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Peter Lee Blasts CMS Proposals For Exchange Health Plans

Covered California Chief Says One "Boggles The Mind"

By Ron Shinkman

Covered California Executive Director **Peter V. Lee** has been fairly taciturn since **Donald Trump** was inaugurated president three years ago, and after failing to repeal the Affordable Care Act, began revising rules and regulations to chip away at the effectiveness of the landmark healthcare law. Lee ended his tongue-biting this week.

On Monday, Covered California issued a lengthy statement that mostly criticized the benefit and payment parameters proposed the prior week by the **Centers for Medicare & Medicaid Services** that would be enacted in 2021. The fairly arcane set of rules govern how health insurance is offered on healthcare.gov and the state-operated exchanges.

CMS Director **Seema Verma**, whose agency's press releases are a propagandistic and often bombastic mixture of contempt for the ACA and praise for Trump, didn't hold back any hyperbole for its proposals.

"From day one, President Trump has been committed to providing more affordable health coverage choices to Americans who can't afford Obamacare's sky-high premiums," Verma said. "His bold measures to promote competition on the individual market have delivered consumers a previously unheard of two consecutive years of lower premiums and increased choice for health plans. That said, premiums remain too high for those without subsidies, and we are dedicated to bringing them down."

Lee saw it differently, personally blasting the proposals as intended to confuse consumers and hurt those with low incomes.

"The administration continues to move away from requiring true patient-centered benefit designs such as those embraced by Covered California and other states," Lee said. "Benefit designs should be about encouraging people to get the right care at the right time and enabling consumers to make apple-to-apple comparisons when they shop. The evidence is clear that the only winners in having a multiplicity of confusing benefit designs are insurance companies and not America's consumers."

Lee was particularly upset at a proposal CMS has put forth that would require enrollees who pay no premium at all due to advanced tax credits to visit the exchange each year during open enrollment and have their eligibility for such a subsidy redetermined. If they do not, they risk losing both their subsidy and their coverage.

"Automatically renewing consumers in an insurance plan – whether it is health, home or auto – is a nationwide industry standard that puts consumers first and protects them from mistakenly becoming uninsured," he said. "The fact that we are discussing placing an additional burden on low-income consumers, where they could lose their financial help entirely if they do not actively reapply, boggles the mind."

Somewhat ironically, zero-dollar health plans were created by the Trump administration's withholding of risk corridor and other supplemental payments to insurers as part of its plan to destabilize the market.

A Covered California spokesperson said the exchange plans to release data on enrollees who pay no premium next week. About 90% of Covered California's nearly 1.4 million enrollees receive some form of premium subsidy.

Lee also criticized CMS for not using the fee it charges health plans, currently 3% of premiums to participate on the federally-operated exchanges (2.5% for state-operated exchanges), for marketing and outreach efforts. CMS collected an estimated $1.2 billion in fees in 2018. CMS lowered the fee by a half-percentage point last year.

(continued on next page)

In Brief

DMHC Levies Fines In Encompass Medical Incident

The **Department of Managed Health Care** has fined five health plans a total of $55,000 for their roles in delegating lives to troubled San Diego provider **Encompass Medical Group.**

The DMHC issued a disciplinary order involving Encompass in August 2018. The regulator alleged Encompass had submitted false documentation in May of that year attesting to its financial solvency. In fact, Encompass had been out of compliance with state solvency regulations since the end of 2017, including having negative tangible net equity and working capital. It also discovered that Encompass' senior management had altered claims files to appear to be compliant with claims payments as far back as 2015. Moreover, some claims were routed to electronic mail boxes where only two employees had access, and hard copy claims were slow to be entered into its computer system leading to a backlog of late and unpaid claims. Encompass also failed to pay interest and penalties on late claims.

As a result, it ordered **Anthem Blue Cross of California** and **UnitedHealth of California** to immediately terminate their relationship with Encompass. The two health plans had delegated just under 1,700 of their enrollees to Encompass.

Moreover, the DMHC fined UnitedHealth $20,000 and Anthem $10,000 for being indirectly involved in the late payment of claims and payments without mandated interest and penalties. Presumably, the differential in fines were due to the number of lives each delegated to Encompass. UnitedHealth had delegated about 1,200 lives, compared to less than 500 for Anthem Blue Cross.

Additionally, **Health Net** was fined $15,000, while **Blue Shield of California** and **Cigna Healthcare of California** were fined $5,000 apiece. All of the health plans agreed to enter into plans of correction.

Peter Lee Blasts CMS Proposals For Exchange Health Plans *...continued*

It said it was considering doing so again, claiming it leads to lower premiums, although the agency has not furnished any evidence showing a direct link between the two.

And despite this fee largesse, the federal budget for marketing and outreach was cut to $20 million last year by the Trump administration, compared to $163 million in 2017 – a reduction of nearly 88%. By contrast, Covered California spends more than $100 million a year on marketing and outreach efforts.

"The question is not whether the federally-facilitated marketplaces should maintain or reduce their user fees, but rather what any exchange should be doing with the money it collects to create meaningful downward pressure on premiums," Lee said. "The federal policy to not use funds collected from consumer premiums to promote enrollment and lower costs by improving the risk mix is costing consumers and the federal government billions of dollars by raising premiums."

Lee did say CMS was moving in the right direction by proposing some changes to the risk adjustment methodology, wherein funds from plans with a lower risk pool of enrollees in the individual and small-group insurance markets out of the exchanges are transferred to plans with higher-risk pools that operate both in and out of the exchanges. The proposed change would be to focus on more recent enrollee treatment data in order to better calculate risks, and incorporate ICD-10 codes into CMS' assessment process. However, Lee suggested the agency was making a half-hearted effort at best.

"The proposed changes to the risk adjustment methodology recognize some of the concerns that insurers have, but they do not go far enough to improve the risk adjustment process and reduce the uncertainty of results," he said.

Covered California said its formal comments on the CMS proposals would be submitted to the agency next month.

Cigna, Dignity Contract Feud Leaves Patients In Limbo

Some Have to Apply to Receive Care at Dignity Hospitals

By Brian Krans

Zoe Friedland is expecting her first child — a girl — on Feb. 15, and she was picky about choosing a doctor to guide her through delivery.

"With so many unpredictable things that can happen with a pregnancy, I wanted someone I could trust," Friedland said. That person also had to be in the health insurance network of Cigna, the insurer that covers Friedland through her husband's employer.

Friedland found an OB-GYN she liked, who told her that she delivered only at **Sequoia Hospital** in Redwood City, part of San Francisco-based Dignity Health. Friedland and her husband, **Bert Kaufman**, live in Menlo Park, about five miles from the hospital, so that was not a problem for them — until Dec. 12.

That's the day Friedland and Kaufman received a letter from **Cigna** informing them their care at Sequoia might not be covered after Jan. 1. The insurance company had not signed a contract for 2020 with the hospital operator, which meant Sequoia and many other Dignity medical facilities around the state would no longer be in Cigna's network in the new year.

Suddenly, it looked as if having their first baby at Sequoia could cost Friedland and Kaufman tens of thousands of dollars.

"I was honestly shocked that this could even happen because it hadn't entered my mind as a possibility," Friedland said.

She and her husband are among an estimated 16,600 people caught in a financial dispute between two gigantic healthcare companies. Cigna is one of the largest health insurance companies in the nation, and Dignity Health has 31 hospitals in California, as well as seven in Arizona and three in Nevada. The contract fight affects Dignity's California and Nevada hospitals, but not the ones in Arizona.

"The problem is price," Cigna said in a statement just before the old contract expired on Dec. 31. "Dignity thinks that Cigna customers should pay substantially more than what is normal in the region, and we think that's just wrong."

Tammy Wilcox, a senior vice president at Dignity, said, "At a time when many non-profit community hospitals are struggling, Cigna is making billions of dollars in profits each year. Yet Cigna is demanding that it pay local hospitals even less." *(continued on next page)*

In Brief

Kaiser Backs Elimination Of Flavored Tobacco Products

Oakland-based **Kaiser Permanente** said this week it is in support of a bill in the Senate intended to eliminate the sales of all flavored tobacco and vaping products. If enacted, the bill, SB 793, would be among the most stringent laws in the nation governing tobacco sales. It would ban sales of menthol cigarettes and flavored chewing tobacco – both of which have been on the market for decades. Many flavored vaping products would also be banned.

In a statement, Kaiser cited grim statistics related to flavored tobacco products. They included data from the **U.S. Food and Drug Administration** reporting that 70% of youth e-cigarette users said flavors were the primary reason they used the products; and data from the **Centers for Disease Control and Prevention** concluding one in four high school students are current e-cigarette users, a rate that has more than doubled in the past two years. The rise in e-cigarette use among middle school students has also tripled since 2017.

"Flavors are proven starter products for youth and have no place on the market whatsoever," said **Behcara Choucair**, M.D., Kaiser's chief community health officer. "Kid-friendly flavors mask the poison, entice kids to experiment with tobacco products, and potentially addict them for life." Kaiser also cited in a statement that since last fall there have been 199 cases of lung illnesses in California related to vaping and four deaths.

Cigna, Dignity Contract Feud Leaves Patients In Limbo *...continued*

In 2018, the most recent full year for which earnings data is available, Cigna generated operating income of $3.6 billion on revenue of approximately $48 billion. Dignity Health reported operating income of $529 million on revenue of $14.2 billion in its 2018 fiscal year.

It's possible Cigna and Dignity can still reach an agreement. Both sides said they will keep trying, though no talks are scheduled.

Disagreements between insurers and health systems that leave patients stranded are a perennial problem in U.S. healthcare. **Glenn Melnick**, a professor of health economics at the **University of Southern California**, said such disputes, which are disruptive to consumers, are often settled.

Melnick believes Dignity is using an "all or nothing" strategy in contract negotiations, meaning either all its facilities are in the insurer's network or none are.

"This allows them to increase their market power to get higher prices, which is not necessarily good for consumers," Melnick said.

Dignity replied in an emailed statement: "We do not require payers to contract with all or none of Dignity Health's providers. We do try to make sure patients have access to the full range of Dignity Health services and facilities in each of our communities."

Dignity faces a number of legal and financial challenges while it works to implement a February 2019 merger with Englewood, Colorado-based **Catholic Health Initiatives** that created one of the nation's largest Catholic hospital systems — known as **CommonSpirit Health**.

California Attorney General **Xavier Becerra** approved the deal with conditions, including that Dignity's California hospitals spend $10 million in the first three years on services for people experiencing homelessness and offer free care to a larger number of low-income patients.

The requirement to treat more poor patients for free followed a period, from 2011-2016, in which Dignity's charity care had declined about 35% while its net income was $3.2 billion.

Last October, CommonSpirit announced an operating loss of $582 million on revenue of nearly $29 billion for the 2019 fiscal year, its first annual financial statement after the merger took effect. Much of the loss was due to merger-related costs and special charges.

The same month, Dignity completed a five-year "corporate integrity agreement" with the **U.S. Office of the Inspector General** following an investigation into how it billed the government for hospital inpatient stays. Dignity said it "fully complied" with the agreement.

Dignity is also defending itself in a class-action lawsuit alleging that it bills uninsured patients at grossly inflated rates even though it claims to provide "affordable" care at "the lowest possible cost."

More recently, an appeals court judge ruled Dignity could not charge higher prices — often a lot higher than state-set rates — for treating enrollees of L.A. Care's Medi-Cal health plan at its **Northridge Hospital Medical Center**.

Dignity disagreed with the court's ruling in that case, saying that although the Northridge facility did not have a contract with **L.A. Care**, many of the health plan's enrollees who initially sought emergency treatment there stayed in the hospital for additional care after they had been stabilized. The hospital "seeks appropriate reimbursement for providing this care," Dignity said.

If Dignity does not reach an agreement with Cigna, its hospitals, outpatient surgery centers and medical groups in most of California will soon be out-of-network for many Cigna enrollees. In-network coverage for Open Access (OAP) and Preferred Provider (PPO) ended on Feb. 1, and for HMO patients it is set to end April 1.

Certain Cigna enrollees can apply to continue visiting Dignity facilities and doctors under California's Continuity of Care law, enacted in 2014. Eligible enrollees include patients with chronic conditions, those already scheduled for pre-authorized services, people in need of emergency care and pregnant women in their third trimester.

Friedland and Kaufman applied, hoping she would be able to continue seeing her Dignity-affiliated OB-GYN at in-network rates.

On Jan. 22, less than a month from Friedland's due date, they received written confirmation that their request had been approved. They wouldn't have to shop for a new doctor or face stiff medical bills after all.

Still, being in limbo for over a month toward the end of a pregnancy, while frantically preparing to be first-time parents, was extremely stressful, they said.

"Zoe's now spent a ninth of her pregnancy with this question over her head of whether she'd be able to deliver with the doctor that she's built a relationship with," Kaufman said. "I think it's important for people in this industry to not forget that there are humans and patients behind their profit."

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The San Joaquin Valley Is Suffering A Unique Healthcare Crisis

Poverty, Pollution And Hunger Disproportionately Impact Its Children

Call it what you want, white privilege and health disparity appear to be two sides of the same coin. We used to consider ethnic or genetic variants as risk factors, prognostic to health conditions. However, the social determinants of health (SDOH) have increasingly become more relevant as causes of disease prevalence and complexity in health care.

As a pediatric hospitalist in the San Joaquin Valley region, I encounter these social determinants daily. They were particularly evident as I treated a 12-year old Hispanic boy who was admitted with a ruptured appendix and developed a complicated abscess, requiring an extensive hospitalization due to his complication. Why? Did he have the genetic propensity for this adverse outcome? Was it because he was non-compliant with his antibiotic regimen? No.

Rather, circumstances due to his social context presented major hurdles to his care. He had trouble getting to a hospital or clinic. He did not want to burden his parents—migrant workers with erratic long hours—further delaying his evaluation. And his Spanish-speaking mother never wondered why, despite surgery and drainage, he was not healing per the usual expectation.

By Alya Ahmad, M.D.

When he was first hospitalized, his mother bounced around in silent desperation from their rural clinic to the emergency room more than 20 miles from their home and back to the clinic, only to be referred again to that same emergency room. By the time he was admitted two days later, he was profoundly ill. The surgeon had to be called in the middle of the night for an emergency open surgical appendectomy and drainage. Even after post-operative care, while he was on broad-spectrum intravenous antibiotics, his fevers, chills and pain persisted. To avoid worrying his mother, he continued to deny his symptoms. Five days after his operation, he required another procedure for complex abscess drainage.

In a 2007 study published in *The New England Journal of Medicine*, "We Can Do Better—Improving the Health of the American People," Steven Schroeder describes the proportional contributors to premature death. Behavioral patterns and social circumstances dominate, causing deaths more than half of the time.

More recently, there appears to be a paradigm shift in how access to care and healthcare systems are viewed. As Schroeder demonstrated, health care delivery plays a relatively minor role in its impact on premature death. What governs the individual behavior of patients are the SDOH, which are a product of:

1. Barriers to appropriate healthcare
2. Economic instability
3. Unsafe environment
4. Poor health literacy and education
5. Limited social and community support
6. Food scarcity
7. Social discrimination and language barriers

These are just a few of the factors that contribute to challenges in patient care and health inequities. Interestingly enough, genetics actually plays a relatively minimal risk factor for disease conditions and diagnosis. We cannot just say that black people have a greater risk of heart disease, diabetes, hypertension, etc. We need to ascertain the social context of our diverse populations in order to address the incidences of chronic disease and its effects. The issue cannot simply be blamed on the genetics of the immigrant, the refugee, the homeless, or impoverished populations that lead to greater morbidity and mortality.

In a recent 2017 report by the Center for Regional Change and Pan Valley Institute, California San Joaquin Valley, children in the area are "living under stress." They are not only born under duress but face lifelong barriers to better physical and mental health. The occurrence of child poverty levels in counties of the San Joaquin Valley (SJV) are profound, ranging between 28% and 38% of the population by county. Furthermore, poverty rates are highest among children of color. The ethnic gap in poverty is 10-35%.

The same fertile communities of SJV, producing the food source of the nation, ironically have the largest limitations of access to food. Food scarcity, where food and especially healthy food is either limited or uncertain, remains above 26 to 29% when compared to a food shortage for the whole of California, which is at 23%.

(continued on page 5)

Alameda Alliance for Health Enrollment and Utilization Table as of 9/30/2019

QUARTERLY STATEMENT AS OF 09/30/19 - ALAMEDA ALLIANCE FOR HEALTH
ENROLLMENT AND UTILIZATION TABLE

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Source of Enroll	Total Enrollees At End of Previous Period	Additions During Period	Terminations During Period	Total Enrollees at End of Period	Grandfathered Enrollees (also included in Column 5)	Cumulative Enrollee Months for Period	Total Member Ambulatory Encounters for Period - Physicians	Total Member Ambulatory Encounters for Period - Non-Physicians	Total Member Ambulatory Encounters for Period	Total Patient Days Incurred	Annualized Hospital Days/1000	Average Length of Stay
1.	Large Group Co	0	0	0	0	0	0	0	0	0	0	0	0
2.	Medicare Risk	0	0	0	0	0	0	0	0	0	0	0	0
3.	Medicare Supple	0	0	0	0	0	0	0	0	0	0	0	0
4.	Medi-Cal Risk	253,439	14,500	18,690	249,249	0	752,794	290,419	146,165	436,584	14,629	233	4
5.	Individual	0	0	0	0	0	0	0	0	0	0	0	0
6.	Point of Service	0	0	0	0	0	0	0	0	0	0	0	0
7.	Point of Service	0	0	0	0	0	0	0	0	0	0	0	0
8.	Point of Service	0	0	0	0	0	0	0	0	0	0	0	0
9.	Small Group Co	0	0	0	0	0	0	0	0	0	0	0	0
10.	Healthy Families	0	0	0	0	0	0	0	0	0	0	0	0
11.	AIM	0	0	0	0	0	0	0	0	0	0	0	0
12.	Medicare Cost	0	0	0	0	0	0	0	0	0	0	0	0
13.	ASO	0	0	0	0	0	N/A	N/A	N/A	0	N/A	N/A	N/A
14.	PPO Individual	0	0	0	0	0	0	0	0	0	0	0	0
15.	PPO Small Group	0	0	0	0	0	0	0	0	0	0	0	0
16.	PPO Large Grou	0	0	0	0	0	0	0	0	0	0	0	0
17.	Aggregate Contracted from Other Plans	0	0	0	0	0	0	0	0	0	0	N/A	N/A
18.	Aggregate Other Source of Enrollment	5,967	498	441	6,024	0	18,026	9,086	3,515	12,601	335	N/A	N/A
19.	Total Membersh	259,406	14,998	19,131	255,273	0	770,820	299,505	149,680	449,185	14,964	N/A	N/A

Source: Quarterly Statement 9/30/2019 Alameda Alliance for Health, Enrollment and Utilization Table

The San Joaquin Valley Is Suffering A Unique Healthcare Crisis *...continued from page 4*

The overall pollution burden, which represents the potential exposures to pollutants and adverse environmental conditions caused by pollutants, is greater than 8 to 10% in the Valley. Not surprisingly, asthma and lung diseases in SJV districts are highest in central California.

Health vulnerabilities in the valley are extreme and burden the limited healthcare systems servicing its communities. Support to implement and maintain medical education and training programs with retention of providers in SJV is necessary. Specific funding allotments for improving mental health, air quality, homelessness among many other SDoH's in the region is vital.

Dr. Nadine Burke-Harris, California's first female Surgeon General, who recently visited the Valley, announced an ACEs Aware campaign. The ACEs Aware initiative is a first-in-the-nation statewide effort to screen for childhood trauma and treats the impact of toxic stress. The bold goal of this state-wide initiative is to reduce Adverse Childhood Experiences and toxic stress by half in a single generation and to launch a national movement to ensure everyone is ACEs Aware.

Starting early, as pediatricians, we can identify kids exposed to ACEs through routine screenings and establish prevention programs in health care, schools and youth-serving organizations. In their critical and early developmental stages, resource allocation of health services can be provided. It is also imperative to know and stay engaged with our region's leaders, telling our stories in health care, enlist our community partners, schools, regulatory agencies, and empower our patients and families to advocate for social and health equity.

Alya Ahmad, M.D. is a pediatric hospitalist who has worked in both private and academic healthcare centers. A version of this article originally appeared at The Health Care Blog.