➢ To collaborate on programs with other payers based on priorities informed by advocates and experts, and
  ➢ To define mutually agreed upon programs and target outcomes.

• Principles in adopting specific strategies.
  ➢ Alignment with other purchasers
    ➢ CMS, CalPERS, DHCS & PBGH
  ➢ Encouraging multi-payer collaboration.
  ➢ Holding health plans accountable for managing contracted networks to reduce variation in performance.
ENSURING THE RIGHT CARE AT THE RIGHT TIME

DIAGNOSIS

1. Many consumers — especially the newly insured — do not have a primary care clinician to be their entry point and guide to the delivery system.

2. Patient care is often fragmented and uncoordinated, resulting in care that delivers inconsistent outcomes and high cost.

3. Payment has been based on “more is better” (the fee-for-service model) and not payments that reward outcomes and effective coordination.

COVERED CALIFORNIA’S SOLUTION

1. Require all plans, regardless of model, to connect Covered California enrollees to a primary care clinician within 60 days of their health plan coverage date.

2. Plans must change payments to support populations rather than widgets
   a) Revenue for alternatives to face to face care and for team-based care
   b) Accountability across specialties and institutional boundaries through Advanced Primary Care (PCMH) and Integrated HealthCare Models (ACOs)
### DIAGNOSIS

1. Payments for volume pays more when things go wrong than right
2. Many patients suffer avoidable complications— with an estimated 400,000 Americans dying annually as a result.
   - a) Low Risk C-section rate range 12 to 68%
   - b) Blood stream infection rate with central line range from 0 to 5.7 times expected

### PRESCRIPTION

1. Work with health plans to connect doctors and hospitals to quality improvement → Track, trend and improve care against measured goals.
2. Require that doctors and hospitals be selected based on quality performance.
3. As of 2019, plans will either exclude low performing outliers or provide a justification for inclusion in the network.
4. Require plans to implement payment reform to reward outcomes and results in hospitals.
NTSV CS Rate Among CA Hospitals: 2014
(Nulliparous Term Singleton Vertex)
(Source: Linked OSHPD-Birth Certificate Data)

Range: 12%—70%
Median: 25.3%
Mean: 26.2%

National Target = 23.9%

40% of CA hospitals meet national target

Large Variation = Improvement Opportunity
Not all the outcomes resulting from social disparities are within the control of the health care system, but will....

Require health plans to track, trend and improve care over time care related to diabetes, asthma, hypertension and depression across all payers to achieve negotiated goals.
Measuring Disparities: Target Metrics

Chronic Disease: Control and Ambulatory Hospitalizations
• Diabetes
• Asthma
• Hypertension
Depression: Medication Adherence to start

Data will be collected for the plans’ entire under 65 population including both Commercial and Medi-Cal

Target reductions in disparities will be negotiated individually for each health plan
Barriers

Fully segmenting population
- SB 853 (2003) required plans to collect ethnic/racial identity to support provision of language services
- Measuring disparities in quality of care requires more complete data collection and/or supplementing with proxy identification methodology

Measuring clinical performance
- Health plans have claims and HEDIS samples only
- Commercial and Medi-Cal metric specs differ
- Robust clinical data exists only in integrated systems
Discussion/Questions