Alternative Strategies to Promote Affordability and Safety Net Continuity through Contracting with Medi-Cal Managed Care Plans

SUMMARY

Offering affordable health plans is a critical priority for Covered California; ensuring high enrollment of low income Californians can't be done without it. Consistent with Covered California's mission and vision, other important goals include encouraging continuity of care for those who have coverage, and maintaining community safety net programs for those who do not have coverage. This Options Brief outlines alternative strategies, which could build on Covered California's selective contracting process to provide even more affordable options for low income Californians between 139% and 200% of FPL, and promotes continuity of care with safety net providers.

The discussion is provided in two options:

Option 1 describes how Covered California's selective contracting process could be used to achieve greater affordability; and

Option 2 identifies potential approaches to foster maximum participation of Medi-Cal Managed Care plans in Covered California to improve continuity of care and support the community safety net.

These options are mutually complementary, but could also be implemented independently. These options are presented to begin the discussion that will lead to potential Board action in early 2013.

BACKGROUND

For low income Californians, the monthly premium cost for health coverage may be the most significant factor in determining whether they will enroll in a plan. Federal subsidies – based on household income will significantly reduce premiums and out of pocket costs. For illustration purposes, Table 1 below provides an example of how these federal tax credits impact monthly premiums of a hypothetical 40 year-old policy holder.

Table 1: Sample Tax Credit for Purchase in the Individual Exchange

Percent of FPL	Annual Income	Unsubsidized Premium for Month	Tax Credit	Monthly Premium after Credit
138%	$15,500	$379	$340	$40
150%	$16,700	$379	$324	$55
200%	$22,300	$379	$262	$117
250%	$28,000	$379	$192	$187
300%	$33,500	$379	$114	$265

Example based on a 40-year-old policyholder using 2014 projected incomes, assuming a "silver" plan covering 70 percent of expected medical utilization costs. Source: UC Berkeley Labor Center "Calculator."

In addition to premium subsidies, cost-sharing reductions will reduce point-of-service costs for individuals with incomes between 100 and 250 percent of the federal poverty level in the silver plan. These federal subsidies effectively cap out-of-pocket expenditures, such as deductibles, copays, and

coinsurance, at a lower level for individuals in this income range in order to help ensure that both premiums and the cost of accessing care remains affordable for lower income Californians. Particularly, for individuals with incomes below 200% of FPL where discretionary income is extremely limited, policies that offer the potential for reducing what consumers pay are likely to encourage higher enrollment.

In addition to affordability, continuity of care is of critical importance to consumers. There are a variety of life experiences that may change an individual's eligibility for subsidized health coverage programs. Examples include changes in family income due to getting or losing a job; changes in family structure, perhaps due to the birth of a child or the "aging out" of a child; or re-location for work or to meet family responsibilities. For some individuals, the change could make them eligible for Medi-Cal; others may find themselves losing Medi-Cal eligibility but perhaps becoming eligible for subsidized coverage offered through the Exchange. This movement between programs is often referred to as "churn." Although there are many administrative costs and complexities related to churn, the issue of continuity of care may be a greater concern for many enrollees. To the extent that churning results in individuals changing health plans with different provider networks, there is always the risk of disruption and confusion.

Beyond the issue about the potential of individuals moving from one eligibility coverage category to another, there is also a concern about continuity of care at the provider level – clinics, individual clinicians, and hospitals. Making it easier for low income individuals to remain in their health plan – and existing provider network may reduce the disruption of on-going care, confusion, and unnecessary administrative complications. The role of Medi-Cal Managed Care plans can be important to address both provider-level continuity and affordability. Today approximately 4.5 million Medi-Cal beneficiaries in 30 counties receive their health care through managed care programs. This number will grow due to the transition of the Healthy Families program and the potential Medi-Cal eligibility expansion to low income childless adults, many of whom are now enrolling in the county-based Low Income Health Program (LIHP). By encouraging Medi-Cal Managed Care plans to participate in Covered California, continuity of care can be promoted by giving low income consumers the option of staying in their same health plan even though their eligibility may shift between Medi-Cal and the Covered California.

In responding to interest in other states in encouraging continuity of coverage and care, CMS recently commented on "Medicaid Bridge Plans" in its December 10, 2012 response to Frequently Asked Questions (FAQ). Specifically, the CMS response indicated that a state-based Exchange could certify a Medicaid Bridge Plan as a QHP. Such a plan "would allow individuals transitioning from Medicaid or CHIP coverage to the Exchange to stay with the same issuer and provider network, and for family members to be covered by a single issuer with the same provider network." This approach, CMS said, is intended to promote continuity of coverage between Medicaid or CHIP and the Exchange. The FAQ outlined several requirements for Bridge Plan proposals:

- *The state must ensure that the health insurance issuer complies with applicable laws, and in particular with section 2702 of the Public Health Service Act.*
- *The Exchange must ensure that a bridge plan offered by a Medicaid managed care organization meets the qualified health plan certification requirements, and that having the Medicaid managed care organization offer the bridge plan is in the interest of consumers.*
- *As part of considering whether to certify a bridge plan as a qualified health plan, the Exchange must ensure that bridge plan eligible individuals are not disadvantaged in terms of the buying power of their advance payments of premium tax credits.*
- *The Exchange must accurately identify bridge plan eligible consumers, and convey to the consumer his or her qualified health plan coverage options.*

- *The Exchange must provide information on bridge plan eligible individuals to the federal government, as it will for any other individuals who are eligible for qualified health plans on the Exchange, to support the administration of advance payments of premium tax credits.*

Medi-Cal Managed Care plans play an essential role in supporting the local health care safety net, which is often the provider of last resort for without health insurance. In "Two Plan" model counties, Local Initiatives are required to include in their provider networks all traditional and safety net providers that agree to the terms and conditions set for other similar providers in its network. Commercial Medi-Cal managed Care plans in these counties are encouraged – but not required – to include these safety net providers in their network.

Although the implementation of the Affordable Care Act will significantly reduce the number of uninsured individuals in California, the need for safety net care will remain. In a November 2012 analysis, the UC Berkeley Labor Center for Research and Education projected that over 3.1 million California would remain uninsured in 2019, even assuming the Exchange's enhanced enrollment model. Of these, only 27% would be exempt from tax penalties – and from the individual mandate – due to immigration status. These uninsured individuals will continue to rely on a robust safety net for their health care needs.

OPTIONS FOR CONSIDERATION

The options presented in this brief address the following issues:

- How can Covered California use its selective contracting authority to achieve a more affordable health plan choice with a very low or zero premium for low income consumers? If Medi-Cal Managed Plans are selected to provide this affordable choice, can this option improve continuity of care for consumers and reduce churn?

- Given the benefits for consumers and the interest of Covered California to include more Medi-Cal Managed Plans to achieve the goals of affordability, continuity of care, and safety net maintenance, are there procedural accommodations that could encourage their participation?

Option 1. Contracting to Achieve Greater Affordability

Under this option, Covered California would negotiate contracts with Local Initiatives, County Organized Health Systems (COHS) or other Medi-Cal Managed Care plans that have robust safety net provider networks to offer a plan option with a very low or zero premium for those earning between 133% and 200% of FPL. To achieve these premiums, the contracting process would need to assure that these health plans would be designated as the lowest Silver Level Benefit Tier. To maximize affordability, a modest differential – in the range of 5%-15% between the second lowest silver plan and the lowest plan would be necessary. Because federal subsidies are based on the second lowest silver plan, this differential would allow low income enrollees to benefit from the federal subsidies in a manner that assures low or zero premiums for these Californians. By relying on the community safety net provider networks offered by Local Initiative, COHS and other Medi-Cal Managed Care plans, this proposal also has the potential for reducing the "churn" between programs and maintaining continuity of care for lower income Covered California enrollees who experience income fluctuations that otherwise would shift their eligibility between Medi-Cal and Covered California.

An initial analysis by Milliman suggests that a differential of 5 to 15% could result in very low or zero cost premiums for low income consumers. At the same time, while these lower premiums could result in making coverage more affordable for low-income Californians, the payment to the Local Initiatives should be able to be at a level significantly higher than is generally paid for Medi-Cal. Tables 2 and 3 present the potential impact on members contributions, payment to plans and provider payments based on two lowest cost non-Medi-Cal Managed Care plan premiums (at second lowest premium at $400 and $500 per month respectively).

What follows are a number of implementation issues that would need to be considered in developing this option.

Participation mechanisms:

- Option 1.A – Medi-Cal Managed Care Plan – Best Price Option: Allow Local Initiative or COHS First Right of Refusal. After Covered California has selected and negotiated rates with its complement of qualified health plans in each region, the Local Initiative or COHS serving that area would have the right of first refusal to bid a qualified health plan below the lowest existing contract premium rate and be offered as the lowest-cost silver plan. The amount below the lowest plan would be enough to assure a very low to no-cost premium. If the Local Initiative did not exercise this option, then any Medi-Cal Managed Care plan would be permitted to make this bid.

- Option 1.B – Allow Any Medi-Cal Managed Care Plan Option to Contract. In this approach, any Medi-Cal Managed Care plan in a county would have the option of bidding. These bids would stipulate that Covered California could adjust the proposed rate – up to a capped maximum – to achieve a very low or zero premium level. In this mechanism, it could be possible for plans to have identical rates, and thus would potentially have more than one "lowest-cost" silver plan in a region.

Consumer Eligibility: Under this option, Covered California would need to consider limiting enrollment to lower income subsidy-eligible individuals (e.g., between 133%-200% or 133% to 250% of FPL). The reason for such a limitation is to mitigate concerns from other plans participating in the Exchange that they would lose potential enrollment. In the proposal for discussion, enrollment would be limited to individuals with income below 200% of FPL. Through 2019, CalSIM estimates are that approximately 930,000 Californians would be in this income category. Using the "Enhanced enrollment model," it would represent about 37% of Exchange subsidy eligible individuals likely to enroll. In the alternative, eligibility could be extended to individuals up to 250% FPL for the purpose of accommodating families with children who are enrolled in Medi-Cal Managed Care Plans. Through 2019, CalSIM estimates that an additional 600,000 Californians would be eligible in this category. Using the "Enhanced enrollment model," this would represent another 20% of Exchange subsidy eligible individuals who are likely to enroll.

Consumer Choice: Under this proposal, eligible enrollees would be encouraged to consider the lowest-cost option, but could select a different qualified health plan in Covered California.

Range of Benefit Offerings for Low Income Individuals (e.g., Platinum, Gold, Silver, Bronze, and Catastrophic): The main benefit to low income consumers is based on their enrolling in the "Silver" benefit design – which is the only design that the cost-sharing subsidy accrues. Federal law requires

each issuer offering a QHP to offer at least one silver and at least one gold plan; state law goes further and requires QHPs to offer plan choices in each of the four precious metal tiers as well as catastrophic. Requiring participating Medi-Cal Managed Care plans to offer all benefit offerings may add unnecessary administrative burdens and complexity to the solicitation process. One option would be to allow Medi-Cal plans serving this specific targeted population to offer only the Silver plan. State and federal legal requirements would need to be addressed to accommodate such a provision.

Implementing in 2014: Contracting and Other Challenges: In addition to assessing a range of state and federal legal issues, there are a number of health plan contracting issues that would need to be addressed as soon as possible, including:

- CalHEERS system design specifications;
- Modifications to the Qualified Health Plan solicitation timeline and standards for Local Initiatives, COHS's, or other Medi-Cal Managed Care plans; and
- Coordination with regulators for review of good standing and rating.
- Risk Management. Medi-Cal Managed Care plans may have concerns about rate adequacy and risk mix. Although risk adjustment, reinsurance and risk corridors may address these concerns to some extent, additional options could be considered. Examples could include a cap on number of enrollees, a phase-in of income eligibility levels, or regulatory checks on rate adequacy. Alternatively, commercial plans that are marketing in the 200%+FPL range may have concerns about the risk mix of the remaining subsidy and non-subsidy population to the extent enrollment is disproportionately higher cost individuals in this market.
- The proposal will require additional analysis to determine the extent to which federal approval is necessary and what state statutory changes may be required.

Advantages and Disadvantages

Advantages/Pros:

- May help maximize enrollment for low income Californians by offering an affordable plan option with very low or zero premium. Could promote continuity of care by reducing churn between Medi-Cal and Covered California plans, while helping to maintain local safety net.
- Leverages the existing Covered California procurement, contracting and quality mechanisms to promote efficient plan processes and oversight.
- For participating Medi-Cal plans: advantages may include increased enrollment at higher premium.

Disadvantages/Cons:

- Adds administrative complexity for Covered California, CalHEERS, and eligibility and enrollment processes.
- From the perspective of competing health plans, this model gives Medi-Cal Managed Care plans a competitive advantage in marketing for the 138% to 200% FPL subsidy eligible target population.
- For Medi-Cal plans considering their participation: it is unclear the extent to which the benefits of incremental enrollment and higher than Medi-Cal payments would outweigh the costs (e.g., new application, managing premium collection from individuals and the federal government). This balancing of risks and benefits is particularly important in the context of the increased effort Medi-Cal plans are facing with the movement of dual eligible to managed care and the potential of Medi-Cal expansion.

- In the context of "Two-Plan" counties, concerns may be raised as to whether Local Initiatives are being given a competitive advantage over the commercial Medi-Cal plan option. Non safety-net providers may also have objections about below commercial market reimbursement rates.

Table 2: Assuming Second Lowest Premium at $400				
		Member Contribution		
Lowest Premium	% Below Lowest Non-Medi-Cal	133% FPL	150% FPL	200% FPL
$380	5%	$16	$34	$94
$360	10%	0	$14	$74
$344	14%	0	0	$58

Source: Milliman. Illustrative example based on draft working analysis, 12/2/2012.
Based on "average" enrollee cost sharing; actual would vary by age.

Table 3. Assuming Second Lowest Premium at $500				
		Member Contribution		
Lowest Premium	% Below Lowest Non-Medi-Cal	133% FPL	150% FPL	200% FPL
$475	5%	$11	$29	$89
$450	10%	0	$4	$64
$430	14%	0	0	$44

Source: Milliman. Illustrative example based on draft working analysis, 12/2/2012.
Based on "average" enrollee cost sharing; actual would vary by age.

Option 2. Potential Streamlining Approaches for Covered California to Encourage Participation of Medi-Cal Managed Care Plans

Covered California has already adopted policies that will benefit low income consumers by encouraging Medi-Cal Managed Care plans to become QHP's. This has a twin benefit: better continuity of care for consumers whose eligibility shifts between Medi-Cal and Covered California; greater inclusion of community safety-net providers. In addition to the policies already adopted (e.g., allowing Medi-Cal plans to potentially join Covered California in 2015 and the schedule for accreditation), these goals could be promoted by streamlining the application process for Qualified Health Plan certification for Medi-Cal Managed Care plans.

Options for Streamlining Application for Certification as Qualified Health Plan for Local Initiatives, COHS, and potentially other Medi-Cal Managed Care Plans

Medi-Cal Managed Care plans are already engaged in intensive implementation efforts relating to an array of new policy initiatives that are bringing new populations into managed care. These populations include individuals with both Medi-Cal and Medicare eligibility - called "Dual Eligibles," Seniors and Persons with Disabilities, children now covered through the Healthy Families Program, and others.

As Medi-Cal Managed Care Plans consider participation in Covered California, they are likely to be mindful of taking on an additional set of implementation challenges, as well as the management and staff "bandwidth" to take more -- at least for a 2014 launch. These challenges could include:

- Developing and submitting a bid package that meets the QHP requirements);
- Establishing a provider network and negotiating rates to the extent the plan does not use existing Medi-Cal contracts and needs to negotiate different terms;
- Defining a rate structure that differs from the current state wrap-around payments for FQHC PPS rates or for carve outs of mental health or certain children services; and
- Creating an administrative structure to handle premium collection from the IRS and individuals, and, to the extent not already done by the plan, the management of deductibles, coinsurance and copayments

In recognition of the unique role that Medi-Cal Managed Care Plans offer and the potential benefits to Covered California consumers, the QHP solicitation process could be revised as follows:

- Allow Medi-Cal Managed Care plans to respond only to those elements of the solicitation that are applicable to a non-commercial health plan (e.g., waive their completing eValue8 elements in 2014).
- Deem Medi-Cal Managed Care plans to have satisfied the Essential Community Provider network requirements by virtue of the composition of their typical networks.
- Accept state Medi-Cal quality and performance requirements as satisfying Exchange quality requirements for year one (2014) certification as a Qualified Health Plan.

These elements would be in addition to implementing the already adopted policy that for plans that are not accredited by NCQA or URAC now, allow Medi-Cal Managed Care plans to initiate the accreditation process now with the intention of completing the process in 2016. In addition, Covered California could work with regulators to streamline regulatory approval that may be required.

In adopting such policies, Covered California would need to determine the extent to which it applied any streamlined processes only to Local Initiatives and County Organized Health Systems, or also to other Medi-Cal managed care plans. And, the extent that other Medi-Cal managed care plans should be treated differently if they currently also operate in the commercial market instead of operating only in Medi-Cal or Healthy Families.

Advantages and Disadvantages

Pros:

- Encourages participation of Medi-Cal Managed Care Plans in Covered California. As already noted, these plans will be needed if Covered California chooses to implement the contracting option for affordability outlined in this brief.
- Helps to support community safety net providers.

Cons:

- Preferential treatment to Medi-Cal Managed Care plans may give them a competitive advantage over commercial plans.
- May increases costs by requiring greater emphasis on contracts with safety net providers and increasing their bargaining power.

REFERENCE MATERIAL

Laurel Lucia, Ken Jacobs, Miranda Dietz, Dave Graham-Squire, Nadereh Pourat, and Dylan H. Roby. *After Millions of Californians Gain Health Coverage under the Affordable Care Act, who will Remain Uninsured?* UC Berkeley Center for Labor Research and Education UCLA Center for Health Policy Research. September 2012. Available online: http://laborcenter.berkeley.edu/healthcare/aca_uninsured12.pdf