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The Impact of the ACA on Population Health Management

September 30, 2014

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Presentation Overview

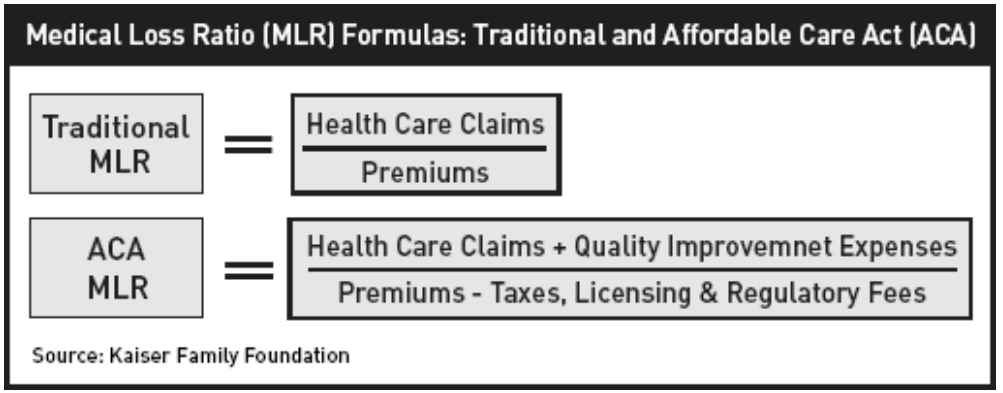
This session will assess how much progress federal and state governments have made in expanding health care coverage and bending the cost curve. Specific insurance reforms to the individual and small group markets will be examined, as well as emerging trends such as the role of accountable care organizations (ACOs), patient accessibility issues, and the drive towards integrated population health solutions.

Goals of the Affordable Care Act:
Improve Health by Increasing Access to Care and Lower Costs

- **Insurance market reforms**
  - No medical underwriting
  - No annual/lifetime limits
  - Essential health benefits
  - Community rating
  - Children up to age 26
- **Expand coverage**
  - Exchanges and subsidies
  - Medicaid expansion

Goals of the Affordable Care Act

- **Increase value of health insurance**
  - Medical Loss Ratio (MLR)
  - Rate review
  - Increase competition



- **Bend the cost curve**
  - Encourage delivery system reform
    - Coordinated care
    - Patient-centered medical home
    - Accountable Care Organizations (ACOs)

Four Year Report Card of the ACA:
Market Reforms

- **Market reforms in place**
  - Almost all states are enforcing
  - Compliance level is high
  - However, some non-compliant plans may continue to be sold until 2016, reducing the number of people benefiting from the market reforms

Expanding Coverage:
Exchanges

- **Enrollment: Exchanges**
  - Initial problems with www.healthcare.gov were largely overcome
  - Some state marketplaces did well; others struggled
  - 8 million enrolled in marketplace coverage
  - Kaiser Family Foundation estimates that 4.6 million were previously uninsured
  - Gallup reports that the percentage of uninsured fell from 18% in the third quarter of 2013 to 13.4% in April 2014

Expanding Coverage:
Medicaid

- **Enrollment: Medicaid**
  - As of July, more than 67 million were enrolled in Medicaid and CHIP
    - Increase of approximately 8 million over October 2013
  - Not all due to expansion of Medicaid
  - Numbers change every month, as enrollment is year-round
  - Enrollment would be significantly higher if all states expand

Increasing Value:
Medical Loss Ratio

- **MLR**
  - Issuers must spend minimum % of premium on health care and activities to improve quality
    - 80% in individual and small group
    - 85% in large group—or pay a rebate
  - $1.1 billion in rebates in 2011
  - $500 million in rebates in 2012
  - $330 million in rebates in 2013
  - Decline is expected and reflects more plans meeting the threshold

Increasing Value:
Rate Review

- **Rate review programs**
  - Grants to states to improve rate review
  - Some have adopted prior review
    - 34 states have in at least some markets
  - Federal program: issuers must provide a justification for rate increases of 10% or above
  - CMS or states review to determine if “unreasonable”
  - Some evidence that rate review leads to lower premiums

Increasing Competition

- **Health insurance markets historically highly concentrated**
  - In 2010, one insurer had at least half the individual market share in 30 states and D.C.
- **ACA seeks to increase competition**
  - Individual mandate: new customers, many with federal subsidies
  - New Marketplaces encourage competition based on cost and quality
  - CO-OP program to assist new entrants

Competition

- **CO-OP program**
  - Non-profit, consumer operated insurance companies funded with federal loans
  - 23 CO-OPs were funded; program was cut in the fiscal cliff deal so no new CO-OPs
  - Existing CO-OPs expanding to new states for 2015
  - CO-OPs reported enrolling 400,000 in 2014
  - Some obtained significant market share while others struggled
    - Maine: 83% of marketplace enrollment
    - Kentucky: 60% of marketplace enrollment

Bending the Cost Curve

- **Increase in costs low to historical trend**
  - Real per capita health spending grew at an average annual rate of 1.1% from 2010-12, compared to 4.6% long-term average
  - Low growth projected to have continued in 2013
  - Health care inflation is at around 1%, lowest since 1963
  - Health care premiums also increasing at lower than historical trends
    - In some cases, decreasing from 2014-2015

- **How much is due to the ACA and how much is due to the recession, among other factors, is highly debated.**

Challenges Ahead

- **Inconsistencies**
  - Citizenship or immigration data matching issues
    - As of August, 210,000 remain open
    - 310,000 people received notices that they had to provide additional information by September 5 or they would lose coverage
    - Q: How will inconsistencies be handled for 2015?

Challenges Ahead

- **Medicaid backlog**
  - Problems transferring data from Exchanges to state Medicaid programs have caused delays in enrollment
  - California reported a backlog of 900,000 pending applications in May
  - Kaiser Health News reported 1.7 million in 15 states in June
  - CMS requested updates on mitigation plans from six states in July

Challenges Ahead

- **Eligibility Redeterminations**
  - CMS to provide notices to people whom IRS data shows may not be eligible for APTC/CSR for 2015
  - Others will keep same subsidies they had for 2014 unless they reapply with the Marketplace with reconciliation at tax time
  - Actual subsidy may change due to change in cost of second lowest cost silver plan
- **Reenrollment**
  - People will automatically be reenrolled in the same plan they had in 2014 if they take no action
  - Process for enrolling in a similar plan if the existing plan is not available

Bending the Cost Curve:
Public Programs

- **Direct effects of the ACA primarily in public programs, especially Medicare**
  - Reductions in excessive payments
- **New payment models**
  - Payments based on outcomes (e.g., reduced hospital readmissions)
- **Accountable care and bundled payment models**
  - Initial results have been mixed

Bending the Cost Curve:
Narrow Networks

- **Narrow networks**
  - Not new to ACA
  - Shown to reduce costs
    - Per McKinsey, premiums in narrow network Marketplace plans are 13-17% lower
    - National Bureau of Economic Health study based on MA experience showed significant decline in health care spending without decrease in quality
- **Cost vs Access vs Choice**

Network Adequacy

- **Network adequacy**
  - General standard: “Access to covered benefits without unreasonable delay”
  - Time and distance requirements
  - Quality not a factor
  - Enforcement is difficult, generally driven by complaints

Transparency/Choice

- **Transparency/Choice**
  - McKinsey reports that 90 percent of people choosing plans in the Marketplace had the choice of a plan with a broad network
  - Price an important factor for most consumers
  - Do consumers know what they are buying?
  - Challenges include providing accurate, up-to-date provider directories
  - Enforcement very difficult

Regulators' Response

- **Washington regulation—access**
  - General standard: "Timely manner", "without unreasonable delay", "reasonable proximity"
  - Ensure that contracting hospitals have adequate capacity to serve entire enrollee population at normal utilization
  - Ratio of primary care providers to enrollees must equal the ratio for the state of the prior plan year
  - Primary care appointments within 10 days; specialist appointments within 15 days
  - Time and distance requirements, e.g., hospital within 30 minutes in urban area, 60 minutes in rural area for all enrollees
  - Primary care, mental health, pediatric services within 30 miles/60 miles for 80% of enrollees

Regulators' Response

- **Washington regulation—transparency**
  - Provider directories updated monthly, contain specified information
  - Network plan must be approved by insurance department
  - Access plan with criteria for referrals out-of-network, process for prior authorization, etc. must be submitted to insurance department
  - Criteria for assignments in tiered networks must be public

Regulators' Response

- **NAIC**
  - Considering amendments to network adequacy model law
  - Previously applied only to managed care plans; contains general language for requirements
  - Not clear whether will continue to recommend adoption of general standards or be more prescriptive
  - Serves as guide to the states, but is not binding

National Association of Insurance Commissioners

Regulators' Response

- **CMS - CCIIO**
  - Network adequacy requirement for QHPs in the federally-facilitated exchange is general—without unreasonable delay
  - For 2014: left network adequacy review to states
  - Required plans to submit information on networks for 2015
  - Considering using network adequacy review based on standards similar to Medicare Advantage (time and distance requirements)

Regulators' Response

- **NCQA**
  - Accreditation for 2015 includes new requirements re: narrow and tiered networks
  - Plans are required to disclose their criteria for including hospitals and physicians in networks
  - Plans required to monitor complaints, appeals and requests for out-of-network services
  - Apply only to Marketplace plans, not to large group markets

Bending the Cost Curve:
ACOs

- **ACOs in commercial markets are growing**
- **Blue Shield of California experience**
  - Insurer, hospital and doctors participate
  - Establish global per member per month target for cost of health care for the population
  - Does not change underlying payment mechanisms (e.g., fee for service or capitation)
  - Share savings and risk for each category of health care service within the per member per month target
  - No savings unless quality goals met

Bending the Cost Curve:
ACOs

- **Blue Shield Experience: ACO Model**
  - First commercial ACO formed in 2010 with Dignity Health and Hill Physicians for CALPERS employees in HMO product in Sacramento, CA
  - Five key strategies to achieve savings:
    - Improve information exchange
    - Coordinate processes such as discharge planning
    - Eliminate unnecessary care
    - Reduce variations in practices and resources
    - Reduce pharmacy costs
  - Partner's share of risk varies depending on its ability to influence costs

Bending the Cost Curve:
ACOs

- **Blue Shield Experience: Results**
  - CALPERS has saved $95 million
  - Partners have shared $10.2 million in savings
  - Hospital days and readmissions have fallen compared to prior year and to those not in program

Bending the Cost Curve:
ACOs

- **Blue Shield Experience: Expanding the Program**
  - 20 ACOs now operating with 227,000 members across the state
  - Average annual increase in cost of health care is 3%, compared to 7% for non-ACO members
  - Reductions in hospital admissions, inpatient days, readmissions and ER visits
  - ACO product will be offered through Covered California, the State Marketplace, in 2015
  - Goal is to expand to cover 50% of members by 2018

Bending the Cost Curve:
ACOs

- **Cost vs Access revisited: the challenge for ACOs**
  - ACOs are narrow networks
  - How can they balance what is needed to reduce costs with what is needed to provide adequate access?
  - How can they provide purchasers with informed choices?
- **Transparency is essential**
  - Who is in the network?
  - Criteria for being included in the ACO
  - Benefits of an ACO
  - Why transparency is key to population health management

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