The Voice of Accountable Physician Groups

December 14, 2015

Commissioner Dave Jones
California Department of Insurance
200 Capitol Mall, Suite 1700
Sacramento, CA 95814

Re: Aetna – Humana, Anthem – CIGNA and Centene – Health Net Mergers

Dear Mr. Jones,

CAPG has previously written to Director Shelley Rouillard concerning the request for inclusion of specific undertakings that are within the authority of the DMHC under th4e Knox Keene Act. We understand that the California Department of Insurance has differing review authority than the DMHC. While CDI does not have the same level of authority, there is historical precedent of collaboration between CDI and DMHC with respect to the Anthem-Blue Cross and United-Pacificare mergers in the mid-2000s. CAPG believes that the further consolidation of the health insurer and plan marketplace will present both pitfalls and unprecedented opportunities for Californian. Your unique position with respect to these pending transactions affords you a tremendous opportunity to shape the direction of the California health care system toward a higher-performing, more accountable and transparent consumer-centric model.

These mergers will amass greater market power in but a few health plans, a consequence which experience has taught us does not produce lower premiums, or higher quality of care delivery, or better access to care for patients. These transactions can, however, deliver on the stated promises of greater efficiency and affordability if their closure is conditioned on executing undertakings that establish clear commitments to advancing California's delivery system through set benchmarks to improve the

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infrastructure for 21st century health care delivery. These undertakings, if required, will help build the kind of infrastructure that is needed to improve the larger healthcare ecosystem and produce higher quality, lower cost, with greater access. Without such undertakings, the merged entities will likely continue to perform as they are structured and legally required; that is, to generate maximum profits for the benefit of their shareholders, a mission that is not well aligned with the interests of California's consumers and providers.

Require Compliance with Adopted Infrastructure Improvement Goals. CAPG has urged the DMHC to adopt the health care system infrastructure improvement goals set forth in the Berkeley Forum report, which states the primary vision for a 21st Century California healthcare system as undertaking requirements in the remaining mergers:

> *"…the Forum Vision calls for a rapid shift towards integrated systems that coordinate care for patients across conditions, providers, settings and time, along with risk-adjusted global budgets that encompass the vast majority of an individual's healthcare expenditures. Specifically, the Forum endorses two major goals for California to achieve by 2022: 1) Reducing the share of healthcare expenditures paid for via fee-for-service from the current 78% to 50%; and 2) Doubling, from 29% to 60%, the share of the state's population receiving care via fully- or highly-integrated care systems."*[1]

HHS Secretary Sylvia Burwell announced similar goals for the Medicare system in January, 2015.[2] California has endorsed these goals as part of its Cal Sim and Let's Get Healthy Task Force processes to establish a strategic plan for healthcare improvement and innovation in this state. At least three of the health plans involved in these pending mergers contributed to the Berkeley Forum Report – Anthem, Blue Shield and Health Net. Secretary Dooley participated in Berkeley Forum and has indicated she supports the goals it adopted. The following commitments are necessary:

- A commitment in accordance with Secretary Dooley's policy statement to increase value-based contracting in the California market, by annually increasing the transition from fee-for-service to value-based and risk-based contracting with providers under all lines of the plan's business, in all operational areas, where qualified providers exist.

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[1] A New Vision for California's Healthcare System. Berkeley Forum, February 2013. Web: http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/Berkeley-Healthcare-Forum-%E2%80%93-Executive-Summary.pdf.

[2] http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html.

- A commitment to increasing the health plan network population to integrated delivery system models, as outlined in the Forum report.
- Annual monitoring, through reports to the CDI, that document the plan's progress with providers toward this contracting benchmark. CAPG is informed that the Department of Public Health may already be monitoring this particular metric, but the Forum, the CHCF or the other organizations could be authorized to handle the monitoring in accordance with the Forum plan. The data sources and methodology are set forth in Appendix II to the Berkeley Forum Report.[3]
- Continued commitment by the plan to financially support California-based, value-based provider incentive programs, such as the IHA pay-for-performance system.
- Proof of the plan's efforts through demonstrated improvement by the plan's provider network on an annual basis with established performance and quality measures, such as MA 5-Star, IHA P4P, the DMHC TAR survey and other accepted standards.
- Failure to achieve substantial performance of these undertaking requirements should result in the issuance of corrective actions and/or cease and desist orders pursuant to the Department's enforcement authority under the Knox Keene Act.

Require Faster, Common Platforms for Claims and Encounter Data Processing. Health plan mergers should produce an improved health information exchange environment that ensures faster, more accurate claims and encounter reporting and processing. Such an infrastructure improvement is fundamental and necessary in order to create the efficiencies that translate to increased transparency for consumers such as automated, online deductible tracking. Too often, mergers produce greater complexity within the healthcare system. According to the Integrated Healthcare Association:

> *"While encounter data have always been important, recent changes in the policy and market landscape heighten the importance of complete and timely data. Increasingly, market competitiveness depends on better data for risk adjustment, performance measurement and incentive programs, consumer cost-sharing, and transparency initiatives."*[4]

The ability of consumers to track their progress against deductibles in a timely and accurate manner, online, without resorting to a shoebox of receipts is but one of the capabilities required of the emerging health care system. The deductible tracking function (a deductible accumulator) is linked to the creation of a common clearinghouse

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[3] http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/Appendix-II.-California%E2%80%99s-Delivery-System-Integration-and-Payment-System-Methodology.pdf.

[4] Integrated Healthcare Association Issue Brief: Encounter Data: Issues and Implications for California's Capitated, Delegated Market (Sept. 20, 2015)

of both claims and encounter data that would operate in near-real time to the provision of medical services to patients. Automated deductible tracking cannot be solved until encounter data reporting is also improved and automated.

- Each of the subsequent mergers should therefore produce funding to build and implement a standardized, all plan, all provider, encounter data clearing house, with a standardized portal for encounter data reporting across the industry, and a standard "deductible accumulator" so that enrollees can access information about their deductible limits as easily as checking their bank balance on a smart phone.
- It is far more efficient to build a common system or utility for use by all plans and providers in California than to require each plan to build and maintain their own individual legacy systems.
- The Department should expand the requirement first set forth in the Blue Shield-Care First undertakings to these three remaining mergers to fund a statewide, independent, third party utility that will accomplish these functions.
- Health Net and CAPG have previously collaborated on a concept for a faster system, based on a technological platform that is analogous to the financial services sector's development of current ATM technology. This concept encourages all types of providers, but especially non-contracted providers, to submit claims and encounter data in near real-time to the delivery of service. The benefit of such a system would be that faster data reporting will drive quicker claims resolution, producing better analytical capability concerning the performance, cost and quality of providers. By driving near real-time claims resolution, a workable, online patient deductible accumulator technology also becomes feasible, improving the transparency of the health care system for consumers and patients.

Create a Funding Pool and Structure for an Online Multiplan Provider Directory. The Department of Managed Health Care has already required Blue Shield to pursue the development of an online provider directory and AHIP is piloting an eventual, national solution to this issue. We have urged the DMHC to impose this requirement on all remaining merger entities to broaden the funding sources for the solution and to drive collaboration throughout the industry.

SB 137 requires an immediate effort by the industry to comply with the July 1, 2016 deadline for health plans to go live with online provider directories. California providers will be hard-pressed to respond to each plan via their individual portals under this new statute, and they will be subject to significant payment withholds should they fail to comply. These inclusion of these financial penalties on providers were lobbied for by health plans involved in these mergers, and therefore, it is fair and appropriate for the Department to facilitate a solution for California providers in these undertakings.

- **CAPG Provider Directory reporting portal pilot** CAPG has initiated a pilot that we expect to start-up in early December that will introduce a single online reporting portal for providers to enter and update their status information in compliance with SB 137 and Medicare Advantage standards. This portal would enable provider groups, individual physicians and facilities to input their data once and make it available to each provider's multiple contracted payers. Payers could then incorporate the data into their own online directory solutions, and eventually to an AHIP-sponsored uniform solution. We will test the pilot in December, and expect to have a sustainable model in place well prior to the July 1, 2016 implementation date for SB 137. We would be happy to brief the Department further on our pilot and we suggest that you consider allocating funding for this portal in one or more of the remaining mergers. As our pilot progresses, we ask the Department to consider the incorporation of our solution into the Multiplan provider directory requirement, and to require funding and collaboration from the merger plans.

Concluding thoughts. Many important initiatives have lagged for years due to the lack of identified funding sources. These mergers provide a unique opportunity to ensure progress toward the Berkeley Forum, CalSim and Let's Get Healthy Task Force goals, as well as many other desirable legislative concepts. Spreading the costs over four near-simultaneous merger transactions would lessen the financial impact to any single health plan and would create a funding pool that is substantial. The creation of this new infrastructure would benefit consumers, who would enjoy much greater ease of use in the California health care marketplace. In summary, we believe that the inclusion of the following goals and projects are worthwhile components of the undertakings:

- Demonstrable commitment to increased value-based payment to providers
- Demonstrable commitment to increased use and facilitation of integrated, coordinated care delivery systems in provider networks
- Funding and creation of a faster, common claims and encounter clearinghouse
- Funding an integrated, automated deductible accumulator technology
- Funding for online provider directory reporting technology

Thank you for the opportunity to provide our suggestions.

Sincerely,

Donald H. Crane
President and CEO

CAPG

Attch. Letter of September 9, 2015 to DMHC Director Shelley Rouillard

The Voice of Accountable Physician Groups

September 9, 2015

Shelley Rouillard
Director, Department of Managed Healthcare
980 Ninth Street, Suite 900
Sacramento, CA 95814-2725

Re: Anthem – CIGNA, Aetna – Humana, Blue Shield – Care First, and Centene – Health Net Mergers

Dear Shelley,

Thank you for inviting CAPG to offer suggestions to the potential undertakings that may apply to the pending mergers of Anthem-CIGNA, Aetna-Humana, Blue Shield-Care First and Centene-Health Net.

The scale of consolidation is unprecedented and carries real risks to consumers of decreased choice and higher premiums and to providers of decreased compensation for the care they deliver. In each of these mergers, health plans will argue that greater synergies will be created as result of the combination of these large plans, including increased geographic coverage for managed care across California, simplification of payer systems and contracting, increased provider networks resulting from the combination, etc. These synergies will only occur if the Department requires undertakings that will ensure a better infrastructure for enrollment and continuity of care delivery for California's covered population. The Department has previously used undertakings in the past Anthem and United Health Care mergers of the mid-2000s that incorporated health system infrastructure commitments.

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The promise of the Affordable Care Act was that more people would have access to affordable health coverage. While in the main that promise has been delivered in California, the available, affordable options have incorporated high deductibles and narrow provider networks. These narrow networks generally incorporate steep financial consequences for stepping out of the prescribed path of access to care. In most instances, the consequence is significantly higher coinsurance or copays. However, in some Covered California offerings, there is no coverage for out of network care.

It is frequently stated as an axiom that health consumers must become better shoppers for health care services. But how can a patient or their family gain the critical information to know that Doctor A is a provider on their particular health plan coverage? Physicians may agree to a contract for one line of service but not for another. Frequent terminations are increasingly the norm. Convoluted coverage language places the risk on the member for a misstep.

CAPG is proposing two initiatives that enjoy wide support in the health industry and policy arena that will empower enrollees to determine which plans and providers deliver the best care at the price that they can afford. Restating from the goals of the Let's Get Healthy Task Force and the CalSim proposal, we urge you to consider the following priorities:

All Payer Claims Database. As we have seen in Colorado under the Center for Improving Value in Health Care (CIVHC) database, consumers can access a wide variety of cost, utilization and quality reports that are currently available on the website by county and zip code. The website is constantly improved as broader payer data and greater consumer utility functions are added. This empowers enrollees to determine which plans and providers deliver the best care at the price that they can afford. California is not that far away from implementing such a system. We already have comprehensive quality information on public websites, we have the ability to collect fee for service claims data. California needs a centralized, all plan, all provider, encounter data clearing house, and we will soon have the DHCS PACES encounter data reporting system that will span 26 health plans. PACES will provide a standardized portal for encounter data reporting across the industry. We will also need a standard "deductible accumulator" so that enrollees can access information about their deductible limits as easily as checking their bank balance on a smart phone (similar to the 2014 bill, SB 1176). The Department could require as undertakings in these four pending mergers the creation of a fund to build a statewide, independent, third party utility similar to that proposed under Senator Hernandez' SB 26.

- **Multiplan Provider Directory**: Fund a single, multi-plan provider directory project under an independent third party entity, or under the auspices of the Department of Managed Health Care, that provides an online portal for near-real time updating of provider status. A provider could log on and update his or her

status and information and the data would be accessible to each of that provider's contracted health plans. The portal could be accessed by the Department for filing compliance and review and the public for network transparency. This will empower enrollees by increasing their ease of access to providers and it will allow them to compare one plan's network against another so that they can make more informed decisions about their health care.

Spreading the costs over four near-simultaneous merger transactions would lessen the financial impact to any single health plan. Consumers would enjoy much greater ease of use in the California health care marketplace. In addition to the specific items above, we suggest that the undertakings include provisions requiring the commitments to be tracked, measured, and enforced.

Thank you for the opportunity to provide our suggestions. Should there be an opportunity for CAPG to participate in the drafting or review of the undertaking, we would ask to be included in that process.

Sincerely,

Donald H. Crane
President and CEO
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