Media Clips

COVERED CALIFORNIA BOARD CLIPS
June 10, 2016 – Aug. 18, 2016

Since the June 10 board meeting, high-visibility media issues included: the announcement of 2017 Covered California health plan rates; a new Covered California rule requiring members have a primary care provider; and a proposal to expand Covered California access to immigrants in California illegally.

Since the June 10 board meeting, the term "Covered California" was mentioned 7,950 times in a Google search and the phrase “California Health Benefit Exchange” was noted one time. The following clips represent a cross-section of media outlets and coverage.

COVERED CALIFORNIA PRESS RELEASES

PRINT

Articles Placed by Covered California

Articles of Significance

BROADCAST

Segments Placed by Covered California

Segments of Significance

COVERED CALIFORNIA

News Release

FOR IMMEDIATE RELEASE
July 19, 2016

Covered California Announces Rates and Plan Expansions for 2017

- *Statewide weighted average increase is 13.2 percent*
- *Three-year average increase of 7 percent is lower than pre-Affordable Care Act trends*
- *Nearly 80 percent of consumers will pay less or see a rate bump of no more than 5 percent if they switch plans*
- *Insurers are expanding to compete in new communities*
- *New benefit changes help consumers save when they access health care*

SACRAMENTO, Calif. — Covered California unveiled its rates for 2017 on Tuesday and announced that some health insurance plans will be expanding into new areas throughout the state to compete for consumers in California.

The statewide weighted average change will be 13.2 percent, up from approximately four percent in each of the last two years. However, most consumers will see a much smaller increase — or pay less next year — if they switch to another plan.

“Shopping is going to be more important this year than ever before,” Covered California Executive Director Peter V. Lee said. “Almost 80 percent of our consumers will either be able to pay less than they are paying now, or see their rates go up by no more than 5 percent, if they shop and buy the lowest-cost plan at their same benefit level. That’s the power of shopping.”

Downloadable comments from Executive Director Peter V. Lee (Video).

Lee said the opportunities to shop and save show that California has succeeded in building a competitive marketplace for health insurance, with rate increases that are still below trends in the individual market before the Affordable Care Act was passed.

“This is a new era of health care, where the consumer is in the driver’s seat with the power to look easily for a better deal, and where subsidies help absorb the impact of rate changes,” Lee said. “These options did not exist before the Affordable Care Act.”

Some consumers who choose to keep their plan will see a significant increase in their premium for 2017, while others will see a more modest increase, depending on where they live and what insurance plan they have. Consumers will begin receiving notices in October, when they will have an opportunity to review their new rates and change plans for their 2017 health coverage.

For many of those insured, the bulk of the premium increase will be absorbed by the subsidy paid by the government to help enrollees buy health insurance. Approximately 90 percent of Covered California enrollees get help to pay for their premiums. The average subsidy covers roughly 77 percent of the consumer’s monthly premium, and while premiums will rise, the subsidies will rise as well.

“Even though the average rate increase is larger this year than the last two years, the three-year average increase is 7 percent — substantially better than rate trends before the Affordable Care Act was enacted,” Lee said.

Covered California Rate Changes

	2014-2015 Change	2015-2016 Change	2016-2017 Change	3-year Average Change
Weighted Average Increase	4.2%	4.0%	13.2%	7.0%
Lowest-Priced Bronze (unweighted)	4.4%	3.3%	3.9%	3.9%
Lowest-Priced Silver (unweighted)	4.8%	1.5%	8.1%	4.8%
Second Lowest-Priced Silver*	2.6%	1.8%	8.1%	4.1%
If a consumer switches to the lowest-priced plan in the same tier	–	**-4.5%**	**-1.2%**	–

*Second-lowest priced Silver plans are the best basis of determining federal tax credit and are often used as a basis for comparison to national rates.

Lee said the average rate increase reflects the cost of medical care for consumers, not excessive profit.

“Under the new rules of the Affordable Care Act, insurers face strict limits on the amount of profit they can make selling health insurance,” Lee said. “So, while all plans are experiencing different cost pressures, we can be confident their rate increases are directly linked to health care costs, not administration or profit, which averaged 1.5 percent across our contracted plans.”

For consumers who get a tax credit to lower their costs – which is about 90 percent of those who sign up through Covered California – the amount they pay is impacted not only by the premium choice, but by changes in their tax credit. While the average rate increase is higher than past years, Covered California’s risk mix — the ratio of consumers who are healthy vs. sick — remains one of the best in the nation according to the Centers for Medicare and Medicaid Services (https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html).

Other reasons for rate increases include:

A one-year adjustment due to the end of a funding mechanism in the Affordable Care Act known as reinsurance which was designed to moderate rate increases during the first three years when exchanges were being established. The American Academy of Actuaries estimates this will add between 4 percent and 7 percent to premiums for 2017.

Special enrollment by some consumers who may be enrolling in health insurance only after they become sick or need care, which seems to have had a significant impact on rates for two insurance plans.

The rising cost of health care, especially specialty drugs.

Pent-up demand for health care now being accessed by those who were locked out of the health care system before the Affordable Care Act was enacted.

Lee said Covered California is working to address some of these issues on multiple fronts. The exchange is aggressively marketing to attract healthy consumers year-round, and it is working to ensure special enrollment is available only to those who meet qualifying circumstances. It is also sampling the special enrollment population to better understand how to make any further improvements needed.

“We work hard to build a robust exchange that drives competition by attracting as many consumers as possible,” Lee said. “Now, consistent with the vision of the Affordable Care Act, we will redouble our efforts to make sure our consumers and potential consumers understand the importance of signing up during open enrollment and remaining covered throughout the year.”

Lee said Covered California's 11 health insurers are competing across the state for its 1.4 million members.

"The sheer number of enrollees and their overall health means consumers in the individual market are benefiting from competition," Lee said.

Below is the complete list of the companies selected for the 2017 exchange:

Anthem Blue Cross of California	Molina Healthcare
Blue Shield of California	Oscar Health Plan of California
Chinese Community Health Plan	Sharp Health Plan
Health Net	Valley Health Plan
Kaiser Permanente	Western Health Advantage
L.A. Care Health Plan	

Rate details by pricing regions can be found in "Covered California's Health Insurance Companies and Plan Rates for 2017," posted online at: http://coveredca.com/news/pdfs/CoveredCA-2017-rate-booklet.pdf

The preliminary rates are subject to a 60-day public comment period and regulatory review by the California Department of Managed Health Care. In addition, the California Department of Insurance will review Health Net's EPO.

Some insurance carriers will be increasing their coverage areas in 2017:

Oscar will be entering the market in San Francisco, Santa Clara and San Mateo counties.

Molina will expand into Orange County.

Kaiser will be available in Santa Cruz County.

With the expansion of its current carriers, almost all consumers (92.6 percent) will be able to choose from three or more carriers, and all will have at least two to select from.

In addition, more than 93 percent of hospitals in California will be available through at least one Covered California health insurance company in 2017, and 74 percent will be available in three or more plans.

Covered California also is improving its patient-centered benefit designs by increasing a consumer's access to care by reducing the number of services that are subject to a consumer's deductible.

Starting in 2017, consumers in Silver 70 plans will save as much as $55 on an urgent care visit and $10 on a primary care visit. In addition, consumers in Silver, Gold and Platinum plans will pay a flat copay for emergency room visits without having to satisfy a deductible, which could save them thousands of dollars.

These improvements build on features already in place that ensure most outpatient services in Silver, Gold and Platinum plans are not subject to a deductible, including primary care visits, specialist visits, lab tests, X-rays and imaging. In addition, some Enhanced Silver plans have little or no deductible and very low copays, such as $3 for an office visit. Even consumers in Covered California's most affordable Bronze plans are allowed to see their doctor or a specialist three times before the visits are subject to the deductible.

In addition, the contract with health insurers for 2017 ensures consumers select or are provisionally assigned a primary care physician within 60 days of effectuation so they have an established source of care.

"Health care reform isn't just about making insurance affordable, it's about doing things to make it easier for consumers to get the right care at the right time," Lee said.

In May, the Centers for Disease Control and Prevention announced that California's uninsured rate had fallen to 8.1 percent at the end of 2015, down from 17 percent at the end of 2013, right before the Affordable Care Act began offering coverage.

"We can all be very proud of the extraordinary gains we have made in reducing California's uninsured rate to a historic low," Lee said.

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, 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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Hispanos Press

Covered California puede ser una mejor opción que COBRA

July 16, 2016

Si usted perdió recientemente su cobertura de salud ya sea porque se cambió de trabajo o perdió su trabajo, y está considerando continuar con su cobertura a través de COBRA, asegúrese de explorar todas sus opciones antes de decidir.

El período de inscripción abierta de Covered California terminó el 31 de enero, pero el haber perdido la cobertura de salud provista por un empleador es uno de los eventos de vida que permite inscribirse en **un plan de Covered California.**

Otros eventos de vida calificados que son comunes y califican incluyen**: casarse, divorciarse, tener hijos (biológicos o adoptados), mudarse de región.**

La inscripción tiene que hacerse dentro de los **60 días desde que ocurra el evento de vida**. Cualquier persona que experimente uno de los eventos de vida calificados que se mencionan anteriormente puede solicitar cobertura inmediatamente.

La cobertura a través del plan de Covered California que seleccione comenzará el primer día del mes siguiente. De esta manera se evita rompimiento en la cobertura.

Si su empleador ofrece cobertura de COBRA al terminar el empleo, usted tiene las siguientes opciones:

1. Usted puede continuar la cobertura bajo COBRA. Por ejemplo, usted puede elegir esta opción si está recibiendo tratamiento médico, o si no quiere hacer ningún cambio a su plan, o a su red actual de médicos y hospitales.

2. Usted puede decidir no participar en COBRA y solicitar inscripción especial a través de Covered California.

Los factores más importantes que debe considerar al momento de tomar una decisión:

- La red de doctores y hospitales disponibles para cada plan.
- El total de la cuota mensual para usted y sus dependientes.
- Los copagos y deducibles de los distintos planes.

La asistencia económica para ayudar a pagar por las cuotas del plan solamente está disponible a través de **Covered California.**

Aproximadamente **9 de cada 10 personas inscritas con Covered California reciben algún nivel de asistencia económica.** Según un informe de Covered California, 759,000 personas **pagaron $100 o menos al mes** por cobertura en el 2015 y 375,000 personas inscritas **pagaron $50 o menos al mes**.

Enfermedad pre-existente: No se preocupe está cubierto

July 2016

El diagnóstico de cáncer siempre es difícil, pero es aún peor cuando son los últimos días en que la persona tiene cobertura de salud.
Jessica López, de 45 años de edad, estaba por cambiarse de trabajo y de quedarse sin seguro médico cuando le diagnosticaron cáncer en la matriz.

“Estaba desesperada. No sabía cómo iba a pagar el tratamiento. Pensé que ya no iría al doctor y que me iba a tener que aguantar. Yo no sabía que tenía opciones”, dijo Jessica.

De acuerdo a la última encuesta sobre la Ley de Salud a Bajo Precio (ACA) conducida por la Universidad del Sur de California (USC Dornsife) y Los Angeles Times, casi uno de cada tres latinos no sabe que pueden obtener cobertura de salud aunque tengan una condición pre-existente. En comparación, sólo el 17 por ciento de los blancos no latinos no conocían este beneficio.

En el caso de Jessica, ella se enteró gracias a una amiga que sí podría comprar un seguro a través de la agencia estatal de seguros de salud, Covered California.

La agente certificada de Covered California que ayudó a Jessica, Yadira López, dijo que con frecuencia llegan a su oficina en Inglewood latinos que no saben que ya no hay barreras para obtener seguro de salud.

“Algunos lo quieren ocultar y hacen preguntas diciendo que si hipotéticamente tienen cáncer o alguna otra enfermedad, si lo tienen que reportar. Yo les digo que para inscribirse no tienen que responder ninguna pregunta médica”, dijo Yadira.

Esta agente certificada recomienda a todas las personas que si conocen a alguien que tiene una situación difícil que busquen ayuda.
En general, la mayoría de californianos apoyan o están de acuerdo con los beneficios de la reforma de salud, indica esta encuesta realizada entre el 19 al 31 de mayo que incluye una gran cantidad de votantes latinos.

“Aparenta que casi todos los votantes californianos que apoyan Obamacare lo hacen porque creen que tiene un impacto positivo en toda la sociedad en lugar de un impacto directo con sus proveedores”, explicó Dan Schnur, director del Instituto de Política Jesse M. Unruh de USC.

La tarjetita

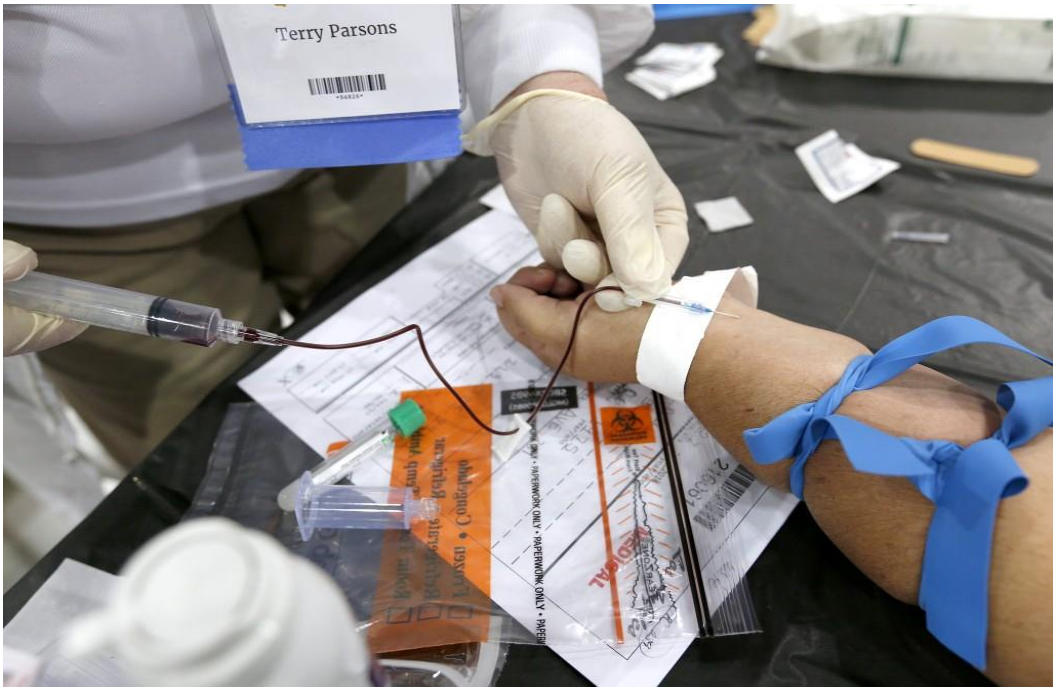
Jessica paga $62.95 mensualmente por su cobertura de salud de Covered California.

“Es tan diferente saber que con esa tarjetita que dice mi nombre y que tiene el logo de Covered California, puedo encontrar la ayuda médica que necesito. Es un alivio. Ese pedacito de papel me da seguridad de que alguien me va a ayudar”, agregó Jessica.

La Opinión

Aunque tengas una enfermedad puedes tener cobertura de salud

June 26, 2016



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Para encontrar un agente o consejero de inscripción certificado cerca de su hogar o si necesita ayuda adicional puede llamar al 1-800-300-0213 o visitar la página web www.coveredca.com/español.

Hispanos Press

June 24, 2016

Enfermedad pre-existente: No se preocupe está cubierto

Casi 1 de cada 3 latinos no saben que pueden obtener seguro de salud a pesar de estar enfermo.

Por **Covered California** - 24 junio, 2016 62

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Las barreras culturales condicionan el acceso a seguros médicos entre los latinos en California

June 22, 2016

La Ley de Salud a Bajo Precio (ACA), conocida como Obamacare, desde que se comenzó a implementar en enero de 2014 cambió las reglas para acceder a un seguro de salud en California, abriendo las posibilidades de cobertura a personas con enfermedades pre-existentes.

En los dos años y medio que lleva este sistema, el índice de personas sin seguro ha bajado; sin embargo, todavía la población latina se enfrenta a barreras que limitan el acceso y, además, la información que se impone es la que se genera en la opinión popular y no siempre es fidedigna.

“La gente escucha más a la comadre o al vecino, aunque la información no sea real”, valoró Sara Calderón, promotora de salud, al referirse al problema que enfrenta la comunidad para conocer las bondades de Obamacare, patrones con los que tienen que lidiar en el día a día.

En una encuesta realizada por la Universidad del Sur de California (USC Dornsife) y el diario Los Angeles Times se reveló que uno de cada tres latinos desconocen que pueden obtener cobertura médica a pesar de tener una condición pre-existente.

Mientras tanto, entre los anglosajones el índice de desconocimiento era menor, porque solo el 17% no sabía ese beneficio, detalló el sondeo realizado entre el 19 y 31 de mayo anterior, en el que se recabaron las opiniones de 1,500 votantes registrados en el que se abordaron diferentes temas.

Jessica López, de 45 años de edad, estaba por cambiarse de trabajo y de quedarse sin seguro médico cuando le diagnosticaron cáncer en la matriz. “Estaba desesperada. No sabía cómo iba a pagar el tratamiento. Pensé que ya no iría al doctor y que me iba a tener que aguantar”, manifestó.

Para su fortuna, una amiga bien informada la orientó. En su caso, advierte que no tuvo que ocultar su condición, contrario a lo que se comenta de forma equivocada. “Para

inscribirse no tienen que responder ninguna pregunta médica", indicó detallando que paga cada mes 62.95 dólares.

Antes de implementarse Obamacare, en el Estado Dorado habían 7 millones de personas sin cobertura médica, siendo el 60% latinos. En este momento, de los 1.3 millones inscritos en Covered California el 37% son anglosajones, 30.6% latinos, 22.4% asiáticos y 2.7% afroamericanos.

A juicio de Yurina Melara, vocera de Covered California, las enfermedades como cáncer, diabetes o gastritis, entre otras, no condiciona a ningún usuario para comprar un seguro como ocurría en el pasado, cuando los pacientes se veían obligados hasta a vender sus casas para pagar un tratamiento.

"La gente no quiere decir que tiene una enfermedad porque antes se les negaba el seguro médico", señaló, enfatizando que a excepción de las personas que no cuentan con estatus regular todos pueden accesar a cobertura de salud, limitación que podrá cambiar en poco tiempo.

"Las personas con bajos ingresos pueden recibir subsidios federales", agregó Melara, dejando claro que después de que el gobernador firmara la ley que amplía la cobertura a inmigrantes indocumentados, solo falta la aprobación federal para que el seguro médico sea universal.

A criterio de Rolando Castillo, presidente del Consorcio de Profesionales y Médicos de Latinoamérica (Cophyla), la comunidad todavía no aprovecha estos recursos debido a las barreras del idioma y cultura, también cree que incide el uso de la medicina alternativa como una opción.

En ese sentido, el experto en Medicina Sicosocial considera que las autoridades tienen el reto de acercar los recursos "realizando campañas educativas y deberían capitalizar la información por medio de grupos comunitarios y promotores de salud que conocen la realidad sociocultural".

Pasadena En Español

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SAN DIEGO LGBT weekly
America's First Cable News Affiliated LGBT Media Company
CNN WIRE

Opportunity remains for thousands to enroll in health coverage through Covered California

June 11, 2016

Although Covered California's third open-enrollment period ended Jan. 31, the door is not closed to uninsured Californians who have experienced life-changing events like having a baby, losing health insurance that had been provided by their job or moving a long distance.

It's Covered California's special-enrollment period, a time when eligible consumers can sign up for coverage outside of open enrollment, as long as they do so within 60 days of the qualifying life event. Some of the more common events that can make someone eligible are:

- Losing health coverage provided by an employer.
- Getting married or entering a domestic partnership.
- Having a baby or adopting a child.
- Moving to California.
- Becoming a citizen, national or lawfully present individual.

Access to health care is an equality issue for lesbian, gay, bisexual and transgender (LGBT) Americans. Prior to the Patient Protection and Affordable Care Act, studies show that nearly 27 percent of transgender people and 7.7 percent of lesbian, gay and bisexual people said they were refused needed medical care. Many transgender people reported having exclusions for their medical needs in their health plans. In addition, providers often lacked cultural competence to LGBT health concerns.

Lesbian, gay, bisexual and transgender individuals face unique health disparities that include experiences of violence, HIV/AIDS and certain chronic conditions.

Thanks to the Affordable Care Act and state laws and regulations, this situation is changing: All health plans in California must comply with the state's Insurance Gender Nondiscrimination Act, which prohibits health plans from denying insurance based on gender identity or expression and requires the removal of benefit and coverage exclusions and limitations regarding gender transition services. Under the Affordable Care Act, plans cannot deny someone coverage due to a pre-existing condition such as HIV/AIDS.

Those who experience any of the qualifying life events listed above can enroll in coverage immediately.

For special enrollment after a qualifying life event, consumers can enroll online at CoveredCA.com or call Covered California at (800) 300-1506 for enrollment help. Covered California's Certified Enrollment Counselors, Certified Insurance Agents, Certified Plan Based Enrollers or County Eligibility Workers also can help with special enrollment.

DATV Magazine

June 2016

Cada vez son más las personas con seguro de salud.

Las autoridades estiman que a nivel nacional el porcentaje de personas sin seguro médico disminuyó a niveles históricos de 9.1 por ciento, mientras que en California es de 8.1 por ciento.

Silvia López, una estilista independiente, se pasó al grupo de los asegurados en marzo cuando descubrió que había perdido su cobertura de Medi-Cal y que por varios meses no tuvo seguro de salud.

"Hace unas semanas me dolía todo el cuerpo y el doctor no encontraba por qué. Me tuvieron en el hospital para hacerme varios estudios, hasta que me dijeron que era pericarditis", dijo López. "De no haber tenido Covered California habría acumulado miles de dólares en deuda, en lugar de los $87 que pago por la cuota mensual".

Una encuesta reciente de los Centros de Control y Prevención de Enfermedades (CDC) indica que a finales del 2015 el porcentaje de personas sin seguro de salud en California se encuentra en el punto más bajo en la historia con 8.1%. Esto es un punto menos del porcentaje nacional de 9.1% de individuos sin seguro médico.

Y el número de personas sin seguro de salud continúa disminuyendo. Personas como López, que pierden su seguro, o quienes han tenido un cambio de vida

como mudarse, casarse o tener un bebé, no tienen que esperar al periodo de inscripción abierta. Estas personas pueden obtener seguro de salud cuando su situación cambia.

"California está teniendo éxito en esta nueva era de cuidado de salud por medio del uso de todas las herramientas de la Ley de Cuidado de Salud [ACA] – expandiendo Medi-Cal y lanzando un mercado de salud estatal que brinda calidad y valor a nuestros consumidores", dijo Peter V. Lee, director ejecutivo de Covered California.

La Dra. Hortensia Amaro, investigadora y catedrática del Departamento de Trabajo Social de la Universidad del Sur de California [USC], opina que los datos demuestran que la ley de salud está beneficiando a todos los grupos étnicos.

"Sin embargo, las cifras muestran que las disparidades aún persisten entre los latinos y los afroamericanos comparados con las personas blancas no latinas... Estos significa que aún se necesita cerrar la brecha del seguro médico entre los latinos y los afroamericanos", acotó la Dra. Amaro.

A nivel nacional, los CDC estiman que el porcentaje de personas sin seguro médico disminuyó de 14.5% en el 2013 a 11.5% en el 2014. Para finales del 2015 el porcentaje bajó nuevamente a 9.1%.

PRIMAS AUMENTAN, PERO NO MUCHO

Un nuevo análisis de la Universidad de California Berkeley sobre las cuotas mensuales de los seguros médicos bajo ACA indica que el mercado de salud estatal, Covered California, ha ayudado a que los 1.3 millones de consumidores obtengan cobertura a mejor precio gracias a que ha podido negociar con las compañías aseguradoras.

California es uno de los pocos estados que negocia con las aseguradoras el precio de las primas y los beneficios en favor de sus clientes, indicó Richard Scheffler, economista de salud de UC Berkeley y autor del estudio.

En los últimos dos años, las primas de los seguros de salud han incrementado en promedio 4.1% a nivel nacional.

STATE OF REFORM

California's waiver sees limited exchange enrollment for undocumented

By: JJ Lee
Aug. 5, 2016

Today, Covered California released its 1332 draft application which outlines its proposal to expand access to undocumented individuals by allowing them to purchase plans on the state exchange. However, estimates by the CalSIM team indicate only about 17,000 undocumented Californians will sign up for unsubsidized coverage with its passage.

That figure is less than 1% (0.7%) of the current undocumented population which tops 2 million individuals and makes up roughly 6.3 percent of the California's total population, according to the Pew Research Center.

According to the waiver application, a significant reason for the modest enrollment estimate is the exclusion of subsidies. The waiver seeks to create a new category of insurance for those ineligible for Qualified Health Plans (QHPs) on the state exchange in the form of California Qualified Health Plans (CQHPs).

If the waiver is approved, all insurers on Covered California will be required to offer CQHPs to those who do not qualify for QHPs due to their immigration status. CQHPs will mirror QHPs in their cost sharing, networks, and benefits. However, they will not offer tax subsidies in the form of Advance Payments of Premium Tax Credits (APTCs) or Cost Sharing Reductions (CSRs).

Though the impact to the undocumented community through direct enrollment appears minimal, the waiver seeks to improve population health by supporting "mixed families,"

those with members of different citizenship statuses, by streamlining their enrollment process.

Health advocacy groups lauded the proposal despite the relatively small proportion of undocumented immigrants expected to purchase coverage on the exchange.

“This is a modest step forward, for a more inclusive and stronger health system. Without subsidies, many undocumented immigrant families will still face affordability barriers. But it will make it easier for mixed-status families to enroll as a family, together, even if some are subsidized and others not. In a big state like California, even the small percentage who take advantage of this enrollment portal would be enough to fill a basketball arena,” said Anthony Wright, executive director of Health Access California, the statewide health care consumer advocacy coalition.

The draft states that approximately 13 percent of California’s school-aged children have an undocumented parent. The passage of this waiver is expected to increase “all family members’ appropriate use of health care” based on findings that individuals tend to adhere to wellness visits and access preventive services if a child who is insured also has an insured parent.

The waiver is not expected to have any impact on overall enrollment in the Medi-Cal, subsidized individual market, or employer sponsored insurance programs. In fact, projected numbers for enrollment years 2019-2023 remain the same with and without the waiver.

Wesley E. Yin, health care economist at the University of California Los Angeles added that waiver-induced enrollment could have a positive effect, if any, on premiums overall and benefit the risk pool.

“For premiums to increase by a non-negligible amount—say, above one percent—uptake would have to exceed 27,000, and the average claims costs of the newly insured would have to exceed 350 percent of claims observed in commercial group plans, radically higher than our upper bound estimates of 150,” states Yin.

CaliforniaHealthline
The Daily Digest of News, Policy & Opinion

Obamacare Expansion A Bumpy Ride For Rural Health Clinics

By: Pauline Bartolone
July 29, 2016

A network of clinics that serves low-income patients in rural Northern California is finally finding balance after being deluged with newly insured patients under the Affordable Care Act.

After a more than two-year moratorium on nearly all new adult patients, the Redding-based Shasta Community Health Center has reopened its doors to some newcomers this month, and it will start accepting more new patients in September.

When Medi-Cal, California's version of Medicaid, was first expanded under the Affordable Care Act in early 2014, the number of people insured under the program doubled to around 40,000 people in the region served by Shasta Community Health. Not only did the clinics see new patients, but the demand for services soared from existing ones who were newly insured.

The clinic network already had a shortage of doctors and nurses. — a problem shared by many other rural health clinics in California.

"The … more new patients we brought in, the more stress on the providers, the more likely [they] were going to leave, the deeper the crisis went," said Shasta Community Health Center CEO C. Dean Germano. So he decided to close the network's five clinics to new adult Medi-Cal patients, though they continued to serve all of their existing patients and accepted new children.

During the moratorium, patients in the region had to travel long distances for primary care, or use the local emergency room, Germano said.

Shasta Community Health Center has since boosted its capacity to provide primary care. It has hired two physicians, created a family practice residency program and has a fellowship program for nurse practitioners and physician assistants. For every new primary care provider, the clinic network can add up to 1,200 new patients, Germano said. The system now serves about 60,000 people in the area.

California Healthline interviewed Germano about his health center's experience adjusting to the changes wrought by the Affordable Care Act. His comments have been edited for length and clarity.

Q: How did the ACA change the type of services you were giving or the type of care the patients needed?

Uninsured people tend to use the system much less and often at the worst possible places.

With the onset of coverage, you have all this relief to pent-up demand, people seeking more regular care and preventive [care], which often for the uninsured is not a priority. They tend to come in because they have acute issues or they have long-term chronic issues that have become complicated.

So [with] people gaining coverage, the uninsured are becoming much like our other insured populations — seeking care at the appropriate moments.

Q: Were you able to meet the demand for all these new services?

No, not at all. We quickly became overwhelmed, although there were a couple of things happening all at once. One was certainly the growth in Medicaid coverage, but at the

very same time, the state of California expanded Medi-Cal managed care into 28 rural counties. We are one of them. We did not have Medi-Cal managed care prior to this.

We were assigned patients, then assigned more patients. We quickly reached a point where we could not take on more new adult patients to our practice. We had to essentially constrain and at one point close the practice to new adult Medicaid patients. We never closed the practice to uninsured patients because they don't have many options, as in the ER. We never close it to homeless or to children or to people with HIV. Interestingly enough, [it was] not a great business model because our best payers are the ones we closed to.

It was a very big hit [to] the community because adult patients had to go further afield to find services outside of the emergency room. Under managed care, it's [the health plan's] responsibility to find a medical home and some of the medical homes were 30 to 40 miles into the mountains. For patients who have transportation issues, there was no doubt that was a real imposition.

Q: Can you describe the region's shortage of providers?

We are close to 20 primary care physicians short in our community, including our insured and Medicare populations. In a rural community, that's a big number. So the deficit has always been there.

It's always been tough for rural areas to recruit [physicians], but in this environment where everyone is struggling to hire, it really made the challenge that much more difficult. Medical students don't go into primary care for lots of reasons. One of them is debt load. Most of the doctors I hire now usually have an average of $300,000 worth of student debt.

In addition, there are not enough family medicine residencies in California. We need a lot more primary care residencies, particularly in family medicine.

Q Do you think an increase in the rates Medi-Cal pays to providers is what's needed to ensure that all areas have the coverage they need?

The gap is so huge now between Medi-Cal and Medicare reimbursement. A five or ten percent adjustment would help the margins, but isn't going to create a wholesale shift of providers into Medi-Cal, because we're seeing in rural areas the provider shortage exists for patients covered by Medicare and private insurance.

Where we feel [the low reimbursements] the most is on the specialty care side. It's very difficult to get referrals in a timely way when the reimbursement is so pitifully poor. And we really lean on our specialty community.

When a specialist looks at a rural community, it's really hard for them to … say "I'm only going to take the insured patients," because typically there aren't enough insured

patients to create a full practice. So they look at the full book of business. They look at what the insured population looks like, what the Medicare population looks like and then everybody else, particularly Medicaid. And in many specialties, particularly in pediatrics and the surgeries, you look at what percentage of your practice is going to be [covered by] Medicaid. In California, if that number is really high, it's often not viable for them to move into that rural community because that book of business doesn't make sense for them.

So, Medicaid being such a low payer has a huge ripple effect. And where that's important in rural communities is that if we don't have an EMT surgeon or a general surgeon or urologist because they can't put together a decent book of business, it's not just the poor people who suffer. It's the whole community.

Q: If increasing the Medi-Cal rates isn't necessarily the silver bullet, how would you remedy the overall problem of provider shortages in certain areas?

First of all, the reimbursement rate has to be better.

Secondly, we have not been good at developing training programs, particularly in the primary care specialties but across the board.

I wish there [were] money for post-graduate residency programs for [nurse practitioners and physician assistants] because if we don't have enough family doctors, general internists and pediatricians, then we're going to lean on our PAs and NPs.

Q: Would expanding the scope of what nurse practitioners can do help bring providers where they're needed?

Well, I have mixed feelings about that. If it's done in the context of a post-graduate residency program, I think that independence makes sense because they should've gotten a lot of what they needed to know. [But] just putting a new practitioner with an independent license out there and letting him hang his shingle out, I have mixed feelings about.

But I do think that if you can marry a post-graduate training program and a pathway for independence, that might work or maybe a certain number of years of practice under a physician's supervision.

Los Angeles Times

Covered California insurance doesn't guarantee the doctor will see you, study says

By: Paul Sisson
July 27, 2016

The recent announcement that Covered California premiums will rise by double digits in 2017 is only part of the challenge for the nation’s largest health exchange.

A newly released study found that 4.38% of Covered California policyholders enrolled in Blue Shield or Blue Cross plans were rejected by doctors who were supposedly accepting their insurance, compared with 1.41% for people with the same plans purchased outside the exchange.

The report, published in this month's issue of the journal Health Affairs, used secret shoppers to schedule appointments during summer 2015 with more than 700 randomly selected doctor offices in five regions of the state, including San Diego, the Central Valley and San Francisco.

Researchers wanted to find out whether patients on health-exchange plans would encounter different access to physicians, and they picked Anthem Blue Cross and Blue Shield of California because no other insurers in the program offer policies across the entire state.

The study took advantage of the fact that both carriers offer "mirrored" plans — those available both in and outside of Covered California. These plans are the same in all but one key aspect, said study coauthor Simon Haeder, a political science professor at West Virginia University.

"The plans have slightly different names on and off the exchange, so it is possible for a doctor's office to tell whether or not it's a Covered California plan," Haeder said.

The secret shoppers called doctor offices and requested appointments, trying once with a Covered California plan and a second time with its non-exchange counterpart. In all cases, the shoppers inquired with physicians who were listed in official directories as participating in their insurance plans.

The gap in access was starkest in San Diego County, where 8% of Covered California callers were told their insurance was not accepted — compared with 0.74% for plans sold outside the exchange.

James Scullary, a spokesman for Covered California, said he had no explanation for the difference in rejection rates.

"We're looking into it," he said.

The insurance companies also offered no explanation, though both said they were working hard to improve the accuracy of their doctor directories.

Haeder said his research did not determine why physicians seemed to be rejecting Covered California enrollees more frequently. Given that 90% of Covered California enrollees have an income-based government subsidy while those not in the exchange must pay full price, Haeder suspects the gap may be financially motivated.

"Maybe there is some sort of economic selection going on," Haeder said.

He also said the problem is likely to extend beyond the Golden State.

“I think it’s probably representative of national insurers that do business on that kind of model,” Haeder said. “It would be hard to think that there are these massive problems in California and they have everything figured out in other states.”

Regardless of their plan, the secret shoppers often had difficulty securing an appointment with their targeted doctor. More than 70% of the callers were unable to get a slot with their first-choice physician, even for weeks or months in advance.

The biggest reason for this failure rate: Doctors were frequently listed under the wrong specialties in the two Blue insurance directories. In San Diego County, 42% of calls were to doctors who had been miscategorized. Offices also regularly told secret shoppers they had no such doctor practicing there, didn’t pick up the phone or didn’t return messages.

Doctor directory inaccuracies initially surfaced in 2014, the first year that Covered California plans were in effect due to the Affordable Care Act mandating that most Americans have health coverage or pay a tax penalty. When customers started complaining about difficulties using their new coverage, the exchange’s officials and insurance companies vowed to do better.

It appears that the inaccuracies were still occurring a year later.

Faced with complaints from constituents and advocacy groups, California legislators passed Senate Bill 137 in October. The bill requires all health plans to update their online directories weekly and printed copies quarterly. It also allows insurers to withhold payment to medical providers who don’t respond to directory information requests and holds carriers responsible for extra health costs incurred by patients who made medical decisions based on faulty directory information.

Both Blue Cross and Blue Shield said they have made “thousands” of updates to their directories since the secret shoppers did their survey last year.

THE HUFFINGTON POST

Uncovered California: Why Millions Have Fallen Into Health Care Gaps

By: Sasha Abramsky
June 28, 2016

CAPITAL & MAIN
INVESTIGATING POWER & POLITICS

“Right now, I have a medicine sitting at Wal-Mart pharmacy that I can’t purchase till payday,” Jacqueline, a 55-year-old San Diegan told me during a telephone interview in mid-April. She asked that her last name not be used for this story. “I’ll go without, eight or nine days till payday. It’s for my high cholesterol.”

Five years after the Affordable Care Act became law, and more than three years after California began moving aggressively to implement its provisions, upwards of three million Californians remain without health care coverage; and millions more, like Jacqueline, have basic coverage but continue to be grievously under-insured. This is the story of how so many Californians continue to fall through the ACA’s cracks.

“Uncovered California” is a three-part series examining how the Golden State is trying to fill holes in its health care coverage. Wednesday, Sasha Abramsky looks at the lack of mental health services for community college students. Thursday, Debra Varnado reports on efforts to expand the role of nurse practitioners to increase medical services for low-income Californians.
Until a few years ago, Jacqueline worked a hospital security job, which paid fairly decently. Then she lost it and ended up with another security job, this one paying only

$11 an hour. It didn't come with health insurance, and so Jacqueline went online to buy insurance through California's health insurance exchange, set up in the wake of passage of the Affordable Care Act. Because her earnings left her well below 400 percent of the federal poverty line – the upper limit for insurance assistance under ACA — she qualified for subsidies.

These subsidies are calculated on a sliding scale according to a recipient's income, so that people pay anywhere from two to 9.5 percent of their income. But, Jacqueline dis covered, buying into a gold or silver plan would still cost more than she could afford. And so, despite the fact that she suffered from diabetes, high cholesterol, neuropathy and other ailments that required frequent doctors visits and a steady array of medications, she bought into a bronze plan.

Five years after the Affordable Care Act became law, upwards of three million Californians remain without health care coverage.
Such plans essentially shift the financial burden from now, when the monthly payment is due, to later – when the bills come in from doctors; prescriptions have to be paid for out of pocket. They cap out-of-pocket expenses at $6,850 for an individual and $13,700 for a family – which, for the working poor, represents a prohibitive outlay of cash. (A Cost Sharing Reduction Subsidies program can significantly reduce out-of-pocket maximums.) Take, for example, the story of Maria Can de Tec, a laundry worker at an Orange County convalescent hospital, who managed to buy subsidized Anthem-Blue Cross insurance for $151 per month but, following an emergency room visit for internal pains and bleeding, ended up with nearly a thousand dollars in bills that she is now having to pay off in $76.92 monthly installments.

The bronze plan that Jacqueline chose still cost her $50 per month — the upper limit of what she could afford — and, as she found out once she began using its medical services, it came with hefty copays and deductibles. It was, in many ways, barely more than catastrophic coverage. Near the end of each month, with no money in the bank and days to go until her next paycheck, she would run out of medicines.

"I can tell the difference when I have my medicine and when I don't," she said. "I have more stress and worry. I wanted to see the doctor about issues of mental health. Stress and tension. And once I found out how much it was going to cost, I didn't go. I came to a decision that I really need this, but I couldn't afford to go. And I'm having really bad issues with my neck, back and legs – and I can't afford to go to the specialists."

When the Affordable Care Act was passed, California embraced its principles more assertively than did most other states. It set up the nation's biggest insurance exchange and invested heavily in Covered California, the organization responsible for bringing the uninsured into the insurance system; it added state dollars to provide additional subsidies to anyone whose earnings placed them at less than 250 percent of the federal poverty line; it expanded its Medi-Cal roles dramatically – the ACA allowed states to cover anyone whose income was no more than 138 percent of the poverty line. And it has spent heavily, for each of the last five years, on outreach to bring children and other

particularly vulnerable groups into primary care settings – since studies indicate that previous expansions of the health care safety net, from the State Children's Health Insurance Program, to Medicare for the elderly, have taken four to five years to bring in all the people they can, and to reach a state of steady enrollment.

The ACA, says Anthony Wright, executive director of the Sacramento-based advocacy organization Health Access California, which campaigns for policies that would bring more Californians into the health care system, "allowed us huge progress. We've cut the number of uninsured by half. We had seven million uninsured prior to ACA. The modeling suggested we would land at around three million – and that three or four million would [eventually] be covered." So far, California has already outperformed these goals, with close to four million newly covered Medi-Cal patients, and upwards of 1.5 million buying into subsidized insurance.

And yet, because of the way the federal law was worded, as well as some of the unique demographic and economic characteristics of the state, six years after the ACA's passage many millions of Californians remain uninsured; data from the 2014 California Health Interview Survey, the most comprehensive study to date, estimates five million. They are, as researchers from the University of California, Berkeley's Center for Labor Research and Education, and the University of California, Los Angeles Center for Health Policy Research calculate, disproportionately Latino and male, and most of them work at least 30 hours per week. In addition to the uninsured, however, hundreds of thousands more, like Jacqueline, bought into bronze plans that essentially provide financial disincentives to seek medical attention and thus leave them significantly underinsured.

There are the spouses and children of workers whose employers provide them with health insurance but either don't offer coverage to family members or offer it only at a price that renders it unaffordable. Because of an accidental miswording in the ACA, these families, even if they are less than 400 percent of the poverty line, aren't eligible for subsidies. It's a trap that advocates refer to as the "family glitch" and it ought to be relatively easy to fix. But because the Republican majority in Congress is more interested in defunding ACA than in filling in holes in its coverage, the glitch remains in place. In 2011 UC Berkeley Labor Center researchers calculated that 144,000 Californians were caught in this trap.

"If my husband, daughter and I all purchased insurance through his employer," wrote Brenda, a 57-year-old woman from the town of North Hills, to Bethany Snyder, who until last May was director of communications at Health Access California, "that amount would be half of his monthly take-home pay, leaving very little for food, housing and other essentials." While her husband was covered through his employer, and their daughter was on another insurance plan, which cost them $161 per month, Brenda herself was unable, because of this, to afford insurance. Instead, she was relying on a cost-sharing plan for her medical bills run through Christian Healthcare Ministries. It was better than nothing, but she still wanted, one day, to be able to access proper health insurance.

In high-cost-of-living areas of the state, there is another problem: families at just over 400 percent of the poverty line, who on paper ought to have plenty of disposable income to buy nonsubsidized insurance, but who spend so much on housing that they end up not having enough to buy insurance.

While there are tax penalties in place for those who go uninsured, those penalties are not imposed on people who can show that to access nonsubsidized insurance they would have to spend more than eight percent of their income on health care policies. In some parts of the Bay Area, for example, health care analysts have found clusters of middle-aged people who are foregoing coverage because of extremely high housing costs, and who are not subject to tax penalties because the cost of insurance, which rises the older one gets, would be more than eight percent of their income.

The last, and largest, remaining group excluded from health care coverage consists of California's millions of undocumented residents. When ACA was passed, Congress explicitly excluded them from access to Medicaid and to federally subsidized insurance policies. As a result, even as most of the legally resident poor in California have accessed some form of coverage in the years following the ACA's passage, the undocumented remain intensely vulnerable. Wright estimates that whereas, before ACA, only one in five of the uninsured lacked legal residency status, today upwards of half of the state's uninsured are undocumented.

Families who ought to have plenty of disposable income to buy nonsubsidized health insurance spend so much on housing that they end up not having enough to buy insurance.

"They have to rely on the emergency room for all their health care needs," explains Don Nielsen, director of government relations at the California Nurses Association. (Disclosure: CNA is a Capital & Main financial supporter.) We've met opposite the Capitol building in a café frequented by the political classes. Nielsen is wearing Ray-Ban sunglasses and a black suit with a "Bernie" pin on a lapel. The CNA had, months earlier, endorsed Bernie Sanders' presidential campaign in large part because of his commitment to single-payer health care. "That's a big roll of the dice," Nielsen says. "They [ERs] have to accept everyone, but they are only required to 'stabilize' them. They don't have to do anything beyond that. It's real hit and miss." CNA's slogan on health care reform was simple: "Everybody in, nobody out." Under single-payer, Nielsen states, no one, regardless of their immigration status, could be denied access to health care.

Says one Sacramento resident, who was undocumented for 16 years and asks to remain anonymous, "My Dad has needed a surgery for a hernia operation for years." Her parents, who live in the southern part of the state, remain undocumented. "He's just been waiting, hanging on, hoping there will be a time he can afford surgery and time to recover. It's a struggle. There's no safety net." The woman's father had worked for

years in a factory that made RVs. But then he became injured and could no longer do the heavy lifting required in the factory, and he was out of work.

“It’s kind of a sad tune we are all familiar with,” his daughter explains. “We know we’re forgoing care. It’s too expensive. It’s too bad, you know?”

Many California counties, no longer having to provide indigent care for poor, able-bodied adults now covered under Medi-Cal, have used some of their savings to expand basic clinic coverage for undocumented residents – realizing that it is actually cheaper to provide more comprehensive primary care coverage than to have to pick up the emergency room bills accrued when the undocumented finally seek treatment in hospital settings. Forty-seven counties are now providing more than just emergency care to these residents, up from only nine just last year. But while that change has been welcomed by advocates, in the long run it is only a scattershot solution to a vast problem – and one that leaves the undocumented vulnerable to changing financial and political winds at the county level.

A more systematic approach has, in the past year, emerged at the state legislative level: In October of last year, Governor Jerry Brown signed a bill that would allow California to use state dollars to provide Medi-Cal to undocumented children. The provisions of this law, which follows passage of similar state measures and city ordinances in Massachusetts, New York, Chicago and Washington State, went into effect in early May of this year, meaning that with good outreach in the coming months almost all of California’s children could end up with health coverage. Wright and other advocates believe that upwards of 175,000 of the estimated 250,000 undocumented children in the state will soon be enrolled in Medi-Cal. The state is also using its own dollars to cover refugees who don’t have their green cards, as well as DACA (Deferred Action for Childhood Arrivals) students. If the U.S. Supreme Court allows DAPA (Deferred Action for Parents of Americans) to proceed, California will stand ready to expand health care access to this group, too.

For the past year, Sacramento has also discussed legislation that would allow undocumented adults to buy nonsubsidized insurance plans on the Covered California exchange. The legislation would require a federal waiver, but since the exchanges are no longer federally funded, such a waiver is likely to be granted. And this year state Senator Ricardo Lara (D-Bell Gardens) has pushed Senate Bill 10, a proposal that would expand Medi-Cal access, again paid for with state rather than federal dollars, to undocumented adults too. Polling from 2015 indicates 58 percent of Californians support this move.

Slowly, California is plugging the ACA’s gaps. It has taken five years to halve the number of uninsured in the state. It will likely take several more years to make a serious dent in the remaining numbers. And some of the problems, such as the family glitch, will likely still remain even at the back-end of years of effort.

But, unlike on the federal level, statewide there is at least now the political will to tackle this problem. And that's a huge accomplishment in and of itself.

NOTICIAS
PALM SPRINGS

Continúa la inscripción especial para Covered California

June 29, 2016

To watch a recording of this television interview, click here: http://noticias.entravision.com/palm-springs/2016/06/29/continua-la-inscripcion-especial-para-covered-california/.

KUNA - Covered California

June 16, 2016

To watch a recording of this television interview, click here:
http://www.kesq.com/kunamundo/61616-kuna-covered-ca/40092746.

Covered California's Health Plan Rates To Jump Sharply In 2017

By: Chad Terhune and Pauline Bartolone
July 19, 2016

California's Obamacare premiums will jump 13.2 percent on average next year, a sharp increase that is likely to reverberate nationwide in an election year.

The increase, announced by the Covered California exchange Tuesday, ends the state's two-year respite from double-digit rate hikes.

The announcement comes as the presidential candidates clash over the future of President Obama's landmark health law and as major insurers around the country seek to announce even bigger rate increases during the open enrollment period this fall.

California won plaudits by negotiating rate increases for its 1.4 million enrollees that averaged 4 percent in the past two years. But that feat couldn't be repeated for 2017, as overall medical costs continue to climb and two federal programs that help insurers with expensive claims are set to expire.

Health policy experts said California is rejoining the pack after keeping rate increases lower than much of the country during the first years of Obamacare.

Critics of the health law, including Republican presidential candidate Donald Trump, have been quick to seize on these rising costs as further proof that the Affordable Care Act warrants repeal for failing the average consumer.

The Obama administration counters that federal subsidies spare most consumers from the full impact of the premium increases and says the health law enables people to shop around for a better deal.

Last week, consulting firm Avalere Health found that the average rate increase being sought for widely sold silver plans on the state and federal health insurance exchanges was 11 percent across 14 states. But consumers could limit the increase by choosing one of the lower-cost silver plans, which are set to go up only 8 percent.

These rate increases apply to people who purchase their own coverage in the individual market, not to the majority of Americans, who get their health insurance through work or government programs such as Medicare and Medicaid.

Peter Lee, executive director of Covered California, said prices for 2017 reflect the rising cost of care, not efforts by insurers to increase their profits.

"Under the new rules of the Affordable Care Act, insurers face strict limits on the amount of profit they can make selling health insurance," Lee said. "We can be confident their rate increases are directly linked to health care costs, not administration or profit, which averaged 1.5 percent across our contracted plans."

Two federal programs that have helped health insurers offset costly medical claims, and cover sick patients in general, are set to end this year. They were intended as a temporary cushion for insurers, who are now required to accept all applicants regardless of their medical histories.

Health insurers and Covered California said rate increases also reflect the ever-increasing cost of care, particularly for expensive specialty drugs.

"The rising trend of health-care costs remains a constant driving factor in health-care premiums," Lee said.

Insurers also have complained about lax rules for special enrollment outside the designated sign-up period. The loose rules have allowed some people to game the system by waiting until they need care to enroll, insurers say, and those people tend to generate more claims and higher costs. Federal and state officials say they have tightened the rules to address these complaints.

To press their case for higher rates, health insurers said they had the benefit of detailed data on exchange customers and their medical claims for the first time since these marketplaces opened in 2014.

Many consumer advocates in California had hoped that UnitedHealth Group Inc. would become another formidable competitor on the state-run insurance exchange. But the nation's largest health insurer is leaving Covered California after just one year of minimal participation — part of a broader pullback nationwide after the company posted heavy losses on individual plans.

The top four insurers in Covered California, led by Blue Shield of California and Anthem Inc., control more than 90 percent of enrollment.

The premium increases in California will vary widely by region and by insurance company and could pinch the pocketbooks of cost-conscious consumers like David Arnson.

Arnson, 57, of Los Angeles, qualifies for a federal subsidy and pays just $32 each month for a Molina Healthcare policy he purchased through Covered California. He said he relies on the coverage to help pay for treatment for ankle and knee problems.

Arnson, who works at a record store and plays in a band, said he worries about his monthly premium increasing next year.

"I make a marginal living," he said. "Like anything, you want to pay as little as possible. I need health care — it is at the top of my pyramid of necessities."

The higher rates in California may spur more consumers to switch health plans. Only 14 percent of Covered California enrollees who returned this year chose a different insurer. On the federal exchange, 43 percent of people switched plans for 2016.

However, the proliferation of narrow networks can make shopping complicated since certain doctors and hospitals may only be available through one or two insurers, and provider directories are often inaccurate.

Since 2014, California has benefited from having a healthier mix of enrollees compared with other states. One reason for that is that state officials defied the Obama administration by requiring insurers participating in Covered California to cancel existing individual policies at the end of 2013.

That unpopular decision quickly moved people into coverage that fully complied with the health law and created one giant risk pool for rating purposes. Those previously insured customers were generally thought to be healthier because, before the switch, insurers could deny coverage to people with pre-existing conditions.

But that positive effect may be wearing off as people get sick over time or leave the individual market for coverage elsewhere, health care analysts say.

The expansion of coverage under the Affordable Care Act has driven the percentage of uninsured Californians to a record low.

The share of Californians lacking health insurance was 8.1 percent at the end of 2015, down from 17 percent in 2013, federal data show.

The expansion of Medi-Cal, the state's Medicaid program for lower-income residents, accounts for a significant part of that reduction. Since January 2014, nearly 5 million people have joined the Medi-Cal rolls, bringing total enrollment to 13.4 million — about a third of the state's population.