July 30, 2012

Peter Lee, Executive Director
Members of the Board of the California Health Benefit Exchange
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Dear Members of the Board and Mr. Lee:

First let us thank you for your service to California. We commend you for taking on perhaps the most challenging domestic policy issue of our time as you strive to meet the mission and vision set forth by the Exchange. The academic medical centers embrace the goals of the Affordable Care Act (ACA) to improve health care access, quality and affordability and are committed to doing everything we can to contribute to the successful attainment of those goals. The Exchange is a crucial element of the ACA and we hope to participate in the products of the Exchange when you become operational.

Meeting the tripartite goals of the Exchange will require crafting a careful balance of multiple factors. We would like to share some observations and recommendations pertaining to one area of your work as you develop the policies and practices which govern how Qualified Health Plans will interact with the Exchange. We offer these thoughts keeping in mind the mission and vision statement you have developed for the Exchange, "to improve the health of **all** Californians by assuring their access to affordable, high quality care." To achieve this mission and vision it will be critical that the Exchange give meaningful consideration to the impact its policies will have on both the delivery system of the state and on the markets outside the Exchange.

The specific issue we would like to address is the use of narrow networks as a strategy to ensure affordability. Besides observations regarding the concept of narrow networks broadly, in the event the Board decides to make use of them, we believe there is a particular need to develop effective implementation policies to prevent unintended negative consequences on essential public interest issues.

With regard to the narrow network concept as a cost containment strategy, we strongly recommend that the Board resist any policy that denies patients their providers of choice who are actively engaged in effective care management strategies or excludes essential societal services or programs. The belief that narrow networks promote greater efficiency, lower costs and therefore will help lower commercial prices and total expenditures is erroneous. Narrow networks do not address broad societal benefits (such as medical education) the underlying drivers of health care costs associated with the delivery system, the other factors reflected in commercial provider prices and ultimately the total health care expenditures in the commercial

market. While we know most of these issues are familiar to you, when considering the potential impact of narrow networks a brief review is worthwhile.

The primary cost drivers internal to the delivery system are the substantial structural shortages across the spectrum of professional and technical positions, unfunded government mandates, government underpayments and the continuing emergence of new technologies, all of which have driven up operating costs for nearly everyone in the delivery system at a rate substantially higher than the rate of general inflation. A review of available OSHPD data between 2000 and 2010 reflects this fact. The systematic nature of the cost drivers is reflected in total hospital operating expenses which have increased at roughly the same annual rate of 8% across all hospitals in the state. On a per case mix index adjusted discharge basis which appropriately recognized that the "product" being delivered in California hospitals is much more complex than a decade ago, the annual rate of increase has been 5.1%. Contrary to previous claims, the size of the hospital, whether or not it is part of a multi-hospital system, or is one that is considered a so-called "must have" hospital is not associated with a significantly different rate of increase.

The primary factor affecting commercial prices is the level of community benefit hospitals provide as part of their mission and ability to support the shortcomings of current financing systems. Included in this category are free and part pay care for the uninsured, losses incurred in serving Medi-Cal and Medicare patients, programs to promote wellness and disease prevention in their local communities and for the major academic medical centers and teaching hospitals in the state, their unique volume and mix of clinical services along with their education and research missions. Finally commercial prices, total commercial expenditures and total healthcare expenditures are driven by increased utilization of healthcare services. Increased utilization is a function of new technologies, public demands, aging of the population, adverse health behavior of people and the absence of payment mechanisms that promote the use of cost effective, high quality approaches to diagnosis and treatment.

Narrow networks are fundamentally contrary to the mission and vision established by the Exchange. For the mission and vision to become real, it is imperative that the Exchange Board members develop policies that achieve these ends not just for the customers of the Exchange but for all Californians. Narrow networks then must be evaluated for their potential to generate real, sustainable savings both in the Exchange and across the entire system. As noted above, narrow networks do not lower the input costs for those delivering health care. Whatever unit price savings may exist in narrow networks do not meet this criterion. To the extent that those covered by a lower unit price in a narrow network benefit, it results in those insured outside the narrow network (whether on another Exchange product or outside the Exchange) ultimately bearing a disproportionately higher portion of the total cost. Total health care expenditures are not reduced. Ironically if the Exchange makes use of narrow networks, it will be adding to the current cost shift problems in the commercial insurance market and narrow networks in reality are another form of inappropriate risk segmentation, the Exchange would be expanding the use of a technique that the health reform effort was intended to reduce.

The real, sustainable savings generated from narrow networks have come from more extensive use of multiple enhanced care management strategies designed to reduce inappropriate utilization in all of its forms. But such care management strategies are not unique to narrow networks.

Among the reasons total healthcare spending has slowed substantially in recent years is due in part to the deployment of these techniques and strategies more broadly across the delivery system. Rather than adopting the false economy of narrow networks, a substantially greater and lasting impact would be achieved if the Exchange built into its policies the requirement that all Qualified Health Plans contract with those entities having the capacity to manage complex chronic disease and engage in more effective care coordination and primary care management. The Exchange should also promote the use of payment methodologies that align incentives for those providing care to do so in a more coordinated, integrated way. Following this path would result in a greater and longer lasting impact, not only for those enrolled through the Exchange but also the entire healthcare system, thereby truly achieving the mission and vision you have established.

In the event the Exchange chooses to use narrow networks, we believe that it is important that the board adopt companion policies in order to avoid unintended negative consequences related to essential public interest questions. One area for your consideration is requirements placed on Qualified Health Plans as they determine which providers they include in their networks for various products. The actions currently being taken by health plans in the commercial market to exclude major academic medical centers from narrow network products are useful to illustrate the point.

Relative to its population, California has a much smaller network of major academic medical centers than the rest of the nation. The organizations most significantly impacted by the existing practices of the health plans (Cedars-Sinai, Loma Linda, Stanford, the University of California Health System and the University of Southern California Health System) represent the facilities in which the most advanced complex medical care and a significant proportion of public safety resources such as trauma centers, transplant services, etc. are located. As well they are the major sources of medical, nursing and other allied health professions education and training. Finally, as the major research centers for the state, they are the places where critical discoveries in science, prevention and the delivery of care are made.

The mission of the academic medical centers and the public interests they serve make them by definition the more expensive components of the delivery system. The clinical service component of their mission accounts for a substantial portion of their cost difference. Having the facilities, equipment, standby services and most important the highly specialized staff required to provide these services makes the academic medical centers more costly. They also are more costly because of the infrastructure required to educate the healthcare workforce of tomorrow. The nature of medical research and its funding also means that the academic medical center component of the system bears an additional cost.

Substantial benefit accrues to the entire system and the state by concentrating these services in the academic medical centers. While as individual facilities they are higher cost, the system as a whole avoids what would be substantially higher capital costs to duplicate the expensive equipment and facilities to provide such services. Total operating costs for the system as a whole would be much higher due to increasing the demand for the highly trained personnel already in critically short supply and duplicating standby costs more broadly in the system. Already recognized as being among the quality leaders in the state (according to available data),

concentrating these services in academic medical centers is an important quality assurance mechanism, as it ensures sufficient volumes in these complex cases to maintain competence among the staff.

The additional investment represented by the academic medical centers' education costs produce enormous benefits and helps keep the entire healthcare system costs substantially lower than they would otherwise be by the direct impact on mitigating personnel shortages. Looking to the future and coverage expansion, there is broad agreement that in order to avoid loss of access for Californians, it will be necessary to expand the number of primary care physicians, nurse practitioners and physician assistants. The major academic medical centers are the primary locus of such training.

The additional cost of research in the academic medical centers returns benefit to the entire state in multiple ways. The scientific and medical advances enhance both quality of life and lifespan. In today's world it is equally important to recognize that the same research apparatus has made the discoveries that have had an enormous impact on improving the efficiency of the healthcare system. Consider just one example – the technology that created the minimally invasive surgery – in which several of the academic medical centers in the state played a substantial role. In this one technology, the benefits of lower costs throughout the healthcare system related to the movement from inpatient to outpatient surgery and enormous reduction in length of stay for most other surgeries are staggering.

As the Exchange develops policies that will determine the rules by which Qualified Health Plans may offer narrow network products it is important that the Exchange consider how it will address several essential public interest issues. They include: what roles the academic medical centers play in both the local delivery system and statewide; what benefit accrues to the healthcare system in California from their additional costs; and, how should the cost/benefit value proposition of the academic medical centers be considered in the context of value-based healthcare purchasing, particularly when it comes to decisions regarding provider network participation.

With regard to the local and statewide roles played by the academic medical centers, it is important to recognize that in addition to being the locus of the most complex care available anywhere in the world, these facilities also serve as the local community hospital for millions of people. In this role on a local level they are a key component of the larger community hospital network which provides that level of service.

The mix of community hospital services and advanced tertiary and quaternary services is important in support of the academic medical centers' education and research mission as it creates the optimal milieu for education and research. But there is another, perhaps more important issue that arises from the community hospital nature of these facilities and the health plans practice to date to exclude them from narrow networks. That is the effect on the people who depend on these facilities for community as well as specialized hospital services. When academic medical centers are excluded from networks based on their relative local cost, those living in the area are discriminated against. With their local hospital and its physicians excluded,

individuals are forced either into more expensive plans or prevented from using the hospital and their doctor of choice and convenience.

With regard to the additional cost of the academic medical centers, and analyzing OSHPD data for 2000 through 2010, the most recent period for which complete data is available, it indicates the following with regard to the statewide premium in commercial payments being made to the academic medical centers as well as their cost management performance relative to the other hospitals in the state. Over the decade the difference in commercial payments to the academic medical center group and that paid to the other hospitals in the state as a percentage of total statewide hospital spending has remained constant. In 2000 it was 10.6% and in 2010 it was 10.5%. Given the substantial difference in the nature and volume of services provided by the academic medical centers, this raw data needs to be adjusted for case mix index differences. Adjusted for case mix index the difference in commercial payments to the academic medical centers as a percentage of total statewide hospital spending has declined from 5.7% in 2000 to 4.1% in 2010.

As the Exchange considers its policy position on academic medical centers and narrow networks this data should be kept in mind. The heart of the problem is that under current practices the health plans determine the cost of their narrow network products based on unit costs and small geographic areas. In so doing however, they are assigning the cost differential of the academic medical centers to that local market when in fact the benefit of the cost differential of the academic medical centers is one that benefits the entire state and beyond.

We urge the Exchange to develop policies that prevent this distortion from occurring. In brief, the cost/benefit value calculation is wrong. Enormous value accrues to the entire state from the 4.1% differential of total hospital spend paid to the academic medical centers. Excluding the academic medical centers will not achieve the system wide cost containment mission and vision for the Exchange; it will unfairly penalize individuals dependent on these facilities for local hospital and physician services; it will compromise an important innovation engine that has and will play a central role in pursuit of cost-effective high quality care and it will exacerbate pressures on an inadequate educational infrastructure to meet the future workforce requirements. The ACA recognizes the need to make adjustments for systemic issues to assure that risk and other appropriate costs of the health care system are appropriately accounted for. One specific example is the provision calling for the redistribution of funds among QHP's based on differences in the risk pools reflected in each patient population. Similarly, we encourage the Exchange to develop policies that spread the cost differential of the major academic medical centers across the entire state which benefits from those additional investment dollars.

In making this request, we want to emphasize that the academic medical centers are not seeking special treatment. They are seeking the development of policies that create an environment that recognizes the legitimate cost differences associated with this aspect of the system. Academic medical centers have demonstrated they have the ability to respond to the cost management imperatives of the future and fulfill their missions of education and research. Academic medical centers already have initiated multiple steps to bend the cost curve.

We embrace your mission and vision. Our commitment is to provide the highest quality of care while educating and training tomorrow's workforce.

Thank you for your consideration of this request. We would be pleased to discuss this matter with the Exchange as you consider this important policy matter and possible solutions.

Sincerely,

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