# Media Clips

**COVERED CALIFORNIA BOARD CLIPS**
**February 18, 2016 – April 7, 2016**

Since the Feb. 18 board meeting, high-visibility media issues included: Covered California's plan to exclude poor-performing hospitals from its network; an increase in competition in the health insurance marketplace; and the demographics of individuals who enroll during special-enrollment periods.

Since the Feb. 18 board meeting, the term "Covered California" was mentioned 10,600 times in a Google search and the phrase "California Health Benefit Exchange" was noted 138 times. The following clips represent a cross-section of media outlets and coverage.

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NEWS RELEASE

March 9, 2016

# NEW ANALYSIS URGES SHIFT TO PATIENT-CENTERED BENEFIT DESIGNS TO CUT COSTS AND HELP CONSUMERS GET CARE

*Lessons Learned in California Can Help Avert a Collision Between Conflicting Reform Initiatives*

SACRAMENTO, Calif. — A new analysis urges state-based marketplaces, the employer-sponsored insurance market and health insurance plans to take action and move toward plan benefit designs that put consumers first, and remove existing barriers to getting needed health care.

In an article written in the *New England Journal of Medicine* by Dr. Elliott Fisher, Director of The Dartmouth Institute for Health Policy and Clinical Practice, and Covered California Executive Director Peter V. Lee, both stress the importance of patient-centered benefit designs to reach the next level of health care reform.

“Health plans, states and employers should take to heart the lesson that offering a lot of different designs does not serve consumers well,” Fisher said. “Too many health plans, in exchanges and the employer sector, offer confusing benefit designs with out-of-pocket costs that prevent people from seeing their doctor.”

Lee said Covered California has a model that has worked for its consumers since the agency opened its door in 2014.

“Covered California has led the way in the fight for consumers by shaping benefit designs that help consumers make apples-to-apples comparisons and to get the health care they need,” Lee said. “A good patient-centered benefit design is critical to making sure consumers get the right care at the right time.”

Fisher and Lee noted that the current health care system seeks to improve care and cut costs through provider-focused and consumer-focused reform initiatives that directly conflict with one another.

For example, provider-focused initiatives encourage physicians, hospitals and other providers to coordinate and improve care to lower costs. However, the consumer-focused approach discourages people from seeing their provider because of increased cost-sharing. Studies show the proportion of Americans with employer-sponsored

Studies show the proportion of Americans with employer-sponsored coverage involving deductibles of more than $1,000 has increased from 10 percent to 46 percent since 2006, with many plans requiring people to fully meet their deductible before receiving any coverage for primary care. A 2015 National Bureau of Economic Research study showed the adoption of a high-deductible health plan in a relatively high-income population led to a 10 percent reduction in the use of preventative services and an 18 percent drop in physician visits, with the greatest reductions occurring in the sickest patients.

"We want consumers to be able to see their doctor when necessary, so their health care needs can be met in the most effective and efficient way possible," Fisher said.

The authors cite California's approach as an example of how it might be possible to avoid this collision between provider- and consumer-focused efforts. Covered California, the state's insurance exchange, requires plans to adopt patient-centered benefit designs that allows consumers at every metal tier (cost-sharing split between insurer and enrollee) to visit their primary care physician without the cost being subject to a deductible. "When a consumer is able to get the right care at the right time, it cuts down health care costs for everyone," Lee said.

The Centers for Medicare and Medicaid Services recently announced it would allow health insurance companies to offer patient-centered benefit designs on the federal exchange.

"This is a good step for consumers," Lee said. "However, more needs to be done if we are going to reach the next level in health care reform."

The article, "Toward Lower Costs and Better Care – Averting a Collision between Consumer- and Provider-Focused Reforms," is available at www.nejm.org/doi/full/10.1056/NEJMp1514921.

**About The Dartmouth Institute**
Since 1988, The Dartmouth Institute for Health Policy and Clinical Practice has been working to find solutions to some of the most challenging problems in health care delivery. Our goal is to help create an affordable, high-performing health system for everyone.

**About Covered California**
Covered California is the state's marketplace for the federal Patient Protection and Affordable Care Act. Covered California, in partnership with the California Department of Health Care Services, was charged with creating a new health insurance marketplace in which individuals and small businesses can get access to affordable health insurance plans. Covered California helps individuals determine whether they are eligible for premium assistance that is available on a sliding-scale basis to reduce insurance costs or whether they are eligible for low-cost or no-cost Medi-Cal. Consumers can then compare health insurance plans and choose the plan that works best for their health needs and budget. Small businesses can purchase competitively priced health

insurance plans and offer their employees the ability to choose from an array of plans and may qualify for federal tax credits.

Covered California is an independent part of the state government whose job is to make the new market work for California's consumers. It is overseen by a five-member board appointed by the governor and the Legislature. For more information about Covered California, please visit www.CoveredCA.com.

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The Modesto Bee

modbee.com

# Peter V. Lee: Don't be misled by bogus claims of rapidly rising deductibles

By: Peter V. Lee
March 16, 2016

More than five years after the Patient Protection and Affordable Care Act became the law of the land and launched a new era of health care in this country, the law and Covered California remain the target of misleading and inaccurate political attacks.

The op-ed “California health insurance deductibles going up” (Page 3I, March 10) is the latest attempt to confuse consumers with a smokescreen of outrageous claims. Fortunately, it is easy to clear the air and find the truth.

The author, Nathan Nascimento of Freedom Partners Chamber of Commerce, mistakenly claims that Covered California consumers need to pay thousands of dollars in deductibles before their health insurance coverage kicks in.

That’s simply not true, and it is irresponsible to make such a misleading claim.

Covered California requires its insurance companies to adopt a system of patient-centered health plan designs that put the consumer first and remove financial barriers to accessing care.

For example, the author does not seem to know that every outpatient service in our Silver, Gold and Platinum plans can be accessed without being subject to the consumer’s deductible. That includes primary care visits, specialist visits, lab tests, X-rays and imaging.

Even our most affordable plans in the Bronze tier promote care, allowing consumers to see their doctor or a specialist three times before being subject to the deductible.

In a historic move, Covered California also put the consumer first when it became the first health insurance exchange in the nation to establish a cap to protect consumers from the high cost of specialty drugs.

All of these benefits are designed to bring health care within reach and to make sure that a Covered California plan is not just an insurance card, but something that opens the door to health care and helps consumers get the services they need and deserve.

In a recent article I coauthored with a leading physician, we urged state-based marketplaces, the employer-sponsored insurance market and health insurance companies to take action and move toward these patient-centered plan designs to help us reach the next level of health reform. We’re pleased the federal exchange is adopting our recommendation for 2017. This will help consumers more easily make apples-to-apples comparisons of plans and make it easier for them to see what services are subject to a deductible and which ones are not.

In addition to promoting health care through our plan designs, Covered California has kept rate changes at historically low levels for two consecutive years, and at a fraction of the rate changes consumers saw before the Affordable Care Act was implemented.

Consumers can also shop around for the best deal that fits their needs, and in many cases they can actually lower their premiums.

While the author tries to raise the specter of financial doom, noting that some health insurance companies have lost money on a national level, the fact is that nearly all of Covered California's plans made a profit in 2014. Two new insurance companies joined our exchange in 2016, because it made good business sense for them and it gives consumers even more choices.

California has put the politics behind us, and thousands across the state – Democrats, Republicans and independents – have worked to implement the law in a way that puts patients first. Millions of people have gained health care coverage, cost increases have slowed, consumers have more choices and life-changing care is being delivered.

Those are the facts, and we are all better served by focusing on them instead of misleading hyperbole.

*Peter V. Lee is executive director of Covered California.*

California Healthline
The Daily Digest of News, Policy & Opinion

# Preventive Care And High Deductibles Work At Cross Purposes, Covered Cal Chief Says

**By: Ana B. Ibarra**
**March 16, 2016**

For years, leading health experts have said the way to improve healthcare quality and lower its cost is to emphasize prevention over treatment and encourage closer coordination among medical providers caring for a patient.

Those goals are at the core of the Affordable Care Act, which aims to push medical delivery in that direction.

But there's a counter trend threatening to undermine that vision, according to an article published March 9 in the New England Journal of Medicine: A rapid move toward health plans that impose a larger share of the cost on enrollees, most notably through high deductibles and copayments.

"The conflict between these two approaches is clear," wrote the article's co-authors, Peter Lee, the executive director of Covered California, and Dr. Elliott Fisher, director of the Dartmouth Institute for Health Policy and Clinical Practice. Boosting quality and cutting costs, they said, "depends directly on having patients engaged with their care team — usually a primary care practice."

The two authors still see an important role for "carefully designed" consumer cost sharing, which can induce patients to "make wise decisions about what discretionary care they truly need and want."

But the high out-of-pocket costs embedded in a growing number of health plans can deter people from getting the preventive primary care they need to stay healthy, Lee and Fisher warned. They urged state-based insurance exchanges and employers who sponsor coverage for their workers to offer health plans that make it easier for people to get medical care.

Peter Lee, executive director of Covered California (Photo by Max Whittaker/Getty Images)

“We need to change the culture of medicine to be about primary care and care coordination,” Lee said in an interview last week. “Employers and health plans in the public sector have benefit designs that directly conflict with the goal of the ACA.”

So much of the health reform law, Lee added, is about ensuring access to care. Yet, high out-of-pocket costs in many plans can block that objective he said.

That is particularly true among those who get health coverage through an employer. And that’s a large number: 147 million people, or 54.6 percent of the non-elderly U.S. population, according to a 2015 survey on employer-sponsored insurance by the Kaiser Family Foundation and Health Research & Educational Trust. [Kaiser Health News, which publishes California Healthline, is an editorially independent program of the foundation.]

Lee and Fisher noted that the proportion of Americans who have employer-sponsored coverage with deductibles of more than $1,000 has increased from 10 to 46 percent in the past decade.

They cited a 2015 study by the National Bureau of Economic Research showing that plans with high deductibles in a population with relatively high income led to a 10 percent decline in the use of preventive care and an 18 percent drop in physician visits. The biggest reduction in care was among the sickest patients.

“We want consumers to be able to see their doctor when necessary, so their health care needs can be met in the most effective and efficient way possible,” Fisher said in a news release.

Fisher and Lee noted that Covered California has taken a different approach — an example they said can help avoid a collision between insurance plans with high deductibles and the ongoing effort to improve the quality and reduce the cost of care. (By cost, Lee and Fisher mean health care costs overall; with high deductible plans, the cost to employers goes down.)

Among 1.3 million Covered California enrollees as of June 2015, they noted, 75 percent could obtain primary care without being subject to a deductible and with “modest co-payments” that varied depending on whether they qualified for federal subsidies.

Yet the other 25 percent of Covered California enrollees — 316,000 people — had chosen the lowest-tier “bronze” option as of mid-2015. Patients in the bronze plan receive one free primary care visit and three visits not subject to the annual deductible. After that they face a $5,000 deductible for primary care visits and other care.

Erin Trish, an assistant research professor at the University of Southern California’s Leonard D. Schaeffer Center for Health Policy and Economics, said the reason why many people chose bronze is simple: despite the high deductibles, people are pulled toward the cheaper premiums.

“They might be able to get these three primary care visits [not subject to the deductible], but if they need other services, it will be at a considerable cost, and that adds to financial hardship,” Trish said.

It’s not just about the cost. Plans catering to patients’ best interests should be easier to navigate, many agree. Too many plan benefit designs, they say, are confusing and convoluted for the average consumer.

Fisher and Lee noted that Covered California — joined by a handful of other states — has standardized deductibles, copayments and other shared costs for its contracted health plans at each of the four levels of coverage: bronze, silver, gold and platinum. That means shoppers can compare plans at each tier of coverage based only on the premium and which doctors and hospitals are in the network.

Not all state exchanges are designed this way, they observed. Consumers in many states are left to choose among a multitude of insurance policies from a wide range of carriers, with differing deductibles and co-payments. Many of the health plans in this “confusing array of products” will undermine initiatives in delivery-system reform,” the authors wrote.

Two weeks ago, the Centers for Medicare and Medicaid Services announced it would allow health insurance companies to standardize benefit designs on the federal exchange next year.

Shana Alex Charles, an associate professor at California State University, Fullerton’s Department of Health Science, said the fact that the federal government is looking to carry out a benefit design similar to Covered California’s is good news for consumers.

“People don’t always want to have a lot of choices; it is difficult and overwhelming,” Charles said. “They want a good product within a limited range of options.”

She said Covered California’s model is probably the most consumer-friendly currently available. “It’s surprising other states aren’t doing the same,” she added.

According to Lee, more people are paying attention to what California is doing. “We’re raising the warning flags,” the exchange director said. “If we don’t improve the pathway for people to see their primary care doctor, we all lose.”

California exchange officials plan to continue pounding the drum. In April, Covered California’s Board of Directors will consider a new rule that would ensure every single patient covered through the exchange has a doctor within 30 days of signing up.

# New enrollment data shows competition increased in the state marketplace

**By: Maria G. Ortiz-Briones**
**Feb. 25, 2016**

New enrollment data released by Covered California shows an increased competition in the state's marketplace during the third open enrollment period.

The new data, released on Feb. 17, included information of the total number of new consumers enroll in health plans as well as consumer enrollment by health insurance carrier.

“We are seeing the effect of vibrant enrolment across state. We finished strong with almost 440,000 new consumers,” said Peter V. Lee, executive director for Covered California.

The third open enrollment period started Nov. 1, 2015 and officially ended on Jan. 31, 2016. However, Covered California extended its original deadline until Feb. 6 for those consumers who started their application process by midnight Jan. 31 but were unable to complete their enrollment due to last-minute rush for health coverage.

According to Covered California, more than 439,000 new consumers signed up for health coverage during the three months of open enrollment period including approximately 14,000 people who received help crossing the finish line during the six-day period Covered California kept its doors open after the Jan. 31 original deadline.

Lee said for this open enrollment period, Covered California saw a bigger number of the younger population seeking health coverage.

“Covered California built a marketplace that is leading to sustainable cost trends because of the good risk mix, and that creates a level playing field for carriers, forcing them to compete on price and quality,” Lee said of Covered California’s aggressive negotiations. “Competition is driving the market. Consumers are shopping around and selecting the health plan that best fits their needs and pocketbook.”

Lee said during the first two open-enrollment periods, approximately 94 percent of consumers signed up for coverage through one of the four major carriers - Anthem Blue Cross of California, Blue Shield of California, Health Net and Kaiser Permanente. However, during the last third open-enrollment period that number dropped to 83 percent.

According to Covered California, the percentage of new consumers who selected a health plan outside the four major carriers nearly tripled this enrollment period compared with a year ago.

Lee added that 88 percent of those consumers who renewed their health coverage with Covered California stayed with their same health plan which not only means those consumers were satisfied with the price, quality and level of coverage but also by keeping the same plan it provides consumers with continuity.

“It’s a win-win for consumers,” Lee said.

He said many people in the federal market place had to change plans while in California consumers were able to keep their plan.

According to Lee, Blue Shield, one of the largest insurance carriers of the 12 health plans in Covered California, with more plan selections than any other carrier in the state’s marketplace, had one of the lowest rate increases in the state for 2016.

Because of this, Lee said 315,000 consumers renewed their health plans with Blue Shield including more than 17,000 Anthem Blue Cross of California consumers who renewed with Blue Shield instead and more than 11,000 consumers who left Health Net for Blue Shield. And more than 117,000 new consumers signed up with Blue Shield during open enrollment.

While California is a big state, Lee said health care is local with data showing that local or regional plans in Sacramento, Fresno, San Francisco, San Diego and Los Angeles gaining substantial enrollment.

In Sacramento, which is considered Region 3 in Covered California pricing regions, Western Health Advantage saw its plan selections increase from 5,773 in 2015 to 8,790 in 2016.

In Fresno area, which is considered Region 11 covering Fresno, Kings and Madera counties, 53.1 percent of new enrollment selected Blue Shield while the rest of the new enrollment was split between Anthem and Kaiser Permanente.

In Region 10 which covers San Joaquin, Stanislaus, Merced, Mariposa, and Tulare counties, 62.4 percent of new enrollment selected Anthem while 26.9 percent selected Kaiser and only 5.7 percent selected Blue Shield.

“This is further proof that the Affordable Care Act is working and that Covered California is working hard to use all the tools to benefit consumers,” Lee said. “We have created a marketplace where there is a good mix of consumers enrolled, which keeps prices down and carriers fighting for people’s business.”

FierceHealthPayer

# Covered California offers peek at consumers who use special enrollment periods

**By: Evan Sweeney**
**Feb. 24, 2016**

Special enrollment made up 13 percent of forced membership for Covered California plans last year--often at a higher cost than open enrollment members--but officials say providing proof of special enrollment eligibility could deter unqualified members and drive costs down.

Special enrollment in Covered California plans saw a slight increase from 11 percent membership enrollment in 2014, although two large plans are approaching 20 percent, according to a presentation in a Covered California board meeting. Officials say that a better verification process for the special enrollment period (SEP) would limit premium increases and result in a healthier risk mix. High premium increases can be a deciding factor in non-subsidized enrollees declining coverage, and for subsidized members, rate increases have implications for the federal budget.

John Bertko, chief actuary at Covered California, outlined six observations of special enrollment plans:

- SEP members have 15-50 percent higher costs per month than open enrollment period (OEP) members in Covered California's four largest plans.
- SEP members are two or more years younger than OEP members, which exacerbates the cost difference. In particular, newborns under one year of age are more expensive than children ages 2-18.
- A large chunk of SEP members do not meet enrollment criteria, and requiring proof of an SEP event (loss of health insurance, marriage, birth, income changes) cuts out 15-35 percent of applicants. The Centers for Medicare & Medicaid Service recently pledged to crack down on abuse by tightening rules surrounding SEP enrollment.
- Although one Covered California plan reported a trend in "Buy to Use" coverage, and other plans reported higher utilization in SEP members during the first three months of coverage, it's still unclear whether SEP members drop coverage after receiving the necessary care, or because they don't need healthcare services. Other insurers have reported as much as 55 percent more utilization in SEP plans, and membership that lasts half as long as OEPs.
- SEPs are trending upward in all Covered California plans and could reach 20 percent of overall membership.

- COBRA enrollment is down slightly, in part because COBRA enrollees are moving toward Covered California plans with lower rates.

Officials proposed adding a verification process for SEPs in which consumers would be required to provide documentation of a SEP event. As part of that proposed plan, Covered California would electronically verify Medi-Cal enrollment or employment-based plans.

California is currently considering regulations that would prevent insurers from cutting off sales commissions for enrolling higher-cost SEP customers, a tactic UnitedHealth and others have adopted amid mounting losses on marketplace plans. Meanwhile, some health experts have argued that tightening SEP enrollment would have detrimental effect on insurers, enrollees, and marketplace plans.

# Covered California, state agencies start 1332 waiver talks

**By: JJ Lee**
**Feb. 23, 2016**

Covered California, the Department of Health Care Services (DHCS), the Department of Health and Human Services (CHHS), and several advocacy groups met today to kick off the formal discussion on 1332 State Innovation Waiver opportunities.

"I look at this as an opportunity to innovate even further, said Diana Dooley, Secretary of CHSS. "This 1332 provision—I don't think anyone could have anticipated—would be a catch all when the law was enacted for possible needs that we would have…I'm less interested in overreaching. That's my worry about my opportunities here."

Dooley reminded the group that the timeframe for submission is short and will require legislative action. While the 1332 Waiver has no formal deadline, states may begin submitting proposals as early as 2017. The Covered California Board will meet on April

7 to consider the issues discussed today and make its recommendation to the legislature.

Both Health Access of California and the Insured the Uninsured Project (ITUP) seized the opportunity to present a framework for priorities.

Lucien Wulsin, Executive Director of ITUP, defined the following potential direction for the waiver:

- Add more affordable plan choices (such as “enhanced bronze”)
- Eliminate family glitch
- Expand tax credit for small businesses
- Allow state and local funds to help pay premiums for those eligible but unenrolled
- Facilitate employer premium contributions for flex workers and small business’ dependents

“As I read 1332, it is kind of a floor and not necessarily a ceiling,” said Wulsin. “So maybe we should think about how much further we can go.”
Wulsin acknowledged that approaching certain affordability issues through the waiver would require long-term planning and years of stakeholder discussions. However, he believes that it is possible to get to affordability goals in the shorter term with a combination of state and local funds. Wulsin pointed to Healthy San Francisco as a model.

Peter Lee, Executive Director of Covered California, pushed back.

“What we’ve said the guidance from our Board was in the near term, we should not ‘violate the treasury’s budget neutrality’ but also [not] be adding liabilities to the California general fund,” said Lee. “What I’ve read—virtually all of the affordability [items] do one or the other. Am I not understanding them well?”
Wulsin responded that there are three forms of affordability—whether people can pay their premiums; whether they can pay copays, deductibles, and get care; and finally the overall rise in spending.

“To the extent that we’re going to get anywhere on the first two, we have to address the third. That’s where I think you need to be saying—we can go so far in Covered California, but we need to have the other purchasers fall in alignment with us to produce the savings to reinvest into improving affordability,” explained Wulsin.

A discussion on tight guard rails and making an actuarially-sound proposal to the federal government ensued.

Anthony Wright, Executive Director of Health Access suggested starting with discrete, “surgical” proposals that have a good chance of passing in 2017 and benching affordability modeling for later.

Wright said that a good choice for inclusion in an upcoming waiver is the pending SB 10 which would allow all Californians, regardless of their documentation status to shop through the Covered California portal without exchange subsidies. In California, 74 percent of families are of mixed immigration status and the move would allow streamlining of coverage and support, according to Wright. He compared the strategy to Massachusetts’ plan to submit its 1332 waiver in two phases. The first will be a modest change to reporting requirements.

Larry Levitt, Sr., Senior Vice President for Special Initiatives at the Kaiser Family Foundation added to this argument that bringing more enrollees into the risk pool is a strong case for savings.

“In many cases these are very healthy individuals, immigrants, and even an infinitesimal improvement in the risk pool and lowering premiums by a very small amount could easily add up to savings,” said Levitt.
Lee reminded that any actuarial analysis or modeling needed for the submission of the 1332 would be “on our dime,” meaning that the process would be funded through Covered California’s budget.

Jennifer Kent, Director of DHCS, asked if each future submission or “bite of the apple” would require legislative action. The legislature would need to grant authority to submit the 1332 and also implement, according to Heather Howard, Director of the State Health Reform Assistance Network at the Robert Wood Johnson Foundation.

Covered California will be accepting public comment until March 1. The Board will meet April 7 to discuss its recommendation.

California Healthline
The Daily Digest of News, Policy & Opinion

# Covered California Takes Aim At System Gamers

**By: Emily Bazar**
**Feb. 19, 2016**

It may soon become harder to enroll in Covered California health plans outside the regular open-enrollment period.

Covered California, the state health insurance exchange, wants to tighten the rules for special-enrollment periods by making consumers provide documentation proving they're eligible.

The change, proposed by Covered California's staff, comes amid concerns that some people are waiting until they get sick to sign up for health insurance during a special-enrollment period, driving up costs.

Consumers can become eligible for special-enrollment periods during the year if they experience certain "qualifying life events" such as the loss of health insurance, marriage, divorce, or the birth or adoption of a child. But no proof is required from Covered California customers, and insurers say that some have abused the process.

The Covered California board of directors is expected to vote on the proposal in April. If approved, it is expected to take effect in June.

"We want people to enroll in special-enrollment periods. … We also have an obligation to make sure that people who enroll in special-enrollment periods qualify," said Covered California Executive Director Peter Lee at the agency's monthly board meeting.

John Bertko, Covered California's chief actuary, said there are "credible indications" that people who sign up during special enrollment have higher health costs than those who sign up during open enrollment. He believes the difference can be attributed partly to people who are gaming the system.

Plus, he said, the number of people who sign up during special enrollment is growing.

Unless Covered California ensures that only those who are eligible qualify for special enrollment, premiums could go up an additional 2 percent to 5 percent, he estimated.

“In the absence of action, we would be potentially facing higher rate increases in 2017,” Lee said.

Obamacare created new enrollment rules for people who buy coverage from a health insurance exchange or the open market. Under the law, they can only sign up or switch plans during the annual open-enrollment period, which ended on Jan. 31 for 2016.

But if they experience one of those life events midyear, they will qualify for a special-enrollment period. Customers of Covered California currently don’t have to prove they are eligible. They “attest” that a qualifying event occurred.

Under the proposal, consumers would have to show documentation –- such as a marriage license or birth certificate. Health plans would forward the documentation to Covered California. If the health plans didn’t receive documentation from consumers within 10 days, Covered California said it would reach out to give them another chance.

Changing the policy could lead to 10 percent to 25 percent lower enrollment during special enrollment, Bertko said.

But consumer advocates opposed the proposal, saying they’re not convinced there’s a problem, especially because the data behind it is “not final or proven,” as Lee said.

They believe requiring documentation will make insurance inaccessible to people who are eligible but have trouble proving it, especially immigrants and low-wage workers. For instance, they said, how can someone prove he was terminated from his minimum-wage job?

“There’s a lot of evidence that reliance on paper documents will serve as a barrier to enrollment,” said Michelle Lilienfeld, senior attorney at the National Health Law Program. “The documentation that will be required in many instances may not even exist.”

Insurers, however, voiced support.

Bill Wehrle of Kaiser Permanente said Kaiser data show that Covered California enrollees who sign up during special enrollment periods have “significantly higher utilization of medical care” than those who sign up for comparable special enrollment periods in the private market, which requires documentation.

About 20 percent of people who apply for a special-enrollment period in the private market are turned away because they can’t document their eligibility, he said.

Of those, he said, about 5 percent later sign up for Kaiser plans through Covered California special enrollment, where they aren’t asked to show proof, he said.

Earlier this year, the federal government tightened rules for special-enrollment periods available through the federal health insurance exchange, Healthcare.gov.

Among other things, it eliminated several circumstances that would trigger eligibility for special-enrollment periods, clarified special-enrollment rules for people who move, and warned that it may seek proof of eligibility from some consumers.

California Healthline
The Daily Digest of News, Policy & Opinion

# California Marketplace May Require Insurers To Pay Agent Commissions

**By: Chad Terhune**
**Feb. 18, 2016**

California's health exchange may require its health plans to pay sales commissions to insurance agents to keep insurers from shunning the sickest and costliest patients.

Covered California is working on a proposal that would force the plans to pay commissions effective next year, said Executive Director Peter Lee. The proposed rules could apply to regular and special enrollment periods, and would leave the specific commission amount or percentage up to insurers, he said.

The issue is expected to be discussed Thursday at Covered California's monthly board meeting.

Regulators in other states have warned insurers about altering commissions in a way that discriminates against higher-cost consumers, but Lee said Covered California may be the first exchange to adopt specific rules.

Health insurers typically pay agents a flat fee or a small percentage of the monthly premium. If companies want to restrict enrollment and avoid some sicker patients, they can try to do so by reducing the incentive for agents to sell their policies across the board or at certain times.

Lee said it has become apparent to him that some insurers are trying to avoid sicker customers by slashing their payouts to agents.

“When one health plan says during special enrollment, for instance, we won’t pay commissions, they are hoping insurance agents won’t sell them and they will sell sick people into another plan,” Lee said. “We aren’t going to let the old games of risk selection happen under the Affordable Care Act.”

The health law banned underwriting and required insurers to accept all applicants regardless of their medical history.

Even after the open enrollment period has ended, people can sign up if they experience a qualifying event such as marriage, a birth or loss of employer coverage. Health insurers have criticized government rules for this special enrollment as too lax, essentially inviting consumers to wait until they get ill to sign up.

Nationwide, several major health insurers have cut or eliminated broker compensation as they reported financial losses in exchange markets. Industry officials have said the moves aren’t discriminatory but rather a prudent business response to higher-than-expected medical costs in the individual market.

A spokeswoman for the California Association of Health Plans said her group won’t weigh in on Covered California’s proposal, leaving the decision up to individual insurance companies. Anthem Inc., California’s largest for-profit health insurer, also declined to comment on it until more details are known.

This issue began attracting more attention in November after industry giant UnitedHealth Group Inc. announced substantial losses on exchanges across the country and pulled back on marketing, including payments to agents.

Lee said he immediately contacted UnitedHealth, which just joined Covered California this year, and advised the company to keep paying commissions in the state.

A spokesman for UnitedHealth said the company didn’t make any changes to broker commissions in California this year. It has said it will decide by midyear whether to continue selling in Obamacare marketplaces.

Lee also weighed in at the federal level in a letter last month. He urged Health and Human Services Secretary Sylvia Burwell to consider setting a minimum commission and to forbid divergence in compensation between open and special enrollment.

The issue is significant because, despite all the hype about government-run websites making the purchase of health insurance easier, many consumers still turn to an insurance agent for help. In Covered California, insurance agents accounted for more than 40 percent of enrollment last year, compared to the roughly 30 percent of people

who signed up on their own online. There were 14,624 certified insurance agents working with the exchange as of last month.

Agents welcomed Covered California's proposal and said they look forward to a debate about what would constitute fair compensation.

"If this issue isn't addressed, we're on a downward path to zero commissions," said Michael Lujan, president of the California Association of Health Underwriters and a co-founder of Limelight Health in San Francisco. "There is a clear need for in-person assistance, and that is being threatened."

In and outside the exchange, agent commissions have been on a steady slide for years. Lujan said he estimates commissions have been reduced by 60 to 70 percent in the individual health insurance market during the past three years.

**Enrollment Totals Posted**

In other developments Wednesday, Covered California released overall enrollment numbers showing that, as expected, Blue Shield of California jumped ahead of Anthem as the most popular plan.

Blue Shield had a 28 percent share of the state marketplace as of Feb. 7 with 433,111 people who were returning customers or newly enrolled. Anthem slipped to second with a 25 percent share, or 394,022 enrollees.

Kaiser Permanente remained in third place with 374,454 people enrolled, a 24 percent share of the market.

Health Net Inc., with a 14 percent share, lost business. Those four top insurers account for 91 percent of Covered California enrollment.

Two newcomers this year, Oscar Insurance Corp. and UnitedHealth, posted meager numbers. Oscar garnered 2,067 enrollees in Los Angeles and Orange counties, and UnitedHealth had 1,370 signups in five regions, primarily rural areas of Northern California.

Lee attributed Blue Shield's gains to smaller rate increases and consumers' continued pursuit of the lowest premiums. On renewals, 88 percent of customers stuck with their current plan for 2016.

"Price matters," Lee said. "Consumers are enrolling in the lowest or second-lowest priced plan with great frequency."

Overall, the state exchange reported more than 439,000 new enrollees and a total enrollment of 1.57 million. That tally will likely drop because some people don't pay their initial premium, or they find coverage elsewhere.

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# Why this move by Covered California could mean big business for VSP

**By: Mark Anderson**
**Feb. 18, 2016**

Covered California on Wednesday announced it selected VSP Vision Care as its vision insurance provider for adults statewide.

Unlike other health coverage offered through the state's health insurance exchange, the vision insurance is not eligible for subsidies under the Affordable Care Act. But the move opens a potentially big market for the company because consumers will be able to buy VSP's insurance via a link from the Covered California website.

And it ends a long-running source of friction between VSP and Covered California that in 2012 nearly drove the company out of state. The statewide exchange last year sought competitive bids from vision plan insurance companies to get linked to the site.

“We’ve been pushing for this for all the state exchanges,” said Jim McGrann, CEO of parent company VSP Global, based in Rancho Cordova. VSP will offer Covered California customers its individual vision and optics insurance.

VSP has been offering direct-to-consumer insurance for four years, and that product has been growing quickly, McGrann said. It is still a small pool of customers compared to VSP’s 80 million insured, but the new offering has doubled in size every year for four years. The insurance has a variety of options and plans, starting at $15 a month.
The coverage provides advantages for people who wear glasses or contacts, and it lowers the cost of eye exams.

For years VSP has been trying to broadcast the general message that an annual eye exam is an important part of overall health screening, McGrann said. Eye doctors can see and detect early signs of high cholesterol, hypertension and diabetes. It provides a huge health and wellness benefit.

Adult vision care is not classed an “essential benefit” for adults under the federal Affordable Care Act, which is why it is not covered by primary insurance. Vision care is considered an “essential benefit” for children.

“Vision coverage is important for our members’ overall health and Covered California has made it easier than ever for them to find quality vision care options through VSP, the industry leader in bringing vision coverage to consumers,” said Peter Lee, Covered California’s executive director, in a news release.

# California Insurance Marketplace Aims To Kick Out Poor-Performing Hospitals

**By: Chad Terhune**
**March 18, 2016**

California's insurance exchange is threatening to cut hospitals from its networks for poor performance or high costs, a novel proposal that is drawing heavy fire from medical providers and insurers.

The goal is to boost the overall quality of patient care and make coverage more affordable, said Peter Lee, executive director of the Covered California exchange.

"The first few years were about getting people in the door for coverage," said Lee, a key figure in the rollout of the federal health law. "We are now shifting our attention to changing the underlying delivery system to make it more cost effective and higher

quality. We don't want to throw anyone out, but we don't want to pay for bad quality care either."

It appears to be the first proposal of its kind in the country. The exchange's five-member board is slated to vote on it next month. If approved, insurers would need to identify hospital "outliers" on cost and quality starting in 2018. Medical groups and doctors would be rated after that.

Providers who don't measure up stand to lose insured patients and suffer a black eye that could sully their reputations with employers and other big customers.

By 2019, health plans would be expected to expel poor performers from their exchange networks.

The idea has already sparked fierce opposition. Doctors and hospitals accuse the exchange of overstepping its authority and failing to spell out the specific measures they would be judged on.

Health insurers, normally at odds with providers, have joined them in the fight. The insurers are balking at the prospect of disclosing their negotiated rates with providers. Health plans have long resisted efforts that would let competitors or the public see the deals they make with doctors and hospitals.

But scrutinizing the negotiated rates would help the exchange identify high-cost providers and allow policyholders with high deductibles to see the differences in price before undergoing a surgery or imaging test.

Lee said it's time for the exchange to move beyond enrollment and flex its market power on behalf of its 1.5 million members. He said insurers haven't been tough enough on hospitals and doctors.

Other public exchanges or large employers could try to replicate the idea, putting more pressure on providers and insurers. Lee has shared his proposal with other state marketplaces, government officials and employer groups to promote similar efforts.

Still, there are limits to this strategy. Exceptions would be granted if excluding a hospital or doctor from a network meant an area wouldn't have a sufficient number of providers. Insurers could appeal and offer other reasons for keeping a provider in the network.

"California is definitely ahead of the pack when it comes to taking an active purchasing role, and exclusion is a pretty big threat," said Sabrina Corlette, a research professor at Georgetown University's Center on Health Insurance Reforms. "There may be a dominant hospital system that's charging through the nose, but without them you don't have an adequate network. It will be interesting to see how Covered California threads that needle."

The composition of networks has typically been left up to insurers. Until now, most of the discussion has centered on the proliferation of narrow networks, with a limited range of

providers, sold under the Affordable Care Act as a way to hold down rates. Astudy in 2015 found that 75 percent of Covered California plans had narrow physician networks, with more restricted choices than all but three other states.

"I don't know of anyone even close to trying this," said Dan Polsky, the study's author and executive director of the Leonard Davis Institute of Health Economics at the University of Pennsylvania. "I applaud Covered California for being bold to improve quality and reduce costs, but I worry about the implementation."

Polsky said measuring quality can be complicated, and steps must be taken to ensure hospitals and doctors aren't penalized for treating sicker patients or serving lower-income areas. Most quality-boosting efforts use financial bonuses and penalties rather than exclusion.

Under the Covered California plan, hospitals would be judged on a wide range of performance and safety measures, from rates of readmission and hospital-acquired infections to adverse drug events. The exchange said it will draw on existing measures already tracked by Medicare and other groups, and it will work with hospitals, consumer advocates and other experts over the next 18 months to finalize the details.

The California Hospital Association said the exchange is moving too fast and acting too much like a regulator.

"The devil is in the details, and the rapidity of this concerns us," said Dr. David Perrott, chief medical officer at the state hospital trade group. "We understand value-based purchasing is here in some form and we do not oppose that. But Covered California is charging ahead with this assessment and trying to figure out the answers when it hasn't been worked out."

California physicians warn that the exchange's proposal could further reduce networks that are already too thin for patients.

"Right now, one of the biggest problems in health care is limited access to specialty care. This allows more narrowing of the networks under spurious guidelines," said Dr. Ted Mazer, a board member of the California Medical Association and a head and neck surgeon in San Diego.

Charles Bacchi, chief executive of the California Association of Health Plans, predicted that Covered California's idea will backfire, discouraging hospitals and doctors from participating in the exchange and driving up premiums as a result.

"It's the right goal but the wrong approach," Bacchi said. "Covered California is proposing a top-down, arbitrary measurement system that carries a big stick. This can make it difficult for health plans and providers to work together constructively."