California Health Benefit Exchange

Board Members
Diana S. Dooley, Chair
Kimberly Belshé Paul Fearer
Susan Kennedy Robert Ross, MD

Executive Director
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MEDIA CLIPS

September 11, 2012 – October 23, 2012

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New York Times
September 14, 2012

SACRAMENTO — The meeting came to order, the five members of the California Health Benefit Exchange seated onstage with dozens of consumer advocates and others looking on. On the agenda: what to name the online marketplace where millions of residents will be able to shop for medical coverage under President Obama's health care law.

An adviser presented the options, meant to be memorable, appealing and clear. What about CaliHealth? Or Healthifornia?

Or Avocado?

"I am kind of drawn to Avocado," declared Kim Belshé, a member of the exchange's board of directors, which is hustling to make dozens of decisions as the clock ticks toward deadlines set by the law.

Delay and outright resistance to the health care overhaul might be the norm in much of the country, but not here. California — home to seven million uninsured people, more than any other state — is at the forefront of preparations for January 2014, when a controversial requirement that most Americans have medical coverage or pay a penalty takes effect.

So far, only 13 states and the District of Columbia have told the Obama administration they intend to set up the insurance exchanges that are supposed to provide a marketplace for people to buy health plans. None are being watched as closely as California, whose singular challenges, from the size, diversity and geographic spread of its uninsured population to its vast budget problems, make it stand out. Many feel a successful rollout here could convince other states with high numbers of uninsured residents that the law can be made to work for them.

"We are the example," said Anthony Wright, executive director of Health Access California, an advocacy group. "If it can be done here, it can be done anywhere."

The California Health Benefit Exchange has already hired 50 employees and is poised to hire 50 more. Construction of the Web portal through which some three million people are expected to buy insurance by 2019, and through which many others will likely enroll in Medicaid, is under way.

This fall, the board will seek bids from insurers to sell plans through the exchange, and it intends to have the portal up and running by next summer, several months before enrollment starts in October 2013.

Realizing that much of the battle will be in the public relations realm, the exchange has poured significant resources into a detailed marketing plan — developed not by state health bureaucrats but by the global marketing powerhouse Ogilvy Public Relations Worldwide, which has an initial $900,000 contract with the exchange. The Ogilvy plan includes ideas for reaching an uninsured population that

speaks dozens of languages and is scattered through 11 media markets: advertising on coffee cup sleeves at community colleges to reach adult students, for example, and at professional soccer matches to reach young Hispanic men.

And Hollywood, an industry whose major players have been supportive of President Obama and his agenda, will be tapped. Plans are being discussed to pitch a reality television show about "the trials and tribulations of families living without medical coverage," according to the Ogilvy plan. The exchange will also seek to have prime-time television shows, like "Modern Family," "Grey's Anatomy" and Univision telenovelas, weave the health care law into their plots.

"I'd like to see 10 of the major TV shows, or telenovelas, have people talking about 'that health insurance thing,' " said Peter V. Lee, the exchange's executive director. "There are good story lines here."

Although the exchange will not start advertising until next year, the California Endowment, a foundation that has spent $15 million promoting the law, is running newspaper and television ads, including one in which the television personality Dr. Mehmet Oz exhorts viewers to "get educated, get engaged, get enrolled." That campaign has targeted Hispanics, who make up more than half of the state's uninsured population.

But for all the progress, California's intractable budget woes loom as a threat to implementation here. Even with the federal government financing most of the insurance expansion, the state's contribution could exceed $2 billion a year, according to an estimate that was made by the administration of Gov. Arnold Schwarzenegger, a Republican, who signed the legislation creating an insurance exchange here in September 2010, earlier than any other state. Diana S. Dooley, the state's Health and Human Services secretary, said the administration of Gov. Jerry Brown, a Democrat, was working on a new estimate.

Mr. Brown, while supportive of the law, has not spent much time talking it up publicly, in part, Ms. Dooley said, because he is "absolutely laser-focused on getting the budget balanced."

To help close a $16 billion deficit, Mr. Brown made more than $1 billion in cuts from Medicaid and other health programs even though about a million of the Californians expected to gain coverage through the health care law by 2019 would get it through a prescribed expansion of Medicaid. (Those who buy private insurance through the exchange will be able to get federal subsidies to help cover the cost if they earn up to four times the federal poverty level, or currently $92,200 for a family of four.)

Mr. Brown is hoping voters will approve a package of temporary tax increases in November to avoid $6 billion more in cuts. Ms. Dooley said that without the tax package, carrying out the health law might be at risk, including the expansion of Medicaid.

"I wouldn't characterize it as all bets are off," she said. "I'm just saying nothing is protected."

The exchange itself has so far been financed by three grants, worth $237 million, from the federal government. Most of the money is committed to consultants, including Accenture, which has a $327 million contract to build and support the initial operation of the enrollment portal.

Ms. Dooley said getting the enrollment system up and running in such a tight time frame was one of her biggest worries. The other, she said, was making sure the health plans sold through the exchange were affordable. The federal law lists 10 categories of "essential health benefits" that plans sold through exchanges must provide, but Ms. Dooley said those categories "go beyond what I would call essential."

"It's all good for consumers," she said. "But somebody's got to pay for it, and that's going to go into the premium."

Despite the full-throttle approach here, another uncertainty is the outcome of the presidential race. Mitt Romney, the Republican nominee, has vowed to repeal the health care law and restructure Medicaid, not only scrapping the planned expansion but making the program much leaner. Even without a repeal, Republicans could undo the federal subsidies and other financing for the law if they won the presidency and even a narrow majority in the Senate.

"If the federal funding stopped," Mr. Lee said, "we would be at a 'press reset' button."

In a Field Poll released on Aug. 20, 54 percent of California voters said they supported the health care law, compared with 37 percent who said they were opposed. Support was strongest among blacks (88 percent) and Hispanics (67 percent), who together make up more than 44 percent of the state's population. Voters of Vietnamese and Korean descent also firmly supported the law, but white and Chinese voters were more divided. The poll of 1,579 voters, conducted in July, has a sampling error of plus or minus 3 percentage points.

Only 17 percent of respondents said they had seen, heard or read anything about the insurance exchange though. Still, 75 percent of those who are not insured through their employer or Medicare said they would be interested in using the exchange to shop for health insurance.

Mr. Lee said the fact that few people had heard of the exchange was "totally unsurprising." A catchy new name might help spread the word, he said; a decision on Avocado and the other finalists should come next month.

"The fact that very few people have heard about us isn't an issue," Mr. Lee said. "Come back in a year."

Treating uninsured immigrants after health care reform
Healthy Cal
October 23, 2012

The Affordable Care Act was intended to provide insurance for the uninsured – with one notable exception. Undocumented immigrants and lawfully present immigrants who've been here less than five years are excluded from health care reform. They are not eligible to purchase private insurance on state exchanges and they remain ineligible for Medicaid.

National Immigration Law Center Health Policy Attorney Sonal Ambegaokar says the decision to exclude those populations was purely political — since excluding them undermines the effectiveness of the reform.

"The goal of the first step was to provide affordable coverage for as many people as possible," Ambegaokar said. "You want as many people in the insurance pool because you want to spread the risk. Excluding immigrants is counter-productive."

As of 2010, there were about 38 million immigrants living in the United States. The Pew Hispanic Center estimates about 11.2 million of them are undocumented.

Non-citizens, both undocumented and lawfully present, are three times more likely then U.S.-born citizens to be uninsured, according to the Kaiser Family Foundation. They tend to work in jobs without employer sponsored health care. Their access to Medicaid and the Children's Health Insurance Program (CHIP) is also limited. Altogether, they account for 20 percent of the uninsured.

The Congressional Budget Office estimates that 30 million Americans will remain uninsured two years after the Medicaid expansion and state health benefit exchanges are established in 2014.

Twenty-five percent of the remaining uninsured will not qualify for coverage because of immigration status, according to a recent report from the UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research.

Spreading the word

The report also found, however, that half of those still uninsured five years after the reforms take effect will actually qualify for the expanded Medi-Cal coverage or health benefit exchange subsidies, but will not enroll because of poor outreach. A large majority of the remaining uninsured will be Latino (66 percent), limited English proficient (60 percent) and/or residents of Southern California (62 percent).

Chad Silva, Policy Director for The Latino Coalition for a Healthy California, worries that the state doesn't realize the resources and grassroots efforts it would take to reach these populations.

Partnerships with community-based organizations are fundamental for connecting to residents that are often labeled "hard to reach," Silva said. Community health educators called promotoras are particularly important, providing both formal and informal networks of people educating their neighbors in Latino communities throughout the state.

Another key reason that people who qualify will remain uninsured is confusion about who is covered and who is not. In 2010, more than 6 million citizen children were living in a "mixed citizenship status" family, with at least one non-citizen parent. These families aren't likely to apply for coverage for anyone in the family, Sonal Ambegaokar said, when they hear that non-citizens aren't covered.

Community clinics can play an essential role in providing for these patients because they will be able to care for the newly insured as well as those who remain uninsured. The 10 clinics in the San Francisco Community Clinic Consortium (SFCCC) provide a medical home for the whole family, said John Gressman, President and CEO of SFCCC.

The SFCCC is developing an outreach plan with other clinics throughout the state to help their patients understand what the reforms will mean for them. They will also help clients enroll when the California health benefit exchange opens October 1, 2013.

Latinos also have the most to gain from the ACA, Silva said. According to recent estimates by the California Pan-Ethnic Health Network (CPEHN) more than two million Latinos will be newly eligible for Medi-Cal or insurance subsidies through the health benefit exchange. The fact that childless adults now qualify for Medi-Cal is also a boon for young Latinos.

Treating the uninsured after the ACA

SFCCC clinics expect 35 percent of their clients will qualify for new coverage, but Gressman is struggling to figure out how to pay for the care of the 25 percent of their patients who will remain uninsured. "We can't use Medi-Cal or any federal dollars through the exchange," Gressman said. "There are many conversations trying to figure out how we can finance this, but I don't think anyone has solved this."

One strategy is to try to reduce their costs and reorganize the way they provide care. The SFCCC clinics are changing to a team-based care model in order to be more efficient. "We want providers and staff members working to the top of their profession and delegating what others can do," Gressman said.

Reducing health disparities is another way providers could reduce cost. SFCCC clinics are trying to do that by training providers in culturally competent health care.

Only 5 percent of doctors in California are Latinos while 38 percent of the population is Latino, Silva noted. Increasing the number of Spanish-speaking doctors is another way to improve cultural competency, currently about one quarter of Californian physicians speak Spanish according to a 2004 UCLA study.

Hospitals will still be required to provide emergency care to anyone who walks through their door. The ACA scales back "disproportionate care payments" to hospitals by about $18 billion from 2014 to 2020 on the premise that there will be less uninsured. But many hospitals are concerned they will continue to bear a disproportionate burden of providing for those who are still uninsured.

Undocumented immigrants avoid hospitals because of fear, Silva said. "They have to be walking dead before they go in," Silva said. Community clinics have provided and will continue to provide an important safety net for uninsured Latinos, he said.

Luis Garcia, an immigrant from Mexico, can't get insurance through the restaurant where he works, so he seeks care from Contra Costa County Community Health Clinics. His uninsured friends, he said, build up personal pharmacies by having relatives send them medications such as antibiotics that are cheaper and more readily available in their home countries. Some also frequent local herberias to seek natural remedies for what ails them.

Health advocates continue to lobby legislators to remove immigration status as a factor for qualifying for coverage in addition to their education and outreach efforts.

"The simpler the system the better the access will be," Sonal Ambegaokar said.

The National Immigration Law Center is supporting the federal Health Equity and Accountability Act proposed in April by Hawaiian Senator Daniel Akaka. The legislation removes immigration qualifications to purchase insurance through the exchange and invests in community clinics and culturally competent care. The bill is currently in committee.Any other changes in health care options for immigrants will likely have to be included in immigration reform, Silva said.

The most contentious issue at the moment is coverage for a group of hundreds of thousands of undocumented immigrants who came here as children, attended school and met other requirements to be allowed to stay in the country without threat of deportation.

The Obama administration ruled that they don't fit the lawfully present definition of the ACA in August. Silva advocates reevaluating what it means to be lawfully present.

"You certainly don't want a large group of people going uninsured," Silva said, "just in terms of public health.

Making Meaningful Name for California's New Health Marketplace
Capital Public Radio
September 23, 2012

(Sacramento, CA)
Sunday, September 23, 2012

The word 'exchange' is government-speak. But the Californians building the online marketplace where can buy health insurance want a name that doesn't communicate wasteful bureaucracy. They want it to sound like a 'fresh approach to what many feel is a broken health system.'

"What we're trying to figure out is... what's a name that's going to stick, that's going to grab hold, that all Californians are going to say 'boy, that's where I go to find healthcare," says Peter Lee Executive Director of California's Health Benefit Exchange.

The California planners hope at least three million customers will enroll starting in 2014. That's why they need a name that will grab *all* Californians.

"Almost half of the people that are going to be eligible for subsidized coverage in the exchange are Latino, many of whom are Spanish-speaking," says Lee.

"But that's not the only market. We have about 600,000 people that speak Asian-Pacific Highlander languages. Some of them speak Mandarin, some speak Hmong."

The first thing they did was hunt for ideas. They got hundreds of suggestions, and tested some with multi-lingual focus groups. A PR firm is helping them.

"We're testing the idea of Avocado, Ursa, Eureka. These are names or concepts or words that have a thread which is unique to California," says Lee.

The name Avocado got laughs, but is now out of the running. Other names borrowed from Spanish, like 'Calvida and Beneficia.' They considered "Healthifornia" and "Wellquest."

But Claudia Caplan, Chief Marketing Officer at RP3 Agency in Bethesda, Maryland. says she's not a fan of slapping two words together, or made-up words.

"I think you want to not be so monolithic. You know, in England they have the National Health Service and I'm not sure in America that a name like that would go over quite as well."

Caplan's done everything from naming fast food hamburgers to digital messaging for non-profits. She says a name for a new health marketplace should have humanity, but shouldn't be too cute.

"This is a whole new world for people in terms of how they're going to access insurance," says Caplan.

"It might be wise to give [future customers] a name that makes them feel good about doing that...as though they're being sort of metaphorically wrapped in some nice, warm arms that are going to take care of them."

Caplan says a name is only one part of building a public image, and can sometimes be counterintuitive.

Think of Dr. Pepper, she says. That's not the first thing you would call a sugary drink. She says a name isn't as important as what you build around it.

"So you better make sure if you're going to give it a great name that embodies a great promise, that the product is also terrific because it's going to be such a turnoff if you give it this great, nurturing name and it just turns out to be the DMV all over again," says Caplan.

California's exchange staff is sharing notes with other exchanges. Maryland just came up with their name and logo. Dr. Joshua Sharfstein is the Health Secretary of Maryland, and Chair of that state's exchange.

"We had some that had like verbs in them like Cover Me Now Maryland, Cover Insure Maryland, Get Health Care Maryland, those sorts of things," says Dr. Joshua Sharfstein, Secretary of the Maryland Department of Health and Mental Hygiene and Chair of the Maryland Health Benefit Exchange.

Sharfstein says one person even suggested www.icantbelieveitsthiseasytobuyhealthinsurance.com.

But the Maryland planners wanted something safe, trustworthy and catchy. They wanted a name that conveyed that exchanges are not providing health care directly, but a place people can buy private health care with confidence.

"In the end we went with Maryland Health Connection. We thought t was simple. It illustrated the importance of connecting - connecting with insurance brokers, producers, connecting people to insurance products as well as connecting people to health care and health," says Sharfstein.

California is expected to release its new name and logo in November. The frontrunners? Eureka, and Ursa- that's bear in Latin. 'Condor' is off the table.

Exchange Considers Community Grants for Outreach
California Healthline
September 21, 2012

Stakeholders and board members mapped out marketing strategies focusing on community outreach for California's new Health Benefit Exchange at a board meeting this week in Sacramento.

Board members realize new rules and opportunities coming into play in 2014 as part of national health reform may be confusing for many Californians and they hope to make the process as simple and straightforward as possible.

The exchange's staff is planning ways to use community-based grants to educate Californians on how and where to sign up for health care. The exchange is paying particular attention to communicating with populations it considers hard to reach, including rural and lower income Californians, according to Juli Baker, chief technology officer for the exchange.

Baker outlined staff plans to create a grant application system to give money to outreach groups, making them responsible for educating the public.

Robert Ross, a member of the board, suggested using volunteer based organizations, such as United Way out of a concern for how long it would take to process applications for grants. Ross and fellow board member Kim Belshé noted that community groups had "localized knowledge" to gain access to populations that would otherwise be unreachable. Enlisting not-for-profit organizations such as United Way would allow these groups to re-grant funds for education and outreach programs, board members said.

Stakeholders representing a variety of hard-to-reach groups weighed in on the board's marketing plans. Groups representing homeless and transient populations, young adults who will soon lose coverage under their parent's insurance, mixed immigration status families and lesbian, gay or transgender families generally saw a need for more grant money to make the education program successful and retain residents within the new insurance system.

Board members agreed, but noted that most grants will be one-time offerings, not a long-term funding stream.

"Even if we commit to a robust level (of funding) that does not necessarily guarantee it will continue," said Ross.

The board will continue to discuss grant funding for groups it considers to have the "greatest opportunity" to reach residents according to Baker's report. Funding comes in part from a federal grant for education and outreach under the Affordable Care Act.

Editorial: State must give on stand-alone vision plans
Sacramento Bee
September 22, 2012

As the first state to authorize a Health Benefit Exchange after President Barack Obama signed the 2010 federal health care reform, California jumps into a national leadership role in defining the new marketplace.

Make no mistake, in a state as large and diverse as California this is a herculean task.

The good news is that medical, dental and vision plans are fighting like the dickens to get a chance to compete in this new marketplace. They are not abandoning it.

So the controversy over how to include vision plans, as reported by Dale Kasler in Wednesday's Bee, should be seen as a healthy sign.

VSP Vision Care, the largest vision benefits company in the United States, founded in 1955 and headquartered in Rancho Cordova, wants to be able to compete to offer stand-alone vision plans through the exchange to currently uninsured individuals and small businesses.

The California exchange board should make that possible – when the exchange opens January 2014, not waiting until future years.

The board already has had to make some tough decisions.

It has had to decide whether the exchange should focus only on offering "essential benefits" plans to individuals and small businesses for the January 2014 opening. Under the federal law, dental and vision coverage is an essential benefit for kids only.

So states have had to decide whether their exchanges also will offer supplemental dental and vision coverage for adults.

The California exchange board has decided to do both essential coverage for kids and supplemental coverage for adults, a good thing.

But here's the rub. While federal law says that essential dental coverage for kids can either be embedded in a comprehensive medical plan or stand alone, it says nothing about vision. So the board, in an initial decision in August, said that essential vision coverage for kids could be offered only if it is embedded in a comprehensive medical plan – not as a stand-alone plan.

This makes no sense. In the current private market, dental and vision coverage is rarely embedded in medical coverage; it is sold in stand-alone policies. In fact, more than 90 percent of dental and vision care in California is delivered by stand-alone plans. In public programs, such as California's existing Healthy Families program, vision coverage is delivered only through stand-alone plans.

Yes, the board is right that the addition of federal subsidies for individuals based on their income makes things complex if you have to divide payments between separate medical, dental and vision plans. But if

the exchange already is figuring out how to handle stand-alone dental, it certainly can do the same for stand-alone vision.

Private employers have been offering medical, dental and vision separately for years, with a mix of employer-subsidy and employee payments.

The exchange can do this, too.

To its credit, the board is allowing stand-alone vision plans for adults as a supplement for small businesses. Oddly, however, it is not allowing stand-alone vision plans as a supplement for individuals.

Certainly it is true that, today, most people get stand-alone vision coverage through an employer; it is not at all common in today's individual market. For example, of VSP's 14.2 million current customers, only 20,000 buy stand-alone vision plans as individuals.

But Al Schubert, a vice president at VSP, sees a growing, emerging individual market ahead with the federal health care overhaul – and sees opportunities in both the small business and individual markets in state exchanges. "We don't want the market correction to leave us behind," he told the editorial board.

The exchange board has said it would revisit its August decision at its October meeting. Stand-alone dental and vision plans should be offered the same way in the exchange's small business and individual markets – as an essential benefit for kids and a supplement for adults on Day 1, 2014. That makes consumer choice simple – and it allows a key local firm to compete in the new marketplace.

Affordable Care Act offers many compliance pitfalls

Sacramento Business Journal
October 12, 2012

Federal health reform is big, confusing — and coming fast — a Massachusetts lawyer told Sacramento employers at a seminar.

The Affordable Care Act also looks like full employment for lawyers and benefit professionals.

"You guys may all meet the requirements, but you will stub your toe and have to pay some penalties," said Peter Marathas, a partner with Proskauer Rose, an employee benefit and compensation law firm.

Marathas speaks with experience. His state pioneered some of the rules now hitting the national stage and he knows the language of Affordable Care Act well enough to say there are plenty of unknowns.

With that, he launched into things employers should be thinking about today, including:

A litigation minefield: Forget about being too big or little for an audit. The U.S. Department of Labor checked the books of a garden shop on Cape Cod with two employees. There's lots of room for employee claims under the act, too. Think workforce realignment to avoid hitting the small employer cut-off, claims about mandated benefits or whistle-blower actions.

The $2,500 health FSA limit: It's effective in 2013 for annual employee contributions, but it does not limit employer contributions.

Comparative effectiveness fee: A $2 per member per year fee starts for plan years ending after Sept. 30, 2012, but it's reduced to $1 for plan years ending before Oct. 1, 2013. The fee is paid by insurers if it's an insured plan; by the plan sponsor if self-insured.

Basic Health Plan numbers do not add up
Capitol Weekly
October 9, 2012

One of the most hotly contested issues for the end-of-year special session called by Gov. Brown on healthcare is whether California should create a "Basic Health Plan." This proposal would take away subsidies for the purchase of private health insurance from an estimated 800,000 lower-income Californians. It would require them to enroll instead in a program run by the state's Medicaid department.

The proponents of the Basic Health Plan claim that it will be vastly more affordable for Californians. But their numbers do not add up.

A recent opinion piece by Los Angeles County Health Services Department Director Mitchell Katz advocating for the creation of a Basic Health Plan used the example of a woman making $1,250 a month. He argued that an Exchange plan would be too expensive for her because it would cost $123 per month or almost 10% of her income.

That's incorrect. For a woman making $1,250 per month, the Affordable Care Act limits the amount she will pay in premiums to 3% of her income. That's $38. And her out-of-pocket expenses are also limited by law to 8% of her total bill. This works out to about $22 per month for a person with average medical expenses.

So the total cost for private health coverage on the Exchange for this working Californian is $60, not $123. That's a big difference.

It is also important to point out that we have no idea whatsoever how expensive Basic Health Plan coverage would be. Some projections put it at $15 per month for a Californian who earns $1,250 per month. But in order for those numbers to add up, the state would have to use the limited group of hospitals and doctors that already provide services to the Medicaid population and would have to pay them little more than the microscopic rates that it pays them currently.

There are many problems with this approach. For starters, the state Medicaid program pays, in some cases, as little as 8% of the total cost of providing healthcare. These unpaid costs must be covered primarily by individuals insured through their employers who are already struggling with astronomical healthcare costs.

Low public program payments hurt the program beneficiaries as well. The narrow networks that serve the safety net populations are already struggling to prepare for the 2 million more Californians who will be eligible for Medi-Cal under the ACA. Trying to shove another 800,000 Californians enrolled in the Basic Health Plan through these same doors into rooms already jammed with people is a terrible way to start the implementation of health reform.

Realistically, the Basic Health Plan would have to spend more money to get more access, broader networks, and better specialty care. But then its costs start to ratchet up and the prospects of providing more affordable coverage than the Exchange will quickly disappear. And California actually gets, by law, 5% less in federal funding for the Basic Health Plan than it does for Exchange subsidies. If the massive

federal cuts slated to take effect beginning next year are not averted, this funding gap will be even greater since exchange subsidies are protected from the cuts while the Basic Health Plan is not.

It is particularly important to get the numbers right when we're talking about coverage for working class people who are making their way up the income ladder. Essential to the promise of the Affordable Care Act is that the health insurance plans will be affordable for them, affordable for us all.

But at the end of the day, the Affordable Care Act isn't only about affordability. It also aims to create a better, simpler, more universal healthcare system. By creating an entirely new public program based on a narrow network of overworked, underpaid healthcare providers, the Basic Health Program belies the promise of healthcare reform.

We need to spend the special session bolstering healthcare reform, not pulling it apart.

Report: Region not ready for health reform in 2014
Sacramento Business Journal
September 28, 2012

About 227,500 Sacramento area residents will be eligible for health coverage in 2014, but an already strained regional safety net is not prepared to care for them, a new market analysis of the region concludes.

Slightly more than half of the newly insured will be Medi-Cal patients, placing a huge burden on emergency departments and community health centers that typically serve this population.

Without community action to beef up the system and collaborate on more comprehensive approaches to care, the system will be overwhelmed, according to the analysis commissioned by the Sierra Health Foundation and aired at a public forum in Sacramento Thursday.

"We have a fragmented safety net. We all know about state and local budget cuts — and the Affordable Care Act will bring thousands more to coverage," Congresswoman Doris Matsui said. "How will we care for them?"

The Sierra Health Foundation launched the Sacramento Region Health Care Partnership in October 2011 to strengthen Sacramento's safety net and examine the region's preparedness for health reform. The partnership conducted research and focus groups. The resulting reports — a marketing analysis and strategic plan — were released Thursday.

Facing the launch of expanded coverage less than 18 months away, the market analysis identified critical issues. The strategic plan provides a road map to address them.

Critical issues include:

- Regional capacity in community health clinics that is below average
- Growing demand for the safety net will accelerate with health reform
- Roughly half the region's community clinics are losing money
- Currently, the safety net is overly dependent on high-cost hospital and emergency department services
- Community clinics and emergency rooms will likely reach capacity before 2016
- The newly insured population is expected to be sicker than the current population in public programs
- About 60 percent of the newly insured patients will be covered by Medi-Cal
- The number of federally qualified health centers — which get higher reimbursement for Medi-Cal patients — is lower than the state average and other regions
- The current safety net lacks a lead agency, coordination and integration
- Health reform offers an opportunity to rethink how primary care is currently provided by the safety net.

Given the short time-frame, the strategic plan picked four top priorities. They include:

- Better collaboration among providers

- Better coordination for patients
- Capacity building for providers
- Better integration between primary and specialty care.

“The ACA. Let’s leverage it; let’s use it to benefit all of us in Sacramento,” Matsui said at the forum. “This is not just another study, another analysis, another plan. We are going to do something about it.”

The market analysis and strategic plan were funded by the Sierra Health Foundation with support from The California Endowment and the Sacramento Region Community Foundation. The team of consultants included The Abaris Group, the Public Health Institute and Hatches Consulting.

Reactions from speakers included praise for the effort, concern about the challenges — and a sense of urgency.

“It’s about time. We have patients out there not getting services and that’s really unconscionable in a community like ours,” said Dr. Claire Pomeroy, CEO of the UC Davis Health System.

After a discussion of the challenges, Dr. Ken Kizer, director of the Institute for Population Health Improvement at the UC Davis Health System offered an urgent call to action.

“I’ve been involved with dozens, if not hundreds of similar conversations over the last 30 years that didn’t go forward in the way we wanted,” he said. “I would hope that, going forward, we would be impatient and look for outcomes, not more rhetoric.’

To propel the effort forward, the Sierra Health Foundation announced a $3 million commitment to launch three parts of the strategic plan over the next 36 months. They include building capacity in area community clinics to meet increased demand, work on public policy to create a climate that’s supportive of the goals in the plan and efforts to educate the public and get residents engaged in the process.

The first step will be discussions with community clinics that want to expand about what kind of technical support they need,followed by a request for proposals for the funding to do it.

150 VSP jobs in California on hold
Sacramento Business Journal
September 28, 2012

VSP Global has put 150 new California jobs on hold pending a decision about whether the company will be allowed to compete for individual members in the California Health Benefit Exchange as a standalone vision plan.

The company threatened to leave town in an angry op-ed in the Business Journal last month when the decision was announced, but the company is in discussions with exchange officials, who have announced they will address the matter at their Oct.16 board meeting.

The jobs cross a variety of levels and disciplines — and include many positions in the company call center in Rancho Cordova. If the exchange decision doesn't go VSP's way, the new jobs will be filled in the company's call center in Ohio, spokesman Pat McNeil said.

"The California jobs are on hold until we have resolution with the California Health Benefit Exchange," McNeil said. This "is unfortunate because many of the open positions are in our customer services areas here in Sacramento, which would have been a nice bridge on the heels of the recent Comcast announcement."

California Plans an Obamacare Reality Show
Forbes
September 28, 2012

Yesterday, Deadline Hollywood discussed a larger story put out by the New York Times. California is one of a few states going full speed ahead with Obama's controversial health care program. Although the Supreme Court upheld most of the program's components, most states are taking the time to figure out how portions of it can best work within their domains.

Not only is California diving right in, but – to paraphrase Deadline's summary –California's exchange board of directors plans to publicize the program well ahead of its mandated January 2014 deadline. To do this, it is hiring public relations juggernaut Ogilvy & Mather, for nearly one million dollars, to publicize the *idea* of the Patient Protection and Affordable Care Act.

"The Ogilvy plan includes ideas for reaching an uninsured population that speaks dozens of languages and is scattered through 11 media markets: advertising on coffee cup sleeves at community colleges to reach adult students, for example, and at professional soccer matches to reach young Hispanic men," says the PR missive.

But wait, there's more. Obama's plan could make great story threads for television: "I'd like to see 10 of the major TV shows, or telenovelas, have people talking about 'that health insurance thing,'" said Peter V. Lee, the exchange's executive director. "There are good story lines here."

The Times goes on to say that Ogilvy plans to pitch Hollywood a reality television show about "the trials and tribulations of families living without medical coverage." The exchange will also seek to have prime-time television shows, like *Modern Family*, *Grey's Anatomy* and Univision telenovelas, weave the health care law into their plots.

It's not surprising that the exchange would enlist Hollywood's help with this. After all, Hollywood is one of Obama's biggest supporters. What is surprising to many, it seems, is the idea that there's money to burn promoting the exchange, when it's not even clear how the exchange will function yet.

It's noteworthy that California would attach Ogilvy to another high-profile initiative. It was Ogilvy Public Relations Worldwide that parted ways with the California High-Speed Rail Authority last year. Rail authorities questioned the firm's billing practices, and whether it was an effective advocate for the proposal to build a 500-mile, high-speed rail system from the Bay Area to Los Angeles.

One of the board exchange members is partial to calling the California health exchange portal "avocado." A show called *Project Avocado* sounds no worse to me than *Here Comes Honey Boo-Boo*. I just don't want to pay for it.

Vision Service Plan presses to participate in health exchange

Sacramento Bee
September 18, 2012

Rancho Cordova's Vision Service Plan, backed by the leader of the state Senate and the region's top business organizations, urged a state agency to reconsider a decision that prohibits VSP from competing for customers in a new state-run health care exchange.

VSP has already hinted that the decision last month by the California Health Benefit Exchange could prompt the Rancho Cordova company to relocate its headquarters to another state. VSP employs 2,100 workers in the Sacramento area.

VSP, along with Senate President Pro Tem Darrell Steinberg and leaders of four of the region's top business organizations, urged the Health Benefit Exchange Board to reconsider its decision.

The board meets today in Sacramento.

The Health Benefit Exchange is a new state agency set up to implement a key piece of the Affordable Care Act, the Obama administration's overhaul of the health care system. The exchange is setting up an online marketplace for individuals and small businesses to purchase health insurance, set to begin in 2014.

Last month the board voted to exclude stand-alone vision care insurers, like VSP, from competing to sell coverage to individuals.

The board did vote to let the stand-alone insurers to sell to small businesses.

The individual market is expected to be significantly larger than the small business market.

In an op-ed piece printed in the Sacramento Business Journal last month, VSP President J. Robinson Lynch said: "Maybe it's time for us to choose to go where we are wanted."

Business leaders in the region took up VSP's cause in a letter to the health board. "VSP is a valued member of our business community that we cannot afford to lose," business leaders wrote the board in a letter last week. The letter was signed by the heads of the Sacramento

Metro Chamber, Valley Vision, the Sacramento Area Commerce and Trade Organization and the Sacramento Area Regional Technology Alliance.

"Aside from being a home-grown California company, VSP is a major employer of over 2,000 Sacramentans in a district struggling mightily to recover from this prolonged recession," wrote Steinberg, D-Sacramento, in a letter to the board.

Following the furor, Peter Lee, the exchange's executive director, announced today the board plans "to revisit the matter" next month.

California spends $900K for Hollywood to promote ObamaCare

Foxnews.com
September 18, 2012

California's ObamaCare-created insurance exchange is planning to spend $900,000 in taxpayer money to a P.R. firm to help enlist Hollywood "to incorporate story lines or mentions of health care reform that would reinforce [public relations] campaign messages" on prime-time TV.

The Hill reports that alongside a possible reality show about life without the health care law, the marketing plan incorporates "a number of popular television programs and personalities such as 'Grey's Anatomy,' 'Modern Family,' 'The Biggest Loser,' 'Dr. Oz' and others will be approached and pitched to incorporate story lines or mentions of health care reform that would reinforce campaign messages."

The New York Times reports that Dr. Mehmet Oz of "Dr. Oz" is already appearing in ads urging people to "get educated, get engaged, get enrolled [in the Obamacare insurance exchange]."

Democrats have come under fire in the past for using $20 million of taxpayers' money to promote and increase awareness of their controversial health-care overhaul.

Regulatory confusion poses concern for state health exchange
Sacramento Business Journal
September 14, 2012

The state's new health benefits exchange is confronting an old problem with health insurance: California's system of dual regulators.

Four speakers brought the matter up in testimony before the exchange Aug. 23 as the board debated policies for health plans that will participate in a new insurance program for individuals and small businesses in 2014.

California is the only state with two agencies that regulate health insurance, and some of their standards are different. This raises questions about consistency across a new insurance program that wants to sell itself on simplified, one-stop comparison shopping for small business owners and individual consumers.

"I'm concerned about the differences and bumps in the road with two regulators," said Gary Passmore, Northern California vice president for the Congress of California Seniors. "I would hope legislation will address that."

The Department of Insurance regulates preferred-provider organizations and traditional indemnity plans that cover 2.4 million state residents. The Department of Managed Health Care oversees mostly health maintenance organizations that cover 21.6 million Californians. But the growth of less-restrictive PPO plans have muddied the waters.

Some PPOs are regulated by one agency, some by the other. Some standards are stricter at one agency, some at the other, and a mix of HMOs and PPOs are expected to be offered in the new exchange.

"This is a big deal," Deborah Kelch, principal at the Kelch Policy Group, told the exchange board Aug. 23.

The California Health Care Foundation agrees and has provided a $350,000 grant to Kelch to study the issue, with the aim of improving coordination of health insurance oversight in California. A 2011 report by Kelch for the foundation concluded that consolidating insurance oversight in one agency is the most efficient solution — but it did not say which agency should swallow the other.

When Congress enacted the Affordable Care Act, it established a common federal standard of benefits and market protections. State law creating the exchange requires it to "consistently and uniformly apply these requirements, standards and criteria to all carriers," Kelch said in written testimony to the exchange.

The exchange should not assume a role as third regulator but as an active purchaser, Kelch added. The program has an opportunity to establish consistent policies that apply uniformly to all health plans in the exchange regardless of the department overseeing the coverage.

Consumer grievance and complaint standards are one area of disconnect. The Department of Managed Health Care has specific response timelines; there is no similar internal grievance process under the California Department of Insurance. Standards for network access are different, too.

“The difficulty is this is not readily recognized by the small-business owner — or consumer — who buys a PPO plan under DMHC versus CDI,” Kelch said this week. “Does he or she understand their employees may not have the same access to providers or may have a different consumer appeal process?”

Cindy Ehnes, a former director at DMHC when the access rules were adopted, is now CEO at the California Children’s Hospital Association. She expressed concern about consumer access to pediatric specialty care if these rules aren’t followed.

“I strongly disagree that the two platforms are consistent,” she told the exchange board last month. “A lower standard in a PPO product is simply the wrong message.”

Part of the problem is a perception that applying more extensive rules on plans sold by CDI may increase their price. Whether that’s true of not is unclear; this is something Kelch is studying.

Politics plays a role, too, because Insurance Commissioner Dave Jones is an elected official who made dual agencies an issue when he ran for office in 2010 and he clearly wants the lead role.

Jones declined to comment, but deputy commissioner Janice Rocco noted that some standards, such as rate review and rules about rescinding policies after they are purchased, are tougher at CDI.

“When you look at the issue generally, it’s important to have an elected insurance commissioner (who) voters can hold directly accountable,” Rocco said. “This must be considered when talking about consolidation.”

Consolidation doesn’t appear likely any time soon. There’s too much other work to do.

Differences are diminishing with federal rules for an essential package of health benefits and legislative action to add coverage to PPOs, said DMHC director Brent Barnhart. For example, recent legislation has added maternity care to PPO benefits, something HMOs already had.

“On standards, we’ll have to see,” Barnhart said of rules like DMHC’s requirements for timely access to care. Some legislators are considering changes pushed by consumer advocates to establish parity where there isn’t.