

# HEALTH CARE REFORM

## BACKGROUND

Enacted on March 23, 2010, the Affordable Care Act (ACA) increases access to private and public health care coverage through various programmatic, regulatory, and tax incentive mechanisms. Effective January 1, 2014, the ACA requires that health plans and insurers cover individuals regardless of their health status, cover a minimum set of services known as the Essential Health Benefits, and that generally all individuals obtain health care coverage or pay a penalty.

To expand coverage, the ACA provides for: (1) the health insurance exchange, a new marketplace in which individuals who do not have access to public coverage or affordable employer coverage can purchase insurance and access federal tax credits, and (2) two expansions of Medicaid—a mandatory expansion by simplifying rules affecting eligibility, enrollment, and retention; and an optional expansion to adults with incomes up to 138 percent of the federal poverty level (FPL).

Medi-Cal (California's Medicaid program) provides comprehensive health care services at no or low cost to approximately eight million low-income individuals including families with children, seniors, persons with disabilities, children in foster care, and pregnant women. The Medi-Cal caseload represents 21.7 percent of the state's total population. Eligibility for Medi-Cal varies depending on the coverage group, but most adults with incomes at or below 100 percent FPL are covered. Single, childless adults currently are not eligible for Medi-Cal unless they are disabled or aged. Today, many of

these adults not eligible for Medi-Cal receive services through county indigent health services programs.

Total spending from all sources on Medi-Cal is approximately \$60 billion, about 27 percent of California's spending. The federal medical assistance percentage (FMAP) is the level of federal financial participation in the Medicaid program and varies by state. California's FMAP is 50 percent, below the national average of 57 percent. Despite the federal government funding only 50 percent of Medi-Cal costs, California covers a relatively greater share of its population through Medi-Cal than other large states or the national average.

The Medi-Cal program cost per case is lower than the national average. Total Medi-Cal costs have grown rapidly, generally between 7 and 11 percent annually during the last decade, due to a combination of health care inflation and caseload growth. Because costs are a function of the number of enrolled individuals, the level of benefits provided, and the rates paid to providers, efforts to control program costs have focused in these areas. While some cost control measures have been allowed, adverse court rulings have prevented the state from fully implementing various provider payment reductions or from providing services only to beneficiaries with the greatest need.

Under the ACA, the federal government promises to initially pay for 100 percent of the costs for newly eligible individuals with funding gradually decreasing to 90 percent by 2020. Other costs will be shared 50-50. California is awaiting guidance on the methodology for claiming federal funding for the expansion. This guidance is a critical factor in determining current and future General Fund obligations.

### **PRIVATE INSURANCE MARKET REFORMS TO INCREASE ACCESS**

Under the ACA, health plans and insurers offering products in the individual and small group markets cannot deny coverage for reasons like health status. This is known as "guaranteed issue". Individuals, with some exceptions, are required to obtain health care coverage—referred to as the "individual mandate". Health plans and insurers also cannot charge higher premiums based on health status or gender.

Health plans and insurers will be required to offer products in the individual and small group markets that provide coverage for ten Essential Health Benefits, similar to those of a typical employer plan. There will be multiple mechanisms to balance risk and protect plans against sick people being concentrated in particular plans (risk adjustment and reinsurance programs). Plans and insurers will be required to continue to spend a

majority of their resources on health care (known as the “medical loss ratio”); standardize coverage to facilitate comparisons of insurance products; standardize rating regions throughout the state; and narrow the range of premiums charged at different ages.

California has already adopted several private insurance market reforms contained in the ACA, including establishing Essential Health Benefits, allowing children up to age 26 to remain on their parents’ insurance coverage, instituting guaranteed issue for children with pre-existing conditions, implementing rate review, and imposing medical loss ratio requirements on plans and insurers.

While every effort will be made to promote affordability, large rate increases in the individual insurance market are likely at the outset, due to the requirement to offer coverage to all individuals, provide a higher level of benefits, and due to a significant increase in enrollment which will increase demand for services.

#### **CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)**

Covered California is a new insurance marketplace that will offer an opportunity to purchase affordable health insurance using federally funded tax subsidies for millions of Californians with incomes up to 400 percent FPL. The open enrollment period will begin October 1, 2013 and coverage begins January 1, 2014. Covered California has many program elements focused on ensuring its premiums are as affordable as possible.

Under the ACA, there will be low-income individuals who will transition back and forth between Medi-Cal and private insurance. To allow these individuals to remain with the same insurance plan and provider network, and to maximize the opportunity for affordable coverage, the Administration, in partnership with Covered California, is proposing to establish a Medicaid Bridge Program. Covered California will negotiate contracts with Medi-Cal Managed Care Plans that have robust local safety net provider networks to offer a plan option with a very low or zero premium for those earning between 138 percent and 200 percent FPL.

#### **MANDATORY MEDICAID EXPANSION**

The ACA requires a Medicaid expansion to currently eligible populations through eligibility and enrollment simplifications. Currently, Medicaid eligibility is based on several factors, including linkage to a specific coverage group, income eligibility (including allowable deductions), assets, residency status, and citizenship status. Major changes include the following:

## HEALTH CARE REFORM

- Establishing a new standard for determining income eligibility, based on Modified Adjusted Gross Income (MAGI), consistent with the standard used to determine eligibility for premium tax credits.
- Eliminating the asset test for individuals whose eligibility determination is based on MAGI.
- Conducting an “ex parte” review when making a redetermination of eligibility. Redeterminations must be made based on available information with a primary reliance on electronic data. The number of individuals who currently lose eligibility at the time of renewal is estimated to be in the range of 20 percent to 35 percent. While many of these individuals re-enroll in the program, under these changes, they would remain in the program for a longer period of time.

Due to a number of factors, including the requirement that most individuals obtain coverage, enrollment and eligibility simplifications, and marketing and outreach activities, Medi-Cal enrollment will increase.

The Budget includes \$350 million General Fund as a placeholder for the costs of the mandatory expansion until a more refined estimate can be developed. Given the outstanding federal guidance, the sheer number of changes, and the interactions between the various policies, developing a more refined estimate will take additional time. As a point of comparison, the state has experienced a significant increase in General Fund costs related to similar eligibility and enrollment simplifications, such as de-linking Medi-Cal eligibility from CalWORKs, allowing individuals who work more than 100 hours to qualify for Medi-Cal services, and eliminating reporting requirements.

### **MEDI-CAL “BRIDGE TO REFORM” WAIVER**

The state initiated an early “Bridge to Reform” Medi-Cal expansion by enacting the Low Income Health Program (LIHP) under a federal waiver in 2010. The waiver permits counties to provide a Medicaid-like expansion to individuals with incomes up to 138 percent FPL through 2013. The purpose of the LIHP is to expand health care coverage to low-income adults prior to the effective date of the ACA. The LIHP is a voluntary, county-run program that is financed with 50 percent county and 50 percent federal funds. Currently, 17 LIHPs are operational and provide coverage to approximately 500,000 individuals in 51 counties. Of the remaining counties, four intend to start programs. Three have opted to not run LIHPs—Fresno, Merced, and San Luis Obispo. This early expansion has resulted in substantial savings for

participating counties by providing new federal funding for costs that were previously borne exclusively by counties.

The LIHPs structure and administer their programs differently—through a consortium of counties or through county health departments. The LIHP expansion contained waivers of several Medicaid requirements, allowing enrollment caps, limited networks mainly based on county-operated providers, and other requirements to limit county obligations.

### **IMPLEMENTING THE OPTIONAL EXPANSION**

California has been and will continue to be a leader in the implementation of federal health care reform, building on the early establishment of the Exchange and the early expansion to adults through the Bridge to Reform waiver. As described below, the Budget outlines two alternatives to the optional expansion—a state-based approach or a county-based approach. Each approach has its own set of strengths, challenges, risks, and benefits. Expansion of health care under either approach will have a substantive effect on both state and county finances for the foreseeable future.

Increased coverage will generate substantial savings for the counties which pay for care for adults who are not currently eligible for Medi-Cal through their local indigent health care services programs. Counties currently meet this responsibility by operating facilities—hospitals and clinics—and/or by contracting with private providers. The state provides funding from the 1991 health realignment to partially fund these costs. To receive these funds, counties also have a required maintenance of effort to spend their own county funding. Currently, counties are spending between \$3 billion and \$4 billion annually on health care costs, though spending varies significantly by county. Counties that own and operate hospitals also use local funds to fund the non-federal share of the Medi-Cal program for inpatient Medi-Cal services provided in their facilities.

Implementing federal health care reform will require an assessment of how much funding currently spent by counties should be redirected to pay for the shift in health care costs to the state. The state will also need to consider how these changes would impact remaining county obligations to provide care to those individuals who remain uninsured, as well as public health programs. As such, the implementation of health care reform will require a broader discussion about the future of the state-county relationship with the goal to strengthen local flexibility, fairly allocate risk, and clearly delineate the respective responsibilities of the state and the counties.

### **STATE-BASED EXPANSION**

A state-based Medicaid expansion would build upon the existing state-administered Medicaid program and managed care delivery system. The state would offer a standardized, statewide benefit package comparable to that available today in Medi-Cal, but would exclude long-term care coverage.

This option would require a discussion with the counties around the appropriate state and local relationship in the funding and delivery of health care, and what additional programs the counties should be responsible for if the state assumes the majority of health care costs. To finance the expansion, the state would need to capture county savings and continue to use those funds to pay for health care coverage for this previously medically indigent population. The counties would assume programmatic and fiscal responsibility for various human services programs, including subsidized child care.

### **COUNTY-BASED EXPANSION**

A county-based expansion of Medicaid would build upon the existing Low Income Health Program. Counties would maintain their current responsibilities for indigent health care services. Under this option, counties would meet statewide eligibility requirements, and a statewide minimum in health benefits consistent with benefits offered through Covered California. Counties could offer additional benefits, except for long-term care.

Under a county-operated Medicaid expansion, the counties would act as the fiscal and operational entity responsible for the expansion. Counties would build upon their existing LIHP and/or county indigent health care services programs as the basis for operating the Medicaid expansion.

The key operational and fiscal responsibilities of the counties in designing and running such a Medicaid expansion would include developing provider networks, setting rates, and processing claims. As was the case when implementing LIHP, implementation of this option would require approval of waivers of specified federal requirements.

### **OUTSTANDING ISSUES**

There are several key aspects of ACA implementation for which federal guidance has not yet been issued. The most significant is the methodology for claiming enhanced federal funding. Guidance is also required with respect to the scope of benefits that

will be required for individuals covered under the optional expansion. In addition, while Medicaid was exempted from the federal Budget Control Act sequester, it is possible that federal funding for Medicaid could be affected by comprehensive budget deficit reduction in the future.

This page intentionally blank to facilitate double-sided printing.