Media Clips

COVERED CALIFORNIA BOARD CLIPS
April 7, 2016 – May 9, 2016

Since the April 7 board meeting, high-visibility media issues included: a proposed bill allowing immigrants in the United States illegally to purchase health insurance through Covered California; new contract provisions requiring health plans to embrace initiatives that improve care for users; and a UC Berkeley study showing California's active purchasing drives down health care costs.

Since the April 7 board meeting, the term "Covered California" was mentioned 10,200 times in a Google search and the phrase "California Health Benefit Exchange" was noted 426 times. The following clips represent a cross-section of media outlets and coverage.

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COVERED CALIFORNIA | NEWS RELEASE

April 27, 2016

COVERED CALIFORNIA ANNOUNCES AGREEMENT WITH EYEMED VISION CARE

EyeMed Vision Care Is the Second Vision Carrier Chosen to Showcase Its Offerings on CoveredCA.com

SACRAMENTO, Calif. — Covered California now has a second pathway to vision plans under an agreement with EyeMed Vision Care.

"We're excited EyeMed is on board to offer another vision care path for consumers to choose from," Covered California Executive Director Peter V. Lee said. "EyeMed Vision Care is a proven leader in the vision service community, and we believe it will bring added value to consumers shopping at CoveredCA.com."

Beginning today, visitors to CoveredCA.com can access EyeMed Vision Care via a link, which will take the consumer to EyeMed Vision Care's website. Once there, consumers will work directly with EyeMed Vision Care to shop for vision benefits and see what coverage options are best for their situation.

"EyeMed is pleased to join CoveredCA.com and provide a pathway for Californians shopping for vision coverage," EyeMed Vision Care President Lukas Ruecker said. "Whether it's our wide choice of providers, exam technology or eyewear solutions, we look forward to providing consumers access to digital, 21st-century tools they need to navigate their choices with confidence."

As part of the agreement with Covered California, EyeMed Vision Care will conduct annual consumer surveys to ensure a positive consumer experience. In addition, EyeMed Vision Care will provide quarterly enrollment reports to Covered California based on those who have accessed EyeMed Vision Care through CoveredCA.com.

Covered California is committed to providing access to a wide range of options for consumers and serving as a one-stop shopping location for all their health care needs. In addition to the health plans offered through the exchange, Covered California also has dental options available. The addition of EyeMed Vision Care to the Covered California platform creates one more option for consumers.

Adult vision care is not an essential health benefit under the Patient Protection and Affordable Care Act, and coverage is handled directly through EyeMed Vision Care. Vision services for children are an essential health benefit and are included in all health plans purchased through Covered California. Enrollment with EyeMed Vision Care into vision plans is available year-round, and there are no open enrollment dates.

The link to EyeMed Vision Care from CoveredCA.com can be found here: www.CoveredCA.com/individuals-and-families/getting-covered/vision.

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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COVERED CALIFORNIA | NEWS RELEASE

April 7, 2016

COVERED CALIFORNIA'S BOARD ADOPTS PRESCRIPTIONS FOR A BETTER HEALTH CARE SYSTEM

New Contract Changes for 2017 Require Health Plans to Focus on Quality and Delivering the Right Care at the Right Time for All Who Have Coverage

SACRAMENTO, Calif. — Covered California announced Thursday that its board adopted significant new changes to its contracts with health insurers as part of its prescription to take health care reform to the next level. The new contract provisions, which will cover the years 2017-2019, will advance ongoing efforts by health insurance companies, hospitals and care providers to ensure that patients receive quality health care.

"Covered California's mission is not just getting patients health insurance; it's about improving the quality of the health care delivery system," Covered California Executive Director Peter V. Lee said. "We are creating a market that rewards quality over quantity and moves health reform forward in an impactful way."

"Covered California is making it clear that we are about more than just getting consumers coverage, by ensuring they get the right care when they need it," said California Health and Human Services Secretary and Covered California Board Chairwoman Diana Dooley. "We are proud of the hard work and extensive collaboration — which has been a hallmark of Covered California's work — engaging with doctors, hospitals, health plans, consumer advocates, patients themselves and other stakeholders who are working together with us to improve quality and strengthen the health care delivery system for all Californians."

The new contract provisions seek to address the challenges in our current health care system and provide concrete prescriptions for the future that will address both quality and costs, such as strengthening value-based, patient-centered benefit designs to improve access to primary care. In addition, Covered California uses core levers to promote better quality and lower costs, such as:

- Requiring providers to meet quality standards without exception, to provide safe care for all, including various racial and ethnic groups.

- Adopting payment strategies that support quality performance.

Adopting proven models of primary care and integrated delivery models.

Providing tools to help consumers make informed choices when selecting providers.

Specifically, the new contract includes the following initiatives.

Ensuring the Right Care at the Right Time, Every Time

Diagnosis:

Many consumers do not have a primary care provider and do not know how to use the current fragmented and costly health care system.

Prescription:

Plans will ensure all consumers either select or are provisionally assigned a primary care clinician within 30 days of effectuation into their plan, so they have an established source of care.

Covered California will encourage plans to promote enrollment in advanced models of primary care, including patient-centered medical homes and integrated health care models, such as accountable care organizations.

Plans will exchange data with providers so that physicians can be notified if their patients are hospitalized and can track trends and improve performance on chronic conditions, such as hypertension or diabetes.

Promoting and Rewarding Quality Care at the Best Value

Diagnosis:

The current health care system rewards providers based on the volume of care delivered, regardless of its quality or value.

Prescription:

Covered California will adopt a payment system for hospitals, such as the one employed by the Centers for Medicare and Medicaid Services (CMS), which, over time, will put at least 6 percent of reimbursement at risk or subject to a bonus payment based on quality performance.

Plans will be required to identify hospitals and providers that are outliers and deliver either poor-quality care or unwarranted high-cost care. Once these providers are identified, health plans will be expected to work with them to improve their care or to lower their costs, and, if they do not and do not provide justification, plans will exclude those hospitals from Covered California networks as early as 2019.

Plans will manage high-cost pharmaceuticals and help consumers better understand the effectiveness and costs of their drug treatments, as well as any alternatives.

Reducing Health Disparities and Promoting Health Equity

Diagnosis:

There are significant health disparities and problems with health equity, meaning that the care received by millions of Californians — and the health status of those Californians — varies because of their race, ethnicity or income.

Prescription:

Plans will be required to track health disparities among all their patients receiving care, identify trends in those disparities and reduce the disparities, beginning with four major conditions: diabetes, hypertension, asthma and depression.

Plans will develop programs to proactively identify and manage at-risk enrollees, with requirements to improve in targeted areas.

Giving Consumers Tools to Make the Best Choices for Themselves

Diagnosis:

Consumers do not have the tools they need to make an educated decision on picking a provider based on cost and quality, and there is a huge variation in costs for consumers.

Prescription:

Plans will be required to help consumers be active participants in their health care by providing tools to help consumers better understand their diagnoses and treatment options and understand their share of costs for medical services — based on the contracted costs of their plan.

“We are insisting on the best care and value for our consumers,” Lee said. “In the near term, keeping costs low is about making sure Covered California has a good mix of enrollees, but over the long term there must be system-wide efforts to lower costs and improve quality for all Californians.”

The improvements were hailed by a wide variety of stakeholders, including CMS and the American Academy of Family Physicians (AAFP).

“We applaud California’s focus on delivery system reform in the California health insurance exchange,” said Dr. Patrick Conway, CMS’s deputy administrator for innovation and quality and its chief medical officer. “Through payment incentives, innovative care delivery and improvement science, and transparent information, the public and private sector can collaborate to transform the health system to achieve better care, smarter spending and healthier people.”

“We applaud Covered California for their leadership in working to ensure that all Californians have an ongoing relationship with a primary care physician and that the care patients receive is truly coordinated across the continuum of services,” said Dr. Douglas E. Henley, executive vice president and CEO of AAFP. “Research has consistently shown that people who have access to a usual source of health care are in

better health and have lower medical costs. This initiative will help make that vision a reality for Covered California beneficiaries because it values primary care and shifts payment toward paying for the quality of care and away from the number of services or procedures."

The contract provisions were developed over the past year in conjunction with consumer advocates, health plans, clinicians, and other stakeholders and subject matter experts. See the full summary of the 2017 contract provisions and the slides presented at the board meeting. In many cases, these improvements will benefit both Covered California members and consumers enrolled outside the exchange.

Covered California is required under both state and federal law to strengthen the health care delivery system; require that health plans improve health outcomes through effective case management, care coordination, chronic disease management and care compliance initiatives; and require health plans to reduce health and health care disparities.

In addition, Covered California will also make improvements to its patient-centered benefit design for 2017 plans. Benefits will be structured to remove financial barriers to consumers getting needed care and will include:

Making all outpatient care in Silver, Gold and Platinum plans not subject to any deductible.

Providing Bronze plan consumers three outpatient visits not subject to the deductible, in addition to the free preventive visits.

Protecting consumers from high specialty drug costs by limiting out-of-pocket costs.

For 2017, Covered California is proposing to build on this structure by lowering the out-of-pocket costs for primary care and urgent care. For more details, see the proposed 2017 Standard Benefit Plan Designs and 2017 Standard Benefit Plan Design Endnotes.

About Covered California

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appointed by the Governor and the Legislature. For more information about Covered California, please visit www.CoveredCA.com.

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HealthLeaders Media
A Division of HCPro

Covered California to Create Quality Standards for Providers

By: Doug Desjardins
April 20, 2016

Under the proposed plan, providers will be rewarded or penalized based on how they meet quality-of-care standards. The program will "over time, put at least 6% of reimbursement at risk or subject to a bonus payment based on quality performance" and phase in those incentives over the course of several years.

Covered California officials approved a plan to create quality-of-care standards for providers within its health plans that will include bonuses and penalties based on performance.

The plan is scheduled to go into effect in 2017 and will include quality-of-care metrics and benchmarks that hospitals and physicians will have to meet to remain part of provider networks. Covered California executive director Peter Lee said the program is designed to reward high-performing providers and will be more in line with payment models based on performance.

"We are creating a market that rewards quality over quantity and moves health reform forward in an impactful way," said Lee. "It's about improving the quality of the healthcare system."

Covered California board members voted to adopt the framework for the quality standards but specific benchmarks and metrics will be developed over the course of several months with input from health plans and hospitals. "The specific metrics still need to be worked out and will be completed this summer," said Covered California spokesperson James Scullary.

Under the proposed plan, providers will be rewarded or penalized based on how they meet quality-of-care standards. According to Covered California, the program will "over time, put at least 6% of reimbursement at risk or subject to a bonus payment based on quality performance" and phase in those incentives over the course of several years.

It also proposes to eliminate hospitals from health plans if they consistently fail to meet quality standards but will include a provision that allows health plans to retain low-performing hospitals through corrective action plans. That provision was included to address concerns that eliminating hospitals in rural areas of the state would create access-to-care issues for patients.

The California Hospital Association (CHA) said it supports the decision to phase in financial incentives over several years rather than implement them all at once. "CHA supports Covered California's decision to phase in financial incentives aimed at encouraging hospitals and physicians to work collaboratively together on improving quality patient care," said CHA vice president of external affairs

The California Association of Health Plans (CAHP) said it was satisfied with how the quality standards have evolved over time. "With many significant issues resolved and the rapidly approaching deadline for health plans to submit next year's rates, it is important to move forward," said CAHP vice president of communications Nicole Evans. "While the contract creates a new approach on quality metrics, we will remain engaged as Covered California works on the specifics on how we implement this new program."

Covered California said its bonus and penalty system will be similar to those used by the Centers for Medicare & Medicaid Services for its Medicare programs but that specific benchmarks will be developed through the summer with input from insurers and health systems.

In a related matter, Covered California staff issued a report recommending that its board pursue a federal waiver that would allow undocumented immigrants to purchase health coverage on Covered California. The request would need to be submitted to the federal government through a federal Section 1332 State Innovation Waiver and would not make the undocumented immigrants eligible for subsidies. The board did not adopt a formal stance on the issue and noted that state lawmakers would first need to approve legislation — Senate Bill 10 from Ricardo Lara (D-Bell Gardens) — before they could move forward with the waiver.

"Allowing undocumented immigrants to buy health insurance through Covered California removes a counterproductive exclusion in the federal law," said Anthony Wright, executive director for advocacy group Health Access California. "This exclusion discourages a crucial part of our economy and society from taking responsibility for their health and finances by purchasing coverage and sends an unfortunate signal to many more."

The New York Times

States Can Contain Health Care Costs. Here's How.

By: Richard M. Scheffler and Sherry Glied
May 2, 2016

THE architects of the Affordable Care Act counted on competition in the health insurance market to keep costs down and quality high. While the law has accomplished many of its coverage and cost-containment goals, its vision of a more competitive insurance market seems to be fading.

The nation's second-largest health insurer, Anthem, is poised to acquire Cigna, the fourth-largest. Aetna, the third-largest insurer, is seeking to acquire Humana, the fifth-largest. If approved by the Justice Department, these mergers would produce

companies controlling about 35 percent of the health insurance market. These mergers would likely leave that market with far fewer competitors — a disappointing result for those who hoped it would increase “choice and competition.” Yet our research suggests that this apparent failure obscures a potential path to success, one that lies between competition and a fully regulated market.

One reason behind the mergers is continued consolidation among hospitals and physician groups. From 2000 to 2013, the number of hospitals that were part of multisite health systems increased by 25 percent. More doctors are working for hospitals or for practices partly owned by hospitals; today, fewer than 20 percent of doctors are in solo practice. As provider organizations become larger, they gain more leverage in reimbursement-rate negotiations with insurers. To re-establish the bargaining balance between providers and insurers, insurers argue that they too must also get larger.

Our recently published research comparing New York and California, as well as previous analyses, suggest that there’s truth to the insurers’ argument. Consolidation in provider markets does raise health care prices. Insurer consolidation does reduce the prices paid to hospitals and physicians. Without further intervention, however, those price reductions don’t get passed along to consumers.

The health care law offers an answer. Under the act, states have some flexibility in designing their marketplaces. States could, for instance, either accept all insurers who seek to participate or select a limited number to sell coverage. New York chose the first course, permitting all willing insurers to join; California chose the second, selecting 12 of the 32 insurers that initially showed interest.

This choice was critical because Covered California, the state’s marketplace, used its leverage in selecting plans to keep initial premiums low. Before the marketplace opened, Covered California calculated how high premiums would need to be to cover the risks of covered populations and still generate a 2 percent profit for the insurers. California used these targets to select which insurers would be permitted to enter the market in the initial round. Then the state made a promise: Among those bidding for the first round, only those health plans selected would be permitted to offer plans for three years, except under unusual circumstances.

California also went further than New York in standardizing coverage. Under the Affordable Care Act, insurers in all marketplaces must offer a defined set of “essential health benefits” in all plans, and may offer plans at four coverage levels: platinum, the most comprehensive and expensive plans, followed in descending order of cost and coverage benefits by gold, silver and bronze. California went beyond this standardization by requiring that within each coverage level, all insurers offer the same deductibles and cost-sharing, and cover identical benefits. This made it easier for consumers to shop on price alone, rather than allowing insurers to obscure higher prices through complex and opaque benefit designs.

New York, by contrast, permitted insurers to offer not just standard plans, but also alternative plans with different cost-sharing and benefit designs.

When we examined the two states, we found that the effect of insurer competition differed greatly. In both states, areas with more hospitals had lower premiums compared with areas with fewer hospitals. But in New York, areas with fewer insurers had higher premiums, suggesting that insurers kept the benefits of greater bargaining power for themselves.

In California, by contrast, areas with fewer insurers also had lower premiums. Why? With initial premiums set at modest but adequate levels, and a vibrant marketplace, there was no need to further threaten insurers who might consider large premium increases. If an insurer tried to raise its premiums too far, consumers could easily shop among the restricted set of insurers for an identical product and switch to an alternative plan. Even in areas with fewer insurers, competition was sufficient to keep cost growth down.

The lesson here is that, especially in a health care system that is becoming more concentrated, competition and regulation can work together. A third party — governmental or quasi-governmental — can use its purchasing power to ensure that negotiating better health care prices benefits consumers, not just insurers.

Other states are getting into the act. Rhode Island has given its Department of Insurance authority to limit the price increases of inpatient and outpatient services; Massachusetts and Colorado have commissions that monitor costs and recommend action to the legislature to keep increases in health care under control.

Over time, we will learn more about how these alternative designs work. But one point is already clear: The choice between regulation and competition is a false one. To best manage our health care system, we will need both.

Richard M. Scheffler is a distinguished professor of health economics and public policy at the University of California, Berkeley. Sherry Glied is the dean and a professor of public service at the Robert F. Wagner Graduate School of Public Service at New York University.

Covered California Helps Keep Premiums in Check, UC Berkeley Study Finds

By: Lisa Aliferis
May 2, 2016

Covered California's Obamacare exchange has helped consumers get a better deal on health insurance in part because of its negotiating power — power that other Affordable Care Act marketplaces don't have — according to a new analysis published Monday.

California is one of the few states that created an "active purchaser" exchange, where the marketplace negotiates premiums and benefits with insurers. Most other states, as well as the federal healthcare.gov, accept any plan that seeks to participate.

Researchers compared California and New York and looked at the growth in premiums in 2014 and 2015 in the face of hospital competition and health plan competition.

While less hospital competition was associated with higher premium increases in both states, the effect of reduced insurance plan competition played out differently.

In New York, less competition in insurance resulted in higher premium growth. But in California, similar “low competition” areas had a slower rise in premiums.

Richard Scheffler, a health economist at UC Berkeley and lead author of the study, said one reason for the slower growth is California’s negotiating power.

“What happens here is an exchange that’s competitive, but is helped by regulation,” Scheffler said, “that clears up the market in the sense that consumers can make apples-to-apples choices.”

Scheffler called it “a problem” that in New York, there were so many plans available “that it became very difficult, if not impossible, for a lot of consumers to be able to make good choices.”

The two states’ experiences highlight a division in the two visions in running an exchange, says Anthony Wright, executive director of Health Access, an advocacy group.

“The approach of not negotiating, of just letting any insurer sell its wares, some would call it ‘the free market,’ ” Wright said. “We call it the ‘flea market’ approach.”

He likened Covered California to a human resources department for the “rest of us that don’t work at Google.”

Covered California plans all have identical benefits. The only difference between plans are price and the hospital and physician networks, making comparison straightforward.

“We create a marketplace where consumers are in the driving seat,” said Covered California executive director Peter Lee. “[In] New York City, the consumers would be picking between 50 different products. What’s the difference between them? Tweaks on co-insurance and insurance babble that most consumers don’t understand.”

“The folklore in economics is that more choice is better,” economist Scheffler said. If offered too many choices in health insurance, “it becomes too much for consumers to look at and analyze and really absorb. So you’re better off having a smaller number of choices to plan on and pick from.”

Scheffler and his co-authors say that the Affordable Care Act marketplaces provide a “natural laboratory” to continue studying the effects of competition among hospitals and insurers.

San Francisco Chronicle

When Covered California goes wrong, insureds get the runaround

By: Kathleen Pender and Victoria Colliver
May 8, 2016

When it comes to signing up customers, Covered California has been a success. But when it comes to serving customers, the independent public agency — now in its third year of helping individuals and small businesses get federally subsidized or free health insurance — still has growing pains.

While the insurance marketplace works for most enrollees, a single mistake can set off an avalanche of errors that blocks coverage or generates inaccurate tax forms. When customers try to get problems fixed, some say, they get bounced from Covered California to their health insurer and back again. Even when all three parties get on a call together and come up with a solution, the fix doesn't get made — or doesn't stay fixed.

The Chronicle has learned that Covered California will submit a budget proposal to its board on Monday that includes $2 million for a new ombudsman's office. In April, The Chronicle reported that Covered California lacked an ombudsman or consumer advocate, unlike many other public agencies.

For Elin Larson of Redwood City, Covered California worked just fine in 2014, but when 2015 rolled around, she discovered that the subsidy she had been getting on her Kaiser Permanente policy had disappeared, even though her income and household size had not changed. "I was on the phone with Kaiser and Covered California for almost three hours every week. It was like a little part-time job," Larson said. "I almost got to the end of my rope on a couple occasions. I was crying."

2 million calls

The office of state Sen. Jerry Hill, D-San Mateo, helped get her subsidy reinstated in March 2015. But when she got Form 1095-A — a tax document showing her coverage, premiums and subsidies for 2015 — it said she had insurance for only one month last year instead of 12. That started a new odyssey. "I think I have post-traumatic stress disorder from all this," she said.

Covered California's customer service department has handled nearly 2 million calls in the past six months, said Peter Lee, the agency's executive director. "Of those, over 97 percent were handled and resolved without being escalated," he said. But "when you are dealing with big numbers, even a very small percent can be a lot of people."

Complaints regarding policies sold through Covered California more than tripled — from 716 in 2014 to 2,273 in 2015, according to new data from the state Department of Managed Heath Care, which regulates almost all private insurers that sell through the exchange. It received an additional 600 complaints over those two years, including eligibility and tax questions, that fell outside its jurisdiction and were forwarded to the insurers or Covered California.

California was the first state to start setting up its own exchange under the Affordable Care Act. Since its inception, Covered California has helped about 2.5 million people get health insurance from private insurers for at least one month — about 90 percent of them with premium subsidies, Lee said. It currently has about 1.3 million people enrolled and has been credited with keeping premium increases lower than many other states.

‘Serious issues’

Nevertheless, in mid-August, the Consumer Health Alliance, a consortium of legal aid groups, wrote a letter to Covered California’s governing board detailing “serious issues faced by Covered California enrollees.” It cited the system’s inability to manually override computer problems and its refusal to correct erroneous 1095-A tax forms. Although Covered California resolved a backlog of complaints outlined in the letter, problems persist, said Jen Flory, senior attorney with the Western Center on Law and Poverty, a member of the alliance.

Ed and Mabel Minamoto of Alameda spent 13 months — and racked up $2,314 in accounting fees — trying to get Covered California to fix a mistake on a 1095-A form. This is the form the federal and state marketplaces send to customers and the Internal Revenue Service showing which members of a household had coverage each month, the premium paid and the federal subsidy received.

Mabel tried to sign up for Covered California in early 2014, but her application was never approved. In March of that year, she became eligible for insurance through her husband’s job, and withdrew the application.

But in February 2015, Mabel got a 1095-A from Covered California showing she had received $4,730 in premium subsidies in 2014, when in fact she had received none. The Minamotos tried unsuccessfully to get a corrected form. Every time they called Covered California, “the right hand could not see what the left hand was doing,” Mabel said.

Tax court

Because of the error, the IRS demanded the Minamotos pay $4,730 or file for a tax court appearance. They chose the latter, and paid a $60 filing fee. Although Covered California never issued a corrected 1095-A, the IRS finally agreed this March that the Minamotos owed no tax.

Hill calls this level of customer service “shameful and embarrassing.” The Legislature set up Covered California as an independent public entity within state government but has limited oversight. It is governed by a five-member board: two are appointed by the governor, two by the Legislature. The fifth is the secretary of the California Health and Human Services Agency, currently Diana Dooley, who declined to comment for this article.

The Legislature oversees most state agencies during the budget process. “That’s when they plead their case and we can get changes that are necessary,” Hill said. But because Covered California gets most of its funding from the federal government, it’s not clear what lawmakers can do to remedy its customer service problems.

Transition points

Consumer advocates say many problems stem from the software system used to sign people up and route them to Covered California or Medi-Cal, depending on their income. Attorney Flory said the system was built too quickly and can't deal with "out of the box" issues. Covered California continues to upgrade the system, but "it's like building a plane while flying," she said.

Agency director Lee said the information technology system is "big and complex," but the service problems are not the IT system's fault.

Based on interviews with more than a dozen customers it appears that many glitches crop up at transition points — when one person in a household switches between Covered California and private insurance, Medi-Cal or Medicare.

When George Carewe's wife turned 65 in January and went on Medicare, he took her off their Kaiser Covered California policy. Carewe, 63, of San Anselmo, received a letter from Kaiser acknowledging the change. He paid his own premiums for January and February, but when he tried to refill his epilepsy drug, was told he no longer had coverage. After a lengthy process, Kaiser reinstated him but refuses to reimburse him for the two months Carewe paid for but did not have insurance.

Berkeley resident Cliff Price's descent into what he calls a "Byzantine labyrinth of catch-22s" started in August when he dropped his 23-year-old daughter from Covered California after she got a job that provided her with insurance. He maintained coverage for himself, his wife and five other dependent children. But when Price got his 1095-A for 2015, "they show us as having dropped the entire family from coverage in August," he said.

Price is a certified financial planner who handles employee benefits. Nevertheless, he has been unable to get corrected 1095-A forms since February, and had to file for an extension to complete his tax returns. Price said he feels stuck in one of the "nine circles of hell," but not limbo, the circle where people don't suffer. "I'm suffering," he said.

When Holly and Ron Vetter notified Covered California a year ago that Ron would be switching to Medicare, "they said we don't know how to do that," Ron said. After numerous phone calls, the Eureka couple got someone to drop Ron — while erroneously yet briefly moving Holly to Medi-Cal.

Incorrect tax forms

In August, they learned that Ron's coverage had accidentally been canceled effective April instead of June, making it look for tax purposes like he had no insurance for two months. Five incorrect 1095-A forms later, the problem still hasn't been corrected.

Holly Vetter said trying to get out of Covered California is like checking out from Hotel California of the Eagles song. “You can never leave,” she said.

Problems also crop up in “mixed households,” in which some members are in Covered California and others in Medi-Cal, the state’s version of Medicaid.

When Robert Bell of San Francisco tried to renew coverage with Anthem for 2016, he went to the Covered California website. “The only information I changed was my income,” he said, but that inexplicably made it look like he was not filing taxes. That somehow threw Bell and his wife, Pascale Leroy, into Medi-Cal, even though they were not eligible. Their 14-year-old daughter, however, has been on Medi-Cal since 2014.

When he tried to make a payment for January to Anthem, it was rejected. Covered California told him it was because “Medi-Cal has a block on your file.” But when he called Medi-Cal, he was told, “We can’t put a hold on your Medi-Cal application because you and your wife have never been covered by Medi-Cal,” Bell said. “At some point in every conversation they say, ‘These mixed households can be a real problem.’” Because of the Medi-Cal mess, he and his wife have yet to get coverage from Anthem this year.

No playbook

Covered California board member Paul Frearer said complaints sometimes reach the board, but that “We are not an operating board. We provide oversight. ... We don’t have a direct connection” with customers.

A big problem, he said, is technology. “We have 50 to 100 projects in the queue,” but the completion dates are in “August, September, not today.” In the meantime, “all these people on the phones are trying to figure out solutions.” Frearer said there’s no “playbook” for service agents, and conceded that they are probably “making mistakes.”

Amy Adams, a senior program officer for the nonprofit California HealthCare Foundation in Oakland, said Covered California’s problems may be complex and stem from many sources, but they need to be fixed.

“The question is, who is going to step up and address this problem head on, make it a priority and figure out how all the different organizations can work together in the consumer’s best interest?” she said. “Everyone is trying and has the same intent, which is to get people covered and keep them covered. But there needs to be clarity and clear action.”

Los Angeles Times

Members of Congress want fix for Covered California glitch dropping coverage for pregnant women

By: Sarah D. Wire
April 29, 2016

Rep. Ami Bera and 15 members of the California delegation are pushing the heads of California Health and Human Services and the California Health Benefit Exchange in a letter to address a computer glitch that is terminating Covered California Care for pregnant women.

California Healthline/Kaiser Health News reported April 18 that about 1,900 women across the state have been automatically transferred from the Covered California health insurance exchange to Medi-Cal since October, even though they were supposed to have the option to stay with Covered California. The article appeared in the Sacramento Bee.

Amy Palmer, the agency's director of communications, told the Bee that the problem was caused by a computer glitch that will not be fixed until September.

Bera and the letter signers say that isn't acceptable.

"While we appreciate your efforts to ensure women can switch between plans, we remain concerned that until the problem is fixed in late 2016, women will continue to be unenrolled from their Covered California plans and lose access to their current medical providers," the letter states.

Bera said in an interview that as a doctor he is worried about pregnant women losing healthcare access for any time. Bera practiced medicine in the Sacramento area and was a dean at UC Davis.

"When someone is pregnant, you want them to get continuous prenatal care," Bera said. "We're just trying to put a little pressure on Covered California. There's no reason we should have to wait until September."

Los Angeles Times

Medi-Cal will soon cover children in the U.S. illegally. The real battle? Getting adults insured

By: Soumya Karlamangla
April 27, 2016

Ever since Obamacare took effect two years ago, many California legislators have been fighting to get health insurance for those it left out — the quarter of all immigrants in the country illegally who live within the state's borders.

Next month, California will make a sizable dent in that effort when immigrants younger than 19 who are here without papers begin receiving free health coverage through Medi-Cal, the state's low-income health program. State officials estimate that 170,000 residents will be eligible.

But insuring children is an easy battle to win, experts say, because of kids' emotional appeal and their low medical expenses. California isn't blazing the way here.

Massachusetts, Illinois, New York, Washington and Washington, D.C., already have extended coverage to children in the country illegally.

The remaining frontier — covering adults — will be a much tougher sell — and a more significant test of California's larger push to provide additional services to those here illegally.

"The next steps are harder, the air gets thinner, the angles get tougher to ascend," said Anthony Wright, executive director of Sacramento-based advocacy group Health Access.

The children's coverage came at a high cost, in a last-minute budget deal. To make it happen, Gov. Jerry Brown pledged $20 million in state funds to provide coverage from May through the end of the fiscal year, and $143 million in the upcoming fiscal year, said Medi-Cal spokesman Tony Cava.

The state had to foot the entire bill. Even though Medi-Cal traditionally is funded with a mix of state and federal money, the Affordable Care Act prohibits the use of federal money to pay for covering immigrants in the country illegally.

Some young people here illegally are already eligible to receive healthcare through county programs, such as My Health LA in Los Angeles County.

Approximately 115,000 youths also get coverage for emergencies through Medi-Cal, according to state officials. They will be rolled into the newly expanded program on May 16, but will be covered retroactively from May 1, Cava said.

As many as 27,500 children who have not yet been signed up for Medi-Cal are expected to enroll in the first year, Cava said. For minors to qualify, a family must earn less than 266% of the federal poverty level — or less than $53,626 for a family of three or $75,650 for a family of five.

Maria Graciela, who lives in South El Monte, plans to get her 14-year-old daughter Ingrid's eyes examined as soon as her Medi-Cal coverage kicks in.

"I just feel so fortunate," said Graciela, who cleans houses and hasn't been able to afford to take her daughter to the ophthalmologist or the dentist in years.

Sonya Schwartz, a research fellow at Georgetown University Health Policy Institute's Center for Children and Families, said offering health insurance to kids is a smart investment, because research shows that children with access to Medicaid have fewer emergency room visits and lower blood pressure as adults. They also are more likely to graduate from college than those who do not have health coverage.

"It's kind of penny-wise and pound-foolish not to cover these kids," Schwartz said.

Even with the expanded coverage, UC Berkeley researchers estimate that as many as 1.5 million of the 2.67 million immigrants who are in the state illegally will remain uninsured by 2019. They would make up roughly half of California's anticipated uninsured population.

"The big piece of unfinished business around health coverage is undocumented adults," said Daniel Zingale, senior vice president of The California Endowment, which leads a statewide campaign called Health4All.

The government already prohibits anyone who turns up in an emergency room from being refused treatment, regardless of immigration status. Zingale said it makes more sense to invest taxpayer money in cheaper, preventive care to stave off serious problems that generate big emergency room bills down the road.

Last year, a bill that would have covered all those here illegally made it through the state Senate but was whittled down to only children during budget deliberations. The original proposal could have cost as much as $1 billion annually.

Opponents of expanding Medi-Cal say it is misguided to spend money on those here illegally when services for Californians lawfully in the country are being cut. They also cite studies that conclude that increasing access to medical care increases use and expenses, instead of lowering costs.

Now, advocates for those here illegally are trying another, less expensive approach.

Sen. Ricardo Lara (D-Bell Gardens) recently introduced a bill in Sacramento that would ask the federal government for permission to allow unauthorized immigrants to buy insurance from the state's health exchange, Covered California. California would be the first state in the nation to do this, but the move would be mostly symbolic, because immigrants still wouldn't get subsidies to help them afford coverage.

The new proposal, combined with the rollout of coverage for those under 19, "will bring us closer to providing coverage to all Californians, regardless of where they were born," Lara said in a statement to The Times.

State officials also are following a Supreme Court case that concerns President Obama's executive actions on immigration. An unusual policy in California allows those granted temporary relief from deportation to sign up for Medi-Cal, and researchers estimate that up to half a million Californians could apply for Medi-Cal if the executive actions being challenged in court are upheld.

Even as advocates fight for more coverage, some who are eligible — whether they are here legally or not — aren't signing up, they say. That's partly because of confusion surrounding the patchwork of coverage.

When the Dolores Huerta Foundation led an effort to knock on thousands of doors in the Central Valley to spread the word about the upcoming Medi-Cal expansion, many people told the advocates they were worried they would endanger themselves or family members in the country illegally by giving information to the government, said Yesenia Contreras, the foundation's civic engagement coordinator.

President Obama has said that immigration officials will not have access to personal information submitted during health insurance sign-ups. But assuaging those fears, and getting eligible immigrants to enroll, remains difficult, Zingale said.

"What most undocumented Californians know about Obamacare is that it excluded them," he said.

For the moment, such exclusion still is being felt even in families about to get at least some health coverage.

Carolina Moran, who lives in Canoga Park, is looking forward to taking her 14-year-old daughter Lizeth to the dentist when the Medi-Cal extension starts. She thinks Lizeth has five unfilled cavities.

As for herself, the mother of five will remain without medical care. Her chronic kidney condition, she says, takes her to the emergency room every few months when she is too sick to go on.

CaliforniaHealthline
The Daily Digest of News, Policy & Opinion

Will Covered California Sell Health Coverage To The Undocumented?

By: Ana B. Ibarra
April 26, 2016

California legislators are attempting to clear the way for undocumented immigrants to buy health insurance through the state's insurance exchange — potentially setting a national precedent.

The fusion of illegal immigration and the Affordable Care Act, two of the most highly charged elements on the periodic table of U.S. politics, could engender a combustible reaction, especially in an election year.

Immigrants living in the country illegally are excluded from the insurance-expanding provisions of Obamacare. They are not eligible for Medicaid (called Medi-Cal in California), and they are not allowed to purchase a health plan from the federal marketplace or any of the state exchanges.

Without that provision, Congress would not have approved the health reform law to begin with.

Now, however, some California families and advocates are pinning their hopes on a bill by state Sen. Ricardo Lara (D-Bell Gardens) that would open the door for undocumented immigrants to buy health plans from the Covered California exchange. Unlike most exchange customers, however, they would get no federal dollars to help them do so.

That, many observers say, makes the proposal a largely symbolic gesture, since most undocumented immigrants would not be able to afford the premiums without financial assistance.

Lara's bill was approved by the Senate last year, and it will be taken up Tuesday by the Assembly's Committee on Health.

The bill faces a number of hurdles.

It would not actually allow immigrants without papers to buy insurance through the state exchange. It would only request that the federal government exempt California from the rule that forbids such purchases. It's the feds who make the call.

If the feds were to greenlight the plan, Covered California would be the first exchange in the country to sell insurance to undocumented immigrants — a prospect that is not welcomed by critics of illegal immigration.

There's no apparent legal reason why the feds wouldn't sign off on such a request, said Tim Jost, a professor emeritus of law at the Washington and Lee University in Virginia. But it could generate some significant political fireworks, especially in a presidential election year, he said.

"I can almost guarantee in the right wing media, this would play a pretty big role," he said. "This would become a case of 'we told you so' that Obamacare would help undocumented workers."

But Katherine Hempstead, a senior advisor at the Robert Wood Johnson Foundation, said the fact that no federal dollars would be involved makes it less of a hot button issue. "It's just another distribution channel," she said.

Before Lara's proposal even makes it to the federal level, it must first get through the legislature and past the desk of Gov. Jerry Brown.

Some health policy experts believe the bill has a decent shot of getting through California's political hierarchy.

Shannon McConville, a research associate at the Public Policy Institute of California noted that while Gov. Brown has been fiscally conservative for the most part, he did sign a law — scheduled to take effect next month — that allows undocumented children to get full Medi-Cal benefits.

"The [Lara] bill, at least in its current state, doesn't have a large price tag, so it seems possible he'd approve it," McConville said. "But you can never know for sure."

At the federal level, the Affordable Care Act provides for an "innovation waiver," which allows states — with federal approval — to modify certain sections of the health reform law in order to expand coverage. Such changes must have no net impact on the U.S. budget, which is why federal subsidies are excluded from Lara's bill.

An analysis of the waiver proposal, presented by Covered California staff members to the exchange's board earlier this month, estimated that enrollment would increase by about 50,000 if immigrants without papers could buy coverage through the exchange.

Covered California's executive director, Peter V. Lee, did not stake out a position on the plan, but he said exchange officials stood ready to assist the legislature in pursuing this option.

"The ball is in their court," Lee said.

Although undocumented immigrants would not qualify for financial help under the proposal, they would still benefit from the considerable investment Covered California has made in infrastructure to inform and enroll consumers, McConville said.

Some opponents of the plan think selling to immigrants without papers should not be a high priority for Covered California. "The state has failed on its commitment to health care providers and their patients, and my budget priority is to take care of them first before expanding the pool," said Sen. Joel Anderson (R-Alpine), who voted against the bill in the Senate last year.

Others simply believe that neither the state nor the federal government should confer any benefits on people who are in the country illegally.

Ira Mehlman, a spokesman with the Federation for American Immigration Reform, said that providing coverage to undocumented immigrants under the Affordable Care Act is tantamount to accepting their unlawful presence in the country.

He predicted that if California is allowed to do it, states like Illinois and New York might follow.

And, he argued, this is just the first step in eventually getting subsidized coverage.

Without subsidies, it is uncertain whether many undocumented immigrants would actually buy Covered California plans.

After all, they can already buy private plans through brokers or directly from insurers, but they are not rushing to do it, said Alex Hernandez, an insurance agent in Merced. "Cost is always what drives them away," he said.

The plans sold by Covered California carry very similar price tags.

Hernandez calculated that a person in her mid-20s, making around $45,000 a year, would pay $304 per month for a standard Anthem-Blue Cross plan through Covered California. That same plan purchased directly from Anthem by the same person would cost $303.30, he said.

Advocates for expanding health coverage concede that allowing people without papers to purchase it on the exchange won't necessarily make it more affordable for them, but they say it would open the door to broader access and a sense of inclusion.

People in mixed-status families — ones with some members who are in the country illegally and others who are legal residents or U.S. citizens — would benefit most, consumer advocates say. Data discussed at a Covered California meeting in February showed that 74 percent of households headed by undocumented immigrants have family members who are citizens.

Proponents of the plan believe that if some family members already interact with Covered California or Medi-Cal, it could encourage others in their household to seek coverage.

Opening the exchange to the undocumented, they say, would simplify enrollment for the entire family by creating a “one-stop shop” for all household members.

“It’s a modest step forward, but important for the goal of health care for all,” said Anthony Wright, executive director of Health Access, a consumer advocacy group. He said supporters of the bill are fully aware that people will continue to face affordability issues, but there also thousands who may be able to afford it.

Maria Galvan, an undocumented resident in San Fernando, California is not one of them. She does not think she would purchase coverage without subsidies. She knows how expensive it can be, even for small business owners like herself and her husband.

Galvan, said she does not seek much preventive care. When she gets sick, she usually weathers it with home remedies. If it gets serious, she goes straight to the emergency room at Olive View- UCLA Medical Center in Sylmar, her nearest hospital.

“Maybe one day the system will improve for us,” Galvan said. “Maybe one day we will receive financial assistance.”

THE SACRAMENTO BEE

Medi-Cal set to expand coverage to undocumented children

By: Sammy Caiola
April 20, 2016

Felix Gonzalez was pulling a typical 13-year-old stunt earlier this month when he piled a friend from his Woodland neighborhood onto the back of his bicycle. The boys were gaining speed until their bike tipped over, sending them into a violent skid that sheared the skin from Felix's right elbow.

What might have been a quick doctor's visit for other parents turned into a strained discussion for the Gonzalez family. Was the elbow bleeding enough to require stitches? Would it get infected without medical attention? Felix, an undocumented teen, doesn't have insurance that covers visits to the local emergency room. Parents Gabriela and Victor Gonzalez, Mexican immigrants accustomed to raising four boys on a tight budget, made a run to Walmart for bandages and ointment and hoped the gash would heal on its own.

Starting May 1, Felix and roughly 170,000 other undocumented children in California will have more options during such crises. They'll gain access to not just emergency coverage but also dental care, checkups, mental health treatment and other vital services following an unprecedented Medi-Cal expansion that provides full coverage to all low-income children in the state, regardless of immigration status.

Home to more immigrants than any other state, California will be the largest in the nation to cover undocumented low-income children, joining Washington, Illinois, New York, Massachusetts and Washington, D.C. The expansion, effective next month, was approved by Gov. Jerry Brown in the October 2015 state budget.

That effort is a major step in meeting the larger challenge of insuring the state's 2.4 million undocumented immigrants mostly left out of California's health reform push. With county health departments and now Covered California taking steps to cover the population, local advocates and community clinic counselors are trying to match eligible families with affordable coverage options that will give them access to the same preventive services as their neighbors.

California's undocumented immigrants are now excluded from purchasing plans under the federal Affordable Care Act and have access only to select Medi-Cal programs for limited populations, such as women with cervical or breast cancer and minors seeking substance-abuse treatment. Those who aren't insured by employers get their health care through a patchwork of county services, safety-net clinics and emergency department visits. Others choose to go without screenings and shots and allow treatable conditions such as diabetes to become life-threatening.

"There is a sentiment that we need to move toward more and more coverage," said Sarah de Guia, executive director of the Pan-Ethnic Health Network, an Oakland-based nonprofit group that has been on the front lines of health advocacy for immigrants. "To have people not being able to access health care services as we move toward expansion just doesn't make sense."

Gabriela and Victor Gonzalez, both farmworkers, moved to Woodland from Michoacán, Mexico, in 2007 to give Felix, then 5, a better life near more of his extended family. They've had three more sons since then – all U.S. citizens on comprehensive Medi-Cal – but their oldest still lacks a Social Security number, making him ineligible for full coverage until now.

Felix does have a Kaiser Permanente plan that only covers him at Kaiser facilities, the nearest of which is in Davis. In May, Gabriela will enroll him in the same, lower-priced plan as his brothers so that she can take them all to a nearby community clinic for routine primary and dental care free of charge.

“For me to get health care is a big step,” Felix said. “Now my mom won’t have to worry about going to Davis. I don’t like it when she’s so stressed.”

The 38-year-old woman has been fatigued and short of breath lately – symptoms the clinic staff worries might signal a heart problem. She’s had to shell out nearly $500 in out-of-pocket medical expenses this month to pay for imaging and consultations not covered by restricted Medi-Cal, the bare-bones plan that is often the only option for California’s undocumented adults.

About a quarter of the 3.8 million Californians under 65 who remain uninsured are not eligible for coverage due to their citizenship status, according to a March 2016 report from the California Health Care Foundation. Immigrants in California make up 6 percent of the population and 10 percent of the workforce, according to the think tank Pew Research Center.

The Medi-Cal expansion for undocumented children is exclusively state-funded and is expected to cost the state Department of Health Care Services about $132 million annually. A 2015 study from the Public Policy Institute of California concluded that about half of the state’s undocumented immigrants have incomes low enough to qualify for Medi-Cal.

With the stalling of recent legislation seeking to expand Medi-Cal to income-eligible adult immigrants, other efforts are in the works to get more people covered. Earlier this month, Covered California announced that it would seek a federal waiver to allow undocumented people of all ages to buy insurance with their own money. Nearly 50 California counties are also offering, or planning to offer, limited coverage to undocumented families. That’s up from just seven at the beginning of 2015, according to a California Healthline report.

However, those options don’t cover preventive care, lab work, dental care or specialty services, said Betzabel Estudillo, health policy coordinator for the California Immigrant Policy Center. Estudillo, now a U.S. citizen living and working in Los Angeles, migrated from Mexico and remained undocumented until 2012. As a child she was enrolled in a county health program, but that ended when she turned 19, she said. She didn’t get covered again until she attended UCLA several years later.

“My whole childhood I had sporadic health care,” she said. “I just remember going to the county hospitals and the county clinics. I thought, ‘That’s what you do. That’s how you go to the doctor.’ ”

Estudillo's story is a common one in undocumented and mixed-immigration-status families, where language barriers, paperwork and fear of deportation dissuade many from seeking out coverage. Even when children are eligible for state and county health programs, parents may not inquire about those options for fear of being asked about citizenship status, said Cecilia Velasquez, enrollment coordinator at La Familia Counseling Center in Sacramento.

Dexsi Reyes Lara, a 25-year-old Honduran immigrant who has been living in California for five years, said she moved quickly to learn more about her health care options when she became pregnant with her daughter Yoselin, now 7 months old. She was able to enroll in a Medi-Cal pregnancy program that covered all of her health needs while she carried Yoselin, now a plump and giggly baby with large brown eyes and thick black hair.

But once Yoselin was born, Reyes Lara was removed from that program and lost her insurance coverage, she said. Since Yoselin is a U.S. citizen, she receives all the care she needs through full-scope Medi-Cal, but her mother is back to relying on the emergency room.

Last December, Reyes Lara brought her brother Jose Reyes Lara, 17 and her sister Merary Reyes Lara, 14, to Sacramento so they could get an education. They learned that their restricted Medi-Cal plans didn't cover the vaccinations required to enter the school system. The family hopes that with the Medi-Cal expansion, the teenagers will be able to get their shots and other basic services.

To qualify, children must be under age 19 and belong to a family defined by the state as low income. Children who are already enrolled in restricted-scope Medi-Cal – about 120,000 in California – will be able to transition to a full-scope plan without filling out a new application.

"I want them to have better doctors and better dental care," Dexsi Reyes Lara said. "Imagine if they were to get sick? Or even have a bad cold? We can't see a doctor. It's very expensive."

Joe Guzzardi, spokesman for the immigration reform group Californians for Population Stabilization, called the health care expansion another draw for illegal immigrants who will further stretch California's limited resources and deepen its financial deficits.

"We're having a hard time sustaining decent quality of life throughout the state," he said. "What the governor should be thinking about doing is better providing for the people who are already here legally, before he goes out to create entitlement programs to incentivize illegal immigrants."

Gabriela Gonzalez said she's looking forward to getting Felix on Medi-Cal so he won't have to live with the same medical uncertainties she faces.

“This month has been really hard; it’s been really tight,” she said in tears while rubbing Felix’s back.

She’s waiting for an appointment at a Sutter clinic in Davis to undergo an MRI for her heart. She said she’s not only anxious about the test results but the hit of the procedure’s out-of-pocket costs on her already strained household budget.

“We’ve noticed a difference with the other three,” she said about her sons who are citizens. “They have access to everything, and the service is better. I’m looking forward to having them all get the same thing.”

MANAGED Care

Cap on, Premiums up

California and other states have put monthly caps on out-of-pocket medication expenses. But the caps might shift some costs over to premiums.

By: Joseph Burns
April 2016

During the beginning part of year, people with high-deductible health plans who have large medical bills can end up shelling out thousands of dollars (up to $6,850 for individuals, $13,700 for families) before their coverage kicks in. This hit to the pocketbook comes after the holiday season when many bank accounts are in recovery mode.

No retailer or financial services firm would recommend asking customers to pay so much at once. Why not spread out the payments?

But health plans may be stuck in the Dark Ages when it comes to out-of-pocket payments, which were—and still are—meant to deter members from overusing their benefits. Cost-sharing also helps to keep premiums down. The problem now is that not only do high deductibles deter members from overusing care, for many people they have become an insurmountable barrier to getting care at all.

Last fall, Drew Altman, president of the Kaiser Family Foundation, told the Baltimore Sun that since 2006 the average deductible more than tripled, from $303 then to $1,077 today—a rate that was 7 times faster than wages in the same period. The Sun quoted Altman as saying, “when deductibles are rising 7 times faster than wages ... it means that people can’t pay their rent.... They can’t buy their gas. They can’t eat.”

It’s possible that they cannot afford medical care, either. When the Commonwealth Fund surveyed 2,762 Americans aged 19 to 64 last summer, 2 of every 5 people who had high deductibles (defined as 5% or more of income) reported not getting needed care because of their deductible, including not going to the doctor when they were sick, or delaying or not getting a follow-up test recommended by a physician. One of five adults surveyed and whose deductibles were deemed affordable said they delayed needed care because of their deductible, the Commonwealth Fund survey found.

California cap

It’s hard to imagine deductibles and other out-of-pocket payments going away entirely. But making them more manageable is certainly doable. Perhaps taking a lesson from retailers, California’s insurance exchange, called Covered California, has put a monthly cap on what consumers pay for medications. The cap is designed to ensure that members in marketplace plans have access to the medications they need, including those high-cost drugs for patients with HIV, AIDS, diabetes, and hepatitis C, Covered California says.

The limit of a $250 payment per script per month eases the pain by spreading it out over 12 months. The Democratic-controlled California legislature thought so much of Covered California’s plan that it adopted a similar measure that requires all health plans in the state—not just those sold on the exchange—to have a $200 monthly cap on medications starting next year.

In a report last fall, the Center on Health Insurance Reforms at Georgetown University said six other states have some caps on drug costs. California, Delaware, Louisiana, and Maryland limit the amount insured persons pay for a month’s supply of drugs.

California’s cap applies to all covered drugs, but in three other states, the cap applies only to specialty drugs. Maine and Vermont have annual caps on out-of-pocket costs for drugs. New York has prohibited specialty tiers, which can result in people facing higher out-of-pocket costs for certain medications. Meanwhile, Hillary Clinton has made caps on out-of-pocket drug expenses one of the chief talking points in her health care proposal, so we may be hearing more about them from the campaign trial.

“It’s too early to tell much about how well these limits are working,” says Justin Giovannelli, a project director at the Georgetown center. “But there is reason to believe that standardization of plans and perhaps caps on out-of-pocket costs will be helpful to consumers.”

Helping consumers afford their medications is the goal, says John Bertko, Covered California’s chief actuary and director of research. By capping payments monthly, patients with costly medications can pay over time.

Let’s say your doctor gives you an expensive prescription in February, says Bertko. Under most health plans, that would mean you’d have to cough up the full deductible right then. Now let’s say that same health plan member got that expensive prescription from his or her doctor in September instead of February. Depending on how much is left in the deductible, that member would have to pay a large chunk of it that month and then the full deductible when the plan year restarts in January if a refill is needed early in the year, says Bertko: “That’s two big hits in succession.” In contrast, Covered California is smoothing out the payment with its $250-a-month cap.

Premium increases

But for every time someone squeezes costs in one place, costs rise elsewhere. And so Bertko has had calculations done showing that capping copayments means premiums

will, indeed, go up for everyone. In other words, Covered California is spreading the risk from those members who have high-cost medications to all members in the form of a premium increase that will total roughly 1% this year. Put this in the category of “the money has to come from somewhere.” Milliman actuaries have estimated the ceiling on out-of-pocket expenses could be responsible for a 3% increase in premiums over the next three years—and that’s before any other costs that might put upward pressure on premiums.

How does Milliman know this? Well, specialty drugs in the pipeline are expected to drive up medication costs for health plan members who have cancer, for example. “In particular, the oncology drugs that are in development look extremely promising and in addition to that promise, the price is set by the pharmaceutical companies,” says Bertko. He expects “the costs to pile up” as more cancer drugs get approved.

Spreading the financial risk to all members certainly appears to be actuarially sound, but opponents counter that premium increases are not without consequence. Each increase in premiums causes health policy observers to cringe as people elect not to buy insurance, even if ACA tax subsidies reduce the net expense.

Celynda Tadlock, Aetna’s vice president of pharmacy development, is one such observer. She worries that when states introduce their own requirements, as Covered California is doing, those rules cause costs to rise and make management of health plans more complex. “We’re not in favor of managed increases in premiums because every new piece of legislation adds on costs. Over time, if more states add new rules, absolutely there would be a concern that premiums would need to rise,” she says.

But like Covered California, her company is concerned that high copayments will result in people not taking medications. Aetna tries to strike a balance, she says, between setting copayments low enough so they don’t discourage adherence while keeping them in line with what competitors are charging. Copayments that are too low can lead to adverse selection and an actuarially untenable situation of attracting too many high-cost members.

Tadlock says entering into value-based agreements with pharmaceutical companies is a better approach to controlling rising drug costs. As an example, she cites the value-based contract that Aetna has with Novartis for its new congestive heart drug, a sacubitril–-valsartan combination that Novartis is marketing as Entresto. The FDA approved Entresto last July. At that time, Novartis said it would cost about $12.50 a day, or $4,500 annually. Under Aetna’s agreement with Novartis, the health insurer will look to find whether the outcomes for Entresto in clinical trials can be matched by those when the drug is prescribed in real-world clinical practice. Novartis has a similar pay-for-performance contract for Entresto with Cigna.

Los Angeles Times

California effort is underway to allow undocumented immigrants to buy healthcare coverage

By: Patrick McGreevy
April 14, 2016

California would be the first state in the nation to ask the federal government to allow immigrants in the country illegally to purchase health insurance through a state exchange under new proposed legislation.

Sen. Ricardo Lara (D-Bell Gardens) authored a bill that would have the state formally request the federal government to give permission for immigrants to pay for coverage through Covered California without cost to the state or federal government.

The federal permission would allow as many as 390,000 immigrants who earn an income too high to qualify for Medi-Cal to purchase healthcare through the exchange under the Affordable Care Act, Lara said.

“This proposal affirms our commitment to embrace and integrate our immigrant community, to lead where the federal government has failed and to acknowledge the hard work and sacrifice of a community that contributes billions of dollars to our GDP,” Lara said in a statement.

The Claremont-based group We the People Rising, which calls for strict enforcement of existing immigration laws, criticized the measure.

“We oppose that [bill] because that encourages illegal immigration,” said Robin Hvidston, executive director of the group. “It sends a message to the world that if you come to our country you will be rewarded.”

The federal Affordable Care Act, also known as Obamacare, prohibits people in the country illegally from purchasing health plan coverage through state exchanges even if they can afford to pay full price.

The proposal, SB 10, has a good chance of passing the Legislature, coming just days after the Covered California board endorsed a proposal to apply for a waiver to allow immigrants in the country illegally to buy health insurance with their own money through the exchange.

Lara said the board understands that “prohibiting immigrants from buying insurance from the state exchange with their own money is an irrational and discriminatory policy that doesn’t reflect our California values."

Gov. Jerry Brown has not taken a public position on the bill, but supporters say it may appeal to the frugal governor because it would not present additional expense to the state.

The proposed waiver would build upon a campaign by the California Latino Legislative Caucus to eventually provide healthcare coverage for all immigrants.

Last year, the Legislature approved a Lara measure extending public healthcare to some 170,000 children who are in the country illegally, at a cost of $40 million.

A waiver for adults with means must be approved by the state Legislature and governor before it can be considered by the federal government, Lara said. The state must certify that the change will not diminish coverage or affordability, and will not add costs for the federal government.

Then the federal Department of Health and Human Services and Department of Treasury have 225 days to make a decision. By expediting state approval of the bill, Lara hopes to have the request considered by President Obama's administration before he leaves office.

FierceHealthPayer

New Covered California contracts push insurers to embrace value-based care

By: Katherine Moody
April 8, 2016

In a move that has drawn praise from federal officials, Covered California has made changes to its plan contracts that require health plans and providers to adopt initiatives aimed at improving care quality in the state.

The contract provisions, which will go into effect for 2017 to 2019, were developed over the past year in conjunction with consumer advocates, health plans, clinicians and subject matter experts, the state exchange said in its announcement.

"We are insisting on the best care and value for our consumers," Covered California Executive Director Peter Lee said. "In the near term, keeping costs low is about making sure Covered California has a good mix of enrollees, but over the long term there must be system-wide efforts to lower costs and improve quality for all Californians."

Among other aspects of the new contract provisions, Covered California will require that insurers:

- Adopt a new payment system for hospitals, which "over time,' puts 6 percent of plan reimbursement at risk or subject to a bonus based on the quality of care.
- Encourage enrollment in patient-centered medical homes or other forms of integrated care.
- Be more active in members' care by tracking and reducing health disparities and creating programs to find and manage at-risk enrollees.
- Exchange data with providers to notify them when patients are hospitalized and allow them to track trends and improve performance on chronic conditions.

The improvements were hailed by a wide variety of stakeholders, including the Centers for Medicare & Medicaid Services and the American Academy of Family Physicians, the announcement said. But insurers and providers alike have already pushed back against Covered California's plan to require health insurers to eject low-performing providers from their networks--a proposal reiterated in the exchange's newly finalized contract provisions.

Los Angeles Times

California's Obamacare exchange takes a step to bring immigrants in the U.S. illegally into the pool

By: Michael Hiltzik
April 8, 2016

Enhancing its position as one Obamacare exchange that takes its job seriously, Covered California on Thursday took a significant step toward bringing health insurance to the largest single group still on the outside looking in: immigrants in the U.S. illegally.

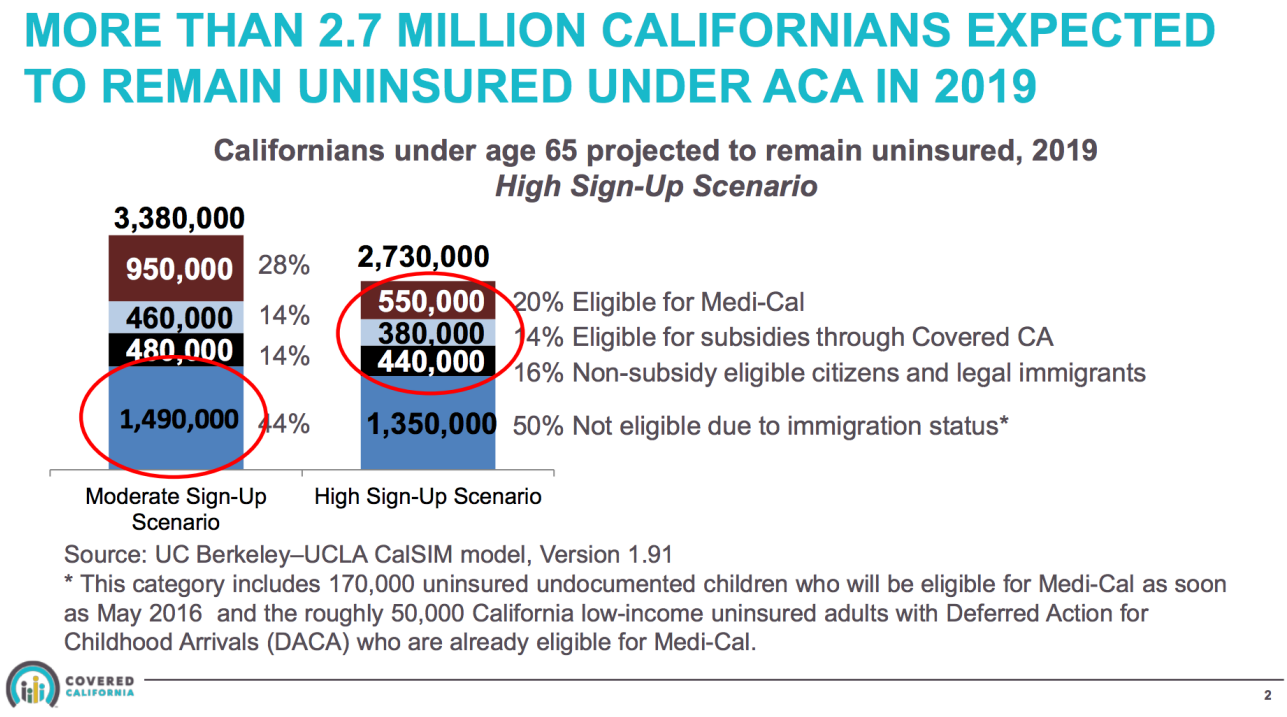
On the surface, the exchange's board didn't do much. It simply produced for the Legislature an analysis of a proposal to seek a so-called Section 1332 waiver, which covers "innovation" in exchange designs. The Legislature must approve the waiver application, which then must be weighed by the U.S. Department. of Health and Human Services. Ultimate approval in Washington is by no means assured, the Covered California staff advised the board.

"This is somewhat symbolic," said Covered California's chair, Diana Dooley, the state's secretary of health and human services. But "symbolism is important."

But the move was interpreted by healthcare advocates as effectively a green light to seek the waiver. A measure to do so already has been introduced in the Legislature. "The analysis says this is workable and feasible and could be done this year," said Anthony Wright, executive director of the advocacy group Health Access California. Although no formal vote was taken, several board members expressed at least implicit support for the idea of providing immigrants in the U.S. illegally with access to plans through Covered California.

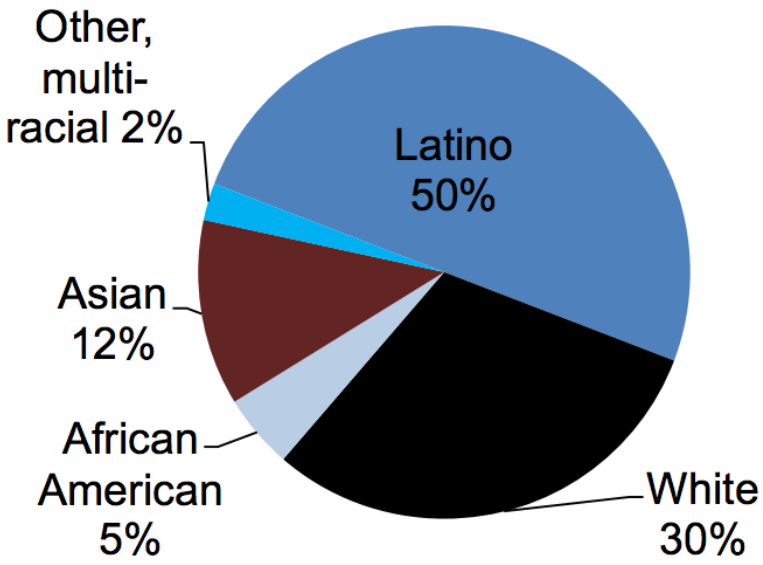
Denying immigrants in the country illegally access to the Affordable Care Act exchanges was a tic in the enactment process in 2010, plainly aimed (unsuccessfully) at securing Republican votes. The measure bars those residents from purchasing health plans through the Obamacare exchanges even with their own money and at full price.

It's one of those punitive anti-immigrant policies that infect our political thinking, like denying immigrants in the U.S. illegally the right to apply for drivers licenses, because what's not to like about having millions of untested drivers tooling around our highways and byways, making the roads less safe for everybody? (California last year became one of 10 states consigning this self-destructive policy to the dustbin, by opening the licensing process to qualified immigrants in the country illegally.)



The result is that as many as 1.5 million California residents may be ineligible for Affordable Care Act coverage because of their immigration status, according to Covered

California estimates. That's more than 40%, and possibly half, of all uninsured individuals in the state. (See graphic above.) Immigration status is only one factor in their missing out on insurance; even if eligible under a waiver, many may not be able to buy it, because the law will continue to prohibit granting residents in the U.S. illegally the tax subsidies that make Obamacare coverage affordable.



The exclusion of so many state residents is a problem in part because the large uninsured population undermines a key goal of expanding healthcare, which is to improve public health generally, not just among families that can afford it. No one gains to have members of the community walking around sick. It also complicates delivery of health coverage to members of families in which some members are eligible for health coverage and others are not.

California's move to extend greater coverage to children in the country illegally may, ironically, have exacerbated that problem. Gov. Jerry Brown last year signed a measure to provide state-subsidized Medi-Cal coverage to about 170,000 children age 18 and younger without legal status, starting next month. The policy will cost about $132 million a year, but the Legislature opted not to extend coverage to adults in the country illegally, which would have raised the cost to as much as $740 million.

As a result of the policy, in some "mixed-status" families the children will be covered while one parent may have legal status and the other lack documentation. California rightly is concerned that fears of legal exposure by those in the U.S. illegally may dissuade such families from seeking coverage even for eligible members, an obstacle that may be reduced by allowing all family members to obtain exchange-based coverage whether subsidized or full price.

Covered California Board approves “historic” quality-improvement changes to 2017 QHP contract

By: JJ Lee
April 7, 2016

Today, the Covered California Board unanimously approved modifications to the 2017-2019 Qualified Health Plan (QHP) Model Contract aimed at reducing health disparities and improving quality.

The now “famous” attachment 7 of these modifications captured stakeholder and media attention for a section that requires exchange plans to report hospitals with outlier poor performance and remove them from their network by 2019. Several stakeholder meetings held with Covered California since that requirement was introduced in February yielded a contract that is much more palatable to all parties.

Amber Kemp, Vice President of Health Care Coverage, for the California Hospital Association (CHA) testified to this spirit of collaboration.

“CHA applauds the Board for delaying finalization of the QHP model contract from Feb. 18 to today, allowing for much needed additional dialogue on the proposed quality initiatives and on the impact the proposal would have on providers and consumers and on networks,” said Kemp.

Stacey Wittorff, Associate Director, Center for Health Policy at the California Medical Association (CMA) joined in Kemp’s praise of the effort between the Board, health plans, and providers. However, she expressed CMA’s lingering reservations over contract modifications.

“As attachment 7 and the appendices will serve as the guiding documents for the implementation for the quality framework, it will have significant impacts on our physician members and on their ability to provide care to Covered California enrollees,” said Wittorff. “CMA has concerns about a set of not-yet-developed quality and cost metrics and their use as the basis of excluding physicians from networks. Our global

concern is in regards to the potential impacts of excluding physicians from networks and on the ability of patients to access care should significant numbers of physicians be excluded."

She continued, "Our more immediate concern is with the approval of a contract attachment with so much yet to be determined."

Wittoff concluded with remarks that, despite some misgivings, CMA was prepared to commit fully as a partner to Covered California.

Athena Chapman, Director of Regulatory Affairs at the California Association of Health Plans echoed this sentiment of cautious support.

"While the contract doesn't necessarily address all of our concerns—health plans still have some things we don't like [such as] some concerns about non-material breach of contract," said Chapman. "But, we feel that it's time to move forward. There are some extra protections that make us feel comfortable at this point. We still have a lot of work ahead of us in finding outliers, working on the quality metrics, and we're looking forward to being part of that process."

In contrast, there was an outpouring of praise for the "historic" move towards quality and consumer protection from advocacy groups.

Beth Capell, lobbyist for Health Access commented: "When Covered California was created and the active purchaser authority was granted, we hoped that it would be used for exactly for such purposes."

"We certainly are making it clear that Covered California is about more than just getting coverage, that we are really looking to assure that our enrollees get the right care when they need it," said Board Chair Diana Dooley. "I do think this is remarkable. It is very ambitious, but there is a lot of flexibility baked into it. We will be reasonable, as we have tried to be throughout. Practicality and administrative ability to do what we want to do have been a hallmark of our work together on this. But if we don't reach high, we won't move the ball forward."

"This is raising the bar, not just here in California, but in the nation," said Lee.
State of Reform will continue to track as California's stakeholders begin the heavy lift of defining specific outlier quality metrics.

Covered California acts to ensure everyone gets a primary care doctor

By: Stephanie O'Neill
April 15, 2016

In an attempt to improve patients' decision-making, Covered California is now requiring all types of health plans to assign a primary care doctor to their members.

The policy shift is in the agency's new contract with insurers, approved by the Covered California board last week. It will affect preferred provider network plans - PPOs - in particular. A consumer favorite, PPO plans allow members to go to any doctor – specialist or otherwise – without a referral from a primary care physician.

A primary care doctor can help a consumer "navigate the system," says Peter Lee, executive director of Covered California. The absence of that relationship in PPO plans is one reason emergency room visits have surged since passage of the Affordable Care Act, he says, in explaining why his agency added the primary physician requirement to its new three-year contract with insurers.

The concept, Lee says, is borrowed from HMOs, such as Kaiser Permanente. The difference is that, under the new Covered California rule, members of PPOs won't be required to visit their assigned doctor before seeking out a specialist.

"These people are not gatekeepers," Lee says. "Their job is to help people navigate a complex system, but not to be the mother-may-I doctors of the past."

The California Association of Health Plans says that its members are prepared to move forward with Covered California's new policy.

"Our members have a lot of experience in the assignment of primary care providers through their HMO products," says CAHP spokeswoman Nicole Evans.

89.3 KPCC

Covered California acts to ensure everyone gets a primary care doctor

By: Stephanie O'Neill
April 14, 2016

California's health insurance exchange will use the threat of exclusion from its approved provider networks as a way to motivate hospitals and doctors to reduce the number of medically unnecessary Cesarean sections.

Beginning in 2019, insurance companies that contract with Covered California must either exclude from their networks any hospitals that don't meet the federal government's 2020 target C-section rate or explain why they aren't, according to the new contract approved by the exchange's board last week.

An insurer that wants to keep an underperforming hospital in its network will have to provide Covered California with "the rationale for continued contracting" and document "efforts the hospital is undertaking to improve its performance," the contract states.

"This is going to catch people's attention and focus the considerable quality improvement activities of hospitals on this area," says Dr. Elliott Main, medical director of the California Maternal Quality Care Collaborative.

When complications arise during pregnancies, C-sections can save the lives of mothers and infants. But experts say in far too many instances, women undergo C-sections when the procedure is not medically indicated.

Attention is focused on how often doctors perform C-sections on first-time moms with low-risk pregnancies, defined as those that have reached the 37th week or later and consisting of one fetus in the head-down position.

The federal government has set a goal of reducing C-sections in these low-risk situations to 23.9 percent by 2020. The national rate was 26.9 percent in 2013, according to the Centers for Disease Control and Prevention.

Many California hospitals are far from the 23.9 percent target: Statewide, 10 percent of hospitals had rates of 33 percent or higher in 2014, according to recent data from the California Hospital Assessment and Reporting Task Force.

Leah Binder, president and CEO of the Leapfrog Group, a national nonprofit focused on health care quality and safety, lauds Covered California’s new policy.

"Covered California is a national leader on quality of care," Binder says. "I don't know of any other state this advanced in demanding better maternity care for its residents."

Covered California's contract also requires insurers to alter their payment structure by 2019 so there is no financial incentive to perform a C-section rather than deliver a baby vaginally.

The California Hospital Association strongly supports Covered California’s goal of reducing medically unnecessary C-sections, says spokeswoman Jan Emerson-Shea. But, she points out, doctors and their patients also play a role in this effort, so "it is important that payment provisions apply to OB-GYN physicians as well as hospitals."

The Maternal Quality Care Collaborative's Main says he would support physicians being held accountable if they are part of larger medical groups that contract with the exchange.

For its part, the California Association of Health Plans will "remain engaged" as Covered California works out the details of its new C-section policy, says spokeswoman Nicole Evans.