California Health Benefit Exchange

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Calif. Receives $196M Grant From HHS To Establish Exchange
California Healthline
August 24, 2012
http://tinyurl.com/8wwkzfc

On Thursday, HHS announced that it has distributed establishment grants to California and seven other states to create health insurance exchanges under the federal health reform law, *The Hill*'s "Healthwatch" reports (Viebeck, "Healthwatch," *The Hill*, 8/23).

The establishment grants are intended to help states that are further along in their exchange planning, according to HHS (Gantz, *Washington Business Journal*, 8/23).

Including planning and development grants, HHS has awarded a total of $1.9 billion to 49 states, the District of Columbia and four territories for their exchanges, according to *U-T San Diego* (Lavelle, *U-T San Diego*, 8/23).

Background on California Exchange

The California Health Benefit Exchange primarily will serve individuals and small businesses.

An estimated 4.4 million California residents are expected to use the exchange by the end of 2016.

Officials plan to open registration for the exchange in October 2013 (*California Healthline*, 8/3).

Details of California Grant

California received a $196 million establishment grant from HHS (*U-T San Diego*, 8/23). It is the third federal grant given to support the state's exchange (Robertson, *Sacramento Business Journal*, 8/23).

California expects the grant to cover operating expenses through June while the state takes steps to prepare for the exchange's launch in 2014, including:

- Creating enrollment policies;
- Deploying an outreach program; and
- Selecting participating health plans (*U-T San Diego*, 8/23).

Other Grant Recipients

The other seven states that received grants are:

- Connecticut;
- Hawaii;
- Iowa;
- Maryland;
- Nevada;
- New York; and
- Vermont ("Healthwatch," *The Hill*, 8/23).

Health Benefit Exchange lands $196M
Sacramento Business Journal
By Kathy Robertson
August 23, 2012
http://tinyurl.com/8sq9ww2

The California Health Benefit Exchange has received a $196 million federal grant to fund operations through June.

The exchange is on an aggressive timeline to launch a new insurance marketplace for individuals and small businesses in January 2014. Enrollment is expected to begin in October 2013.

Key over the next year will be development of an easy-to-use program for eligibility and enrollment — and outreach efforts to get individuals and small employers to sign up.

Major activities will include soliciting health plan bids and selecting plans that will participate in the new purchasing pool; final planning for "assisters" who will help with the enrollment process; design and launch of a technology platform to handle eligibility and enrollment, and development of operational, accounting and finance support for the exchange.

The small current staff is expected to swell to more than 200 by June 2013, an employment boost for the Sacramento area.

"We're committed to implementing health care reform, and today's award reflects the strong partnership we have with the federal government," Diana Dooley, California Health and Human Services secretary and chair of the exchange, said in a news release. "These funds will be used to develop the backbone of a new health care system — one that promises coverage to millions of Californians who, for a variety of reasons, including cost, currently go without it.

This is the third round of funding for the California exchange. Startup funding of $1 million was awarded in September 2010. A $39 million grant in 2011 allowed the exchange to accelerate planning and development.

For more information, go to HealthExchange.ca.gov.

Feds give state $196M for insurance exchange
San Diego Union Tribute
By Jane Lavelle
August 23, 2012
http://tinyurl.com/8regyx7

California has received a third federal grant, this one worth more than $196 million, to continue establishing a health insurance exchange where individuals and small businesses can comparison shop for health plans starting in 2014.

California was one of eight states to receive a new round of grants, U.S. Health and Human Services Secretary Kathleen Sebelius announced Thursday.

The insurance exchanges are mandated by the federal Affordable Care Act, and are envisioned as a marketplace where consumers can buy health insurance at affordable prices with the help of federal subsidies for low- and middle-income households.

California already received a $1 million grant in 2010 and a $39 million grant in 2011 to create the agency, which will soon set standards to qualify health plans that can be sold in the exchange. The agency also has approved a $360 million contract with Accenture to design and maintain a website where consumers can buy insurance and access the federal subsidies. The third grant is expected to cover operating expenses for a year while the agency creates enrollment policies, selects the health plans, launches a public outreach program, and executes other elements of the exchange in preparation for its 2014 opening.

On Thursday, Sebelius announced grants to California, Connecticut, Hawaii, Iowa, Maryland, Nevada, New York and Vermont. Forty-nine states, the District of Columbia and four territories have received a total of $1.9 billion in federal grants for their exchanges. Alaska is the only state that has not applied for or received at least one grant.

A Top official looks at health care in California
Capitol Weekly
By Greg Lucas
September 10, 2012
http://tinyurl.com/99fq3m5

At the epicenter of the health-care discussion in California is Diana Dooley, Gov. Brown's Secretary for Health and Human Services and the chair of the landmark Health Benefit Exchange, the mechanism that will push ahead federal health care reforms in the state. Capitol Weekly's ***Greg Lucas*** *sat down with Dooley last week for an extensive interview.*

CW: When you give speeches and people ask what is the state of health care in California, what's your answer?

DD: I haven't been asked that question quite like that. The state of health care -- I don't want to parse it too much -- the state of health in California is pretty good. We consistently rank above the median in outcomes like infant mortality and some of the other key measures but knowing what to measure is precisely the reason I suggested and the governor agreed to appoint the Let's Get Healthy California (advisory board) to look at all the different measures. Our task is to pick a measure that we think will tell us how healthy California is and then set a target so that at the end of the decade we can reach our goal is.

CW: So what do you use as yardsticks?

DD: It's always difficult to determine what you're going to measure because everybody, like Garrison Keillor says, wants to be above average. This is one of the big challenges of the Health Benefit Exchange's work is creating a marketplace that clearly and transparently explains what the costs are, what it is you're buying and what are you going to get for that.

It's very opaque right now. It's hard for people to understand. So we're going to measure outcomes, we're going to measure access and we're going to measure cost so people can make a value calculation.

CW: Out there in the marketplace

DD: Well, we call this a marketplace of health care but it doesn't operate like any economic market where you're actually buying the product. You're buying the insurance and the insurance company is negotiating the rates of your care. I don't go and get a bill from my doctor that I pay, my insurance company pays it. But it doesn't operate like insurance in a lot of ways either because I don't want my house to burn down to use my homeowners insurance. I don't expect to make a claim. I'm really happy if I don't make a claim. But in health care it's a lot like a pre-paid benefit.

You expect to get your money's worth but most people expect to get more than their money's worth. Nobody wants to be part of the population that's making the investment but doesn't use the service. And yet that's how insurance works. That's how risk pools work.

You want to have some healthy people that don't have a need but if they have one at some point the coverage is there for them. We spend an awful lot on health care where we're not buying the care directly but buying the insurance. Rarely do we really stop and look at what the out-of-pocket expense is and what we're getting for it. Of course that's only an issue for the 85 percent that do have insurance. Most of the health care reform conversation is around the 15% that don't have insurance.

CW: Who is that 15 percent?

DD: Either they're unemployed or they're self-employed or contractors. I don't know the profile of the uninsured. I think there's a lot of movement. They have insurance sometimes and then they don't. They don't elect to insure their dependents because the cost is too much. There's a variety of factors.

CW: What are the biggest fears out there about the Affordable Care Act?

DD: A lot of people are afraid that it's going to change something they already have. In a time of instability with the economy, people are nervous, nervous that they're going to lose what they already have. That's one of the things that the act tried to address right from the top. That you can keep the plan you have. It's not going to affect anything about the plan you have.

If people get over that fear then they're worried it's going to somehow cost them more, both individually and collectively. Its hard to understand how the federal government – cause this is all federal money – can make this investment and there's not going to be an adverse consequence. Most of that worry, sadly from my perspective, just comes from the antipathy that people feel about government more broadly typified by what I thought was the kind of crazy arguments raised during the debate over (the Affordable Care Act) itself. Like "Keep government out of my Medicare."

CW: Medicare being a government program.

DD: A government program that they like and, if they like it, it can't be government. It's like HMOs. HMOs are bad but people love Kaiser. Kaiser is the largest, longest lasting HMO but no one would put HMO on Kaiser because people like it. One of the themes of the Affordable Care Act is we need more coordination and integration of care. That's what managed care should be. What managed care became was only an economic incentive on the payer's part to maximize profit. Everybody is making profit on health care. Something like 85 percent of our hospitals are nonprofit but they all operate at a margin and make money and they reinvest that money in the communities. Physicians are in the business to make money. Pharmaceuticals are in the business to make money. Device manufacturers. Its not just the health plans.

CW: Talking to fee-for-service advocates they'll say intrinsically there's nothing wrong with managed care. The chief complaint they raise is the transition from fee-for-service to managed care. How can you make the transition easier?

DD: It's going to be hard. Any change is difficult. We've made the transition (in Medi-Cal) with seniors and persons with disabilities a year ago. It's gone relatively smoothly. Some places people haven't been able to get their same doctors —

CW: Or the right meds –

DD: But we're working that out. The department (of Health Care Services) itself had a survey of about 5,000 people where 85 percent were at least as happy or happier with their managed care services. They had more access, more responsiveness, better care than they had trying to shop around for a fee-for-service physician. That's one thing we're working on is to hold the plans accountable for having networks that get patients the care they need.

CW: What's health care delivery going to be like five years from now?

DD: The opportunity for more people to get basic care through the Affordable Care Act is going to encourage reform in the delivery system that we could never have really designed by government regulation in terms of how the doctors and medical professionals are going to treat patients. Because they're going to have so many patients with needs, they're going to change their own delivery of medicine with physician extenders, with more nurses and nurse practitioners with pharmacists, with acupuncturists. There's going to be so much demand in the marketplace that we're going to have some of this consolidation, integration, coordination of care because we're going to have capacity challenges we can't meet any other way. I think people's expectations of the care they need and the care they'll get will move them to managing their own care.

An example I use is mammograms. A report came out a few years ago on who needs a mammogram based on your personal history. I don't really need an annual mammogram based on my history and my family's history. But the first time I skipped I was so nervous because the advertising for annual mammograms is so intense I was nervous not to do it. As the capacity is absorbed by more people having coverage we may see some change in the advertising or the recommendations.

CW: Are Medi-Cal reimbursement rates going to go up?

DD: Not anytime soon. That's, in part, why we're moving from fee-for-service to managed care so we can have a population that needs care, manage it on a per member rate and care for that whole person. Providers may extend more care to some and less care to others based on their need.

CW: Right now one in five Californians are on Medi-Cal. We're going to go to one in four over the next four years. How does that change the way health care is provided in California?

DD: Whatever the expansion turns out to be, the idea of universal coverage both through an expansion of Medi-Cal and the products sold on the Exchange with a subsidy so as close to everybody as possible will have what I call health security means the people who are very expensive in the system now – the uninsured – will cost less to keep or make healthy. I call it health security instead of health coverage because that's really what it is -- knowing that you're not one major illness away from bankruptcy. So with that expanded coverage those people who aren't getting preventative care, who aren't getting planned care because they're uninsured and are only being treated in clinics and emergency

departments when they have health crises where there's no reimbursement for the care will receive more effective care. Their costs won't be shifted onto the commercial plans to the same extent. If you can manage that care for those people at la lower cost because you're going to get them when they're not in crisis you're going to cut down the cost in the emergency room, which is the most expensive care that is delivered. I don't think it's reasonable to suggest we're going to lower health care costs in the future but I hope we can reduce the rate of growth in those costs.

Enter, stage left, the Health Benefit Exchange

Capitol Weekly
By Max Theiler
September 4, 2012
http://tinyurl.com/8qopg3j

The clock is ticking on a crucial aspect of health care reform in California.

As the Jan. 1, 2014 deadline approaches, preparations continue at the Health Benefits Exchange, the organization that will oversee the state's implementation of President Obama's national healthcare reform. In 2010, California became the first state in the country to enact legislation establishing an exchange, which will allow Californians to shop online for coverage at competitive prices.

Here's how it will work.

Private insurers that meet a set of minimum coverage requirements are collected into a single online hub. The plans are sorted into pre-defined tiers, dubbed Bronze, Silver, Gold and Platinum, that correspond to different levels of payment and coverage. Bronze plans would have the lowest monthly premiums, but would require the highest copayment for medical expenses, and vice versa for Platinum. By going to the exchange website, prospective buyers can choose from a variety of companies at a variety of prices.

Comparing rival plans often pose a challenge to consumers, but the Exchange believes that buying coverage ultimately may prove as straightforward as purchasing books off Amazon or a new hard drive from Frys.

The hope is that by demystifying the process of shopping for health insurance, more uninsured Californians will look into purchasing coverage and reap the benefits of federal subsidies.

"We're trying to work out ways to streamline it." says David Panush, the Exchange's Director of Government Relations. "The process should be simple."

Following federal rules, the degree of coverage will be uniform across the tiers. Pre-existing conditions, meaning any personal medical history beyond age, location, and tobacco use, will not be factored into rate calculations.

In order to qualify for the exchange, an insurance plan must offer the 10 "essential" benefits outlined by the ACA: hospitalization, maternity, and mental health care, as well as ambulatory, emergency, prescription, rehabilitative, laboratory, preventive, and pediatric services.

Knowing each plan conforms to the same coverage template, new ratepayers can base their decision on easily comparable bottom-line prices. "It's apples to apples." says Gerald Kominski, Director of the UCLA Center for Health Policy Research. "If a you see two identical plans and one costs $100 more per month, that company is going to have to justify the extra cost somehow."

As an additional incentive to use the Exchange, families and individuals earning less than 400% of the poverty level (in 2012, four times the poverty level would be $44,680 per year for individuals and $92,200 for a family of four) will also have access to federal subsidies in the form of tax breaks to help pay for coverage under an HBEx plan.

Those earning less than 138% will qualify for free Medicaid coverage under the auspices of Medi-Cal. Meanwhile, tax penalties will be phased in for families and individuals who remain without coverage longer than three months and who would not have to pay more than 8% of their annual income in premiums.

Ideally, ease of use and access to tax breaks will attract a large pool of potential ratepayers to the HBEx, giving it the power to bargain collectively on their behalf with the insurance companies who come looking for new customers. But a lot depends on the enthusiasm of the private sector. Although the board is currently awaiting a second federal grant to continue setting up shop before enrollments begin, after 2015 the HBEx is expected to fund itself entirely using fees collected from participating companies.

A “Basic Health Plan” option for those with incomes above the 138% cut-off but below 200% of the poverty level, proposed by Ed Hernandez (D-West Corvina) in Senate Bill 703, will be debated in the legislature in the coming weeks. This program would re-allocate tax subsidies for ratepayers within this income bracket to create a separate single-payer plan for them, similar to Medi-Cal.

A study released on Aug. 10 by the UCLA Center for Health Policy Research and the UC Berkeley Center for Labor Research and Education suggests that a Basic Health Plan for this income bracket would increase overall coverage in California, but reduce the number of Exchange enrollees available to private companies and thereby hurt the HBEx’s bargaining power.

Either way, the Exchange anticipates a substantially broader base of health insurance coverage starting in 2014. Californians increasingly seem to share this optimism, with some reservations. A Ffield Poll released in August (See Page xx) showed support for Affordable Care Act at 54%, with the number claiming to “strongly support” the law is up from 31% in 2011 to 38% in 2012. However, a plurality of 46% believed the reforms would have “not much impact” on themselves and their families.

Of course, how these results will translate into participation when the Exchange opens its doors for pre-enrollment in October 2013 remains to be seen. Next year, the Exchange also will be conducting preliminary tests of the system.

Health Benefit Exchange looks at new names
Sacramento Business Journal
By Kathy Robertson
September 4, 2012
http://tinyurl.com/bpvlea9

Gearing up to brand itself at an affordable new health insurance program coming for individuals and small employers in 2014, the California Health Benefit Exchange is kicking about names to see what sticks. A decision could be made at the Sept. 18 board meeting.

Possibilities run the gamut from the traditional to the "interesting."

Traditional names range from CaliHealth, CalAccess and Wellquest to PACcess and Covered, Cal. Next comes the interesting, from Ursa ("Where Californians find their health options") to Healthifornia ("A better state of healthcare"), Eureka ("Discover affordable healthcare"), Beneficia or Benefica, Cal-Vida, Condor and Avocado ("A uniquely California approach to affordable healthcare").

Marketing will be key for the program, which hopes to serve more than 4 million Californians when it gets in full swing. Enrollment will begin in October 2013; the program will launch Jan. 1, 2014.

Branding includes lots of things, from the name and tagline, to a logo and images. It has to sell the program at first blush.

Maybe not Condor — a vulture fighting extinction — board member Robert Ross said at the Aug. 23 meeting.

Avocado resonated with board member Kim Belshe, but drew a few laughs from the audience.

VSP Furious over Health Exchange Vote
Sacramento Business Journal
By Kathy Robertson
August 31, 2012
http://tinyurl.com/ce4vktb

A key policy decision made by the **California Health Benefit Exchange** last week handed one big local employer a victory — and made another hopping mad.

The exchange board voted Aug. 23 to allow stand-alone dental plans to compete in the new insurance program for individuals that debuts in 2014, but barred stand-alone vision plans for at least the first year. Both will be allowed to compete in a companion program for small employers.

The decision showcases what's at stake in policy decisions coming out of the exchange as it fashions a new insurance marketplace under the federal health care overhaul.

It puts Delta Dental in a good spot to compete directly for new business in the individual market, which could mean more jobs at local offices in Rancho Cordova. San Francisco-based Delta Dental has about 1,000 local employees.

But it leaves VSP Global, also based in Rancho Cordova, out unless it contracts with a medical plan to provide the benefit. VSP has about 2,000 local employees.

VSP declined to comment on the board decision. But in an op-ed essay published in this week's edition of the Business Journal, Lynch blasted the exchange for narrowing consumer choices and failing to support a 57-year-old Sacramento nonprofit that's grown into the largest health insurer in the nation, with more than 58 million members.

He suggested VSP might move its headquarters out of state.

"Like other successful California companies, we have been heavily solicited to relocate out of state with incentives and subsidies," Lynch wrote. "Maybe it's time for us to choose to go where we are wanted."

Lynch isn't alone in arguing that the exchange should support local businesses.

"VSP has one of the largest business headquarters in California," said Albert Lowey-Ball, a Sacramento health care consultant. "It makes little sense to act in a way that's discriminatory to a California-based business."

Beyond barring VSP as a stand-alone plan from the state exchange's individual market, the decision poses a potentially larger threat to the company by setting a precedent. California is barreling ahead on decisions about its health insurance exchange, and the decision sets an example that could pave the way for exclusion in other states.

Depending on who is counting, projections for individual enrollment in California run as high as 3.8 million, a figure tallied by the California Health Care Foundation.

It's unclear how many small employers will buy group insurance in the exchange and how many will instead let employees buy their own coverage in the individual pool. But the Washington, D.C.-based Institute for Health Policy Solutions estimates enrollment in California's small-employer program at 450,000 to 650,000 people.

The Affordable Care Act defines 10 broad categories of essential health benefits. Health plans must offer benefit packages to individuals and small employers both in and out of the exchanges that include a range of services from all 10 categories, but they are not required to provide benefits beyond that.

Pediatric dental and vision services are required, but adult coverage is not. However, small employers commonly purchase supplemental dental and vision benefits for their employees and offering those benefits in the employer program is considered a way to increase participation.

The California exchange will offer separate purchasing programs for individuals and small employers, so some requirements may be different.

The ACA requires states to consider bids for stand-alone pediatric dental benefits, said Andrea Rosen, staff counsel and lead on qualified health plan issues. The federal law does not require bids from stand-alone vision plans.

Al Schubert, vice president for managed care and health policy at VSP, tried to persuade the exchange board before the decision last week to include stand-alone vision plans in the individual market. He pointed out that two other states that are early adopters of health exchanges, Massachusetts and Maryland, chose to allow them.

Michael Lujan, director of the small-employer program at the exchange, suggested the possibility of changes for the individual program in the future.

"Probably not in the first round," he said. But "We didn't say absolutely not."

The economic impact on VSP from the state's decision is unclear. Stand-alone vision benefits are more likely to be purchased by employers than individuals, and VSP serves employers of all sizes; it says one in three Californians are members.

Delta Dental supports the recommendation, spokesman Jeff Album said. The company serves 26 million people nationwide, including 17 million California. The company's largest single office is in Rancho Cordova, where more 1,000 employes process claims and answer phones in a call center.

"It's fair to say an increase in Delta Dental business would mean jobs in Rancho Cordova," he said. "I just can't say how many."

Delta Dental — like other health plans — will be watching future developments.

Still pending are big decisions about the way health plan choices will be presented to consumers when enrollment begins. Will dental be listed along with medical plans or be an afterthought?

A vote to limit health choices
Sacramento Business Journal
By Rob Lynch
August 31, 2012
http://tinyurl.com/9goakkm

On Aug 23, the California Health Benefits Exchange board voted to exclude stand-alone vision plans from offering coverage in the California Health Benefits individual exchange. The reasons given were that these plans are "not allowed" to participate and because of administrative complexity and cost.

This means that consumers who will be accessing vision care through the California exchange will be limited to vision plans associated with medical plans only — something that United Healthcare and Kaiser, who own their own vision plans, lobbied hard to achieve. This also means that our company, VSP Vision Care, a national stand-alone not-for-profit vision plan headquartered here in Sacramento, will not be able to directly compete in the California Exchange.

Needless to say, we are dismayed and disappointed that our home state did not see the importance of choice to consumers or supporting a business that was started here 57 years ago and has grown into the largest health insurer as ranked by the number of members covered — more than 58 million people.

What's even more inconceivable is that in California, VSP is also the largest insurer by membership — larger than Anthem Blue Cross, Kaiser and Blue Shield combined with 14.3 million Californian's covered by our company. Department of Managed Health Care data confirms that 93 percent of vision care coverage is provided through stand-alone plans like VSP. This was accomplished by VSP directly competing with other stand-alone vision plans as well as plans owned by medical insurers.

So, why did the health exchange board decide to exclude one of the state's largest providers? The organization's staff report to the board indicated that stand-alone vision plans are not allowed — which is simply not true. While they were left out of the Affordable Care Act, the U.S. Department of Health and Human Services issued guidance to states that specifically left open the question of including stand-alone vision plans.

As a result, other states — such as Maryland — have included stand-alone vision plans in their state exchanges. Many more are moving to do the same: For example, the Massachusetts Health Connector, arguably the longest running exchange program, is adding stand-alone vision and dental options. Why? Because its leaders have come to the realization that it will make their exchange more attractive and cost effective.

VSP has grown by having the ability to openly compete in the marketplace. As a not-for-profit health plan we provide coverage to Medi-Cal, Medicare, CHIP and Healthy Families participants on a cost effective and non-discriminatory basis.

Like other successful California companies, we have been heavily solicited to relocate out of state with incentives and subsidies. Choice is important in the marketplace. California has chosen not to support one of its own home-grown successful businesses, with 2,000 employees in California.

Maybe it’s time for us to choose to go where we are wanted.

Employers frustrated with health reform's lack of details
Sacramento Business Journal
By Kathy Robertson
August 29, 2012
http://preview.tinyurl.com/czzldta

Now that the U.S. Supreme Court has upheld a requirement in the Affordable Care Act that most Americans have health insurance in 2014 — or pay a fine — employers have a ton of questions about how the mandate will affect them and what to do next.

With 16 months to go before the California Health Benefit Exchange launches a purchasing pool for individuals and small employers, there are no answers to fundamental questions such as how much coverage will cost and whether it will be more cost-effective for business owners of all sizes to provide coverage or pay the penalty.

The mandate is in place and folks at the exchange are jamming to meet a tight timeline, but projected premiums won't be known for a year or more. Key decisions, including what the basic benefit plan will be and how many health plans will participate must be made before rate negotiations can begin.

In the meantime, employer frustration is widespread.

Sam Manolakas, president of the Brookfields Restaurants chain in Sacramento, employs about 180 full- and part-time employees. He offers health insurance to everybody who works 27 hours or more a week — and picks up a portion of the cost, with more support going to longtime workers.

He has no idea whether it will make more sense to pay penalties or continue to provide insurance. Some of his workers don't take coverage because they can't afford their portion of the premium.

"Quite honestly, over the last four years, I've just been trying to stay afloat," Manolakas said. "Like so many others in the labor-intensive restaurant industry, the profit margins are not that great."

He's asked trade groups for direction on the health care law, but they don't have the answers.

"They can't tell me how much the exchange will charge — nobody has it," Manolakas said. "I'm gravely concerned as to what health care will do to my business."

Be patient and stay engaged, says Diana Dooley, secretary of the California Health and Human Services Agency and chair of the exchange board.

"You can't crunch the numbers because we haven't made all the decisions," she said. The exchange won't launch until January 2014.

"By late 2013, we'll be able to put the charts together," Dooley said. "The idea is to overlap with the typical open enrollment period in the fall."

The tight timeline poses another potential complication: Will the exchange be ready on time?

"I believe we'll be able to offer products to people in the exchange in 2014, but it may be that we start with a less ambitious program and build on it," Dooley said.

'Don't hire more than 49'

No employer is currently required to provide insurance. More than half the residents under the age of 65 in the Sacramento area who have coverage get it through work, though. That's likely to continue, experts agree.

Come Jan. 1, 2014, most local folks without insurance will have to buy it or pay a fine. The state exchange will launch a new marketplace for individuals and small employers, the two groups that traditionally lack the clout and volume needed to leverage good prices.

Employers with fewer than 50 employees won't face penalties — but larger businesses could. One full-time employee who receives subsidized coverage in the exchange can trigger annual employer penalties of up to $2,000 or $3,000 per person.

On the flip side, the health reform law already offers tax credits to help cover the cost of insurance.

Depending on perspective and politics, federal health reform offers a tax incentive to expand coverage in what could be a more affordable marketplace — or a disincentive to grow at a time when the state needs jobs.

"The employer mandate tells small businesses not to hire more than 49," said John Kabateck, executive director of the California chapter of the National Federation of Independent Business. The trade group was the plaintiff in the lawsuit challenging the individual mandate that was upheld by the U.S. Supreme Court in June.

That said, NFIB likes the notion of insurance exchanges.

"We do believe there is a diamond in the rough in the exchange, if done in the right way," Kabateck said.

When the Affordable Care Act is fully implemented in 2019, 3.1 million Californians — 150,000 of them Sacramento-area residents — will be eligible for subsidized coverage through the exchange, according to a study by the UCLA Center for Health Policy Research and the UC Berkeley Labor Center.

Some will be individual consumers; others covered by their employers. Businesses with 50 or fewer employees will be able to shop in the exchange in 2014; the size increases to 100 employees in 2016.

"My vision is a simple, intuitive marketplace that clears some of the fog for small business employers and employees regarding choice," said Michael Lujan, director of the Small Business Health Options Program, better known as SHOP.

One important distinction of the new program will be an ability to add employees and their dependents at the same time, Lujan said. Open enrollment usually starts with the employee and involves a laborious process of adding dependents.

The plan is to start enrollment Oct. 1, 2013, but Lujan expects a "Countdown to Coverage" to start in January. Insurance agents — who write roughly 80 percent of small business health insurance coverage now — will remain in the loop.

"We'll start with agents and get staff ready, trained and certified," Lujan said. "There will be fanfare we have not seen in California before. Massachusetts (when it kicked off marketing for its program of universal insurance) used local sports actors like the Boston Red Sox. I expect California will use all its celebrity power."

That could work when enrollment starts, but confusion reigns for now.

"First thing we need to do is educate people," said Scott Hauge, president of Small Business California, a grassroots advocacy organization in San Francisco.

"In February, 75 percent of people didn't know about the exchange and 77 percent had never heard of the tax credits," he added. "There's a lot of information that's not getting out and a lot of misinformation. I get a lot of information that's just flat-out wrong."

When the Sacramento-based California Employers Association held a webinar on health care reform last month, the organization attracted more than 150 participants, triple the normal number, executive director Kim Parker said.

"Employers are overwhelmed right now," Parker said. "They want to do what's best for their employees — and their company. I don't know if they — or we — will do better the way it is now or in the exchange."

Brokers are stepping into the void with new tools. They won't offer definitive answers until more details emerge from the exchange, but some software programs crunch potential taxes and penalties for employers based on what they offer now — and how the impact changes if they tinker with benefits and costs.

A tool offered clients at Woodruff-Sawyer & Co. uses data on employee census, current plans and employer contribution — and data from the U.S. Census on household size and income — to calculate the range of costs an employer might expect under each provision of the law.

"We look at it as a living document," said Linda Hunter, vice president Woodruff-Sawyer's Sacramento office. "It's an initial report. As things gel in the exchange, when rates and plan design are released, our tool does the 'what-ifs?' "

Rapid implementation of the reform law looks to be very good for individuals, said Albert Lowey-Ball, president of a local health economics firm. "There's potential opportunity for small business … but it depends on how well the program reaches out to and convinces employers to participate."

There's likely to be plenty of private-sector competition outside the exchange, he said.

Health exchange puts off decision on choice
Sacramento Business Journal
By Kathy Robertson
August 24, 2012
http://tinyurl.com/c2xavjf

The California Health Benefit Exchange barrelled through important decisions Thursday about the new insurance marketplace pending for individuals and small businesses in 2014, but delayed action on the degree of employer and employee choice.

"We'll continue to seek comments," Peter Lee, executive director of the exchange, said after lengthy testimony from consumer advocates and industry representatives.

Exchange staff presented three options;

• Employer choice of tier and employee choice of plan would provide broad choice not currently available in the small employer market. The employer establishes a tier of coverage for employees and allows workers to select among available health plans within that tier. Employees have the choice of many plan types and insurers.

• Employers could select two insurers and two tiers; employees would pick from the offered plans and tiers.

• Employers choices the plan and employees choice the level of coverage among the tiers.

Exchange staff recommended the first two options, but encouraged discussion on the third.

The debate boils down to how choice may or may not affect the viability of the exchange and affordability of the coverage offered.

"Employee choice is the single biggest benefit and difference from the outside market," said John Arensmeyer, founder and CEO of the Small Business Majority. The first option provides any carrier in a tier, he said. The second, more choice per tier. The third, multiple tiers and one carrier. "Will that increase costs?" he posed.

Garry Maisel, CEO at Sacramento-based Western Health Advantage, expressed support for the first option, as the only one different from the current market.

"With all due respect, the current market is broken. That's why we are here," Maisel said."Let the free market work — it works best when the employee has choice."

California's health exchange considers a fruity new name
Los Angeles Times
By Chad Terhune
August 24, 2012
http://tinyurl.com/cwrx9qf

Want to buy health insurance from an avocado? California thinks you might.

Officials at the California Health Benefit Exchange, knowing their new online marketplace for medical insurance is a mouthful, are considering some new brand names to generate buzz with millions of consumers.

"Avocado: A uniquely California approach to affordable healthcare" was one possibility presented at a board meeting Thursday.

Other names tossed around were CaliHealth, Wellquest, Health Hub, Eureka and Condor. Officials said the monikers must still undergo more consumer testing and research before a final decision is made later this year.

Enrollment in the exchange begins in October 2013 with policies taking effect in January 2014.

Marketing is crucial for the new exchange, which is responsible under the federal healthcare law for enrolling nearly 2 million new people in Medi-Cal, the state's Medicaid program for the poor, and helping an additional 2 million Californians purchase coverage with federal subsidies.

The state exchange, like some others across the country, will negotiate with insurers for the best rates and assist consumers and small businesses in choosing a plan by separating them into five categories based on cost and level of benefits.

Kim Belshe, an exchange board member and former state health official, said "I am drawn to avocado."

Diana Dooley, chairwoman of the exchange board and secretary of California's Health and Human Services agency, said she thought CaliHealth might appeal to younger consumers, a key target audience among the uninsured.

Condor may not send the right message since it's a vulture and it has battled extinction, said Robert Ross, another board member and chief executive of the California Endowment.

Avocados certainly have a distinct California flavor. The state's nearly 5,000 avocado growers produce more than 90% of the nation's avocado crop.

The marketing folks at Calavo Growers Inc. in Santa Paula, the state's biggest avocado producer, initially laughed when told about the possible tie-in with health insurance, deductibles and co-pays. But they welcomed the free publicity.

"I think it would be fantastic and I hope they pick it," said Lee Cole, chief executive at Calavo. "Avocados are probably one of the healthiest foods around."

Opinion: Affordable health care foundation is in place in California
San Jose Mercury News
By Bob Schoonover and Roxanne Sanchez
August 23, 2012
http://tinyurl.com/bnkkvwg

It's widely known health care reform is coming to California, with access to affordable health coverage expected to expand significantly starting in January 2014.

What is not widely known is that a critical decision is coming about how millions of Californians will enroll in affordable health care coverage. The five-member California Health Benefit Exchange Board is deliberating Thursday on what system will best meet the eligibility needs of Californians seeking affordable health care.

Fortunately, counties have been gearing up for the influx of calls from people, and we stand ready to handle the job through our existing local network of county customer service centers.
The exchange board can choose to build on this network that performs Medi-Cal eligibility determination -- or try to build a new system from scratch. The latter involves creating a state-based system that could divide eligibility work between counties, the state and even private contractors. This new system would require hiring a new cadre of workers to do work that today is performed by trained county staff. This option is riskier, likely to cost more, and would create a more complex, untested network for our customers to navigate.

Under the Affordable Care Act, Medi-Cal -- known nationally as Medicaid -- will expand, with between 1.2 and 1.6 million Californians expected to be newly covered by 2016, according to UC Berkeley researchers.

California's county workers and health and human service agencies have been preparing for this. Our state's network of customer service centers staffed by county eligibility workers already exists to determine eligibility for clients seeking Medi-Cal, CalFresh and CalWORKS services. These skilled workers are prepared to handle the new million-plus inquiries about qualifying for affordable health insurance. County customer service centers are cost-effective and staffed with knowledgeable workers who know how to best help families in their communities. The centers offer an easy-to-use, efficient option to get families and individuals the information they need about getting their basic food, housing and medical needs met as they try to work themselves off assistance and back into the workforce.

These local service centers offer clients both the option to talk to a highly trained worker live, or use a voice response system to find out information such as the status of their cases or to report changes. Families have a convenient option to access the information they need, and our county agencies are effectively and efficiently responding to the demand.

By year's end, 24 counties will operate customer service centers, with 2,000 staff answering 1 million calls each month.

Now California has the opportunity to leverage this valuable existing resource to ensure all Californians, regardless of income level, experience the promises of the Affordable Care Act. This is not only the best option for clients; it's also the best value for taxpayers.

In the midst of the recession, counties enrolled more than 1 million new people into Medi-Cal over a three-year period. Clearly, we know what it takes to respond to demand.

And thanks to simplifications contained in the Affordable Care Act, more of the intake work will be able to be done by phone -- a change that counties welcome.

California was the first state in the nation to enact legislation creating a health benefit exchange under federal health care reform, and we have the opportunity to continue being a leader even as we face a tight timeline to bring the promises of the Affordable Care act to life in just over a year.

Let's build on the well-established foundation we have, and stay focused on what's best for all Californians.

Radio Clips

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