Health Affairs
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#CAHealth
California: Leading The Way?

Alan Weil @alanrweil
Editor in Chief, Health Affairs @health_affairs
RAND Corporation, Santa Monica, CA
September 17, 2018
Thanks
Health Care in California

California has led the nation in coverage gains related to the Affordable Care Act, but it struggles to provide health services for its large population of undocumented immigrants and hold down prices for everyone. This datagraphic shows where residents get their health coverage, who’s uninsured and why, and which areas of the state have the most heavily concentrated hospital and physician markets. It then turns its eye to state and local efforts to improve health outcomes through the prevention of heart attacks and maternal deaths and limits on childhood vaccines exemptions.

Health Affairs

The Legacy of Consolidation: Rising Prices

The consolidation of hospitals and physician practices in California has made it difficult for the state to control rising health care costs. For instance, growth in the price per admission for hospitals in the two largest multi-hospital systems for surpassed that for all other hospitals over the past two decades. Similarly, a rising trend of hospitals purchasing physician practices was associated with higher M&A premiums and increases in specialty and primary care prices. Between 2010 and 2016, a growing number of counties had high “concentration scores,” or indices, that reflect various measures of hospital, physician, and insurance concentration.

Improvements in Health Indicators

Statewide and local initiatives have helped improve various health outcomes in California. In San Diego, a public-private partnership that disseminates evidence-based practices to improve hypertension lipids and blood sugar control was associated with lowering of hospitalizations due to heart attack. Vaccine exemptions for school children declined—reversing a decades-long increase—after the state began requiring that health care providers counsel parents seeking exemptions. Meanwhile, across California, maternal mortality rates began to fall after the state launched a series of data-driven quality improvement projects.
Welcome

Sandra Hernández, PhD,
President and CEO, California Health Care Foundation

Peter Long, PhD
President and CEO, Blue Shield of California Foundation
Panel 1:

Delivery System Innovation
Beneficiaries Respond to California’s Program to Integrate Medicare, Medicaid and Long-Term Services: Evaluation of Cal MediConnect

Carrie Graham, PhD, MGS
Pi-Ju (Marian) Liu, PhD
Brooke Hollister, PhD
Stephen Kaye, PhD
Charlene Harrington, RN, PhD

University of California, San Francisco & Berkeley

Funded by The SCAN Foundation with additional Funding from NIDILRR and ACL
The Coordinated Care Initiative: California’s Dual Financial Alignment Demonstration

- New capitated managed care product called “Cal Medi-Connect” in 7 demonstration counties.
- By January 2018, over 112,989 duals enrolled.
- About half of eligible duals “opted out” of the Medicare portion of the program.
- Cal MediConnect plan includes new benefits:
  - Managed Long Term Services and Supports
  - New care coordination benefit
  - Non-emergency transportation services
Post-enrollment Telephone Survey Assessed Satisfaction, Access, Utilization & Unmet Need At 2 Time Points

- Time 1 (2016) and Time 2 (2017)
- 744 CMC enrollees at T1 → 488 at T2
- 735 non-demo duals at T1 → 474 at T2
- Domains included:
  - Primary, specialty, behavioral, & acute care
  - Durable medical equipment & prescription Rx
  - Long term services and supports & care coordination
- Methods:
  - Ordinal Regression compared CMC and non-Demo groups at T2;
  - Wilcoxon Sign Rank tests assessed within group changes over time
Key Findings

- Comparisons of CMC and non-demo groups at T2
  - CMC enrollees were less likely to report out of pocket spending for Rx.
  - CMC enrollees more likely to get all the help they need for personal care assistance.
  - No difference in measures of care coordination.

- Post-enrollment trends between T1 and T2 for CMC
  - Increased ratings of quality of care and satisfaction between T1 and T2.
  - 60% had increased IHSS hours (Medi-Cal personal care)
  - Decreased self-reported hospitalizations (18%) and Emergency Department (26%) visits
  - No changes in use or unmet needs for Care Coordination for CMC enrollees
Policy Changes Informed By The Evaluation

- Revised CMC health risk assessment that now includes 10 mandatory question on LTSS need
- New CHIS module will include questions on LTSS needs of Californians
- A revised, clearer CMC Beneficiary Toolkit
- New Stakeholder workgroup to improve Care Coordination in CMC
- CMS revised rules on Care Coordination for D-SNP and Medicare Advantage plans (Chronic Care Act 2018)
- Unlimited non-emergency transportation from CMC plans
One in Five Fewer Heart Attacks: Impact, Savings and Sustainability in San Diego County Collaborative

Christine Thorne, MD, MPH
Be There San Diego Framework

Healthcare Team Activation
Activate Healthcare Teams to ensure every patient in our region is receiving the best treatment for the prevention of heart attacks and strokes.

Healthcare System Activation
Activate our regional healthcare system to work collaboratively to eliminate heart attacks and strokes.

Community Activation
Activate San Diegans at risk for heart attacks and strokes through partnerships with community based organizations.

Grounded in a commitment to Health Equity and Collaborative Approaches to Driving Down Heart Attacks and Strokes through Control of LDL, BP and HbA1c
Age-Adjusted AMI Hospitalization Rates by Year and Period for San Diego County and the Rest of California

Source: Authors’ analysis of data from the Office of Statewide Health Planning and Development and the State of California Department of Finance. Note: The pre-period (before the initiation of Be There San Diego) was 2007-10; the early post period (after the initiation) was 2011-2014 and the late post period was 2015-16. During the two post periods, hospitalization rates declined significantly more in San Diego County relative to the rest of California.
Calculated AMI Hospitalizations Avoided and Cost Savings during Post-BTSD Periods

- San Diego
  - Acute MI Hospitalizations Avoided: 3,826
  - Cost Savings: $85.8 Million (2011-2016)

- California
  - Potentially avoidable AMI’s if California had matched San Diego’s AMI rates: 41,706
  - Potentially avoidable costs associated with those AMI’s: $935 Million over 6 years
The Right Care Initiative’s launch of the San Diego University of Best Practices collaborative and associated research was funded by the National Heart, Lung, and Blood Institute, National Institutes of Health (1RC2HL101811). The work of Be There San Diego has been partially funded by the Department of Health and Human Services (HHS) through the Centers for Medicare and Medicaid Services (1C1CMS331345) and Centers for Disease Control and Prevention (U58DP005622). The contents are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.
Evaluation Of The Behavioral Health Integration And Complex Care Initiative In Medi-Cal

Todd Gilmer, Marc Avery, Elizabeth Siantz, Benjamin Henwood, Kimberly Center, Elise Pomerance, Jennifer Sayles

HealthAffairs
## Organizations participating in the Behavioral Health Integration and Complex Care Initiative (BHICCI)

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<th>Type</th>
<th>Date began participating</th>
<th>No. of clinics</th>
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<td>FQHC</td>
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<td>Multispecialty clinic</td>
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<td>Behavioral health clinic</td>
<td>September 2015</td>
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<td>Riverside University Health System Department of Behavioral Health</td>
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<td>July 2016</td>
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<tr>
<td>Social Action Corps Health System</td>
<td>FQHC</td>
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<td>Telecare Corporation</td>
<td>Behavioral health clinic</td>
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**Demographic characteristics of patients enrolled in the Behavioral Health Integration and Complex Care Initiative (BHICCI)**

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<td>Clinical outcomes</td>
<td>Cost outcomes</td>
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<td>Number</td>
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<td>5,212</td>
<td>3,065</td>
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<td>Mean age, years (SD)</td>
<td>48 (15)</td>
<td>48 (15)</td>
<td>47 (15)</td>
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<tr>
<td>Female</td>
<td>59%</td>
<td>60%</td>
<td>60%</td>
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<tr>
<td>Race/ethnicity</td>
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<tr>
<td>Non-Latino white</td>
<td>34%</td>
<td>33%</td>
<td>32%</td>
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<td>Non-Latino African American</td>
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<td>10</td>
<td>10</td>
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<tr>
<td>Latino</td>
<td>41%</td>
<td>42%</td>
<td>45%</td>
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<tr>
<td>Non-Latino other</td>
<td>14%</td>
<td>15%</td>
<td>13%</td>
<td></td>
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<tr>
<td>Disabled</td>
<td>24%</td>
<td>25%</td>
<td>25%</td>
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Rates of screening and changes in clinical outcomes among 5,212 patients enrolled in the Behavioral Health Integration and Complex Care Initiative (BHICCI)

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<tr>
<th></th>
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<th>Follow-up</th>
<th>Value at baseline</th>
<th>Value at follow-up</th>
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<tr>
<td>Number</td>
<td>3,786</td>
<td>2,281</td>
<td>1,890</td>
<td>16.8</td>
<td>11.8****</td>
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<tr>
<td>Percent or mean</td>
<td>73%</td>
<td>60%</td>
<td>83%</td>
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<td><strong>SYSTOLIC BLOOD PRESSURE</strong></td>
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<tr>
<td>Number</td>
<td>4,556</td>
<td>1,087</td>
<td>996</td>
<td>152.8</td>
<td>137.3****</td>
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<tr>
<td>Percent or mean</td>
<td>87%</td>
<td>24%</td>
<td>92%</td>
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<tr>
<td><strong>HEMOGLOBIN A1C</strong></td>
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<tr>
<td>Number</td>
<td>2,123</td>
<td>867</td>
<td>691</td>
<td>9.3</td>
<td>8.8****</td>
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<tr>
<td>Percent or mean</td>
<td>41%</td>
<td>41%</td>
<td>79%</td>
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<td><strong>BODY MASS INDEX</strong></td>
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<tr>
<td>Number</td>
<td>4,290</td>
<td>2,365</td>
<td>2,098</td>
<td>38.2</td>
<td>37.9****</td>
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<tr>
<td>Percent or mean</td>
<td>82%</td>
<td>55%</td>
<td>89%</td>
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</table>
Standardized difference-in-differences estimates of changes in per member per month costs among 3,065 BHICCI patients relative to a comparison group of 3,065 IEHP enrollees.
Key Steps for Improving Care “At Scale”

- Linking public health surveillance to actions
- Mobilizing a broad range of public and private partners
- Developing a rapid-cycle Maternal Data Center to support and sustain QI projects
- Implementing a series of data-driven large-scale quality improvement projects
Maternal Mortality Rate, California and United States; 1999-2013

California: ~500,000 annual births, 1/8 of all US births

CMQCC’s Key Stakeholders/ Partners

State Agencies
- CA Department of Public Health, MCAH
- Regional Perinatal Programs of California (RPPC)
- DHCS: Medi-Cal
- Office of Vital Records
- Office of Statewide Health Planning and Development (OSHPD)
- Covered California

Professional Groups (California sections of national organizations)
- American College of Obstetrics and Gynecology (ACOG)
- Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN)
- American College of Nurse Midwives (ACNM),
- American Academy of Family Physicians (AAFP)

Membership Associations
- Hospital Quality Institute (HQI)/California Hospital Association (CHA)
- Pacific Business Group on Health (PBGH)
- Integrated Healthcare Association (IHA)

Public and Consumer Groups
- Consumers’ Union
- March of Dimes (MOD)
- California HealthCare Foundation (CHCF)
- Cal Hospital Compare
- Amniotic Fluid Embolism Foundation

Key Medical and Nursing Leaders
- UC, Kaiser (N&S), Sutter, Sharp, Dignity Health, Scripps, Providence, Public hospitals

All these groups are represented on the CMQCC Executive Committee
CMQCC Maternal Data Center

Rapid-cycle data: metrics available within 45 days after every month

- PDD—Discharge Diagnosis File (ICD9/10 Codes)
  Monthly uploads: mother and infant PDD

- Birth Certificate (Clinical Data)
  Monthly uploads: electronic files for ALL California births

- Chart Review (select metrics/QI projects)
  Supplemental files or limited chart reviews

Automated Linkage of all 3 files

Interactive Analytics Guide QI Practice

Links over 1,000,000 mother/baby records each year!
Improving Health Care Response to Obstetric Hemorrhage Version 2.0

Audrey Lyndon, PhD, RNC, FAAN\textsuperscript{a}; David Lagrew, MD\textsuperscript{b}; Larry Shields, MD\textsuperscript{c}; Elliott Main, MD\textsuperscript{d,e}; Valerie Cape\textsuperscript{e}, Editors.

University of California, San Francisco\textsuperscript{a}; Memorial Care Health Systems\textsuperscript{b}; Dignity Health\textsuperscript{c}; California Pacific Medical Center\textsuperscript{d}; California Maternal Quality Care Collaborative\textsuperscript{e}

>10,000 Downloads to date

CMQCC.org
<table>
<thead>
<tr>
<th>Years</th>
<th>Projects</th>
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<tbody>
<tr>
<td>2006</td>
<td>California Pregnancy-Associated Mortality Review established</td>
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<tr>
<td>2008</td>
<td>CMQCC/CDPH OB Hemorrhage Task Force</td>
</tr>
<tr>
<td>2009-10</td>
<td>CMQCC Hemorrhage QI collaboratives I and II</td>
</tr>
<tr>
<td>2010-11</td>
<td>CMQCC/CDPH Preeclampsia Task Force and QI collaborative</td>
</tr>
<tr>
<td>2011</td>
<td>Release of CDPH maternal mortality report and education campaign</td>
</tr>
<tr>
<td>2011-14</td>
<td>HEN/CMQCC/CHA-HQI QI collaborative focused on hemorrhage and preeclampsia</td>
</tr>
<tr>
<td>2015-16</td>
<td>CMQCC/Merck for Mothers QI collaborative for hemorrhage and hypertension severe morbidity</td>
</tr>
<tr>
<td>2016-19</td>
<td>CMQCC QI collaboratives (3 cohorts) for supporting vaginal birth and reducing primary cesarean delivery</td>
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</table>
Maternal mortality rates per 100,000 live births in California, by race/ethnicity, 1999–2013

**SOURCE** Authors’ reproduction of data from the California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, March 2015; and the California Birth and Death Statistical Master Files. **NOTES** Maternal mortality and the maternal mortality rate calculation are defined in the text. The mortality disparity ratio is the mortality rate for non-Hispanic blacks divided by the rate for non-Hispanic whites.
We thank our funders:
California Dept. of Public Health (Title V sub-contract)
California Health Care Foundation
Centers for Disease Control (CDC)
Merck for Mothers Project
Yellow Chair Foundation
Health Affairs
Thanks
The California Competitive Model: How Has It Fared, And What’s Next?

Glenn A. Melnick
Katya Fonkych
Jack Zwanziger

HealthAffairs
California Model Was Successful - But Not Any Longer

- California health plans leveraged competitive market conditions in provider markets to stimulate price/quality competition
- Two powerful trends eroded conditions needed to sustain market competition
  - Adoption of “Prudent Layperson” regulations affecting hospital EDs
  - Multi-Hospital Systems expansion
- Policy makers can and should act to restore competitive conditions.
Prices Were Declining (Really) Then Turned Up and Accelerated

% Change, 1999-2016
Net Revenue per Day: 361%
CPI: 65%
Prices Were Declining (Really) Then Turned Up and Accelerated – What Happened?

Two Factors Reduced Hospital Price Competition
- “Prudent Layperson” ER Law
- Hospital Systems Expand/Negotiate Contracts as “All-or-None”
ER Use Had Been Declining – Then Increased Along with Admissions Thru the ED

Exhibit 1: Total Emergency Room Visits per 1,000 People and Introduction of Prudent Layperson Regulation, California

Exhibit 2: Percentage of Inpatients Admitted Via Emergency Rooms in California, selected years

- 2001: 45% % Total Admits - All, 53% % Total Admits - Less Live Births
- 2011: 57% % Total Admits - All, 66% % Total Admits - Less Live Births
- 2016: 58% % Total Admits - All, 68% % Total Admits - Less Live Births
Billed Charges Surged After Prudent Layperson Enacted

Billed Charges per Day

“Prudent Layperson”

Net Revenue

<table>
<thead>
<tr>
<th>Year</th>
<th>Billed Charges per Day</th>
<th>Net Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>$1,851</td>
<td>$0</td>
</tr>
<tr>
<td>1996</td>
<td>$1,805</td>
<td>$0</td>
</tr>
<tr>
<td>1997</td>
<td>$1,741</td>
<td>$0</td>
</tr>
<tr>
<td>1999</td>
<td>$1,713</td>
<td>$0</td>
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<tr>
<td>2002</td>
<td>$2,402</td>
<td>$4,400</td>
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<td>2008</td>
<td>$7,071</td>
<td>$12,453</td>
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<td>2012</td>
<td>$16,113</td>
<td>$19,649</td>
</tr>
<tr>
<td>2016</td>
<td>$19,649</td>
<td>$25,000</td>
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</table>
Prices for Hospitals in Largest Two Systems Were the Same and Then Increased Sharply

Price per Admission (adjusted for differences in hospital case-mix and cost of labor and outpatient volume)

- CA Hospitals in multihospital systems grew: from 39% to almost 60%
- Two largest Systems 50 hospitals (in 2016)
Conclusion

It’s The Prices, Stupid.....” Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan

HEALTH AFFAIRS VOL. 22, NO. 3
PUBLISHED: MAY/JUNE 2003
Where Will Needed Changes Come From

• Public Policy
  – Regulators
  – Legislators

• Private Sector
  – Courts

• And Will They Come Soon Enough
With Roots In California, Managed Competition Still Aims To Reform Health Care

Alain Enthoven
Laurence Baker

HealthAffairs
Reflecting On Managed Competition In California

• Growth of managed competition over time

• Some observations
  – The importance of organizations that integrate insurance and health care provision
  – The importance of scope and context
  – The importance of choice among multiple plans
  – The need for information about choices for consumers
Consolidation Trends In California’s Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices

Richard M. Scheffler
Daniel Arnold
Christopher Whaley

Health Affairs Issue Briefing
RAND Corporation, Santa Monica, CA
September 17, 2018
Key Trends In Horizontal Concentration And Vertical Integration In California, 2010-2016
For 40 Of 58 Counties With Population Under 0.5 Million
Geographical Variation in Concentration ‘Hotspots’ Across CA Counties, 2016

Source: Authors’ analysis of data sources provided in exhibit 1. Notes: Each county has a market concentration score based on six measures: the average Herfindahl-Hirschman Indices (HHIs) (explained in the text) for hospitals, insurers, primary care physicians, and specialists; and the percentages of primary care physicians and specialists (explained in the notes to exhibit 1) working in practices owned by hospitals. Higher index values indicate greater concentration. Counties are assigned one point for each HHI greater than 2,500 and for the percentage of primary care and specialist ownership greater than 32.33 percent and 32.35 percent, respectively (the medians for the period 2010–16). Higher scores indicate greater market concentration. The scores can also be interpreted as a thermal gradient, with the cool colors indicating counties that warrant lower concern and scrutiny by regulators and the hotter colors indicating counties that warrant increasingly more.

Draft: Do not cite, quote or distribute
Hospital concentration and vertical integration have a positive interactive effect on ACA premiums, 2017

- If hospital HHI doubles from 3,500 to 7,000 then the average monthly ACA premium for a forty-year-old person:
  - Blue line - is predicted to increase by 11% if percentage of physicians owned by hospitals is 30%
  - Red line - is predicted to increase by 22% if percentage of physicians owned by hospitals is 55%
Summary of Key Findings

- Horizontal consolidation has resulted in hospital HHIs > 7,000, specialist HHIs > 5,000, and insurer HHIs > 3,000 for the 40 of 58 counties in CA with population under 0.5 mn.
- Vertical integration has increased to 2.7x its value for specialists and 1.5x for primary care physicians from 2010 to 2016.
- The counties with the highest hotspot concentration score of 6 are Amador, Calaveras, Mendocino, Mono, Plumas, Siskiyou, and Tuolumne.
- The increase in vertical integration from 2013 to 2016 is associated with a 12% increase in ACA premiums, a 9% increase in specialist prices and a 5% increase in primary care prices.

*Draft: Do not cite, quote or distribute*
Medical Loss Ratios For California’s Dental Insurance Plans

Assessing Consumer Value And Policy Solutions

Katrina Connolly, PhD

HealthAffairs
Medical Loss Ratios And The ACA

• Medical Loss Ratio (MLR): a spending minimum on health services and quality improvement

• ACA requires MLRs for health plans as a financial measure and consumer protection tool:
  – 85% large-group plans; 80% small-group/individual
  – Rebates paid to consumers if thresholds not met

• The ACA did not set minimum MLRs for dental plans

• California law in 2014 required dental plans to report MLRs but stopped short of setting minimum thresholds

• Analyzed 2014-2015 dental plan MLRs in California against ACA, Senate Bill 1008, and NAIC thresholds
### Dental Insurance Product MLRs California 2014–15

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<th>Market</th>
<th>Number</th>
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<th>PPOs</th>
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<td>129</td>
<td>65</td>
<td>84</td>
<td>79</td>
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<td><strong>MEDICAL LOSS RATIO</strong></td>
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<td>Minimum</td>
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<td>4%</td>
<td>14%</td>
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<td>Standard deviation</td>
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### MET THRESHOLD OF:

#### NAIC
- **Number**: 41, 90, 22, 42, 67, 131
- **Percent**: 41%, 70%, 34%, 50%, 85%, 57%

#### California
- **Number**: 11, 54, 13, 15, 37, 65
- **Percent**: 11%, 42%, 20%, 18%, 47%, 29%

#### Affordable Care Act
- **Number**: 3, 17, 5, 8, 7, 20
- **Percent**: 3%, 13%, 8%, 10%, 9%, 9%

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SB1008
Results Highlights

- Few products achieved ACA MLR thresholds
- Most Californians served by products with MLRs that met NAIC and California SB1008 thresholds
- Product size and type matter
  - Generally, the more lives insured by a product, the higher the MLR
  - PPO products were more likely to reach MLR threshold than HMO products
- 3.8 million and 1.25 million Californians served by products not meeting SB1008 and NAIC thresholds, respectively
- Consumers in these products may not receive sufficient value for premiums paid
Policy Implications

• Dental products with large enrollments can achieve minimum MLRs; challenging for other plans to deliver value
• A legislatively mandated MLR could offer a remedy and ensure better value for dental products
• MLRs difficult to set given multiplicity of plans
• Legislators could consider differentiated MLRs and consequences for non-compliance
• Task NAIC to develop MLRs according to benefit classes and cost-sharing requirements
California’s Drug Transparency Law: Navigating The Boundaries Of State Authority on Drug Pricing

Katherine L. Gudiksen
Timothy T. Brown
Christopher M. Whaley
Jaime S. King
2018 Pharmaceutical Legislation

Key:  
- Blue: Enacted
- Light Blue: Considered
- Gray: No Legislative Session

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CA SB-17 Key Features

- Plans that Register with DMHC or CDI Must Disclose:
  - 25 Most Costly Drugs,
  - 25 Most Prescribed Drugs, and
  - 25 Drugs with the Greatest Increase in Annual Spending.
  - Large plans: Must designate the portion of premiums and premium increases due to pharmaceutical drugs.

- Manufacturers Must Provide:
  - 60-day notice of an increase in the Wholesale Acquisition Cost (WAC) that would make the cumulative increase over the current year and the prior two calendar years > 16%.
    - These increases are only disclosed to registered purchasers.
  - Quarterly reports for drugs including financial and non-financial factors used in the decision to increase the price.
  - Notice of new drugs priced above the level of a Medicare specialty drug
    - Report marketing and pricing plans within 30 days
Navigating the Federal Preemption Waters
Where Can States Go From Here?

- Continue to pass legislation designed to test the boundaries of state-based pharmaceutical price controls.

- Encourage the federal government to amend ERISA.

- Bolster successful pharmaceutical price transparency initiatives with consumer incentives.
  - Reference Pricing
  - Right to Shop Initiatives
California Nurse Practitioners Are Positioned To Fill The Primary Care Gap, But They Face Barriers To Practice

Ulrike Muench, RN PhD
Assistant Professor, School of Nursing
Philip R. Lee Institute for Health Policy Studies
Healthforce Center
University of California, San Francisco
Joint work with:

• Joanne Spetz, PhD, FAAN
  Professor, Philip R. Lee Institute for Health Policy Studies
  Associate Director for Research, Healthforce Center
  University of California, San Francisco
Primary care provider shortages in CA

- 2025 FTEs
  - Supply
  - Demand

- 2030 FTEs
  - Supply
  - Demand

- PAs
- NPs
- Physicians
- Total
Study aim

• To what degree are NPs concentrated in areas that have fewer physicians?
Study data

• Survey on NPs commissioned by the CA Board of Registered Nursing

• Employment patterns, degree to which NPs provided primary care, practice barriers they face

• Responses received by 1,271 NPs (56.5%)

• Other data:
  – Number of primary care physicians by county in 2015
  – Number of newly licensed NPs by county in 2016
Analysis

Counties in CA with higher-than-average density of primary care physicians, NPs, and both

- Descriptive statistics on demographics, employment, satisfaction
- Regressions with NP and PCP density as outcome
Selected key results

**Descriptive analysis:**

Low density NP and PCP areas:
- Larger share of underrepresented minority NPs, younger NPs, initial education associate degree

High density NP areas:
- Larger share having trouble finding a job, plan to move to another state

Low density NP areas:
- Larger share use skills to full scope of practice

**Regression analysis:**

- Significant association with minority NPs, newer graduates and entry level associate degrees in low density counties
Policy implications

• Target younger NPs and RNs who have come out of RN associate programs

• Distribution of NP education programs problematic
  – Distance learning opportunities
  – NP residencies and rotational clinical programs important for NPs who want to serve in underserved areas

• Expansion of NP scope of practice regulations
Thank you

- ulrike.muench@ucsf.edu
Background and Introduction

• Family planning reduces unintended pregnancies, improves birth outcomes, saves $, saves women’s lives

• California’s Family PACT program provides contraception to uninsured low-income residents
  – Unmet need remains

• ACA Medicaid Expansion, January 2014
  – Increased income cutoff to 138% federal poverty guideline (FPG)
  – Expanded eligibility to individuals without dependent children
Research Objective

• How has the ACA’s 2014 Medicaid expansion changed:
  – Health Insurance coverage
  – Having a usual source of care
  – Access to needed medical care or prescriptions without delay
  – Contraceptive counseling
  – Prescription contraception

Among low income (< 138% FPG) women aged 18-44
Study Data and Results

• **California Health Information Survey (CHIS)**
  – Before (2013) and after (2014 – 2016) the ACA
  – Women of reproductive age (ages 18 – 44)
  – Incomes <138% FPG (n = 4,567)

• **Increasing coverage is not increasing care**
  – No change in needed medical care or prescriptions without delay
  – No change in receipt of contraceptive counseling or prescriptions
Conclusion and Recommendations

• Continued investment in family planning is needed

• Monitoring and continuous quality improvement is key
  – Ensure access to highly effective reversible methods
    • Subdermal implants and IUDs

• Increase in number and training of clinician workforce, national quality measures, address reimbursement and other system issues

• Strive for walk in, same day free service for all cost-effective preventive measures
Mandatory Health Care Provider Counseling For Parents Led To A Decline In Vaccine Exemptions In California

Malia Jones, Alison Buttenheim, Daniel Salmon, and Saad Omer
September 17, 2018
RAND Corporation, Santa Monica CA
Vaccine Mandate Exemptions, California Kindergarten Enrollees

Private Schools

Public Schools

AB2109
School-Level Clustering (Isolation Index) in Exemptions, California Kindergarten Enrollees

Private Schools

Public Schools

AB2109
Change In School-level Clustering Of Exemptions By County Following AB2109
Conclusions

- Mandatory Health Care Provider Counseling For Parents Led To A Decline In Vaccine Exemptions In California but...
  - the decline was modest
  - private schools showed relatively weak response to the policy
  - AB2109 had little effect on school level clustering statewide
  - In some counties, including some with large populations, school-level clustering increased
Policy Implications

- Other states considering a similar policy solution to rising vaccine rates should be aware that this policy was modestly effective.
- It did not address clustering of exempted children within their schools.
- There is a need for State-level policy that explicitly addresses the clustering of students at risk for infectious disease outbreak.
The Impact Of Medicaid Expansion On People Living With HIV (PLWH) With Behavioral Health Needs

Emily Arnold, PhD, Shannon Fuller, Valerie Kirby, Wayne Steward, PhD
University of California San Francisco
The ACA Brought Changes For PLWH

- Nationally, Medicaid coverage increased among PLWH by 6% to 42% under ACA
- Medicaid includes insurance for co-morbidities and behavioral health care services
- The Ryan White Program continues to cover HIV-related care and services for 48% of PLWH, including 38% of those on Medicaid
- Multiple funding sources introduced fragmentation for PLWH seeking behavioral health care services
- We sought to describe physical and behavioral healthcare navigation for PLWH after ACA and Medicaid expansion
Successes And Challenges For PLWH

- Comprehensive coverage, including for behavioral health, was a welcome development for PLWH
- Complex landscape of behavioral health systems and payers based on acuity of symptoms
- Need for cultural competence, particularly in caring for sexual and ethnic minority populations
- Lack of integrated care settings led to patient attrition and loss to follow up
- Wrap around services, provided by Ryan White, continued to be necessary
Implications For PLWH With Behavioral Health Needs Under Medicaid

- Integrated care is associated with better health outcomes and is cost effective
- More robust, culturally competent, provider networks across the state are needed
- Wrap around services to address housing instability, food security, and transportation needs improve HIV-related health outcomes
- Maintaining access to comprehensive physical and behavioral health services through Medicaid is essential to achieving viral suppression and ending the epidemic
Thank you!

Funding was provided through the California HIV/AIDS Research Program (RP-15-SF-096 and RP-11-SF-02) for this research.
Access To Care Differences Between Mexican-heritage And Other Latinos In California After The Affordable Care Act

Arturo Bustamante
Background

• Latinos are 39% of California’s population

• Differences across Latino heritage groups

• Mexican heritage are 64% of Latinos

• Undocumented profile is changing
Research Objectives

• Examine changes in coverage and access

• Before (2007-13) and after (2014-16) ACA

• Mexican heritage vs other Latinos in California

• Investigate the role of documentation status
Main Findings

• Insurance coverage increased driven by public coverage

• Disparities between Mexican and other Latinos narrowed after ACA

• Legal status still plays a major role (~20%) in predicting disparities
Policy Implications

• Lessons from California’s experience

• Large numbers of Latinos are still uninsured

• Uncertainty about the future of the ACA

• Opportunities for state and local governments
Thanks
Panel 4:

Looking Ahead: California’s Healthy Future

Walter Zelman
Lucien Wulsin, Jr.
Andrew Bindman
Ninez Ponce
Paul Hsu

Health Affairs
Health Affairs
Thanks