



California's Uninsured and Insured: Changes Under Federal Reform

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The Uninsured

California has one of the highest rates of uninsured in the nation, estimated to have increased recently from 6.5 to 8.2 million due to the recession.¹ Reform presents an opportunity to cover more than 80% of California's uninsured, if done wisely.

Medi-Cal eligibility will increase to cover over a quarter (1.7 million) uninsured Californians with incomes up to 133% of FPL (\$14,000 for an individual).² The population that benefits most will be MIAs (Medically Indigent Adults – individuals who are not disabled, aged or the parents of minor children living in the home). Since 1983 their care has been the responsibility of California counties. Far smaller portions are parents since federal reform will increase Medicaid eligibility nationwide to 133% of FPL. California's Medicaid income eligibility levels are already at 106% of FPL, and its medically needy share of cost program already picks up all the most expensive cases.

Nearly 40% of uninsured (2.3 million) Californians have incomes between 133 and 400% of Federal Poverty Level (\$88,000 for a family of four) and will be eligible for refundable tax credits through the Exchange.³ The Exchange will also be open to the privately insured (45% or about 900,000 individuals have incomes less than 400% of FPL and thus would be eligible for the refundable tax credits⁴), all individuals, all small businesses up to 50 employees (subsidies available for small and low wage) and then those with up to 100 employees beginning in 2016. This group is a pretty evenly divided mix of families and individuals.

Over 15% of uninsured (close to a million) Californians have incomes in excess of 400% of FPL⁵ (\$44,000 for an individual and \$88,000 for a family of four), who will be required to purchase a minimum level of basic coverage, defined as bronze or 60% of expected medical claims. If their coverage is unaffordable (premiums are over 8.5% of income), they are entitled to a hardship exemption. If they choose to exercise this option, they are also entitled to purchase the catastrophic coverage. Affordability problems for this group of uninsured are highest for older adults and for families with children, where coverage is typically three times as costly as for younger adults or families without children. This group of uninsured is far more likely to consist of individuals than of families.

About 20% of uninsured (1.4 million) Californians are either undocumented or new legal permanent residents (in the country less than 5 years).⁶ Most are adults and a smaller number (estimated less than 200,00) are children.⁷

The undocumented (1.2 million) are explicitly ineligible for federal coverage subsidies under reform and are not even eligible to purchase coverage without subsidies through the Exchange. Under long-standing federal law, they are however eligible for emergency or restricted scope Medicaid (Medi-Cal) that pays for genuine emergencies, deliveries and pre-natal care. Some may be eligible for coverage by their employers.

Uninsured new legal permanent resident children are eligible for full scope Medi-Cal and Healthy Families under the new 2009 CHIPRA legislation.⁸ Uninsured new legal permanent resident adults (about 130,000) are eligible for emergency Medi-Cal and for

participation in the refundable tax credits through the Exchange.⁹ California covers full scope benefits for new legal permanent residents under Medi-Cal; it may be financially advantageous to the state to switch them into the Exchange to the maximum degree possible.

In general, there are huge potential gains in coverage for California's uninsured under reform. The biggest residual problems for the uninsured are 1) affordability for older adults and large families with incomes in excess of 400% of FPL¹⁰ and 2) the ongoing federal and state limits on coverage for non-emergency care to the undocumented.

Counties' Impacts

Until reform becomes operational, counties remain the payer of last resort for care to the indigent uninsured under their Welfare and Institutions Code §17000 obligations. Once federal reform becomes operational, those responsibilities for the most part disappear and shift to Medi-Cal and the Exchange. In the interim, there are three options for counties.¹¹

1. Effective April 1, 2010, states can secure a federal match for Medicaid (Medi-Cal) coverage of the MIAs, using the county CPE (certified public expenditures) or IGTs (intergovernmental transfers) as the match.
2. California can seek a federal waiver, using county CPE or IGT as the match, which expands coverage of the MIAs, with stepping stones and benchmarks from their current, very different systems to full scale Medi-Cal managed care in 2014.
3. Counties can maintain the status quo and wait to see what if anything actually happens in 2014 when the federal government is scheduled to pay 100% of the costs of MIAs.

As of 2017, a match is scheduled for states, beginning at a 95/5 match in 2017 and tapering to a 90/10 match in 2020 for the costs of coverage for MIAs and newly eligible parents. *It would not be a surprise for the state to require counties to pay the match with their realignment funds from the state.*

Most counties are payer counties, and they will simply stop paying for their CMSP and MISP programs; these will become a component of Medi-Cal and the Exchange. The major transition will be from county payment of providers (currently) to managed care payments to local providers.

Outstanding questions for such counties to consider are:

1. Do county realignment funds revert to the state to balance its budget?
2. Do these funds beef up public health and prevention efforts?
 - a. In what fashion do they coordinate their public health efforts with the new federal investments in prevention and coverage expansion?

A number of large counties operate public hospitals and clinics. They will now be transitioning to competitive managed care markets for care to MIAs, which heretofore were reimbursed exclusively in the county's own delivery system. Others outside the county network who delivered uncompensated care will have an opportunity to participate and be compensated for their care. Most county delivery systems will make this transition smoothly as they already compete very effectively in the Medi-Cal

managed care and Healthy Families markets. Some will face a more difficult transition if their systems are not well designed with the primary care, managed care, chronic disease case management components needed to move from episodic to managed care. If that transition is too difficult or unsuccessfully executed, county facilities could be transferred to new private owners or shuttered.

Counties that operate public hospitals and clinics will continue to treat undocumented persons who are seen in the emergency room or county clinics. True emergency care in those facilities will be compensated through Medi-Cal, while the rest of county care will not.

Some questions to consider:

1. Will these counties wish to provide care to their residual uninsured patients in the same managed care context as the rest of their patients (e.g. following the Healthy San Francisco and other Bay Area system models)? Will they prefer episodic care systems that are more typical in Southern California public systems?
2. Will they wish to keep their systems disconnected from the non-profit clinics and private hospitals, which also see these patients on an episodic basis? Or will they choose to collaborate with these providers in the care each extends (as Alameda and Los Angeles prominently do for primary care)?

Counties' mental health systems will be comparably impacted. However this service is carved out of Medi-Cal managed care and instead operated by the county mental health department. County mental health is the exclusive source of reimbursed care for Medi-Cal patients with serious emotional illness, and mental health is completely disconnected from physical health.

Considerations:

- The first decision for state and local policy makers is whether mental and physical health should reconnect for Medi-Cal patients?
- The next consideration is with whom: while Medi-Cal is likely to have managed care for MIAs and families, it might still have fee for service for the elderly and disabled. The organized county mental health system may more readily interface and coordinate with a comparable organized system for families and MIAs than with the unorganized fee for service systems for the aged and disabled.
- The third is whether these should continue to be exclusive systems or should they have competitors (if so, whom)?
- And finally, does the county mental health community wish to engage with the state on the same funding and organizational options discussed above for the MIAs – i.e. transitional stepping-stones through a §1115 waiver or do they prefer a more abrupt transition either now or in 2014?

State Impacts

The State will assume responsibility through Medi-Cal for the MIAs, a responsibility that was transferred with reduced funding to the counties in 1983 with a small increase in coverage for parents (106 to 133% of FPL). The state will have no or a very minimal

financial stake in managing their costs of care due to the very high rates of federal match. We assume the state will prefer to operate these new responsibilities through contracts with its existing managed care networks.¹² This will increase enrollment in these plans by 50% and present the plans with new challenges – specifically, care to the small subset of MIAs who are homeless, with some severe cases of mental illness, substance abuse and economic dislocation. It is unclear whether all the managed care contractors are ready and capable to undertake the challenges of coordinating the mix of social and health care challenges for this population. This is not to say that county governments have excelled at this task, but it is important to recognize that they have hard-learned experiences that should be absorbed and built on, rather than ignored and forgotten.

The state has an array of programs for the uninsured that may be subsumed into the Medi-Cal expansion and the Exchanges while others may have ongoing vitality albeit in a much reduced scope.¹³

- *Coverage for perinatal care through AIM and the component of the Medi-Cal program between 133 and 200% of FPL.* We assume that most of these women and infants will be covered for full scope benefits through the Exchange and the programs will stay in place for a small residual number of uninsured – the undocumented. The state should see significant program savings.
- *Prevention and treatment of breast, cervical and prostate cancers up to 200% of FPL.* We assume that prevention and treatment of all cancers will be covered through the Medi-Cal expansion and the Exchange. A residual program would cover these cancers for undocumented men and women at a very small cost with very significant program savings for the state.
- *Family PACT covers family planning services for men and women up to 200% of FPL.* This was a state Medicaid waiver and under reform will now become an optional Medicaid eligibility category. The difference is that the state no longer needs to negotiate the terms for this coverage with the federal government – a negotiation that proved to be problematic several years ago. Family planning services will be a covered service under the Medicaid expansion and through the Exchange. The participation of the uninsured in Family PACT is likely to decline significantly and shift to the Exchange and Medi-Cal managed care. There is likely to be some, but minimal cost savings to the state since Family PACT is already a 9/1 match. It would be preferable for Family PACT clinics to participate fulsomely in their patients' health plans, so that coverage is more readily accessible without the need to navigate between two different programs. Family PACT has strict patient confidentiality protections, which ought to be preserved in any event.
- *CCS (California Children's Services) and GHPP (Genetically Handicapped Persons Programs)* are programs for children and adults with designated conditions. Most of their program participants will be eligible under the Exchange and Medicaid expansions. Those who are on these programs because they are medically uninsurable will now have a wide range of plan and benefit choices. Not every plan will offer the right network for a subscriber's conditions, so better and more reliable information to these individuals/families about plans and their provider networks will be critical. Most but probably not all CCS and GHPP

services will be covered through their plans under Medicaid and the Exchange at 100% federal cost, and subscriber participation and program costs are likely to drop quite sharply. Should the state decide to continue these programs, one of the issues that must be resolved is whether to continue to carve out the services from managed care in Medi-Cal, Healthy Families and now the Exchange and pay for them on a fee for service basis. This would continue to bifurcate their care between capitated payment for primary care from the plan and fee for service for the treatment of their designated conditions from the state programs and is not in our view optimal as the whole child should be treated in a consistent fashion.

- *The Medically Needy component for families and the disabled.* This program pays for families and the disabled with incomes above the state's income thresholds; often there is a share of cost, reflecting the monthly difference between the family's income and the states MNIL (medically needy income level). This program is particularly important in paying for hospital care and very expensive drug regimens and rehabilitation services. It will be largely subsumed by the adoption of the Exchange and the increase in eligibility for the Medicaid program to 133% of FPL, both paid for by the federal government, creating a large budget savings for the state.
- *AIDS Drug Assistance Program (ADAP).* This pays for costly drug regimens for AIDS patients with incomes above the Medicaid level. It too will be largely subsumed by the adoption of the Exchange and the increase in eligibility for the Medicaid program to 133% of FPL. It will be paid for by the federal government creating a large budget savings for the state.

The state and counties will get a substantial coverage windfall from federal reform; the open question is how to reinvest the savings.

- One popular option will be paying down the state's structural budget deficit if this pressing issue has not been resolved by then.
- A second equally imperative option is restoration of dental, vision and hearing services, which the state terminated.
- A third very important option would be to increase payments to the underpaid medical professionals who are the bulwark of the Medi-Cal program to as close to the Medicare levels as the state can afford.

Insurance Reforms

The federal reforms will require guaranteed issue and renewal of individual and small employer coverage in 2014 and will bar rescissions beginning in 2010. It will eliminate pre-existing condition exclusions; it will permit premiums to vary by age (3:1), geography, family size and tobacco use (1.5:1). It will change California's individual insurance market quite dramatically, but the small employer market will be only modestly changed.

For the small employer market, California will need to limit age variation to 3:1, eliminate the 6 month pre-existing condition it now permits, repeal the +/-10% rate band on health status or claims experience and permit variations of 1.5/1 for tobacco use.

These federal and state changes will be of minor to no impact to small employers and their employees because AB 1672 enacted most of these reforms in 1992.

- The state may wish to revisit its policy on geographic variations by specifying 6 geographic areas that will be common to all plans so that plans are more readily comparable to small employers in these regions.
- The state permits variations based on four different family compositions; this has worked well and should be retained.
- We recommend adhering to the federal 3:1 rate band on age because further constricting age rating would have younger, typically lower wage employees cross-subsidizing the premiums for older, better paid workers. The 3:1 rate band that is part of federal law is typical of small employer age rating we see prevalent in the California market.¹⁴

The refundable tax credits for small employers will pay up to 35% of the employer share of the premium during the interim period to 2014; the credits phase down between employer sizes 10 through 25 and average wages from \$25,000 to \$50,000. These credits should help some small low wage employers who would otherwise drop coverage to continue to offer coverage during this interim period.

After reform, the credits increase to a maximum of 50% of the small low wage employer's share of premium. We think that at that point, the credits may have the needed impetus to increase the rates of small employer offerings and can be a useful building block to increase the low offering rates of smaller lower wage employers.

- These credits are only good for two years. If they do have the desired effects, Congress might wish to extend the length and phase out of the credits.

The far bigger changes of federal reform apply to California's individual market, which now operates with few or none of the federal reform protections. The necessary changes will include the underwriting reforms of guaranteed issue and renewal, no pre-existing condition exclusions, 3:1 age rate, bands, rates based on geography and family size that apply to small employers. These medical underwriting reforms plus the MLR (medical loss ratio) in the individual market, the Exchange, the refundable tax credits, the individual mandate and the minimum essential benefits will completely transform California's individual market for the better. Those who want to retain their existing coverage can do so.¹⁵

In the current individual market, premiums have been increasing beyond the consumer's capacity to sustain them. In turn, individuals are buying less and less coverage, leaving them with fewer protections in the event of a serious medical illness or accident and less coverage than the new federal minimums. Insurers have been tightening medical underwriting exclusions and increasing their rescissions of coverage, leaving out those who most need it. Consumers who get sick experience "plan lock" – the inability to change plans/benefits and shop for better coverage.

In the reformed market, many more (mostly uninsured) individuals are likely to enter this market, more than doubling its size. Individuals with private individual insurance will be

able to change plans, upgrade or keep their existing covered benefits, and many will receive substantial refundable tax credits through the Exchange to help pay their premiums and reduce their out-of-pocket costs.

Some of the issues that the California legislature will need to address are as follows:

- *Separation or merger of the individual and small employer risk pools.* California can merge the risk pools for its individual and small business markets or keep them separate. The argument for merging is that Massachusetts set a successful precedent. The argument against merger is that they will become very different markets under reform. The individual market with the mandate will no longer be subject to adverse selection; whereas the small employer market under reform remains a voluntary one. Large percentages of currently insured and uninsured individuals will automatically buy through the Exchange because of access to the refundable tax credits, while small employers will have less incentive to use the Exchange.
- *Age rating.* In the individual market, premiums increase based on age in increments of 5 years, while in the small employer markets, they increase in increments of 10 years. In the individual market, premiums for some plans are higher for infants than for older children. California could apply the age rating rules for the small employer market to the individual market to keep the two compatible. The state could instead codify and standardize the individual market's age rating practices so that there is a more gradual change in individual premiums based on age.
- *Family size.* In the small employer market, there are four family size configurations. In the individual market, premiums increase with each additional child. California could apply the small employer market rules to the individual market, which will reduce individual premiums for larger families and somewhat increase the premiums for smaller family sizes.
- *MRMIP for the medically uninsurable.*¹⁶ This is now a \$40 million program that enrolls about 7,000 subscribers who have been denied individual coverage due to medical conditions. It will be augmented by over \$700 million in new federal funds for the period between now and 2014. This change augments the covered benefits by removing the annual cap on costs of benefits, changes the eligibility rules by requiring the individual be uninsured for at least 6 months and reduces the premiums from 125% of the costs of coverage in the individual market to 100%. The time frame for implementing this is now. An AskCHIS inquiry showed that there are at least 200,000 uninsured Californians in poor health status, who, it is fair to assume, would be medically uninsurable; this aspect of reform could cut those numbers quite significantly. There is a federal maintenance of effort requirement during the interim period so California cannot simply apply the federal funds to fill its gaping budget deficit. Some of the issues for California to consider include:
 - Reducing premium levels to 100% of the individual market
 - Increasing annual and lifetime caps to the amounts required by federal law
 - Use the \$40 million to subsidize lower income medically uninsurable individuals who otherwise cannot afford to participate; or use the funds to

- pay for coverage during the interim 6 months period until individuals qualify for the federal funds
 - Broaden the choice of plans from the three who now participate
 - Standardize the reasons permissible to deny coverage to a person as medically uninsurable so that all carriers compete on a level playing field, and the scarce federal funds are allocated to those with the most serious and costly conditions while the others are assured their conditions cannot be denied coverage in the individual market.¹⁷
- *Upgrading/downgrading.* Federal law provides four different levels of coverage from bronze to platinum in addition to a catastrophic coverage option for young adults and those with hardship exemptions. Some individuals who receive a diagnosis of a severe and costly disease may wish to upgrade their policy in order to reduce their exposure to readily foreseeable out of pocket costs. In ABX1 1 (Nunez), the Speaker and Governor agreed to a policy that allows individuals to upgrade their coverage only one level each year to prevent adverse selection. This policy merits some discussion and deliberation as it inhibits individuals whose economic circumstances improve or disintegrate from adjusting their scope of coverage to meet their increased or decreased available income.

Exchange Implementation¹⁸

Under the federal reform act, the Exchange is available to purchase coverage for small employers (2-50), for individuals, for mid-sized employers (50-100) beginning in 2016 and eventually for larger employers at state option. The Exchange is the lynch pin of coverage for the uninsured and more affordable coverage for the already insured because it will distribute refundable tax credits to individuals and small low wage employers. It is also critical in developing coverage for the flex workforce – the part-time, seasonal, contract workers, micro-businesses and others who lack the full time, full year jobs, which are the backbone of employment based coverage. Finally, the Exchange may play an important role in slowing the rise in health spending to the extent that it coordinates its purchasing policies with other purchasers.

In California, we tested an Exchange (known as the HIPC, then PacAdvantage) for small employers that showed initial promise, then failed to grow and ultimately succumbed to adverse selection.¹⁹ The object lessons are clear: first, the Exchange cannot be designed and operated to become the high risk dumping pool for carriers, and second, the Exchange must be at least as nimble or more so than carriers if it is to offer and add value for its customers. A second version of the Exchange administers the Healthy Families, AIM and MRMIP programs, which negotiates and purchases coverage from willing carriers for those programs and has been a signal success insofar as its funding has allowed. California's adoption of Healthy Families was slow and halting, then gained steam and has become a remarkable success. In the Exchanges, we will need to move much more quickly with the certitude gained from those experiences. The 28-page application was a disaster, not to be repeated, while in-reach was quite successful, particularly in those clinics, counties and communities ready to move quickly. Due to Healthy Families, we are now more prepared with the local infrastructure for the necessary outreach.

The Exchange will be more complex and challenging than Healthy Families for several reasons: first, because it reaches subsidized and unsubsidized individuals and families; second, because it will be active in both the small business and individual markets; and third, because it must inter-relate with federal, state and local government agencies, with private plans, small businesses and foremost the individual consumer.

What issues need to be addressed?

- *Governance*
 - MRMIB is the logical vehicle, but should conceivably have greater operational and decision-making independence from the state (a quasi-governmental agency) as it's funding is from the subscribers and the federal government, not the state government.
- *Outreach and enrollment strategies*
 - Enrollment should be a simple online or mail-in process with the assistance of CAAs and brokers as and if the subscriber chooses
 - Outreach should be constantly monitored and assessed for its cost and enrollment efficacy; we need efficient approaches that will reach populations and employers as diverse as our state.
- *Comparative information and strong transparency*
 - This is likely to be the Exchange's bread and butter.
 - Information needs to be very strong and easily accessible, comparable and useable for individuals and employers.
- *Relationship to contiguous states and their exchanges*
 - California is large enough to operate its own Exchange, and care to its residents is not fluid across state boundaries as in for example New York, Connecticut and New Jersey.
 - The plans and providers in Southern Oregon and the Reno area of Nevada should be sought as participants for the convenience of Californians who live close to state borders.
- *Managed competition incentives and reference pricing*
 - The federal subsidies/refundable tax credits are tied to the second lowest price plan (the reference plan). Thus the credits for an individual or family with incomes between 300 and 400% of FPL will be tied to the second lowest priced "silver" plan.
 - Many of the participants are likely to be quite sensitive to the differences in premiums and out of pocket costs as they will be paying the incremental cost differences for the more expensive plans and more expensive benefits with no tax subsidies.
 - The Exchange will be an important test of whether managed competition can increase quality and slow the rise in prices and premiums.²⁰
- *Relationships to employers of varying sizes*
 - The small employer market is going to be a tougher market for the exchange to gain entry than the individual market. It must offer value to small employers in a market that is far less dysfunctional than the individual market. The three items of value that it can and should offer are

- employee choice of plans and managed competition, a better mix of price and quality than available on the open market, and ease of operation.
- The mid sized employer (50-100) market is even more challenging as premiums are typically composite and experience rated, making the pool into a potential bad risk dumping ground if it fails to match the ways in which carriers price their products outside the Exchange.
 - *The development of co-ops and national plans*
 - The appeal of a national non-profit plan is in the *name*, as none to my knowledge yet exist. The national plan would still need to contract with local California providers, and it is unclear why any national plan that does not already have a large presence in California would be particularly effective in the contracting process in California's diverse markets.
 - Co-ops can be very effective in delivering high quality care at lower prices; however, they are time consuming to create, and must build on a network of providers who see the co-op as a better alternative than the existing market for their services. They must be created locally, and learn and grow in their ability to deliver better care at local prices. The Exchange should nurture their creation, particularly in non-competitive markets, but without expectation of an immediate panacea.
 - *Extent of regulation of contracting plans*
 - Plans will have a choice of participating inside and outside the Exchange, but credits are accessible only in the plan.
 - The level of regulation inside the Exchange will need to be directly tied to the value it extends to subscribers. Plans who perceive the Exchange as onerous are likely to keep the bulk of their business outside the plan.
 - The Healthy Families model is generally praised by participating plans; however participation by some commercial plans is limited to non-existent. Healthy Families covers less than 3% of Californians, whereas the Exchange will be offering coverage to more than 10% of Californians.
 - *Risk adjustment inside and out*
 - Risk adjustment is needed so that the plans that attract and treat the most severely ill and costly patients are appropriately compensated while those who care for the healthiest are appropriately compensated as well. Adverse selection can result from marketing, plan design and the excellence of provider networks. The incentives for adverse selection will increase as a result of reform.
 - California should convene participating carriers to design the risk adjustment mechanisms, apply them to those participating in the Exchange and to those who do not, and assure there are adequate rewards and incentives built in for those plans and their provider networks who do the best jobs of improving their patient outcomes.
 - *High cost dumping and enforcement*
 - Some plans will continue the practices of dumping and dodging high cost subscribers although possibly in subtler forms.
 - Enforcement should be a single, tough third-party entity, possibly a unit in the Department of Managed Health Care.

- *Selective contracting or any willing plan*
 - Selective contracting is one way for the Exchange to secure the most favorable rates and best quality for their subscribers. The plans with higher costs, poorer quality or lower value would not make the cut.
 - Any willing plan would allow all plans who meet the minimum definitions of the Exchange to participate and would depend on consumers to make informed judgments based on the information displayed on the Exchange.
 - The approach of Pacific Business Group on Health (PBGH) and CalPERS has been to partner with selective willing plans and provider networks on the necessary systemic reforms to improve value.
- *Competition in non-competitive markets*
 - There is little plan and provider competition in rural, underserved communities, as well as in those with a single dominant provider network.
 - The Exchange could increase competition by pairing these communities with the more competitive regions where plans and providers are more cost competitive. The Exchange could also foster co-ops among willing and dedicated providers in these communities who are willing to seek to increase quality and benefit through gain sharing from their successes, rather than simply raising their prices.²¹
- *Safety net plans and providers*
 - In some communities there are two, sometimes more distinct networks; one serves the indigent and Medi-Cal patients (the safety net) while the other serves the commercially insured and Medicare patients. Safety net providers in these communities have comparatively limited participation in and revenues from commercial plans. In other communities, there is a single network.
 - The Exchange will use the commercial model to cover the previously uninsured with incomes above 133% of FPL, and federal reform specifies these plans must accommodate participation by public hospitals and community clinics. There is no commitment to a particular reimbursement rate or to a given share of patients, and the safety net will need to compete on a level playing field.²²
 - There is nothing in the federal law that discusses participation by safety plans, of which we have many signal successes in California. The advantage of a safety net plan is that it offers an organized system of care. California policy makers may wish to assure participation by the safety net plans on a level playing field with their commercial counterparts. It may wish to encourage safety net providers to better coordinate and integrate their services so that they will be an attractive option for those subscribers who prefer their location, language, familiarity and other qualities.
- *Ease of enrollment and paperwork reductions*
 - At one end of this spectrum is the Medi-Cal program's application or the individual insurance policy application. At the other is the simple signature required to enroll in your employer's health plans.

- Healthy Kids programs have pioneered simpler, more streamlined applications and Health-E-App and One-E-App have pioneered an electronic application process as well.
- The Exchange is required to make its enrollment process as simple and time efficient as possible for subscribers. They need to know the following information: adjusted gross income (AGI) from one's tax form, age, family composition, place of employment and any offer of employment based health insurance and your citizenship or legal permanent residency status to determine eligibility for the refundable tax credits.
- *Relationships to existing state and county programs*
 - While many state and local programs will be subsumed, the remaining relationships need to be as seamless as possible so individuals are neither ping-ponged between program administrations nor fall through the cracks.
 - One contact should be sufficient to access any of the public programs with timely follow up as needed to successfully enroll the individual.
 - The attitude of programs, their contractors and their personnel needs to shift to a "culture of coverage".
 - Healthy Families, California's CHIP program, will receive enhanced federal funds through 2015 and program renewal through 2019, but it is unclear what its future design and role should be.
 - Parents may prefer that the entire family enroll in the Exchange plan. Healthy Families benefits could be wrapped around this coverage.
 - Parents may prefer that the entire family is enrolled in the employer offered plan, but be unable to afford the employer share of dependent coverage. Healthy Families could offer premium assistance.
 - State policy makers and families themselves may prefer a far simpler future model of coverage, built around the expansion of the Exchange, and Healthy Families conceivably should be subsumed within that model.²³
- *Incentives for plans and providers*
 - The Exchange should coordinate its incentives for improved quality, better customer service and a slowed rate of spending growth with the payment and delivery reform incentives being developed and implemented in the other public and private markets.
 - There are two other California purchasing pools with which the Exchange should coordinate its strategies – Pacific Business Group on Health (PBGH) for large private employers and CalPERS for public employees.
 - While the Exchange has the potential to be a leader in shifting the state towards the delivery and reimbursement system of care we all want, this is a vague and shifting aspiration, which will leave the Exchanges caught between the reluctance and resistance of some plans and provider networks and the need to move swiftly to achieve reform objectives while the momentum remains strong. PBGH has found willing plan and provider

partners to collaborate with its efforts. The Exchange may wish to pursue a comparable effort to build collaboration with a “coalition of the willing”.

- *Ancillary benefits*
 - The Exchange will need to contract with and offer ancillary benefits such as dental and vision for those who wish to purchase these vital services.²⁴
 - The state will need to decide if it wishes to provide any financial assistance for those in need of ancillary services, but with inadequate financial resources to afford them.

Remaining Uninsured

After reform, there will be three primary groups remaining uninsured – the undocumented, the exempt and the reluctant, those who due to inattention, mistake or conscious choice do not enroll. If their incomes are less than 133% of FPL, they are always eligible to enroll in Medi-Cal, which provides three months retroactive coverage so that providers and the dilatory enrollee are not at any financial risk. If they are exempt, they can enroll in coverage through the Exchange or the individual market at some point in the future. There may be penalties and fees for those who have financial means but choose not to enroll; the penalties are stiff enough to catch one’s attention, but significantly less than the cost of coverage and may need to increase if there is significant non-compliance, which we do not expect.

The care of undocumented uninsured workers will be the largest issue for California, since they comprise 20% of California’s uninsured and about 4% of the state’s overall population.²⁵ The undocumented utilize much less care than do US citizens, and most (two-thirds) of that care is emergent, and to a more limited degree perinatal services.²⁶ Emergency Medi-Cal is well designed to pay for most of the care that the undocumented seek. Community clinics are also well situated to provide primary care and prevention that is otherwise unavailable. Most counties do not pay for basic care to the undocumented, but county hospitals and private emergency rooms do, regardless of one’s immigration status. The best alternative for care to the undocumented going forward is to build on employment based coverage since a very high percentage of the undocumented are employed. To the extent that more employers offer coverage after reform is implemented, as was the case in Massachusetts, this is going to be beneficial to some undocumented families. Healthy San Francisco and ACE/Well program in San Mateo County are promising models. Sustainance of Healthy Kids with local fund-raising is another approach that has had enormous success in a number of counties; it can and ought to be augmented and simplified with the wrap-around of restricted scope Medi-Cal. Federal immigration reform, if it passes, would be highly beneficial in allowing long time community residents to adjust their status; eventually they could qualify for benefits, as needed. The bi-national coverage pilots are plagued by the extreme difficulty of border-crossing; they would likely see increased attention if immigration reform allowed more regular entries and returns for those with deep roots in both Mexico and California. We also need to acknowledge that in a number of counties, the state and federal government, there is not the political will nor consensus to cover these hardworking, extraordinarily poorly compensated families and individuals.

DSH and SNCP

DSH (Disproportionate Share Hospitals) and SNCP (Safety Net Care Pool) are two programs, funded in part by local governments and in part by the federal government that pay for uncompensated care, which is defined as care to the uninsured that results in bad debt and charity care, or underpayment by the Medi-Cal program; in this case the difference between what Medi-Cal pays and what Medicare would pay, also known as the upper payment limit (UPL).

Uncompensated care in the form of bad debt and charity care averages about 3% of hospital expenses, but increases substantially in severe recessions.²⁷ If reform is well implemented, this will likely decrease to less than 1%, but will still vary widely among hospitals, with those serving the uninsured sometimes running a percentage of bad debt and charity care that is six times as high as other community hospitals. Uncompensated care in the form of underpayment by Medi-Cal may also be reduced due to the hospital fee of AB 1383 (Jones) and the 2005 waiver's arrangement to pay public hospitals at cost.

The federal reform legislation proposes to scale back both Medi-Cal and Medicare DSH payments once significant numbers of the uninsured are covered within a designated time frame. In our view, this is good policy, but needs to be accompanied by a redirection of federal DSH funds to those states and hospitals within those states that serve the largest volumes/percentages of residual uninsured. California needs to fight for its fair share of these funds, but also retarget them where the needs are greatest within the state.

SNCP funds are part of the state's §1115 waiver and pay for uncompensated care to the uninsured in outpatient settings, both inside and outside the hospital; they do not pay for outpatient care to the undocumented. It is likely that after implementation of reform, these funds too will be reduced by federal administrators and will need to be redirected to those facilities with the largest percentages of remaining uninsured.

Enrollment

The complex Medi-Cal enrollment process is somewhat improved by requiring seamless coordination with the Exchange and electronic applications. Hospitals can take and receive applications and make presumptive eligibility determinations.

The Exchange will decide on its own process, which one hopes would be simple, electronic wherever possible and easily accessible. Federal legislation simplifies eligibility determinations within the Exchange and for new Medicaid eligibles (MIAs and parents) by tying income eligibility to AGI (adjust gross income).

While the undocumented are specifically excluded, there is no repetition of the roundabout DRA (Deficit Reduction Act) provisions, requiring US citizens to prove their citizenship with precise and not easily accessible birth certificates.

Unfortunately, there was no simplification of existing Medi-Cal eligibility rules so the complex counting, calculating and disregarding of different forms of income persists for some Medi-Cal eligibles and disappears for others; California might wish to seek a

Medicaid waiver to use AGI for all program eligibles. Federal legislation did not eliminate outdated resource tests for adults, although California can and should choose to do so.

Financing

Overall reform will generate \$124 billion (\$930 billion nationally) in federal support for California's health care systems for the uninsured and underinsured and private individually insured over the next 10 years.²⁸ Half will be financed by new taxes, primarily the increases in Medicare payroll taxes on individuals making over \$200,000 and families over \$250,000 as well as the Cadillac benefits tax; and half by slowing the growth in Medicare and Medicaid spending, such as using competitive bidding to reduce overpayments to Medicare Advantage plans.²⁹ It reduces the federal deficit by \$130 billion over the next ten years and \$1.2 trillion over the following ten years, primarily by slowing the rise in federal Medicare and Medicaid spending and the rise in federal tax subsidies for the employment based system.

In 2018, the federal government will be spending an estimated \$18 billion on care to California's uninsured and some of those with individual private insurance.³⁰

Who precisely gets some of these benefits?³¹

- Refundable tax credits through the Exchange will benefit Californians by about \$11 billion in 2018-19, of which \$8 billion will go to the uninsured with incomes between 133 and 400% of FPL and \$3 billion to the privately individually insured with incomes less than 400% of FPL.
- Medicaid expansions for adults will cost about \$7 billion in 2018-19, of which California will pay less than a 10% match (less than \$700 million) so that the net benefit to the state is \$6.3 billion.
- Federal tax credits for small employers through the Exchange will average \$600 million annually.
- Increased federal funds for California's community health centers will be \$1.4 billion over the next five years.
- Federal funds for California's high-risk pool will be at least \$700 million between now and 2014.
- Federal funds will also pay for an increase in Medi-Cal primary care reimbursements to Medicare levels at a cost of about \$400 million annually for at least two years.

What budget savings will California government see (a coverage dividend)? California counties reported spending roughly \$1.8 billion on care to the uninsured in 2006. The state of California projects that its own General Fund spending on the uninsured in 2018 would be \$1.6 billion, absent the federal reform.³²

- In 2018-19, the Department of Health Care Services programs (e.g. ADAP, Family PACT, GHPP, Breast, Cervical and Prostate Cancer Treatment) would see a savings of \$1.8 billion of which \$760 million is General Fund

- MRMIB operated programs (e.g. Healthy Families, AIM and MRMIP) would see a savings of \$520 million of which \$615 million is General Fund.
- California Department of Public Health Programs would see a savings of \$500 million of which \$240 million is General Fund.
- California counties would see a savings of \$1.4 billion in their 2005-06 levels of spending on the uninsured, of which an indeterminate amount is state realignment funding and county General Fund.

Where would California be required to reinvest its “coverage dividend” under federal reform?³³

- Eligible but not enrolled children in Medi-Cal and Healthy Families -- \$310 million General Fund in 2018-19
- Eligible but not enrolled adults -- \$523 million General Fund in 2018-19
- The shift of children between 100 and 133% of FPL from Healthy Families to Medi-Cal -- \$230 million General Fund in 2018-19.
- The 10% match for Medi-Cal coverage of the MIAs and parents between 106 and 133% of FPL -- \$700 million in 2020.

Where might California wish to reinvest?

- An increase in Medi-Cal reimbursement rates for professionals to Medicare levels -- \$2 billion in 2018-19³⁴
- A restoration of dental, vision and hearing services to the poorest of the poor
- Coverage of dental care for adults in the Exchange
- State budget deficit reduction.

The Insured

The already insured benefit from the reform in several ways: the coverage of preventive services and the elimination of annual and lifetime caps for everyone; the ability for family members to access refundable tax credits if their coverage is unaffordable and their incomes are below 400% of FPL (\$88,000 for a family of four); an improved delivery system and better functioning, more responsive health care marketplace; and the assurance of continuity of coverage regardless of unforeseeable changes in their lives. Individuals can reduce or increase their exposure to out of pocket spending (risk) with the knowledge that they know what coverage they are getting and they can keep it; they can contrast and compare prices, benefits and out of pocket cost requirements and pick the coverage, plan and providers that best meet their families’ needs. On the other hand, they no longer have the option to go without any coverage.

Individuals

Individuals must purchase minimum basic coverage (60% of expected medical costs for hospitals, doctors and prescriptions) or face a fee/fine, which eventually increases to \$695

or 2.5% of adjusted gross income, whichever is more. However, those individuals with less coverage at lower premium costs can keep it if they prefer. For the most part, those would be individuals with private individual coverage as employer coverage averages about 80% of expected medical costs (actuarial value).

Nearly 45% of individuals with individual coverage have incomes less than 400% of FPL and would likely be eligible for refundable tax credits in the Exchange; so one key task for California is to provide relevant information to these families. Individuals with unaffordable employer based coverage (i.e. exceeds 8-9.5% of income) can access the Exchange with a voucher, representing their employer's contribution; this is likely a very small subset.

Individuals with employment based or individual coverage may add their adult children up to the age of 26 to their policies. It is up to the employee to pay for this added cost unless the employer chooses to pay for older children.

Employers

Small employers (less than 50) have no obligation to offer coverage. But if they choose to do so, they can receive a small employer tax credit, targeted to those with less than 25 employees and less than \$50,000 in annual wages.

Large employers are not required to offer any particular level of coverage, but they must pay a fee if their employees use refundable tax credits in the Exchange. If the employer offers coverage, and if even one of those employees uses the refundable tax credits, the fee is \$3,000 per employee using the credits or \$2,000 for every employee, whichever is less. Why would that happen? For example, the employer might exclude certain classes of workers or pay such a small share of premiums that their employees qualify for tax credits in the Exchange. If the employer does not offer coverage and if one employee uses the refundable tax credits, the fee is a steeper \$2,000 per employee; however in this calculation, the fee is calculated on the basis of exempting the first 30 employees.

In 2018, the Cadillac benefits tax will impose a 40% excise tax on health plans for the incremental costs of their benefit plans in excess of \$10,200 for individual coverage or \$27,000 for family coverage. Dental and vision are not included in the calculation of costs and there is an additional protection for early retiree plans and high-risk professions. The most important feature is that the cost of living adjustment (COLA) for this tax is CPI plus 1%, which gives employers, employees and plans strong future incentives to restrain the growth in premiums for employer plans. A comparable incentive applies to Medicare program expenditures.

Medicare beneficiaries

Medicare beneficiaries experience an upgrade in coverage in several ways: first, the coverage of preventive services with no co-pays, and second the slow filling of the donut hole of prescription drug coverage, starting with a \$250 rebate in 2010 and fully closing it by 2020 so that Medicare pays 75% of the prescription drug costs in what used to be the donut hole.

Veterans

Veteran's benefits are not changed. Veterans who are unsatisfied with VA care can use the Exchange to buy private insurance with refundable tax credits if their income is less than 400% of FPL.

Medi-Cal beneficiaries

Medi-Cal eligibility for existing eligibles is unchanged. However we project that a significant number of eligibles with incomes above 133% of FPL will switch to the Exchange for a broader choice of plans and providers. The state does have the option of increasing Medi-Cal eligibility up to 150% or even 200% if it so chooses with the federal government paying 95% of what coverage would cost through the Exchange.

- In our view, the state should seek a federal waiver to draw a clear bright line between Medi-Cal and the Exchange where all eligibility would be determined consistently on the basis of adjusted gross income (AGI), rather than the multiple and complex rules for determining Medicaid eligibility that under the federal reform law are preserved for most existing eligibility categories while using AGI for new eligibility categories.

The biggest challenge for the program going forward is the rapid integration of the MIAs into managed care, which would increase managed care enrollment by 50% and effectively supplant most of county health programs for the indigent. The state has the option for benchmark coverage of the MIAs, rather than the Medi-Cal scope of benefits.

Foster care children are eligible to continue their Medicaid coverage until age 25. California must offer premium assistance and wrap-around benefits to Medi-Cal beneficiaries who are offered employer-sponsored coverage. There is a new eligibility category for current Family PACT participants, negating the state's need to secure and retain its waiver.

For California, which wishes to better coordinate care for the Medi-Medis who have dual eligibility for Medicaid and Medicare, there are five-year waivers for such integrated care.

Healthy Families Children

The program is extended through 2019, with appropriations through 2015, federal matching increased by 23%, and maintenance of effort (eligibility) requirement. We anticipate many families will choose to have the entire family in a single plan through the Exchange, rather than a separate plan through Healthy Families. A challenge for the state is whether and how it wishes to coordinate Healthy Families coverage and plans with the Exchange plans for wrap around coverage of these children. Another option is for the state to fold Healthy Families back into Medi-Cal, but we see no good reason to do so and would prefer that Medi-Cal evolves toward the less complex and more easily and efficiently administered Healthy Families program.

Long-term Care

The federal reform includes a number of almost unmentioned improvements in long term care for Medi-Cal and the adoption of the CLASS act, a voluntary, subscriber funded program for long term care in home settings.

In Medicaid, state will now have the option to cover home and community based services for individuals qualifying for long-term care institutional services, typically in nursing homes. Previously this would require a state waiver now it can be done with a plan amendment. This does not solve the problem of how to pay for the extended services. California may wish to expand SHMOs (Social HMOs) or PACE programs as a way to control the costs and trade-offs between home-based and institutional care.

The CLASS act allows individuals to pay premiums into the program for 5 years through their workplace for a program that would cover home and community based long term care at the point in the future where their health has deteriorated and their capacities to undertake the activities of daily living (ADLs) are impaired to the point that home care is required to maintain their independence.

¹ Lavarreda and Brown, Number of Uninsured Jumped to More than Eight Million from 2007 to 2009 (UCLA Center for Health Policy Research, March 2010) at www.healthpolicy.ucla.edu

² Lavarreda and Brown, National Health Care Reform Will Help Four Million Uninsured Adults and Children In California (UCLA Center for Health Policy Research, October 2009) at www.healthpolicy.ucla.edu

³ Ibid.

⁴ We asked CHIS for the numbers of Californians with private individual insurance by income, their answer is 887,000 (45% of individuals with private individual insurance) had incomes below 400% of FPL. See Reckling and Wulsin, Improving Affordability under Federal Reform (November, 13, 2009) at www.itup.org/reports

⁵ Lavarreda and Brown, National Health Care Reform Will Help Four Million Uninsured Adults and Children In California

⁶ Ibid.

⁷ Ibid.

⁸ MRMIB, CHIPRA Impacts and Implementation Mandates at http://www.google.com/url?sa=t&source=web&ct=res&cd=4&ved=0CBoQFjAD&url=http%3A%2F%2Fwww.mrmib.ca.gov%2FMRMIB%2FAgenda_Minutes_031710%2FAgenda_Item_7.g.Workplan_CHIPRA_Chart.pdf&ei=vEbRS-PQLoXitgOW8PTFCQ&usq=AFOjCNGeQsjrcvXN6_lz3tGy9-2H_yAp7Q&sig2=Nz13mTqFCDX13t4tzhqTdA

⁹ As written in HR 3590 The Patient Protection and Affordable Care Act, Sec. 1312(f) and Sec

¹⁰ Reckling and Wulsin, Improving Affordability under Federal Reform

¹¹ Ashley Cohen, Rebecca Pizzitola and Lucien Wulsin, Covering the MIAs: Federal Reform and a State Waiver (April, 2010) at www.itup.org

¹² Since the first three years of federal reform cover 100% of the cost of the MIAs, the state may wish to use fee for service to establish a baseline cost. However providers are more likely to resist a switch from fee for service to managed care after 3 years, than if they began coverage in a managed care arrangement. The state and the plans may wish to develop reinsurance for some of the highest costs

¹³ See California Department of Health Care Services, Health Care Reform, Cost and Savings Estimate: Full Implementation, HR 3590 Patient Protection and Affordable Coverage Act

¹⁴ See Fox, 2006 Overview of the Uninsured: California (Insure the Uninsured Project, December 2007) at www.itup.org/reports.html#californiascounties

¹⁵ CBO projected that individual premiums for some subscribers could rise by 10-13% due to the impacts of the benefit increases (an average of 25% more benefits) under the law; although these increases are far more than offset by the new refundable tax credits which reduce the cost to the subscriber by on average 55-60%, some subscribers without the credits may wish and can choose to retain their existing policies with less coverage, but lower premiums. See CBO, An Analysis of Health Insurance Premiums under the Patient Protection and Affordability Act, Letter to Senator Evan Bayh (November 30, 2009) at www.cbo.gov/doc.cfm?index?10781

¹⁶ Dougherty and Sloyan, Implementing Health Reform: Temporary High Risk Pool (Insure the Uninsured Project, March 26, 2010) at www.itup.org/reports.html

¹⁷ AB 2 (Dymally) of 2007 included a comparable proposal.

¹⁸ Dougherty and Wulsin, Designing for Success: California's Health Insurance Exchange (Insure the Uninsured Project, April 19, 2010) at www.itup.org/reports.html

¹⁹ See Wicks, E. Building a National Exchange: Lessons from California (California HealthCare Foundation, July 2009) at www.chcf.org

²⁰ Exchange models per se have not shown any notable success in curtailing the rise in premiums. The issues posed by Alain Enthoven and others are whether with adequate market penetration and adequate incentives for subscribers, the Exchanges can achieve these goals. Enthoven, A. Making Exchanges Work in Health Care Reform, Committee for Economic Development (December, 14, 2009)

²¹ For an example of building quality in a rural community, see the presentations and recording of the Innovations for Quality in Rural Communities session, 14th Annual ITUP Conference, February, 10, 2010 at www.itup.org/this-years-conference.html

²² Safety net public hospitals and most community clinics have a significant advantage in the Medi-Cal program as they are paid at cost, while their competitors are typically paid much less. There is no comparable advantage in the Healthy Families program, where some safety nets have competed successfully and others have not. For inter county comparisons of the performance of local safety nets, see Tuttle and Wulsin, California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured (Insure the Uninsured Project, October, 2008) at www.itup.org/reports.html and Wulsin and Crall, Summary of 10 Year Trend Reports in Eight California Counties (Insure the Uninsured Project, October 2009) at www.itup.org/reports.html

²³ The federal reforms allow states to develop their own models and seek and secure federal waivers to enable them to implement them, beginning in 2017. §1332 of HR 3590

²⁴ The legislation covers dental care for children as part of the essential benefits but not for adults. §1302

²⁵ Lavarreda and Brown, National Health Care Reform Will Help Four Million Uninsured Adults and Children In California

²⁶ Cal Health Reform, Myths and Facts: Are Undocumented Immigrants a Major Drain on Public and Private Health Resources at www.calhealthreform.org/content/view/47

²⁷ Wulsin and Dam, A Summary of Health Care Financing for Low Income Californians 1998-2008 Insure the Uninsured Project, August, 2008 at www.itup.org/report.html#lowincomecalifornians

²⁸ House Energy and Commerce Committee, The Benefits of Health Care Reform in California (March, 2010)

²⁹ CBO, Analysis of HR 3590, Letter to Senator Harry Reid (March, 11 2010) at www.cbo.gov/doc.cfm?index=11307

³⁰ Ibid. See also California Department of Health Care Services, Health Care Reform, Cost and Savings Estimate: Full Implementation, HR 3590 Patient Protection and Affordable Coverage Act. We calculated that California would receive 15% of the refundable tax credits through the Exchange as California accounts for 15% of the nation's uninsured; we used the same calculations for the high-risk pool and the community health center funding. We used the Schwarzenegger Administration's projections to calculate the benefits to California of the federal Medicaid expansion and the primary care rate increase.

³¹ California Department of Health Care Services, Health Care Reform, Cost and Savings Estimate: Full Implementation, HR 3590 Patient Protection and Affordable Coverage Act

³² Ibid.

³³ Ibid.

³⁴ Ibid.