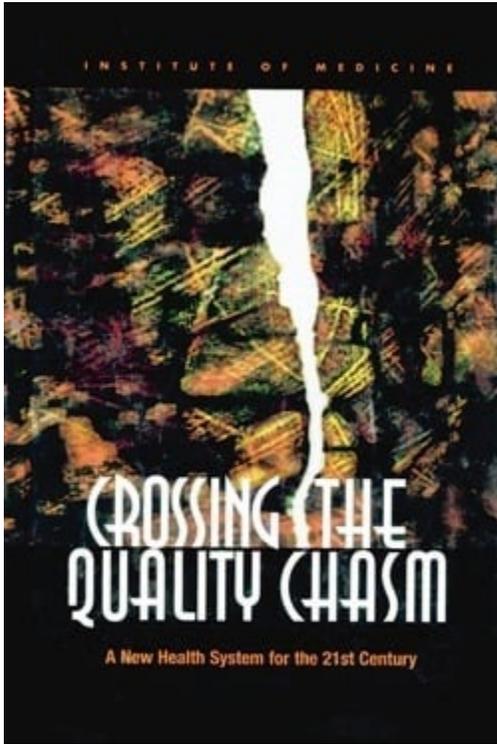




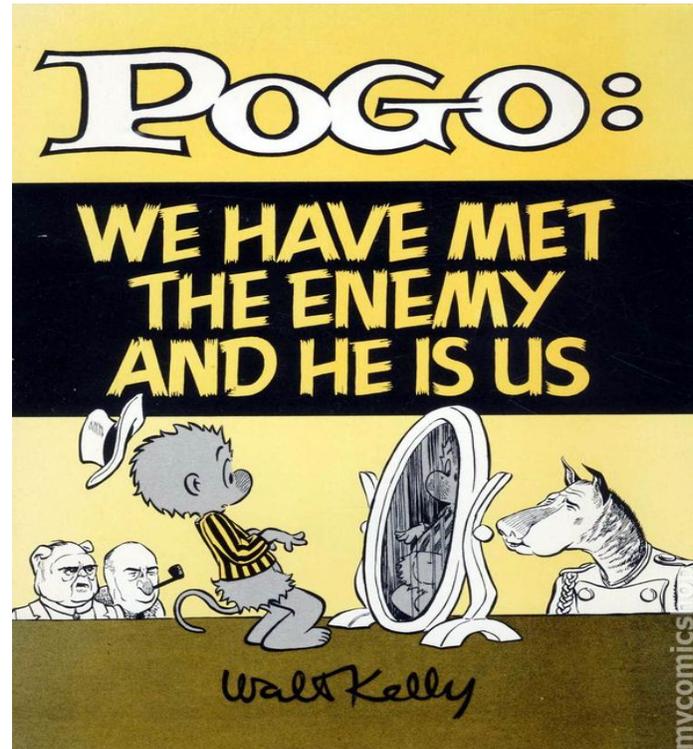
Lessons from Covered California to Address Affordability, Choice and Quality

Peter V. Lee
CalPERS Board of Directors
January 18, 2022

Twenty Years and the Quality Chasm Remains



2001 – Call to Action: All health care organizations, professional groups and private and public purchasers should pursue six major aims; specifically, health care should be safe, effective, patient-centered, timely, efficient and equitable.



2021 – Sad Reality: Best of intentions in measurement, payment and support have led to anemic changes to how health care is paid for, with many purchasers still anchored in fee-for-service payment; measures galore – with too many that do NOT matter; EHR's too often in service of billing and coding – not making clinicians or patients lives better. Results: little improvement in quality or equity; costs still out-of-control.

Ongoing Challenges for Health Care Nationally

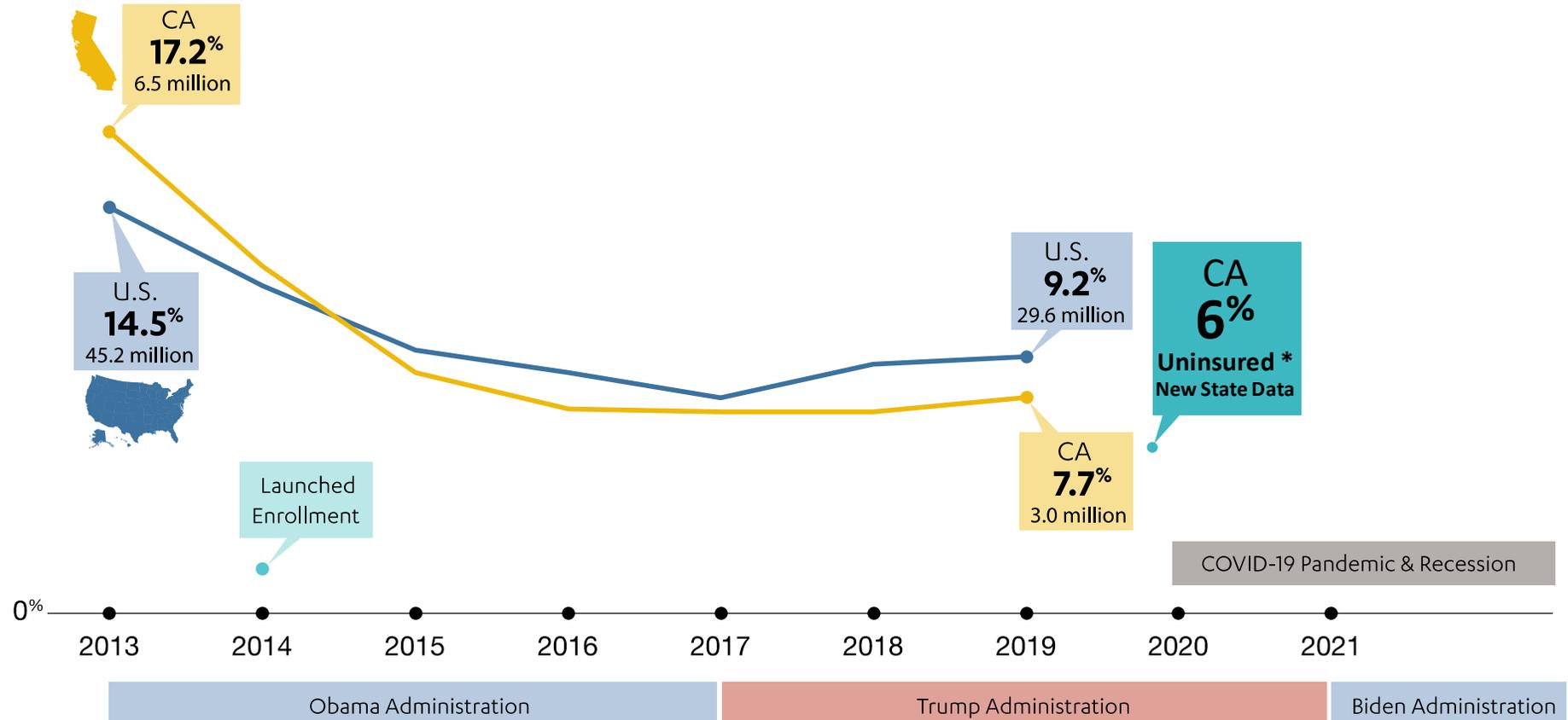
From 2001 to 2021 – the nation has made DRAMATIC improvements in coverage and in making care more affordable for millions of Americans. Yet, those positive results and accomplishments have occurred in the context of challenges that are shared by consumers across the nation, including:

- **Health Care Costs:** over the past decade the cost of health care has risen more than twice as much as the median hourly wage, which has fed into problems of affordability and underinsurance as employers have shifted costs to employees in the form of higher premiums and deductibles. We ALL live in glass houses: hospitals, physicians, pharmaceuticals are all drivers; however, over the past 20 years, the net cost of health insurance was the fastest growing category of spending, with an annual average growth rate of 7.7%.
- **Coverage and Affordability:** with the Affordable Care Act, more than 31 million Americans have gained insurance coverage (14.8 through Medicaid expansion and 11.3 through Marketplaces). At the same time, about 31 million Americans remain without insurance, with huge variation in the rates of the uninsured, from a low of 3% in Massachusetts to a high of 25% in Texas. Coverage, however, does not guarantee affordability. While Medicaid provides robust low/no cost coverage for lower income Americans and Marketplace subsidies provide financial support directly linked to consumers' income, about 25% percent of both those with employer coverage and those with Medicare are “underinsured.” Few employers income adjust their contributions for employee premiums or out-of-pocket costs.
- **Health Plan Role and Choice Overload:** health plans are playing an increasingly prominent role in the U.S. healthcare ecosystem across Medicaid, Medicare, Marketplace and ESI. Health plans have generally NOT proven themselves to be engines fostering improvement in health quality, equity or reducing rate of increase in underlying cost of care. Rather, health plan “innovation” often means providing numerous options that vary on premiums, deductibles, copays, networks, medical benefits covered and, to a limited extent, services to address health-related social needs. Evidence shows that many consumers – particularly in Medicare Advantage – find this abundance of choice overwhelming, leading to inertia in terms of actively shopping and choosing among plans. Standardized patient-centered benefit designs – such as those implemented by Covered California – means that health plans compete on key attributes like price and network value.
- **Quality and Health Equity:** despite hundreds of quality measures and hundreds of millions of dollars invested in quality improvement, progress has stagnated over the last decade. Quality is uneven across and within health plans, resulting in many consumers – particularly those from communities of color and lower income Americans – receiving poor quality care.

Record Decrease in California's Uninsured Rate

Comparing the Rate of Uninsured in California and the United States

- California experienced the nation's largest drop in the uninsured rate.
- More than 4.7 million Californians have gained coverage since 2013.
- As of 2019, about 3 million uninsured, with about 60% undocumented/ ineligible for federal programs ("currently eligible" uninsured rate is about 3 percent).

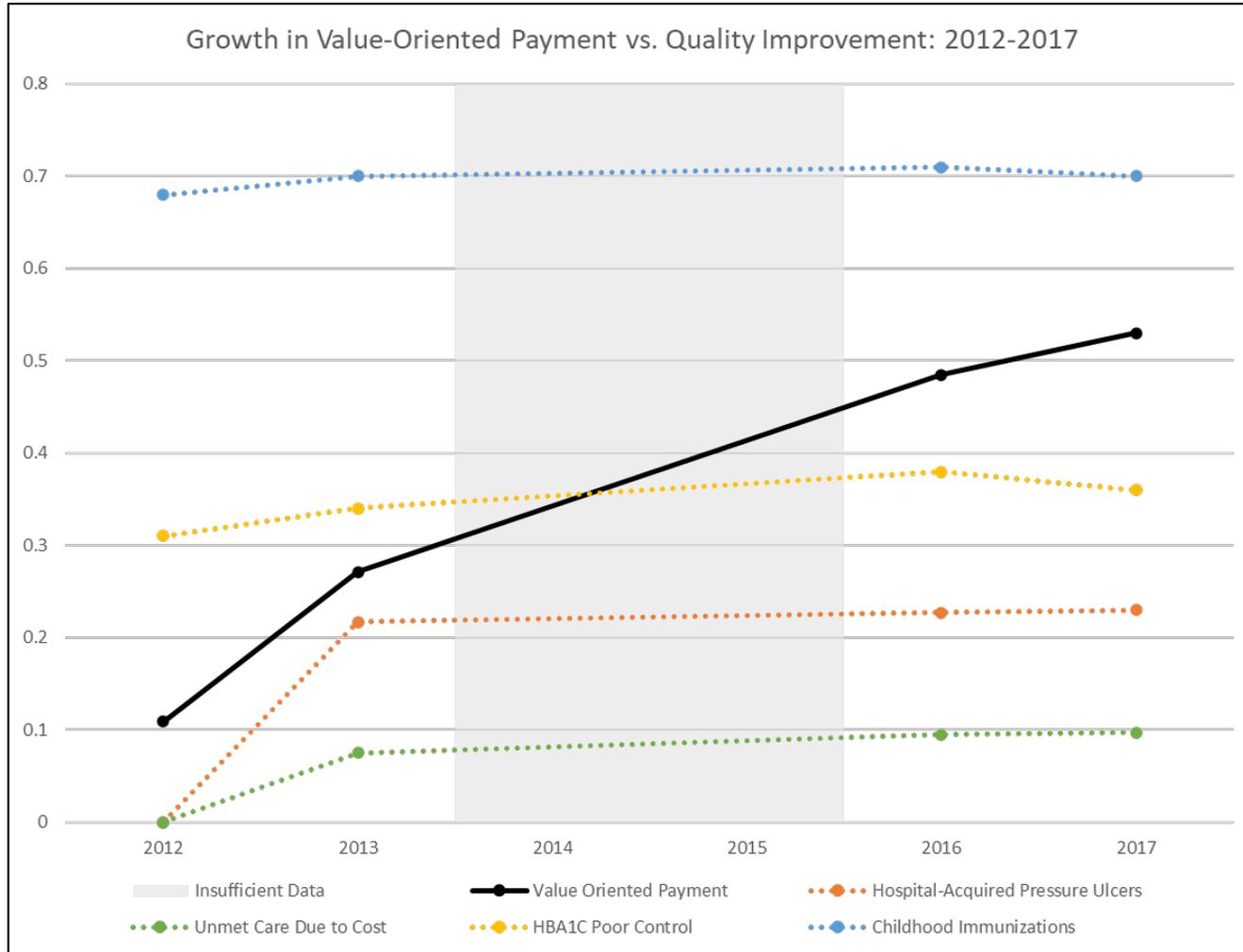


Source: U.S. Census 2014-2020

*Source: California Health Insurance Survey, Sept. 22 - <https://healthpolicy.ucla.edu/publications/Documents/PDF/2021/access-to-care-policybrief-sep2021.pdf>.

The survey is based on interviews conducted continuously throughout the year with respondents from more than 20,000 California households in a variety of languages. U.S. Census data on California's uninsured rate in 2020 has been delayed due to the pandemic and is not reflected.

Many “Payment Reform” Efforts – No Evidence of Improvement in Quality



Value-oriented payment – increased to over 50 percent of payments, but small portions of payments, unaligned and little movement to global payment.

Catalyst for Payment Reform

DATA SOURCES

Value-oriented payment Source: *Analysis by Catalyst for Payment Reform, eValue8 data*

Unmet care due to cost Source: *Analysis by Catalyst for Payment Reform 2019, BRFSS data (CDC) 2013-2017*

HBA1c poor control Source: *NCQA HEDIS® 2019; Notice of Copyright & Disclaimer Information Available*

Hospital-Acquired Pressure Ulcers Source: *AHRQ National Scorecard on Hospital-Acquired Conditions 2019*

Childhood Immunizations Source: *CMWF & America's Health Rankings*

The Quality Chasm Then...

2003: Adults receive about half of recommended care

55% = Overall care

55% = Preventive care

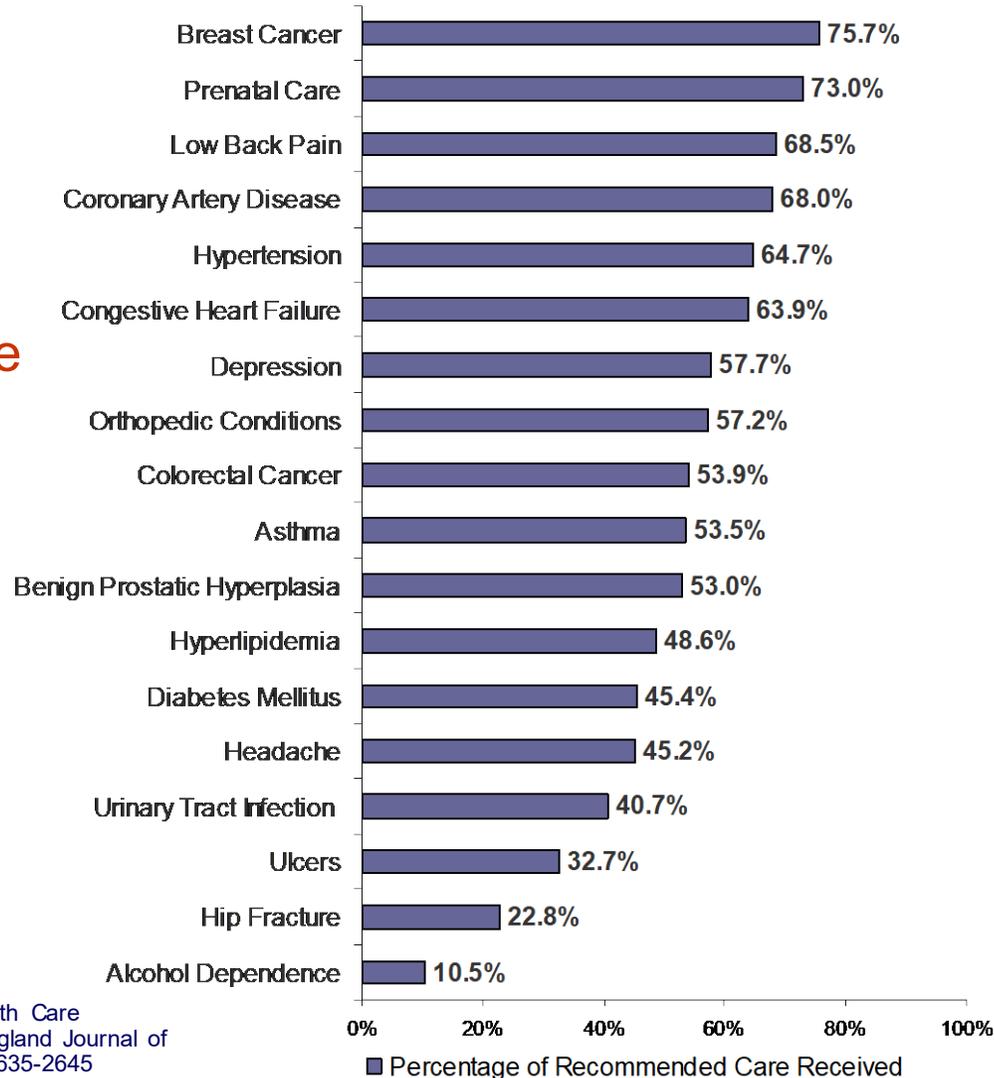
54% = Acute care

56% = Chronic care

Source: McGlynn EA, et al., "The Quality of Health Care Delivered to Adults in the United States," New England Journal of Medicine, Vol. 348, No. 26, June 26, 2003, pp. 2635-2645



Adherence to Quality Indicators



And NOW...

Efforts to stimulate improved quality have included public reporting, pay for performance, and value-based purchasing... maintenance of certification, systematic reviews of research, practice guidelines, electronic health records and quality improvement programs... Despite these programs and infrastructure, there is little evidence that quality has improved systematically in the United States.

Source: McGlynn EA, "Measuring and Improving Quality in the US: Where Are We Today?" J Am Board Fam Med 2020; 33: S28-S35.

Covered California's Quality Story is the Story of a Nation's Failure to Improve Quality

Good News:

- In 2020 85% of enrollees were in QHPs that received 3 stars or better for Getting Right Care, with one plan receiving 5 stars in 2020, and two receiving 4 stars as of 2021.

Bad News:

- QHP performance has not consistently or substantively improved over time.
- Three QHPs – Anthem, Molina and Oscar (representing 13% enrollees) received 2 stars for three consecutive years (2019, 2020 and 2021) for Getting the Right care.

Qualified Health Plan Issuer	2021 Enrollees	2016	2017	2018	2019	2020	2021
Anthem HMO	1.9%	3	-	-	-	NA	NA
Anthem PPO	-	2	-	-	-	-	-
Anthem EPO	4.5%	2	NA	3	2	2	2
Blue Shield HMO	7.4%	NA	NA	NA	2	3	3
Blue Shield PPO	20.6%	2	2	3	2	3	3
CCHP HMO	0.3%	3	3	3	3	3	3
Health Net HMO	8.3%	3	3	3	3	3	3
Health Net EPO	0.05%	NA	2	3	2	3	NA
Health Net PPO	2.7%	-	NA	NA	NA	3	2
Kaiser Permanente HMO	36.9%	5	4	5	5	5	4
LA Care HMO	6.1%	1	3	4	3	4	3
Molina Healthcare HMO	3.5%	2	3	3	2	2	2
Oscar Health Plan EPO	4.3%	NA	NA	3	2	2	2
Sharp Health Plan HMO	1.5%	4	4	5	4	4	4
Valley Health Plan HMO	1.4%	3	3	5	4	4	3
Western Health Advantage HMO	0.6%	3	3	3	2	2	3

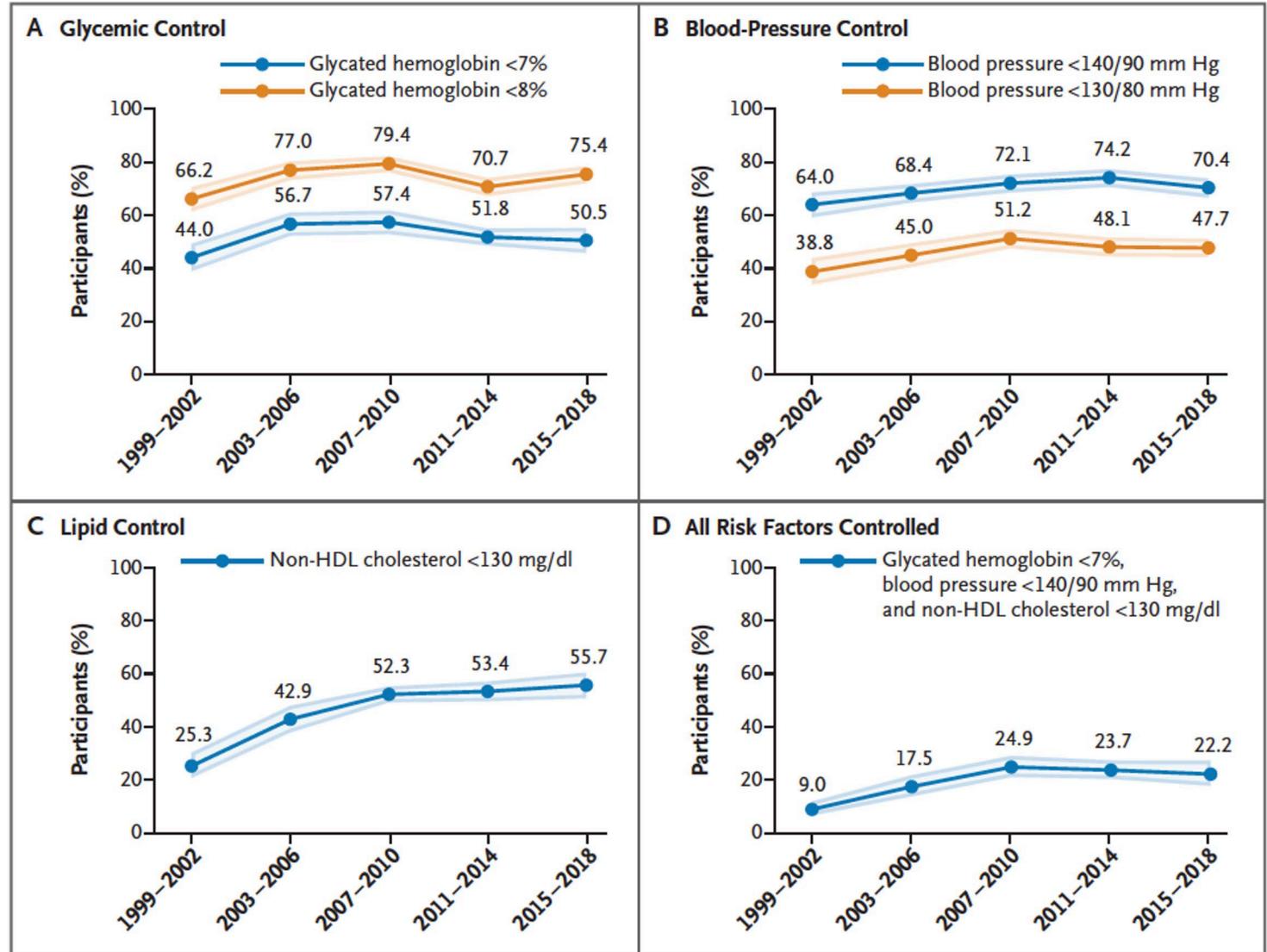
* 2021 represents measurement year 2020 which may not be representative due to COVID-19

It's About the Care, Stupid – Diabetes as Case in Point

Prevalence of Glycemic, Blood Pressure, and Lipid Control Among Adult NHANES Participants With Diagnosed Diabetes, 1999–2002 to 2015–2018

- Consistent improvement in blood glucose, lipid and blood pressure control from 1999-2010.
- After 2010, stagnation and decline in measures.
- By 2018, **FEWER** patients with good blood glucose or blood pressure control, two of the most important clinical risk factors for cardiovascular disease like heart attacks and strokes.
- **At the same time, the prevalence of diabetes in adults increased by more than 45%, from 9.8% to 14.3%.**

Shaded areas indicate 95% confidence intervals. To convert the value for non-density lipoprotein (non-HDL) cholesterol to millimoles per liter, multiply by 0.02586. NHANES denotes the National Health and Nutrition Examination Survey.



**The Big Question For The Path Forward:
Can We Make Health Plans Reliable Engines of
Quality Improvement and Cost Reduction?**

Covered California's 2023 Strategic Approach to Foster Quality Improvement by Health Plans – Theory of Change

- **Quality improvement happens at the delivery system:** Covered California's overarching goal is to drive towards integrated, coordinated care in order to achieve and sustain improvements in quality and equity. This will require a multifaceted approach that not only ties significant financial consequences to performance, but also drives payment reform as well as investments in primary care, behavioral health, and clinically oriented data systems.
- **Market signals to health plans and providers, amplified by alignment on measures:** Covered California is committed to aligning with other purchasers to send strong and consistent quality improvement direction to health plans and providers. Parsimony is critical given that quality improvement happens at the delivery system, and most "systems" are unable to improve on more than a few areas at a time – precisely because they are not systems.
 - Common core measures and aligned incentives across Covered California, Medi-Cal and CalPERS (collectively 42% of Californians), and ideally with Medicare and employers.
 - Parsimony of core measures that matter (outcomes, impact, feasibility, availability) to tie to significant financial consequences.
 - Covered California will continue to monitor and revise over time (e.g., IHA's Align.Measure.Perform and CMS' Quality Rating System).
- **Substantial financial consequences to make quality/equity matter to health plan's bottom line.**
 - As much as 4 percent of premium (NOT "ASO fees") at risk for quality.
 - Consequences not ONLY for being horrible (under 25th percentile), but to promote being GOOD (sliding scale of consequence up to at least 50th percentile, potentially up to 75th).
 - Remove health plans providing sub-par care (if health plan is below 25th percentile on collection of "right care" HEDIS measures for two years; must rise above that threshold IN two years or it is OUT of the marketplace).
 - Only allow NEW carriers that demonstrate better than "sub-par" care.
- **Public notice:** Amplify the impact of financial consequences by making them VERY public (it works for doctors – why not health plans?).
- **Monitor and control for unintended consequences:** Particular concern for exacerbating disparities if health plans that disproportionately provide care to poorer patients and patients with high levels of social needs will have higher financial assessments that ultimately impede their ability to support providers and care improvement. Require corrective action plans detailing pathway to improvement.

Covered California's 2023 Strategic Approach to Foster Quality Improvement by Health Plans – Theory to Action

- **Overarching goals in health plan contracting**
 - Ensure that each Covered California enrollee receives the best possible care at lowest possible cost
 - Achieve the best possible health and healthcare for **all** California residents, both as a “public good” and because consumers move between payers but we all pay for poor outcomes
 - Establish a process that will ensure continual improvement of California’s health care system through well-aligned near-term incremental changes and longer-term transformational reforms
 - Provide a model that can spread broadly and insights/tools that others can adopt to help scale
- **Long view with near term action on quality, equity and delivery system transformation**
 - 2023-2025 contract focuses on disparities, behavioral health, advanced primary care/value based care, data exchange and affordability/cost; future contracts will build on these and other contracting terms.
- **Covered California making quality and equity a bottom-line for health plans**
 - **Quality Transformation Initiative (QTI):** Proposal to tie 1% - 4% premium to performance on four core measures (blood pressure control, diabetes control, colorectal cancer screening, childhood immunizations)
 - **Selective Contracting for new entrants and removal of poor performers:** Proposal to notify health plans that have performed at or below 25th national percentile on Marketplace clinical measures for 2 consecutive years that they have 2 years to improve their performance or else will be removed from Marketplace for a minimum of 2 years.
- **Alignment is THE most vital ingredient:**
 - Covered California only represents 6% of covered lives in California. To have carriers focus their attention on improvement it is critical to have consistent measures and incentives on health plans. IF Covered California, CalPERS and DHCS are well aligned – we represent 42 percent of Californians and send market signals that are far more powerful than any of us can send alone.
 - Core measures aligned across purchasers and aligned incentives.

Potential Carrier Responses to the Purchasers Raising the Bar on Quality and Equity

Expert, policy-maker and advocate comments underscored the concern that while the hope was to motivate “positive” health plans actions, some actions taken could have significant unintended and potentially negative effects on consumers. Responses could include (from more “positive” to “potentially negative:”

- 
1. Engaging and supporting provider groups in improvement activities, for example development of registries and data analytics, facilitating data exchange, and innovative approaches to patient engagement in order to improve coordination, integration and care delivery.
 2. Contract with higher quality providers (which may result in decreased affordability if higher cost providers).
 3. Developing quality incentive programs for contracted providers and groups narrowly focused on the same or similar measures (which may improve measures but may or may not improve underlying systems of care).
 4. Use consumer incentive programs to target desired behavior (no strong evidence that this is effective but may be an additional lever).
 5. Focusing on data issues, including completeness (which is foundational, but doesn't represent true improvements in quality and will not impact outcomes).
 6. Eliminating poor performing providers or provider groups from their contracted networks (a strategy that would necessarily be limited by the need to meet access and network adequacy requirements from both regulators and Covered California but could have the unintended consequence of penalizing providers serving higher risk or more vulnerable patients).

For more information:

[Covered California: Ten Years of Experience Promoting Competition and Health Plan Accountability](#)

[Covered California: Potential Major Health Plan Contracting Changes for 2023 and Beyond to Promote Quality Improvement & Health Equity, November 10, 2021](#)

Contact Peter V. Lee
Executive Director, Covered California
Peter.Lee@covered.ca.gov