

Federal Health Care Reform and California Counties

Sacramento – May 16, 2013



RESOURCE GUIDE TABLE OF CONTENTS

Course Syllabus	1
Overview of the Affordable Care Act (<i>Lee Kemper and Judith Reigel</i>)	3
Summary of New Health Reform Law (<i>Kaiser Family Foundation</i>)	17
Health Reform Implementation Timeline (<i>Kaiser Family Foundation</i>)	31
County Delivery Systems in California	36
Understanding California County Health Care Systems	37
<i>(Institute for Local Government)</i>	
Residual Populations and County Responsibilities (<i>Srija Srinivasan</i>)	41
Role for County Public Health (<i>William Mitchell</i>)	47
Critical Role of County Public Health in Health Care Reform	55
<i>(County Health Executives Association of California)</i>	
After Millions of Californians Gain Health Coverage under the Affordable Care Act, Who will Remain Uninsured?	59
<i>(UCLA Center for Health Policy Research & UC Berkeley Center for Labor Research)</i>	
Health Care Reform and Behavioral Health	81
Understanding Medicaid and Essential Health Benefits	91
<i>(National Health Law Program)</i>	
County Eligibility Operations	95
<i>(County Welfare Directors Association of California)</i>	
CMHDA-CADPAAC Health Care Reform Principles	97
<i>(California Mental Health Directors Association)</i>	
Predicted Increase in Medi-Cal Enrollment under the Affordable Care Act: Regional and County Estimates	91
<i>(UCLA Center for Health Policy Research & UC Berkeley Center for Labor Research)</i>	
1991 Health Realignment	103
Glossary of Key Health Reform Terms (<i>Kaiser Family Foundation</i>)	105

COURSE SYLLABUS



331 Federal Health Care Reform and California Counties

Thursday, May 16 (Sacramento)

Description

As 2014 approaches counties must continue to prepare for implementation of the federal Patient Protection and Affordable Care Act is law. This course will provide a balanced, fact-based discussion of how federal health care reform is being implemented in California and its effect on county health, mental health and social services.

Four key areas will focus the course: 1) case studies of the implementation and effects on county services and funding; 2) who is left uninsured and how to manage those populations; 3) what areas are left to be resolved and a look at the Legislature's special session on health care; and 4) upcoming decisions for counties. Discussion addresses specific county programs and funding and how those are changing as the law is implemented. Other issues examined include trends in how people are using their new insurance to seek health care, county responsibilities for the uninsured, potential impacts on realignment funding, and funding changes in the Governor's proposed 2013-14 budget.

Learning Objectives

- ◆ Provide an overview on health care reform and the status of its implementation in California
- ◆ Identify what is left to be done in California on implementation of the Act and discuss potential (or actual) outcomes from the Special Session on health care reform
- ◆ Understand what upcoming decisions counties will need to make
- ◆ Explore how individuals are now using their new insurance and strategies to move clients from emergency rooms to their health care provider
- ◆ Discuss who is left uninsured and how to manage those populations: examine county responsibility and options
- ◆ Identify impacts from the Governor's proposed budget and what funding streams may be at risk as health care reform continues to be implemented

Course Curriculum

Times are approximate

10:00 **Welcome**, introductions, agenda and course overview – Lee Kemper

10:10 **ACA and California Counties – Lee Kemper (CMSP), Judith Reigel (CHEAC)**
Framework of the Patient Protection and Affordable Care Act (ACA) of 2010 and how it will affect California Counties.

- ◆ Overview of ACA and key elements which affect counties
- ◆ Coverage expansion components:
 - Who's covered: Medicaid, State exchange
 - Cost sharing

- Enrollment period
- Penalties
- ◆ Governor's Medicaid Expansion proposals

11:20 **Residual Populations and County Responsibilities**

Srija Srinivasan (San Mateo), Bill Mitchell (San Joaquin)

After the implementation of ACA it is anticipated that some people will remain uninsured.

- ◆ Who will be left uncovered?
- ◆ What are the options?
- ◆ What are the county responsibilities?
- ◆ How is public health impacted?

12:15 LUNCH BREAK

12:45 *Panel Discussion* **Key Policy Issues Yet to be Addressed**

Sarah Muller (CAPH), Patricia Ryan (CMHDA), Cathy Senderling-McDonald (CWDA)

The panel will address remaining issues and how counties are approaching them. A focus will be on the issues/decisions coming out of the Legislature's Special Session on Health Care Reform.

- ◆ Medicaid Bridge Program
- ◆ Counties as providers issues
- ◆ Behavioral health parity
- ◆ Enrollment and eligibility

2:15 *Panel Discussion* **The Fiscal Focus – Lee Kemper, Sarah Muller, Judith Reigel**

- ◆ Programs and funding
- ◆ New opportunities: medical homes; accountable care organizations; prevention programs; care coordination
- ◆ Effect on Realignment and other funds
- ◆ 2013-14 proposed budget impacts

3:15 *Conclusion* **Where We Are Headed in Health Care in California: 2013-14 Proposed Budget**

Explore any additional issues on health reform and realignment which emerge in the Governor's Proposed Budget. Summary comments tying together discussions of the day.

3:30 Evaluations and adjournment

Federal Health Care Reform and California Counties

Overview of the Affordable Care Act

Overview of the Affordable Care Act (ACA)

CSAC Institute
May 16, 2013

Lee Kemper
Director of Policy & Planning
County Medical Services Program (CMSP) Governing Board

Judith Reigel
Executive Director
County Health Executives Association of California (CHEAC)

Overview of the Affordable Care Act (ACA)

- Requires most U.S. citizens and legal residents to have health insurance
- Creates state-based Health Benefit Exchanges for the sale of individual and small business health coverage
- Provides premium and cost-sharing credits to individuals/families with income between 133-400% FPL
- Requires employers to pay a penalty when their employees receive tax credits for health insurance through an Exchange (exceptions for small employers)
- Imposes new regulations on health plans in the Exchanges and in the individual and small group markets
- Expands Medicaid eligibility to cover single adults under age 65 up to 138% FPL

2

Individual Mandate, Penalties & Exemptions – Summary

- ACA requires most U.S. citizens and legal residents to have “qualifying health coverage” or incur a penalty.
 - This requirement is commonly known as the individual mandate.
- The penalty for those without coverage:
 - Greater of \$695 per year up to a maximum of three times that amount (\$2,085) per family or 2.5% of household income.

3

Federal Health Care Reform and California Counties

Overview of the Affordable Care Act

Individual Mandate, Penalties & Exemptions – Summary

• Penalty phases in:

- Flat Fees:
 - \$95 in 2014
 - \$325 in 2015
 - \$695 in 2016
- Percent of Income:
 - 1.0% of taxable income in 2014
 - 2.0% of taxable income in 2015
 - 2.5% of taxable income in 2016

Exemptions: financial hardship, religious objections, American Indians, people without coverage for less than three months, undocumented immigrants, incarcerated, lowest cost plan option exceeds 8% of income, people with incomes below tax filing threshold.

4

Premium Credits and Subsidies for Individuals/Families – Summary

- Eligibility limited to U.S. citizens and legal immigrants with income between 100-400% FPL
 - Requires verification of income and citizenship
 - Includes legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S.
- Employees who are offered coverage by an employer and
 - the employer's plan does not have an actuarial value of at least 60%, or
 - the employee share of the premium exceeds 9.5% of income

5

Premium Credits and Subsidies for Individuals/Families – Summary

- Refundable and advanceable
- Used to purchase insurance coverage through the Health Benefits Exchange
- Tied to the second lowest cost SILVER PLAN in the area
- Individual's contribution to premium limited to percentages of income:
 - 100-133% FPL: 2% of income
 - 133-150% FPL: 3 - 4% of income
 - 150-200% FPL: 4 - 6.3% of income
 - 200-250% FPL: 6.3 - 8.05% of income
 - 250-300% FPL: 8.05 - 9.5% of income
 - 300-400% FPL: 9.5% of income
- Premium contributions for those receiving subsidies increase annually

6

Federal Health Care Reform and California Counties

Overview of the Affordable Care Act

Premium Credits and Subsidies for Individuals/Families – Summary

Cost-sharing Subsidies

- Cost-sharing subsidies to eligible individuals and families
- Reduce the cost-sharing amounts and annual cost-sharing limits
- Have the effect of increasing the actuarial value of the basic benefit plan

7

Employer Mandate – Summary

- Requires employers with 50 or more full-time employees to offer health coverage
 - Assesses those employers that do not offer coverage *and have at least one full-time employee who receives a premium tax credit* a fee of \$2,000 per full-time employee
 - excludes first 30 employees
- Requires certain employers with 50 or more full-time employees that offer coverage to pay a penalty
 - If at least one full-time employee receives a premium tax credit
 - penalty is equal to the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee
 - excludes the first 30 employees

8

Employer Mandate – Summary

- Exempts employers less than 50 full-time employees from any of the penalties
- Requires employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer.
 - Authorizes employees to opt out of coverage.

9

Federal Health Care Reform and California Counties

Overview of the Affordable Care Act

Premium Subsidies to Employers & Small Business Tax Credits

- Provides small employers with 25 or fewer employees and average annual wages of less than \$50,000 that purchase health insurance for employees with a tax credit

Phase I

- For tax years 2010 through 2013, the tax credit is up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium
- Full credit is available to employers with 10 or fewer employees and average annual wages of less than \$25,000.
- Credit phases-out as firm size and average wage increases.

10

Premium Subsidies to Employers & Small Business Tax Credits

Phase II

- For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, the tax credit is up to 50% of the employer's contribution if the employer contributes at least 50% of the total premium cost.
- Credit is available for two years
- Full credit is available to employers with 10 or fewer employees and average annual wages of less than \$25,000
- Credit phases-out as firm size and average wage increases

11

Health Benefit Exchanges & Small Business Exchanges (SHOP)

- ACA authorizes states to establish a Health Benefits Exchange to serve as a central marketplace for individuals, families, and small businesses to purchase health coverage
- Administered by a governmental agency or non-profit organization
 - **Covered California** in California
- Individuals and small businesses with up to 100 employees may purchase qualified coverage through the Exchange
- Businesses with more than 100 employees may purchase coverage in the SHOP Exchange beginning in 2017
- Eligibility to purchases through the Exchange limited to U.S. citizens and legal immigrants who are not incarcerated

12

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Overview of the Affordable Care Act

Essential Benefits Package

- Effective 1/1/2014, creates an essential health benefits package
 - comprehensive set of services
 - covers at least 60% of the actuarial value of the covered benefits
- Limits annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010)
- Is not more extensive than the typical employer plan
- At least the essential health benefits package must be offered by all qualified health benefits plans
 - Exchanges
 - Individual and small group markets outside the Exchanges

13

Insurance Market Rules for Individual and Group Plans

- Guaranteed issue
- Premium ratings
- No lifetime limits on the dollar value of coverage
- No rescinding coverage, except in cases of fraud
- No pre-existing condition exclusions for children
- No annual limits on the dollar value of coverage

14

Dependent Coverage

- Provides dependent coverage for children up to age 26 for all individual and group policies
- Took effect 6 months following enactment of ACA

15

Federal Health Care Reform and California Counties

Overview of the Affordable Care Act

Medical Loss Ratios and Premium Rate Reviews

- ACA requires health plans to:
 - Report proportion of premium dollars spent on clinical services, quality, and other costs (1/1/2010)
 - Provide rebates to consumers when the amount of premium spent on clinical services and quality is:
 - Less than 85% for large group market (1/1/2011)
 - Less than 80% individual and small group markets (1/1/2011)

16

Tax Changes Related to Health Insurance Coverage

- Imposes a tax on individuals without qualifying coverage:
 - Greater of \$695 per year, up to maximum of three times that amount, or
 - 2.5% of household income (to be phased-in beginning in 2014)
- Imposes an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed:
 - \$10,200 for individual coverage
 - \$27,500 for family coverage
 - Certain exemptions apply
- Imposes new annual fees on the pharmaceutical manufacturing sector, according to the following schedule:
 - \$2.8 billion in 2012-2013
 - \$3.0 billion in 2014-2016
 - \$4.0 billion in 2017
 - \$4.1 billion in 2018
 - \$2.8 billion in 2019 and later

17

Tax Changes Related to Health Insurance Coverage

- Imposes an annual fee on the health insurance sector, increasing each year
 - \$8 billion in 2014
 - Increases to \$14.3 billion in 2018
- Imposes an excise tax of 2.3% on the sale of any taxable medical device
 - Effective for sales after December 31, 2012)

18

Federal Health Care Reform and California Counties

Overview of the Affordable Care Act

National Prevention Strategy

- Created the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities.
- Council released the *National Prevention Strategy: America's Plan for Better Health and Wellness* (June, 2011) with four strategic directions:
 - Healthy and Safe Community Environments
 - Clinical and Community Preventive Services
 - Support People in Making Healthy Choices
 - Elimination of Health Disparities
- ACA established:
 - Prevention and Public Health Fund for prevention, wellness, and public health activities including prevention research and health screenings
 - Education and Outreach Campaign for preventive benefits, and immunization programs
 - Fund has already provided over \$2 billion for prevention and public health activities

19

National Prevention Strategy

Community Transformation Grants

- Administered by the Centers for Disease Control and Prevention
- Awards grants to state and local governments and community based organizations to design and implement community-level programs that prevent chronic diseases such as cancer, diabetes, and heart disease
 - \$173 million awarded in 2011 and 2012
- 9 California counties awarded directly and 12 through a grant administered by the Public Health Institute

20

Coverage of Preventive Services

Private insurance

- New insurance plans (i.e. newly issued policies) are required to cover certain prevention services (such as immunizations and evidence-informed preventive care and screenings) under guidelines established by the United States Preventive Services Task Force
- Limits patient cost sharing for preventive services
- Plans issued on or before March 23, 2010 are exempt from the majority of the requirements

21

Federal Health Care Reform and California Counties

Overview of the Affordable Care Act

Coverage of Preventive Services

Medicare

- Eliminates cost-sharing for Medicare-covered preventive services and screenings
- Annual wellness visits including risk assessments to identify potential medical concerns

Medicaid

- Requires tobacco cessation services for pregnant women
- No requirement for elimination for cost sharing for preventive services; states that chose to do so eligible for a one percentage point increase in federal matching payments

22

Covered California: Health Benefit Exchange

Key Dates

- October 1, 2013: Pre enrollment begins
- January 1, 2014: Coverage begins
- January 1, 2015: Federal funding for exchange operations ends

Target Populations

- Estimated 2.6 million people who will qualify for sliding scale subsidies (i.e. those with incomes between 138% and 400% of FPL)
- Estimated 2.7 million who do not qualify for subsidies but will benefit from guaranteed coverage and can enroll through Covered California or other avenues

23

Covered California: Premium Subsidies

Percent of FPL	Annual Income for Individual	Maximum Premium	Annual Premium After Tax Credit	Monthly Premium After Tax Credit
150%	\$17,235	4%	\$689	\$57
200%	\$22,980	6.3%	\$1,448	\$121
250%	\$28,725	8.05%	\$2,312	\$193
300%	\$34,470	9.5%	\$3,275	\$273
399%	\$45,960	9.5%	\$4,366	\$364

24

Federal Health Care Reform and California Counties

Overview of the Affordable Care Act

Medicaid Expansion and Changes – U.S. Supreme Court Decision

- With the challenge to the ACA's Medicaid requirements on states, the Court considered:
 - Congress' authority to place conditions on federal grants to states
 - The proper balance of power between the federal government and the states
- The Court:
 - Issued its decision about the constitutionality of Medicaid expansion on June 28, 2012
 - Found – for the first time – that a federal condition on a grant to states was unconstitutionally coercive
 - Maintained the Medicaid expansion in the ACA, but limited the authority of the Secretary of HHS to enforce it
 - Secretary cannot withhold *existing* federal Medicaid program funds from a state if the state does not implement the Medicaid expansion

28

Medicaid Expansion and Changes – Outcome of Court's Decision

- Medicaid expansion is optional to states
- Beginning 1/1/2014, a state *may* expand Medicaid participation for adults under age 65 with incomes at or below 138% FPL
 - For 2014-2016, the federal matching rate for coverage of the expansion population is 100%
 - Federal matching rate gradually declines between 2017 and 2020
 - In 2020 and thereafter, states bear a 10% share of the cost of health services to the population
 - States that participate must provide benchmark benefits, including essential health benefits, to the newly eligible population
 - Only U.S. citizens and legal immigrants with more than five years residence in U.S. are eligible for coverage
 - Undocumented immigrants and legal immigrants with less than five years residence in U.S. are ineligible

29

Medicaid Expansion and Changes – Other Provisions

- Beginning 1/1/2014, ACA makes changes to outreach, enrollment processes, and eligibility standards for Medicaid:
 - Simplifies standards used to determine eligibility
 - Streamlines enrollment processes
 - Coordinates with other public entities that will offer subsidized health insurance coverage to low and moderate income persons
 - Enhances outreach activities to encourage participation in health insurance and Medicaid
- Beginning 1/1/2013, increases federal Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors to 100% of the Medicare payment rates

30

Federal Health Care Reform and California Counties

Overview of the Affordable Care Act

Medicaid Expansion and Changes – Other Provisions

- Requires states to maintain current income eligibility levels for children in Medicaid and the Children’s Health Insurance Program (CHIP) until 2019
 - CHIP benefit package and cost-sharing rules continue as under current law
- Increases Medicaid drug rebate percentages and extends the drug rebate to Medicaid managed care plans
- Prohibits federal payments to states for Medicaid services related to health care acquired conditions

31

Medicaid Expansion and Changes – Other Provisions

- Reduces aggregate Medicaid DSH allotments
 - \$.5 billion in 2014
 - \$.6 billion in 2015
 - \$.6 billion in 2016
 - \$1.8 billion in 2017
 - \$5 billion in 2018
 - \$5.6 billion in 2019
 - \$4 billion in 2020
- Requires DSH reductions be distributed so that the largest reductions are made to states with the lowest percentage of uninsured

32

Governor’s Proposal on Expansion of Medi-Cal (Medicaid)

- Governor proposed two alternatives for expansion of Medi-Cal to cover single adults up to 138% FPL: State based or county based option.
- CSAC conducted a thorough analysis of both proposals and concluded that the county option was not viable.

33

Federal Health Care Reform and California Counties

Overview of the Affordable Care Act

Governor's Proposal on Expansion of Medi-Cal (Medicaid)

CSAC Board of Directors adopted Medi-Cal expansion principle on March 28, 2013

- Expansion should start on 1/1/14
- State option is best framework
- Programmatic realignment is problematic
- Counties should retain sufficient health realignment funds to fulfill residual responsibilities (remaining uninsured and public health services).
- Savings should be redirected to local health, public health and behavioral health systems.
- Counties opposed to program realignment absent revenue protections and protections from future costs associated with state and federal law changes.
- State and county fiscal impacts associated with Medi-Cal expansion and continued health responsibilities need to be identified, on an ongoing basis, to inform future decisions regarding shared financial risks.

34

Governor's Proposal on Expansion of Medi-Cal: State-County Relationship

- Governor proposes that any county "savings" from the ACA should be redirected to pay for new health care costs to the state resulting from the ACA
 - Governing originally proposed to increase county programmatic and financial responsibility for child care and other social service programs
 - Pending May Revision, Governing may propose a revenue transfer that allows the State to offset State General Fund costs for Cal WORKS or other social services program
 - Brown Administration continues to argue counties will enjoy significant "savings" from the Medi-Cal expansion, but the evidence of such "savings" is highly questionable

35

ACA's Effect on State and County Finances

- Fiscal effects of ACA implementation on the state and counties, notably from the Medicaid provisions, is highly uncertain
- Major factors contribute to this uncertainty for counties:
 - Size of the newly eligible Medi-Cal population
 - Extent to which this newly eligible population will enroll
 - Pace at which they will enroll
 - Residually uninsured, including undocumented
 - For public hospital and provider counties:
 - Flow of Medi-Cal enrollees
 - Payment rates for services
 - Average enrollee costs
 - Composition of uncompensated care post 2013
 - Loss of federal disproportionate share (DSH) Medicaid funding and loss of funding under existing Medi-Cal waivers

36

Federal Health Care Reform and California Counties

Overview of the Affordable Care Act



ACA's Effect on State and County Finances

- Governor's budget plan incorporates certain estimated ACA related costs for the state:
 - Medi-Cal budget originally included a \$350 million General Fund placeholder
 - This may change pending May Revision
- State DHSC budget does not include the fiscal impacts of modifying or eliminating other state programs

37



Optional Expansion of Medi-Cal – Key Policy Issues

- All of the following need to be determined:
 - Specific benefit coverage for the population
 - How new Medi-Cal eligibility standards under ACA will be implemented
 - Whether to modify or eliminate other existing state health programs for populations that would be eligible under the expansion
 - Whether to establish a Basic Health Program, a “Bridge Program” between Medi-Cal and the Exchange, or some other program to make coverage more affordable for populations not covered by Medi-Cal
 - Financing for optional expansion versus financing for all other ACA related Medi-Cal changes

38



Key sources for presentation:

- **Kaiser Family Foundation** (various) at <http://www.kff.org/>
- **Office of Legislative Analyst** at <http://www.lao.ca.gov/laoapp/PubDetails.aspx?id=2681>

39



SUMMARY OF NEW HEALTH REFORM LAW

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. The following summary of the law, and changes made to the law by subsequent legislation, focuses on provisions to expand coverage, control health care costs, and improve health care delivery system.

Patient Protection and Affordable Care Act (P.L. 111-148)	
Overall approach to expanding access to coverage	Require most U.S. citizens and legal residents to have health insurance. Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 133-400% of the federal poverty level (the poverty level is \$18,310 for a family of three in 2009) and create separate Exchanges through which small businesses can purchase coverage. Require employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. Impose new regulations on health plans in the Exchanges and in the individual and small group markets. Expand Medicaid to 133% of the federal poverty level.
INDIVIDUAL MANDATE	
Requirement to have coverage	<ul style="list-style-type: none"> Require U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of \$695 per year up to a maximum of three times that amount (\$2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: \$95 in 2014, \$325 in 2015, and \$695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was \$9,350 for singles and \$18,700 for couples).
EMPLOYER REQUIREMENTS	
Requirement to offer coverage	<ul style="list-style-type: none"> Assess employers with 50 or more full-time employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with 50 or more full-time employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee, excluding the first 30 employees from the assessment. (Effective January 1, 2014) Exempt employers with up to 50 full-time employees from any of the above penalties.
Other requirements	<ul style="list-style-type: none"> Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.
EXPANSION OF PUBLIC PROGRAMS	
Treatment of Medicaid	<ul style="list-style-type: none"> Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (as under current law undocumented immigrants are not eligible for Medicaid). All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges. <p>To finance the coverage for the newly eligible (those who were not previously eligible for at least benchmark equivalent coverage, those who were eligible for a capped program but were not enrolled, or those who were enrolled in state-funded programs), states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2019 they receive the same</p>

Patient Protection and Affordable Care Act (P.L. 111-148)

EXPANSION OF PUBLIC PROGRAMS (continued)	
Treatment of Medicaid (continued)	federal financing as other states (93% in 2019 and 90% in 2020 and later). States have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular FMAP until 2014. In addition, increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2014)
Treatment of CHIP	<ul style="list-style-type: none"> Require states to maintain current income eligibility levels for children in Medicaid and the Children’s Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue as under current law. Provide states with the option to provide CHIP coverage to children of state employees who are eligible for health benefits if certain conditions are met. Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges.
PREMIUM AND COST-SHARING SUBSIDIES TO INDIVIDUALS	
Eligibility	<ul style="list-style-type: none"> Limit availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee share of the premium exceeds 9.5% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits.
Premium credits	<ul style="list-style-type: none"> Provide refundable and advanceable premium credits to eligible individuals and families with incomes between 100-400% FPL to purchase insurance through the Exchanges. The premium credits will be tied to the second lowest cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income levels: <ul style="list-style-type: none"> 100-133% FPL: 2% of income 133-150% FPL: 3 – 4% of income 150-200% FPL: 4 – 6.3% of income 200-250% FPL: 6.3 – 8.05% of income 250-300% FPL: 8.05 – 9.5% of income 300-400% FPL: 9.5% of income Increase the premium contributions for those receiving subsidies annually to reflect the excess of the premium growth over the rate of income growth for 2014-2018. Beginning in 2019, further adjust the premium contributions to reflect the excess of premium growth over CPI if aggregate premiums and cost sharing subsidies exceed .54% of GDP. Provisions related to the premium and cost-sharing subsidies are effective January 1, 2014.
Cost-sharing subsidies	<ul style="list-style-type: none"> Provide cost-sharing subsidies to eligible individuals and families. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level: <ul style="list-style-type: none"> 100-150% FPL: 94% 150-200% FPL: 87% 200-250% FPL: 73% 250-400% FPL: 70%
Verification	<ul style="list-style-type: none"> Require verification of both income and citizenship status in determining eligibility for the federal premium credits.
Subsidies and abortion coverage	<ul style="list-style-type: none"> Ensure that federal premium or cost-sharing subsidies are not used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or cases of rape or incest (Hyde amendment). If an individual who receives federal assistance purchases coverage in a plan that chooses to cover abortion services beyond those for which federal funds are permitted, those federal subsidy funds (for premiums or cost-sharing) must not be used for the purchase of the abortion coverage and must be segregated from private premium payments or state funds.

PREMIUM SUBSIDIES TO EMPLOYERS

Small business tax credits

- Provide small employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees with a tax credit.
 - *Phase I:* For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium.
 - *Phase II:* For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.

Reinsurance program

- Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers or insurers for 80% of retiree claims between \$15,000 and \$90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate \$5 billion to finance the program. (Effective 90 days following enactment through January 1, 2014)

TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM

Tax changes related to health insurance

- Impose a tax on individuals without qualifying coverage of the greater of \$695 per year up to a maximum of three times that amount or 2.5% of household income to be phased-in beginning in 2014.
- Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. (Effective January 1, 2011)
- Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer MSAs) of the disbursed amount. (Effective January 1, 2011)
- Limit the amount of contributions to a flexible spending account for medical expenses to \$2,500 per year increased annually by the cost of living adjustment. (Effective January 1, 2013)
- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016. (Effective January 1, 2013)
- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% [from 1.45% to 2.35%] on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly and impose a 3.8% tax on unearned income for higher-income taxpayers (thresholds are not indexed). (Effective January 1, 2013)
- Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) for years beginning in 2020). The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by \$1,650 for individual coverage and \$3,450 for family coverage. The threshold amounts may be adjusted upwards if health care costs rise more than expected prior to implementation of the tax in 2018. The threshold amounts will be increased for firms that may have higher health care costs because of the age or gender of their workers. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage, excluding dental and vision coverage. (Effective January 1, 2018)
- Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments. (Effective January 1, 2013)

TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM (continued)

<p>Tax changes related to financing health reform</p>	<ul style="list-style-type: none"> • Impose new annual fees on the pharmaceutical manufacturing sector, according to the following schedule: <ul style="list-style-type: none"> – \$2.8 billion in 2012-2013; – \$3.0 billion in 2014-2016; – \$4.0 billion in 2017; – \$4.1 billion in 2018; and – \$2.8 billion in 2019 and later. • Impose an annual fee on the health insurance sector, according to the following schedule: <ul style="list-style-type: none"> – \$8 billion in 2014; – \$11.3 billion in 2015-2016; – \$13.9 billion in 2017; – \$14.3 billion in 2018 – For subsequent years, the fee shall be the amount from the previous year increased by the rate of premium growth. <p>For non-profit insurers, only 50% of net premiums are taken into account in calculating the fee. Exemptions granted for non-profit plans that receive more than 80% of their income from government programs targeting low-income or elderly populations, or people with disabilities, and voluntary employees' beneficiary associations (VEBAs) not established by an employer. (Effective January 1, 2014)</p> • Impose an excise tax of 2.3% on the sale of any taxable medical device. (Effective for sales after December 31, 2012) • Limit the deductibility of executive and employee compensation to \$500,000 per applicable individual for health insurance providers. (Effective January 1, 2009) • Impose a tax of 10% on the amount paid for indoor tanning services. (Effective July 1, 2010) • Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit. (Effective January 1, 2010) • Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance. (Effective upon enactment)
<p>HEALTH INSURANCE EXCHANGES</p>	
<p>Creation and structure of health insurance exchanges</p>	<ul style="list-style-type: none"> • Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (Funding available to states to establish Exchanges within one year of enactment and until January 1, 2015)
<p>Eligibility to purchase in the exchanges</p>	<ul style="list-style-type: none"> • Restrict access to coverage through the Exchanges to U.S. citizens and legal immigrants who are not incarcerated.
<p>Public plan option</p>	<ul style="list-style-type: none"> • Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan. If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.
<p>Consumer Operated and Oriented Plan (CO-OP)</p>	<ul style="list-style-type: none"> • Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. (Appropriate \$4.8 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)

HEALTH INSURANCE EXCHANGES (continued)	
<p>Benefit tiers</p>	<ul style="list-style-type: none"> • Create four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets: <ul style="list-style-type: none"> – <i>Bronze plan</i> represents minimum creditable coverage and provides the essential health benefits, cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit (\$5,950 for individuals and \$11,900 for families in 2010); – <i>Silver plan</i> provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits; – <i>Gold plan</i> provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits; – <i>Platinum plan</i> provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits; – <i>Catastrophic plan</i> available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market. • Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels: <ul style="list-style-type: none"> – 100-200% FPL: one-third of the HSA limits (\$1,983/individual and \$3,967/family); – 200-300% FPL: one-half of the HSA limits (\$2,975/individual and \$5,950/family); – 300-400% FPL: two-thirds of the HSA limits (\$3,987/individual and \$7,973/family). These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan.
<p>Insurance market and rating rules</p>	<ul style="list-style-type: none"> • Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchange. • Require risk adjustment in the individual and small group markets and in the Exchange. (Effective January 1, 2014)
<p>Qualifications of participating health plans</p>	<ul style="list-style-type: none"> • Require qualified health plans participating in the Exchange to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information. • Require qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.
<p>Requirements of the exchanges</p>	<ul style="list-style-type: none"> • Require the Exchanges to maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. Require states to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone. Permit Exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the Exchanges. • Require Exchanges to submit financial reports to the Secretary and comply with oversight investigations including a GAO study on the operation and administration of Exchanges.
<p>Basic health plan</p>	<ul style="list-style-type: none"> • Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.
<p>Abortion coverage</p>	<ul style="list-style-type: none"> • Permit states to prohibit plans participating in the Exchange from providing coverage for abortions. • Require plans that choose to offer coverage for abortions beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) in states that allow such coverage to create allocation accounts for segregating premium payments for coverage of abortion services from premium payments for coverage for all other services to ensure that no federal premium or cost-sharing subsidies are used to pay for the abortion coverage. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at no

Patient Protection and Affordable Care Act (P.L. 111-148)

HEALTH INSURANCE EXCHANGES (continued)	
Abortion coverage (continued)	less than \$1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Prohibit plans participating in the Exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.
Effective dates	<ul style="list-style-type: none"> Unless otherwise noted, provisions relating to the American Health Benefit Exchanges are effective January 1, 2014.
BENEFIT DESIGN	
Essential benefits package	<ul style="list-style-type: none"> Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (Effective January 1, 2014) Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, except grandfathered individual and employer-sponsored plans, to offer at least the essential health benefits package. (Effective January 1, 2014)
Abortion coverage	<ul style="list-style-type: none"> Prohibit abortion coverage from being required as part of the essential health benefits package. (Effective January 1, 2014)
CHANGES TO PRIVATE INSURANCE	
Temporary high-risk pool	<ul style="list-style-type: none"> Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age; maximum cost-sharing will be limited to the current law HSA limit (\$5,950/individual and \$11,900/family in 2010). Appropriate \$5 billion to finance the program. (Effective within 90 days of enactment until January 1, 2014)
Medical loss ratio and premium rate reviews	<ul style="list-style-type: none"> Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011) Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases. Provide grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010)
Administrative simplification	<ul style="list-style-type: none"> Adopt standards for financial and administrative transactions to promote administrative simplification. (Effective dates vary)
Dependent coverage	<ul style="list-style-type: none"> Provide dependent coverage for children up to age 26 for all individual and group policies. (Effective six months following enactment)
Insurance market rules	<ul style="list-style-type: none"> Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibit insurers from rescinding coverage except in cases of fraud. Prohibit pre-existing condition exclusions for children. (Effective six months following enactment) Beginning in January 2014, prohibit individual and group health plans from placing annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary. Grandfather existing individual and group plans with respect to new benefit standards, but require these grandfathered plans to extend dependent coverage to adult children up to age 26 and prohibit rescissions of coverage. Require grandfathered group plans to eliminate lifetime limits on coverage and beginning in 2014, eliminate annual limits on coverage. Prior to 2014, grandfathered group plans may only impose annual limits as determined by the Secretary. Require grandfathered group plans to eliminate pre-existing condition exclusions for children within six months of enactment and by 2014 for adults, and eliminate waiting periods for coverage of greater than 90 days by 2014. (Effective six months following enactment, except where otherwise specified) Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the individual market, in the Exchange, and in the small group market. (See new rating and market rules in Creation of insurance pooling mechanism.) (Effective January 1, 2014)

CHANGES TO PRIVATE INSURANCE (continued)	
<p>Insurance market rules (continued)</p>	<ul style="list-style-type: none"> • Require all new policies (except stand-alone dental, vision, and long-term care insurance plans), including those offered through the Exchanges and those offered outside of the Exchanges, to comply with one of the four benefit categories. Existing individual and employer-sponsored plans do not have to meet the new benefit standards. (See description of benefit categories in Creation of insurance pooling mechanism.) (Effective January 1, 2014) • Limit deductibles for health plans in the small group market to \$2,000 for individuals and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of any plans. (Effective January 1, 2014) • Limit any waiting periods for coverage to 90 days. (Effective January 1, 2014) • Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. Finance the reinsurance program through mandatory contributions by health insurers totaling \$25 billion over three years. (Effective January 1, 2014 through December 2016) • Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)
<p>Consumer protections</p>	<ul style="list-style-type: none"> • Establish an internet website to help residents identify health coverage options (effective July 1, 2010) and develop a standard format for presenting information on coverage options (effective 60 days following enactment). • Develop standards for insurers to use in providing information on benefits and coverage. (Standards developed within 12 months following enactment; insurer must comply with standards within 24 months following enactment)
<p>Health care choice compacts and national plans</p>	<ul style="list-style-type: none"> • Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. Compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the state Exchanges. (Regulations issued by July 1, 2013, compacts may not take effect before January 1, 2016)
<p>Health insurance administration</p>	<ul style="list-style-type: none"> • Establish the Health Insurance Reform Implementation Fund within the Department of Health and Human Services and allocate \$1 billion to implement health reform policies.
STATE ROLE	
<p>State role</p>	<ul style="list-style-type: none"> • Create an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange for individuals and small businesses and provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, and to define rating areas. • Enroll newly eligible Medicaid beneficiaries into the Medicaid program no later than January 2014 (states have the option to expand enrollment beginning in 2011), coordinate enrollment with the new Exchanges, and implement other specified changes to the Medicaid program. Maintain current Medicaid and CHIP eligibility levels for children until 2019 and maintain current Medicaid eligibility levels for adults until the Exchange is fully operational. A state will be exempt from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL for any year from January 2011 through December 31, 2013 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year. • Establish an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for people with private coverage in the individual and small group markets. (Federal grants available beginning fiscal year 2010) • Permit states to create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the Exchanges. (Effective January 1, 2014) Permit states to obtain a five-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit. (Effective January 1, 2017)

COST CONTAINMENT

Administrative simplification

- Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than \$1 per covered life. (Effective April 1, 2014)

Medicare

- Restructure payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates, with higher payments for areas with low FFS rates and lower payments (95% of FFS) for areas with high FFS rates. Phase-in revised payments over 3 years beginning in 2011, for plans in most areas, with payments phased-in over longer periods (4 years and 6 years) for plans in other areas. Provide bonuses to plans receiving 4 or more stars, based on the current 5-star quality rating system for Medicare Advantage plans, beginning in 2012; qualifying plans in qualifying areas receive double bonuses. Modify rebate system with rebates allocated based on a plan's quality rating. Phase-in adjustments to plan payments for coding practices related to the health status of enrollees, with adjustments equaling 5.7% by 2019. Cap total payments, including bonuses, at current payment levels. Require Medicare Advantage plans to remit partial payments to the Secretary if the plan has a medical loss ratio of less than 85%, beginning 2014. Require the Secretary to suspend plan enrollment for 3 years if the medical loss ratio is less than 85% for 2 consecutive years and to terminate the plan contract if the medical loss ratio is less than 85% for 5 consecutive years.
- Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. (Effective dates vary)
- Freeze the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above \$85,000/individual and \$170,000/couple. (Effective January 1, 2011)
- Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning April 2013, require the Chief Actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U and CPI-M, based on a five year period ending that year. If so, beginning January 15, 2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for one year) will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by January 1, 2015.
- Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided (Effective fiscal year 2014)
- Eliminate the Medicare Improvement Fund. (Effective upon enactment)
- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012)
- Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011)
- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions. (Effective October 1, 2012)
- Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)

Patient Protection and Affordable Care Act (P.L. 111-148)

COST CONTAINMENT (continued)

<p>Medicaid</p>	<ul style="list-style-type: none"> • Increase the Medicaid drug rebate percentage for brand name drugs to 23.1 (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price. (Effective January 1, 2010) Extend the drug rebate to Medicaid managed care plans. (Effective upon enactment) • Reduce aggregate Medicaid DSH allotments by \$.5 billion in 2014, \$.6 billion in 2015, \$.6 billion in 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019, and \$4 billion in 2020. Require the Secretary to develop a methodology to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for 1115 waivers. (Effective October 1, 2011) • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective July 1, 2011)
<p>Prescription drugs</p>	<ul style="list-style-type: none"> • Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment)
<p>Waste, fraud, and abuse</p>	<ul style="list-style-type: none"> • Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of DME suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, strengthen standards for community mental health centers and increase funding for anti-fraud activities. (Effective dates vary)

IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE

<p>Comparative effectiveness research</p>	<ul style="list-style-type: none"> • Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. (Funding available beginning fiscal year 2010) Terminate the Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act. (Effective upon enactment)
<p>Medical malpractice</p>	<ul style="list-style-type: none"> • Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. (Funding appropriated for five years beginning in fiscal year 2011)
<p>Medicare</p>	<ul style="list-style-type: none"> • Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016) • Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012) • Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012) Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. (Reports to Congress due January 1, 2011)
<p>Dual eligibles</p>	<ul style="list-style-type: none"> • Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles. (Effective March 1, 2010)

Patient Protection and Affordable Care Act (P.L. 111-148)

IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE (continued)	
Medicaid	<ul style="list-style-type: none"> • Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for home health-related services, including care management, care coordination, and health promotion. (Effective January 1, 2011) • Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015). • Expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). (\$11 million in additional funds appropriated for fiscal year 2010)
Primary care	<ul style="list-style-type: none"> • Increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2013) • Provide a 10% bonus payment to primary care physicians in Medicare from 2011 through 2015. (Effective for five years beginning January 1, 2011)
National quality strategy	<ul style="list-style-type: none"> • Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011) • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning in FY 2011)
Financial disclosure	<ul style="list-style-type: none"> • Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Report due to Congress April 1, 2013)
Disparities	<ul style="list-style-type: none"> • Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment)
PREVENTION/WELLNESS	
National strategy	<ul style="list-style-type: none"> • Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment) Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010) Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment) • Establish a Prevention and Public Health Fund for prevention, wellness, and public health activities including prevention research and health screenings, the Education and Outreach Campaign for preventive benefits, and immunization programs. Appropriate \$7 billion in funding for fiscal years 2010 through 2015 and \$2 billion for each fiscal year after 2015. (Effective fiscal year 2010) • Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010)
Coverage of preventive services	<ul style="list-style-type: none"> • Eliminate cost-sharing for Medicare covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waive the Medicare deductible for colorectal cancer screening tests. Authorize the Secretary to modify or eliminate Medicare coverage of preventive services, based on recommendations of the U.S. Preventive Services Task Force. (Effective January 1, 2011)

Patient Protection and Affordable Care Act (P.L. 111-148)

PREVENTION/WELLNESS (continued)	
Coverage of preventive services (continued)	<ul style="list-style-type: none"> • Provide states that offer Medicaid coverage of and remove cost-sharing for preventive services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations with a one percentage point increase in the federal medical assistance percentage (FMAP) for these services. (Effective January 1, 2013) • Authorize Medicare coverage of personalized prevention plan services, including a comprehensive health risk assessment, annually. Require the Secretary to publish guidelines for the health risk assessment no later than March 23, 2011, and a health risk assessment model by no later than September 29, 2011. Reimburse providers 100% of the physician fee schedule amount with no adjustment for deductible or coinsurance for personalized prevention plan services when these services are provided in an outpatient setting. (Effective January 1, 2011) • Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective January 1, 2011 or when program criteria is developed, whichever is first) Require Medicaid coverage for tobacco cessation services for pregnant women. (Effective October 1, 2010) • Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective six months following enactment)
Wellness programs	<ul style="list-style-type: none"> • Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011) • Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment) • Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective January 1, 2014) Establish 10-state pilot programs by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment)
Nutritional information	<ul style="list-style-type: none"> • Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)
LONG-TERM CARE	
CLASS Act	<ul style="list-style-type: none"> • Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of \$50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective January 1, 2011)
Medicaid	<ul style="list-style-type: none"> • Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 (effective 30 days following enactment) and allocate \$10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014). • Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan. (Effective October 1, 2010) • Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. (Effective October 1, 2011) • Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term services and supports. (Effective October 1, 2011 through September 30, 2015)

LONG-TERM CARE (continued)	
Skilled nursing facility requirements	<ul style="list-style-type: none"> • Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities. (Effective dates vary)
OTHER INVESTMENTS	
Medicare	<ul style="list-style-type: none"> • Make improvements to the Medicare program: <ul style="list-style-type: none"> – Provide a \$250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 (Effective January 1, 2010); – Phase down gradually the beneficiary coinsurance rate in the Medicare Part D coverage gap from 100% to 25% by 2020: <ul style="list-style-type: none"> • For brand-name drugs, require pharmaceutical manufacturers to provide a 50% discount on prescriptions filled in the Medicare Part D coverage gap beginning in 2011, in addition to federal subsidies of 25% of the brand-name drug cost by 2020 (phased in beginning in 2013) • For generic drugs, provide federal subsidies of 75% of the generic drug cost by 2020 for prescriptions filled in the Medicare Part D coverage gap (phased in beginning in 2011); Between 2014 and 2019, reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage; – Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care (Effective no earlier than January 1, 2012); – Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result (Effective upon enactment); – Provide a 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015; and – Provide payments totaling \$400 million in fiscal years 2011 and 2012 to qualifying hospitals in counties with the lowest quartile Medicare spending; and – Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program. (Effective January 1, 2011)
Workforce	<ul style="list-style-type: none"> • Improve workforce training and development: <ul style="list-style-type: none"> – Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy. (Appointments made by September 30, 2010) – Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for payments for the expenses associated with operating primary care residency programs. (Funds appropriated for five years beginning fiscal year 2011) – Increase workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary) Support the development of interdisciplinary mental and behavioral health training programs (effective fiscal year 2010) and establish a training program for oral health professionals. (Funds appropriated for six years beginning in fiscal year 2010) – Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. (Initial appropriation in fiscal year 2010) Provide grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. (Funds appropriated for five years beginning in fiscal year 2011)

Patient Protection and Affordable Care Act (P.L. 111-148)

OTHER INVESTMENTS (continued)	
Workforce (continued)	<ul style="list-style-type: none"> – Support the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. (Funds appropriated for five years beginning in fiscal year 2010)
Community health centers and school-based health centers	<ul style="list-style-type: none"> • Improve access to care by increasing funding by \$11 billion for community health centers and by \$1.5 billion for National Health Service Corps over five years (effective fiscal year 2011); establishing new programs to support school-based health centers (effective fiscal year 2010) and nurse-managed health clinics (effective fiscal year 2010).
Trauma care	<ul style="list-style-type: none"> • Establish a new trauma center program to strengthen emergency department and trauma center capacity. Fund research on emergency medicine, including pediatric emergency medical research, and develop demonstration programs to design, implement, and evaluate innovative models for emergency care systems. (Funds appropriated beginning in fiscal year 2011)
Public health and disaster preparedness	<ul style="list-style-type: none"> • Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency. (Funds appropriated for five years beginning in fiscal year 2010)
Requirements for non-profit hospitals	<ul style="list-style-type: none"> • Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of \$50,000 per year for failure to meet these requirements. (Effective for taxable years following enactment)
American Indians	<ul style="list-style-type: none"> • Reauthorize and amend the Indian Health Care Improvement Act. (Effective upon enactment)
FINANCING	
Coverage and financing	<p>The Congressional Budget Office (CBO) estimates the new health reform law will provide coverage to an additional 32 million when fully implemented in 2019 through a combination of the newly created Exchanges and the Medicaid expansion.</p> <p>CBO estimates the cost of the coverage components of the new law to be \$938 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees, including an excise tax on high-cost insurance, which CBO estimates will raise \$32 billion over ten years. CBO also estimates that the health reform law will reduce the deficit by \$124 billion over ten years.</p>

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HEALTH REFORM IMPLEMENTATION TIMELINE

In March 2010, President Obama signed comprehensive health reform into law. The following timeline provides implementation dates for key provisions in the law.

2010
<p>Insurance Reforms</p> <ul style="list-style-type: none"> Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. (Effective 90 days following enactment until January 1, 2014) Provide dependent coverage for adult children up to age 26 for all individual and group policies. Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prior to 2014, plans may only impose annual limits on coverage as determined by the Secretary. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children. Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. Provide tax credits to small employers with no more than 25 employees and average annual wages of less than \$50,000 that provide health insurance for employees. Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until January 1, 2014) Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011) Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases.
<p>Medicare</p> <ul style="list-style-type: none"> Provide a \$250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and gradually eliminate the Medicare Part D coverage gap by 2020. Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result. Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office. Reduce annual market basket updates for inpatient and outpatient hospital services, long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and units. Ban new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31; limit the growth of certain grandfathered physician-owned hospitals.
<p>Medicaid</p> <ul style="list-style-type: none"> Create a state option to cover childless adults through a Medicaid state plan amendment. Create a state option to provide Medicaid coverage for family planning services up to the highest level of eligibility for pregnant women to certain low-income individuals through a Medicaid state plan amendment. Create a new option for states to provide Children's Health Insurance Program (CHIP) coverage to children of state employees eligible for health benefits if certain conditions are met. Increase the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans. Provide funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). Require the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP.
<p>Prescription Drugs</p> <ul style="list-style-type: none"> Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

2010 (continued)

Quality Improvement

- Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute.
- Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency.
- Reauthorize and amend the Indian Health Care Improvement Act.

Workforce

- Establish the Workforce Advisory Committee to develop a national workforce strategy.
- Increase workforce supply and support training of health professionals through scholarships and loans.

Tax Changes

- Impose additional requirements on non-profit hospitals. Impose a tax of \$50,000 per year for failure to meet these requirements.
- Limit the deductibility of executive and employee compensation to \$500,000 per applicable individual for health insurance providers.
- Impose a tax of 10% on the amount paid for indoor tanning services.
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit.
- Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance.

2011

Long-term Care

- Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Medical Malpractice

- Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

Prevention/Wellness

- Eliminate cost-sharing for Medicare covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waive the Medicare deductible for colorectal cancer screening tests. Authorize the Secretary to modify or eliminate Medicare coverage of preventive services based on recommendations of the U.S. Preventive Services Task Force.
- Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.
- Provide grants for up to five years to small employers that establish wellness programs.
- Establish the National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation's health.
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

Medicare

- Require pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.
- Provide a 10% Medicare bonus payment to primary care physicians, and to general surgeons practicing in health professional shortage areas. (Effective 2011 through 2015)
- Restructure payments to Medicare Advantage plans by setting payments to different percentages of Medicare fee-for-service rates.
- Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.
- Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012.
- Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels, and reduce the Medicare Part D premium subsidy for those with incomes above \$85,000/individual and \$170,000/couple.
- Create an Innovation Center within the Centers for Medicare and Medicaid Services.

Medicaid

- Prohibit federal payments to states for Medicaid services related to health care acquired conditions.
- Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for health home related services including care management, care coordination and health promotion.
- Create the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based longterm care services.
- Establish the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

2011 (continued)
Quality Improvement
<ul style="list-style-type: none"> • Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. • Establish a new trauma center program to strengthen emergency department and trauma center capacity. • Improve access to care by increasing funding by \$11 billion for community health centers and by \$1.5 billion for the National Health Service Corps over five years; establish new programs to support school-based health centers and nurse-managed health clinics.
Workforce
<ul style="list-style-type: none"> • Establish Teaching Health Centers to provide payments for primary care residency programs in community-based ambulatory patient care centers.
Tax Changes
<ul style="list-style-type: none"> • Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through a health reimbursement account or health flexible spending account and from being reimbursed on a tax-free basis through a health savings account or Archer Medical Savings Account. • Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the disbursed amount. • Impose new annual fees on the pharmaceutical manufacturing sector.
2012
Medicare
<ul style="list-style-type: none"> • Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care. • Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. • Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions. • Reduce annual market basket updates for home health agencies, skilled nursing facilities, hospices, and other Medicare providers. • Create the Medicare Independence at Home demonstration program. • Establish a hospital value-based purchasing program in Medicare and develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. • Provide bonus payments to high-quality Medicare Advantage plans. • Reduce rebates for Medicare Advantage plans.
Medicaid
<ul style="list-style-type: none"> • Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).
Quality Improvement
<ul style="list-style-type: none"> • Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.
2013
Insurance Reforms
<ul style="list-style-type: none"> • Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. (Appropriate \$6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013) • Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than \$1 per covered life. (Effective April 1, 2014)
Prevention/Wellness
<ul style="list-style-type: none"> • Provide states that offer Medicaid coverage of and remove cost-sharing for preventive services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations with a one percentage point increase in the federal medical assistance percentage (FMAP) for these services.

2013 (continued)

Medicare

- Begin phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (to 25% in 2020, in addition to the 50% manufacturer brand-name discount).
- Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.

Medicaid

- Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100% federal funding.

Quality Improvement

- Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

Tax Changes

- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.
- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly and impose a 3.8% assessment on unearned income for higher-income taxpayers.
- Limit the amount of contributions to a flexible spending account for medical expenses to \$2,500 per year increased annually by the cost of living adjustment.
- Impose an excise tax of 2.3% on the sale of any taxable medical device.
- Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

2014

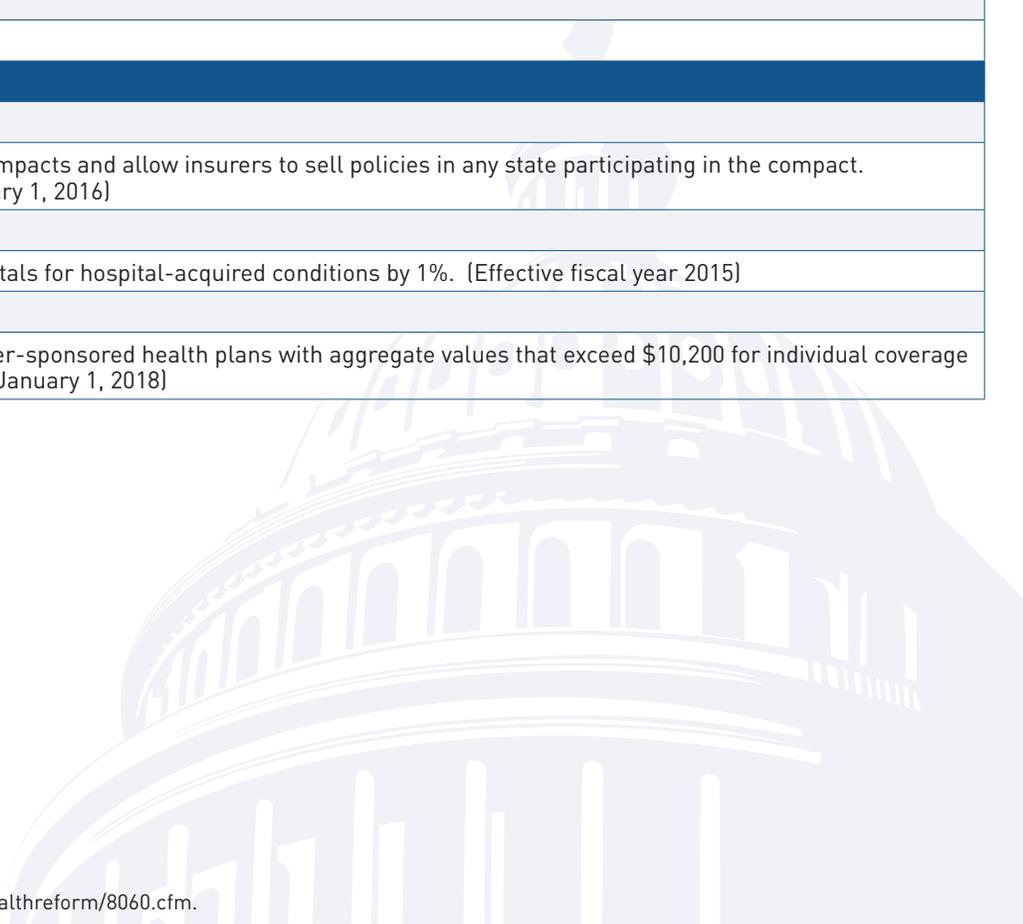
Individual and Employer Requirements

- Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).
- Assess employers with 50 or more employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with 50 or more employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee, excluding the first 30 employees from the assessment. Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

Insurance Reforms

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchanges.
- Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
 - o 100-200% FPL: one-third of the HSA limits (\$1,983/individual and \$3,967/family in 2010);
 - o 200-300% FPL: one-half of the HSA limits (\$2,975/individual and \$5,950/family in 2010);
 - o 300-400% FPL: two-thirds of the HSA limits (\$3,987/individual and \$7,973/family in 2010).
- Limit deductibles for health plans in the small group market to \$2,000 for individuals and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits.
- Limit any waiting periods for coverage to 90 days.
- Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan.
- Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.
- Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange.
- Allow states the option of merging the individual and small group markets.
- Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.
- Require qualified health plans to meet new operating standards and reporting requirements.

2014 (continued)
Premium Subsidies
<ul style="list-style-type: none"> • Provide refundable and advanceable premium credits and cost sharing subsidies to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges.
Medicare
<ul style="list-style-type: none"> • Reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (effective through 2019). • Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. • Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. • Require Medicare Advantage plans to have medical loss ratios no lower than 85%.
Medicaid
<ul style="list-style-type: none"> • Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI) and provide enhanced federal matching for new eligibles. • Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments. • Increase spending caps for the territories.
Prevention/Wellness
<ul style="list-style-type: none"> • Permit employers to offer employees rewards of up to 30%, increasing to 50% if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Establish 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.
Tax Changes
<ul style="list-style-type: none"> • Impose fees on the health insurance sector.
2015 and later
Insurance Reforms
<ul style="list-style-type: none"> • Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. (Compacts may not take effect before January 1, 2016)
Medicare
<ul style="list-style-type: none"> • Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)
Tax Changes
<ul style="list-style-type: none"> • Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage. (Effective January 1, 2018)



For additional information, see <http://www.kff.org/healthreform/8060.cfm>.

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Family Foundation is a nonpartisan, nonoperating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

COUNTY DELIVERY SYSTEMS

COUNTIES THAT OWN AND OPERATE HOSPITAL SYSTEMS (12)

Alameda	San Bernardino
Contra Costa	San Joaquin
Kern	San Francisco
Los Angeles	San Mateo
Monterey	Santa Clara
Riverside	Ventura

Note: All of these counties operate a Low Income Health Program (LIHP).

COUNTY MEDICAL SERVICES PROGRAM – The County Medical Services Program (CMSP) provides health coverage for low-income, indigent adults in 35, primarily rural California counties. The CMSP Governing Board, established by California law in 1995, is charged with overall program and fiscal responsibility for the program.

Alpine	Lake	Shasta
Amador	Lassen	Sierra
Butte	Madera	Siskiyou
Calaveras	Marin	Solano
Colusa	Mariposa	Sonoma
Del Norte	Mendocino	Sutter
El Dorado	Modoc	Tehama
Glenn	Mono	Trinity
Humboldt	Napa	Tuolumne
Imperial	Nevada	Yolo
Inyo	Plumas	Yuba
Kings	San Benito	

Note: CMSP operates one LIHP on behalf of these 35 counties.

NON-CMSP, NON-HOSPITAL COUNTIES (11)

Contract-only counties	Counties that operate a clinic(s)
Fresno	Placer*
Merced	Sacramento*
Orange*	Santa Barbara
San Diego*	Santa Cruz*
San Luis Obispo	Stanislaus
	Tulare*

**Operate or are planning to operate a LIHP.*

Understanding County Health Services in California: A Brief Overview

Introduction

Counties in California have been providing health services in California for almost 150 years. Since 1933, California law (Welfare and Institutions Code Section 17000) has required counties to provide relief to the poor, including health care services and general assistance. County residents receive these services, regardless of whether they live in the unincorporated area of the county or within city limits.

Summary of County Health Services¹

The county health department is also the cities' health department. With the exception of the cities of Berkeley, Long Beach, and Pasadena which operate separate health departments for residents, county health services cover residents in both the unincorporated and incorporated areas of the county – that is, within the county and city limits.

Administrative Structure

The county health system is usually an agency or department within the county and is administered by an Administrative Director who is appointed by either the County Administrative Officer and/or the Board of Supervisors. The Board of Supervisors also appoints a Public Health Officer, who is a physician, and who serves as the chief medical officer for the county on public health issues. The organizational structure and programs offered vary from county to county.

The discussion below summarizes the responsibilities and services provided by county health departments.

Alcohol-Drug — Assures necessary substance abuse services are available to the public through a network of public operated and private contracted providers. Services typically include inpatient and outpatient care, residential recovery, detoxification, information, education, prevention, and early intervention.

Detention Facilities — Assures that necessary medical, dental, psychiatric, and substance abuse services are provided to adult and juvenile persons incarcerated in county facilities.

¹ The information is adapted from information provided by the California State Association of Counties (www.counties.org).

Environmental Health — Provides all health related approvals and permits relating to land development (well water permits, septic permits, and land use permits), consumer protection (food facility inspections/permits, public pools, small water systems, solid waste, and food borne illness investigation), and hazardous materials [underground storage tanks, medical waste, Proposition 65 reporting (safe drink water enforcement), chemical spills, and incident response].

Emergency Medical Services (EMS) — If designated as the local Emergency Medical Services agency, responsibilities involve ambulance permitting and monitoring, Emergency Medical Technician certification, emergency medical dispatch approvals, and disaster planning.

Hospitals — Currently 13 counties operate hospitals. Most of these hospitals are full service teaching hospitals affiliated with university medical schools. Services vary slightly from hospital to hospital but generally include medical, surgical, emergency, trauma, outpatient, and a wide variety of specialty services. The following counties operate hospitals.

- Alameda
- Kern
- Modoc (until 2011)
- Riverside
- San Francisco
- San Mateo
- Ventura
- Contra Costa
- Los Angeles
- Monterey
- San Bernardino
- San Joaquin
- Santa Clara

Indigent Medical Care — Provides medical care to indigent persons, including Medically Indigent Adults, in a variety of ways including operating a county hospital and/or primary care clinics, or using a wide variety of contracts with providers of care to fulfill their responsibilities. Indigent persons are uninsured, low-income adults who have no other source of health care and are not categorically linked to other public health insurance programs.

Medically Indigent Adults (MIA) — Medically Indigent Adults are those individuals age 21-64 who do not qualify for Medi-Cal. Generally, childless adults are excluded from Medi-Cal. These individuals typically earn too little to purchase either health care or health insurance.

The twenty-four most populous counties administer their own programs for Medically Indigent Adults. Each county sets its own eligibility standards, services, and provider networks.

The other thirty-four counties, primarily rural counties, pool their resources to provide indigent health services; the County Medical Services Program (CMSP) administers this indigent health program.

Mental Health — Provides a wide range of psychiatric services to the public either directly or by contract with private providers. Services typically include acute inpatient care for persons who are a danger to themselves, others, or are gravely disabled, long-term care in facilities that treat mental disease, local crisis services, day treatment, and outpatient care.

Public Health — Services include prevention, early intervention, education, and treatment through a wide range of specific programs and services. These typically include:

- Adult health screening;
- HIV/AIDS testing and counseling;
- Communicable and infectious disease control;
- Immunizations; family planning;
- Children's services, including the Child Health and Disability Prevention program, physical exams, medical, nutrition, etc.;
- Sexually transmitted diseases;
- Home nursing visits; tuberculosis;
- Women, Infants and Children (WIC) nutritional services; and vital statistics registration involving birth/death certificates and burial permits.

Normally an onsite laboratory performs all public health related tests required by the nursing functions of the agency in addition to testing for rabies, water, food, Lyme disease, parasites, bacteria, and microorganisms.

Other Useful Resources for Understanding County Health Services

Several other resources offer information about how counties provide health services to Californians.

- **California State Association of Counties** (www.counties.org)

(See especially the “What Counties Do” section under the California’s Counties tab.) The California State Association of Counties’ website includes information about county health services and links to information about other county services.

- **The Crucial Role Counties Play in the Health of Californians**

“The Crucial Role Counties Play in the Health of Californians”² provides in depth information about the health and health-related services counties provide, including information about how the services are funded. It also discusses challenges faced by

² “The Crucial Role Counties Play in the Health of Californians” is authored by Deborah Reidy Kelch, M.P.P.A. for the California Health Care Foundation (www.chcf.org).

counties in providing these services. While the document was produced in 2004, it remains relevant.

Federal Health Care Reform and California Counties Residual Populations and County Responsibilities

“Residual Populations” and County Responsibilities What does it mean for us?

Srija Srinivasan
San Mateo County Health System

CSAC Institute
May 16, 2013



**The ACA = Major coverage expansion but
uninsured residents will remain**

“Residual Uninsured” = those whom
we expect to remain uninsured even
after the ACA’s coverage expansion
provisions are implemented

**The “residual uninsured” include those in-
eligible for Medi-Cal and the Exchange and
those who opt out of coverage**

- Residents who are undocumented are not eligible for new coverage
- Other residents may obtain exemptions from requirement to obtain coverage
 - Religious exemption
 - Native American
 - “Unaffordable”

Federal Health Care Reform and California Counties Residual Populations and County Responsibilities

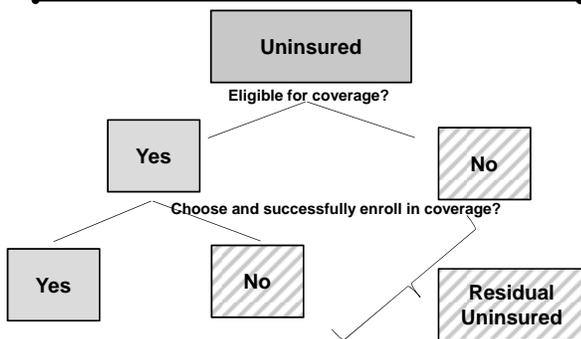
The “residual uninsured” also include those who do not successfully enroll in **Medi-Cal or the Exchange**

- Eligibility and enrollment processes require information and follow-through from clients
 - ACA rules encourage this to be much easier for consumers
 - Implementation of “easy” will be up to Exchange and County Social Services

The “residual uninsured” also include those who do not successfully enroll in **Medi-Cal or the Exchange**

- Exchange will have designated “open enrollment” period
 - Must enroll by 3/31/14 or wait until 1/1/15 unless you have “qualifying event”
 - “Qualifying events” ≈ current employer practices (marriage, divorce, birth of a child, loss of job...)

Counties still have responsibility for the uninsured



Federal Health Care Reform and California Counties

Residual Populations and County Responsibilities

Residents who remain uninsured will continue to rely on the healthcare safety net

- Community clinics, hospital emergency rooms, providers willing to extend charity care will be needed
- These providers expect reductions in funding – e.g., Disproportionate Share Hospital funding -- for care to the uninsured

Counties' responsibilities to the uninsured will continue

- Indigent care programs
- Eligibility and enrollment processes
- Safety net healthcare providers
- Safety net social services programs
- Public health protection and prevention

Counties must consider decisions amidst context of many unknowns

(example on next slide)

- Should we alter eligibility rules for local indigent care programs?
- What role can we play in “culture of coverage” and “no wrong door” aspirations?
- Can we sustain provider capacity to meet needs of residually uninsured?

Federal Health Care Reform and California Counties

Residual Populations and County Responsibilities

eg.) If low-income person does not enroll in Covered CA plan during open enrollment, Counties must determine how indigent care program will intersect

- Should they be eligible for indigent care program?
- How should cost of healthcare they need be supported – by providers, by consumer?
- What would encourage them to enroll next year?

Counties' approaches vary now and will continue to vary in the future

- Small, medium and large counties have different capacities and landscapes
- Provider vs. Payer vs. Hybrid roles lead to different future implications
- Counties have allocated health realignment \$ differently

Experiences in LIHP and other local coverage expansion efforts have illuminated some key operational issues

- Storage and sharing of information across different systems is difficult and expensive
- We have not reduced administrative costs while continuing to expect lower healthcare costs
- Many consumers are unable to navigate the complexity

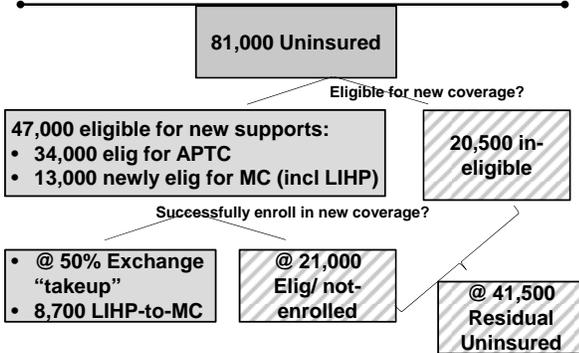
Federal Health Care Reform and California Counties

Residual Populations and County Responsibilities

For the data geeks among us, our epidemiologists can help us bound some of the #s...

- American Community Survey (census), at County level updated annually
- Can analyze uninsured by FPL groups:
 - 0-138% FPL
 - 138-200% FPL
 - 200-400% FPL
- Can estimate undocumented population based on DHS, operational data and other sources
- Can estimate “takeup” from actuarial analyses

For SM County, such data analysis helped us develop a picture of what we expect



Many large questions to be answered and learned over next few years and beyond

- What functions are counties best positioned to carry out and how?
 - Role of private healthcare providers
 - Role of public and private health plans
 - Role of community-based supports
- What capacity needs to be strengthened and how?
- How do our roles in health (public health and healthcare delivery), behavioral health, social services and criminal justice intersect and align?

Federal Health Care Reform and California Counties Role for County Public Health in Health Care Reform

Critical Role for County Public Health in the Era of Health Care Reform

CSAC Institute – May 16, 2013

William Mitchell, MPH, Director, Public Health Services
San Joaquin County



County Health Executives Association of California
CHEAC

The Public's Health

- The Centers for Disease Control and Prevention (CDC) estimate national medical costs associated with obesity to be as high as \$147 billion in 2008.
- CDC also estimates that nearly one-third of all US adults are obese (over 72 million) with 17% of US children considered obese as well.
 - In California, a 2010 CDC study found 24% of all adults to be obese.
- Finally, three behaviors (poor nutrition, lack of physical activity and tobacco use) contribute to four diseases (heart disease/stroke, cancer, diabetes and respiratory disease) that result in over more than 50% of all deaths nationally.

What county public health departments do

- Prevent Epidemics and the Spread of Disease
 - Disease surveillance, public health lab testing, immunizations, tuberculosis patient monitoring
- Plan for and Respond to Public Health Emergencies
 - Planning and training for health emergencies including pandemic influenza, bioterrorist attack, community disease outbreaks and natural disasters like earthquakes or floods
- Promote and Encourage Healthy Behaviors
 - Nutrition programs (WIC), Tobacco Education and Prevention programs, and local Maternal, Child and Adolescent Health programs
- Protect the Health of the Community
 - Food facility permitting and inspections, hazardous material release clean-up oversight and monitoring solid waste transfer and disposal facilities

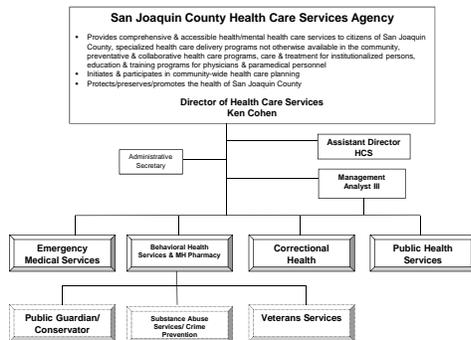
Federal Health Care Reform and California Counties

Role for County Public Health in Health Care Reform

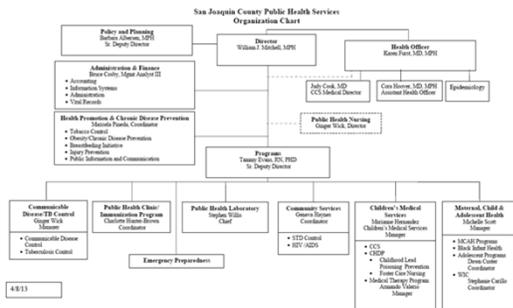
California's Public Health Mandates

- Counties have a broad mandate, under H&S §101025 to "take measures as may be necessary to preserve and protect the public health...of the county..."
- California Regulations require each local health department to offer "at least" the following basic services:
 - Data collection and analysis
 - Health Education Programs
 - Communicable Disease Control
 - Environmental Health
 - Laboratory Services
 - Services Promoting Maternal and Child Health
 - Nutrition Services
 - Chronic Disease Prevention Services
 - Public Health Nursing Services

What health agencies look like



What public health departments look like



Federal Health Care Reform and California Counties

Role for County Public Health in Health Care Reform

Federal Health Reform & Public Health

The Good News

- Creation of the Prevention & Public Health Fund
 - \$1 billion appropriated for federal FY 2012
 - Community Transformation Grants (\$226 million for FFY 2012)
 - CTG Grants in CA: Direct grants to San Francisco, San Diego, LA, Kern, Fresno, Stanislaus, Ventura, Sonoma, Santa Clara Counties; Public Health Institute Grant that provides direct funding for Calaveras, Humboldt, Imperial, Madera, Mendocino, Merced, Monterey, Shasta, Siskiyou, Solano, Tulare and Tuolumne
 - Epidemiology & Lab Capacity Grants (State level grants)
- National expansion of Maternal, Infant, and Early Childhood Home Visitation Programs
- Creation of a National Prevention Strategy
- Expansion of preventive health services coverage for group health plans

Federal Health Reform & Public Health

The Bad News

- Continued attacks on funding for the federal Prevention Fund given federal fiscal environment
- Grant programs are competitive, so only some communities benefit
- No guidance yet on how preventive services provided through private plans or through publicly funded programs will integrate with existing public health services

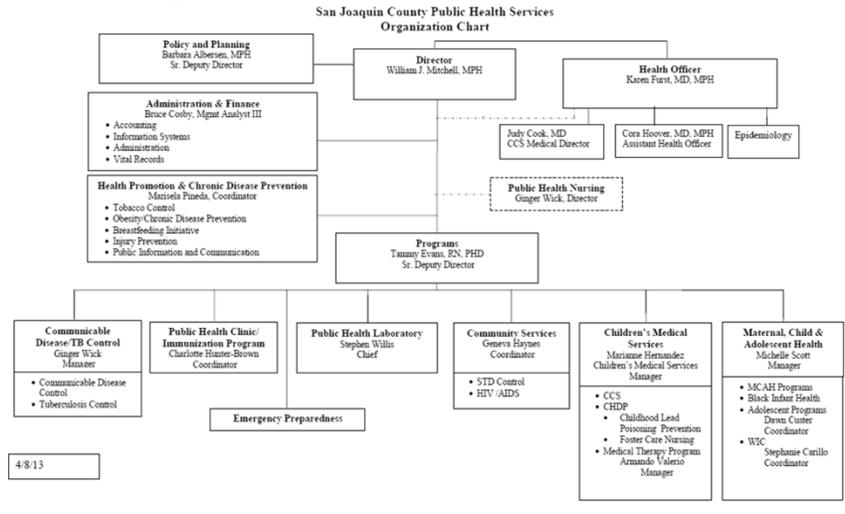
Health Department Funding

- Both indigent health care services and public health services are funded through a broad range of funding sources
 - Health Realignment
 - County General Funds
 - State & Federal Categorical Funds

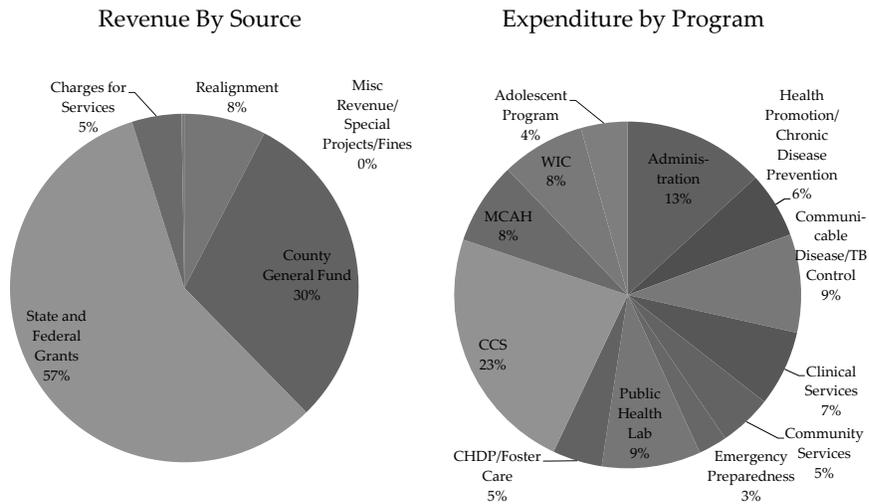
Federal Health Care Reform and California Counties

Role for County Public Health in Health Care Reform

What public health departments look like



San Joaquin Budget

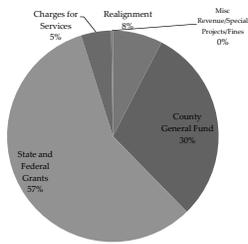


Federal Health Care Reform and California Counties

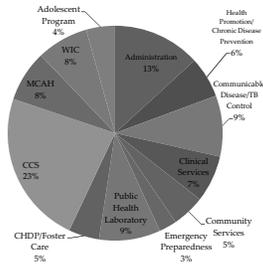
Role for County Public Health in Health Care Reform

San Joaquin Budget

Revenue By Source



Expenditure by Program



Declining Funding

- Most of these revenue sources have declined over the past few years.
 - 17% decline in Health Realignment funding between FY 07/08 and FY 10/11.
 - The FY 09/10 State Budget eliminated all state General Fund dollars for maternal & child health programs, local immunization programs and all but \$1 million in state funding for HIV/AIDS programs.
 - In Federal FY 2012, the Public Health Emergency Preparedness (PHEP) grant was reduced by 15%.

Continued need for county public health services

- Broad public health mandates on counties will remain
- Chronic disease on the rise (heart disease/stroke, cancer, diabetes and respiratory disease)
- Emerging infectious diseases remain a threat (eg: SARS, avian influenza, ebola, drug-resistant tuberculosis)

Federal Health Care Reform and California Counties

Role for County Public Health in Health Care Reform

Public Health:

A changing landscape

- With near universal health care coverage, what should be local public health's role?
 - Primary care providers?
 - Specialty care providers? (eg: HIV/AIDS, STDs, Immunizations)
 - What are appropriate funding levels for public health services as preventive services expand both through private coverage and publicly financed coverage?

The Critical Role for County* Public Health in the Era of Health Care Reform

The Affordable Care Act (ACA) is landmark legislation which promises to improve the health of every American. While most public attention is being paid to the critically important coverage expansions, the ACA also makes a commitment to prevention, as evidenced by the inclusion of a National Prevention Strategy establishing a national health agenda that states, *“Preventing disease and injuries is key to improving America’s health.”* As California implements the ACA, maintaining a robust local public health system is critical for meeting these health improvement goals.

What Does County Public Health Do?

Public Health saves lives and creates healthier communities. Never has a government function been more a victim of its own success. County health departments are on the front lines of this public health effort – you may not always see the work they do, but our communities are safer and healthier because of it.

When the United States Public Health Service first started collecting disease data from state health authorities in 1912, the most common diseases reported were diphtheria, measles, polio, scarlet fever, tuberculosis, typhoid and small pox. Among the top ten causes of death that same year in the United States were tuberculosis, diarrhea and enteritis, and premature birth. The reason these are largely consigned to the history books is because *public health works*.

For decades, the United States has set goals and objectives for health promotion and disease prevention. In the December 2010 launch of Healthy People 2020, U.S. Health and Human Services Secretary Kathleen Sebelius stated, *“Our challenge and opportunity is to avoid preventable diseases from occurring in the first place.”* Secretary Sebelius went on to note that *“Chronic disease, cancer and diabetes are responsible for seven out of every ten deaths among Americans each year and account for 75 percent of the nation’s health spending. Many of the risk factors that contribute to the development of these diseases are preventable.”*

Local public health departments work toward reducing these preventable diseases and making our communities healthier through many activities, including:

- Monitoring, investigating and containing communicable and food-borne disease outbreaks;
- Planning for and responding to local disasters, such as pandemic influenza, fires, earthquakes and floods;
- Ensuring our water supplies are safe;
- Enforcing local and state health and safety codes;
- Educating the public about emerging health risks and prevention measures;
- Tracking the health status of our communities in order to develop community based responses.

By statute, code and policy, California’s local governments are required to assure the population’s health. Every Californian is touched by these critical local public health services every day.

** The cities of Berkeley, Long Beach and Pasadena also provide these essential public health services.*

California Mandates for Local Public Health

Under Health and Safety Code Section 101025, counties have a broad mandate to “...take measures as may be necessary to preserve and protect the public health...of the county...” Furthermore, the California Code of Regulations Title 17, Chapter 3, Local Health Services, requires that each local health department “*shall offer at least the following basic services to the health jurisdiction it serves*”:

- Data Collection and Analysis
- Health Education Programs
- Communicable Disease Control
- Environmental Health
- Laboratory Services
- Services Promoting Maternal and Child Health
- Nutrition Services
- Chronic Disease Prevention Services
- Public Health Nursing Services

Counties are also required to respond to emergencies and disasters, including floods, fires and earthquakes with local public health staff as an integral part of the local government response to these life-threatening events.

Moreover, local public health departments provide varied additional services and their staff engage in a broad array of activities addressing the local needs of their communities.

Funding

Counties provide these services through a broad range of funding sources, including Health Realignment, county general funds, and state and federal categorical program funding. Most of these funding sources have been declining in recent years, and as a result, staffing levels in local public health departments have also declined. Findings from a recent survey conducted by the County Health Executives Association of California (CHEAC) found that between FY 07/08 and FY 10/11 local public health departments lost, on average, 17% of their full-time equivalent employees. Some public health departments saw staff reductions as high as 30% to 40%. That same time period saw a 17% decline in Health Realignment funding for local public health services, largely due to declines in new car sales and the sales tax.

On the state level, the FY 09/10 budget eliminated all state General Fund dollars for maternal and child health and local immunization programs and all but \$1 million in state funding for HIV/AIDS programs. The children’s dental disease program was also eliminated that year. Public health departments are increasingly dependent on federal public health funding, which is also under constant threat of cuts. The Public Health Emergency Preparedness (PHEP) grant, which is core funding for local public health emergency preparedness, was reduced by 15% last year.

It is within this constrained fiscal environment that local public health departments must continue to develop strategies to provide core public health services as well as meet new challenges in preventing chronic disease.

The Continued Need for County* Public Health Services

The ACA’s health coverage expansions will not replace the need for local public health services. To the contrary, local public health departments are key partners in assuring that California meets the broad health improvement goals of the ACA. Maintaining current funding for local public health services is essential for meeting the mandated responsibilities of local health departments and keeping our communities healthy.

The Critical Role for County* Public Health in the Era of Health Care Reform

What County* Public Health Departments do for You!

Prevent Epidemics and the Spread of Disease

A core function of county public health departments is to quickly identify and prevent the spread of communicable and food-borne illnesses. Local health department strategies to prevent and control diseases include the provision of clinical services, health promotion and education, and surveillance and containment.

- Epidemiologists identify and investigate outbreaks of communicable disease in their communities, including influenza, tuberculosis (TB), meningitis and sexually transmitted diseases (STDs) and food-borne illnesses to contain the spread of disease. Public health officers receive and evaluate reports from health providers and laboratories on more than 80 statutorily reportable diseases, and report the information to the California Department of Public Health (CDPH).
- County public health laboratories perform diagnostic testing to aid in communicable disease surveillance and control efforts. In addition, public health labs provide environmental testing services, such as identification of food borne illnesses and water quality to support county health department response to E. coli or salmonella outbreaks in restaurants and keep drinking and beach water safe. These essential lab services are not provided by private clinical labs.
- Public health nurses and immunization staff work closely with schools to ensure that children have the necessary immunizations to prevent illness – the recent pertussis (whooping cough) outbreak demonstrated the continued need for vigilance to improve immunization rates.
- County public health department staff take other measures as necessary to stop the spread of communicable diseases. This may involve partner tracking and education for STDs and public health nurse visits to TB patients to ensure they are taking their medications.

Plan for and Respond to Public Health Emergencies

When a disaster, disease, outbreak or other health emergency strikes, the county public health department plays a lead role in protecting the health of the community.

- California's county public health departments plan and train on a regular basis in order to be prepared to respond to all types of health emergencies, including pandemic influenza or bioterrorist attack, community outbreaks of meningitis or pertussis and natural disasters such as a wildfires, earthquakes or floods.
- During threats of pandemics, such as the recent H1N1 influenza outbreak, local health departments lead crucial public information/education campaigns in their communities, increase lab capacity to test a large influx of specimens submitted by community hospitals and providers, and stage large scale vaccination clinics with a focus on the most vulnerable populations in their communities.
- During natural disasters such as wildfires, public health staff perform essential functions in both response and recovery phases including educating the public about how to protect themselves, planning safe evacuations, operating shelter facilities and ensuring vital medical care for displaced medically fragile residents.

Promote and Encourage Healthy Behaviors

Public health sounded the alarm on the obesity epidemic years ago. The Centers for Disease Control and Prevention (CDC) estimates that national medical costs associated with obesity are as high as \$147 billion. A 2010 CDC study of state obesity rates found that in California 24% of adults are obese. Today three behaviors (poor nutrition, lack of physical activity and tobacco use) contribute to four diseases (heart disease/stroke, cancer, diabetes and respiratory disease) which result in more than 50% of deaths nationally.

- Local health departments administer nutrition programs, including WIC (Special Supplemental Nutrition Program for Women, Infants and Children), which provides direct client services, and the Nutrition Network, which focuses on community strategies to encourage healthy eating and physical activity.
- Public health departments are local lead agencies in tobacco education and prevention programs. Working in concert with the CDPH state level activities, local health departments have played a major role in the reduction of tobacco use in California.
- Local Maternal and Child and Adolescent Health (MCAH) programs provide services to at-risk pregnant women and new mothers connecting this population to services to improve health outcomes for their children. Public health nurses make home visits to at-risk new mothers and their babies to ensure that new families get the best possible start.
- Injury prevention programs, such as the buckle-up program, instruct parents on how to properly install car safety seats for their children. County public health promotion staff also work with community organizations and senior groups to offer exercise classes to increase seniors' flexibility and stability to prevent falls, a leading cause of serious injury for older adults.

Protect the Health of the Community

Routine inspections by county environmental health inspectors help to protect restaurant diners from food poisoning, swimmers from disease and provide a safe environment for all residents. Local environmental health staff:

- Inspect and permit restaurant and food establishments, multiple housing units, hazardous materials storage facilities, wells, septic tanks and community swimming pools.
- Oversee the clean-up of groundwater and property from hazardous material releases.
- Monitor solid waste transfer and disposal facilities. Monitor conditions at creeks, lakes and lagoons and beaches to be sure they are safe for recreational use.

**The cities of Berkeley, Long Beach and Pasadena also provide these essential public health services.*

*County Health Executives Association of California
December 2012*

CalSIM

California Simulation of Insurance Markets

The California Simulation of Insurance Markets (CalSIM) model is designed to estimate the impacts of various elements of the Affordable Care Act on employer decisions to offer insurance coverage and individual decisions to obtain coverage in California. It was developed by the UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research, with generous funding provided by The California Endowment.

After Millions of Californians Gain Health Coverage under the Affordable Care Act, who will Remain Uninsured?



Laurel Lucia, Ken Jacobs, Miranda Dietz, Dave Graham-Squire, Nadereh Pourat, and Dylan H. Roby

**UC Berkeley Center for Labor Research and Education
UCLA Center for Health Policy Research**

September 2012

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Contents

Executive Summary	4
Introduction	6
Findings	7
Many Californians will gain coverage under ACA due to expanded eligibility	7
Many Californians eligible for coverage could remain unenrolled	8
Majority of remaining uninsured Californians predicted to be exempt from tax penalties	9
Many remaining uninsured Californians predicted to lack an affordable coverage offer	9
Majority of remaining uninsured Californians predicted to be Latino or Limited English Proficient . . .	10
Six out of ten remaining uninsured predicted to reside in Southern California	11
Most remaining uninsured Californians will be low-income	13
Other characteristics of remaining uninsured Californians	13
Appreciable share of remaining uninsured Californians will lack coverage for short time periods. . . .	15
Recommendations	15
Outreach and enrollment efforts needed to minimize the number of remaining uninsured	15
California will still have a great need for a strong safety net system post-ACA	17
Programs needed for Californians left with no affordable coverage option	17
Conclusions	18
Appendix 1: Additional Exhibits	19
Appendix 2: Methodology	22
Endnotes	23

EXECUTIVE SUMMARY

The implementation of the Affordable Care Act (ACA) is predicted to expand coverage to millions of Californians by 2019. This increase in coverage will primarily result from the expansion of Medi-Cal and the availability of subsidized coverage in the California Health Benefit Exchange (Exchange). However, three to four million Californians could remain uninsured even after the law is fully implemented.

We use the California Simulation of Insurance Markets (CalSIM) model, version 1.8, to estimate the size and characteristics of the remaining uninsured under age 65 in California under two scenarios. In a base scenario we assume that take up of Medi-Cal follows current trends and that take up in the Exchange reflects typical individual behavior patterns from the health economics literature. In our enhanced scenario, we assume that eligibility determination will be simplified, outreach and enrollment efforts will be escalated in a culturally sensitive and language appropriate manner, and that the majority of individuals currently enrolled in existing categorical public programs that provide services but not full coverage will transition to Medi-Cal and the Exchange.

We predict that by 2019 when the ACA is fully implemented:

Health coverage will significantly expand in California

- The number of uninsured Californians under age 65 will decrease by between 1.8 and 2.7 million.
- Of the uninsured Californians who are predicted to gain coverage as a result of the ACA, between 640,000 and 1.0 million will newly enroll in Medi-Cal and between 790,000 and 1.2 million will enroll in subsidized coverage in the Exchange.

Many Californians will remain uninsured

- 3.1 to 4 million Californians are predicted to remain uninsured in 2019.
- Almost three-quarters of the remaining uninsured in California will be U.S. citizens or lawfully present immigrants.
- Half of all remaining uninsured, or two million Californians, will be eligible for Medi-Cal or Exchange subsidies but remain unenrolled under the base scenario. Barriers to enrollment could include lack of awareness about the programs, challenges in the enrollment process, or inability to afford subsidized coverage. With stronger outreach and enrollment efforts, this group of uninsured would be reduced to 1.2 million or fewer.
- 72 percent of remaining uninsured Californians will be exempt from paying tax penalties under the minimum coverage requirements of the ACA due to income, lack of an affordable offer of coverage or immigration status. Approximately three percent of all Californians will owe a tax penalty due to not obtaining minimum coverage.
- Nearly 40 percent of the remaining uninsured will lack an offer of affordable coverage with premiums costing eight percent of household income or less. Some uninsured Californians will be ineligible for subsidized coverage due to income or immigration status, while others will be eligible for subsidized plans in the Exchange with premiums that exceed the affordability standard.
- Some of the remaining uninsured will lack coverage for short time periods due to life transitions.

Some demographic groups will be more likely to remain uninsured

- Two-thirds (66%) of Californians remaining uninsured will be Latino, compared to a projected 45 percent of the non-elderly population in 2020.
- Nearly three out of five California adults who remain uninsured will be Limited English Proficient.
- 62 percent of California's remaining uninsured will be residents of Los Angeles and other Southern California counties.
- 57 percent of Californians who remain uninsured will have household incomes at or below 200 percent of the Federal Poverty Level.

Recommendations

Outreach and enrollment efforts are needed to minimize the number of remaining uninsured

Outreach and enrollment efforts should be customized to reflect the groups of Californians with the highest rates of uninsurance: Latinos, Limited English Proficient adults, and residents of Southern California. We predict that nearly 800,000 more Californians would enroll in Medi-Cal or Exchange subsidies if there were robust outreach and enrollment efforts, based on the enhanced scenario. Outreach efforts are also needed to reduce the number of Californians who are uninsured for a short period of time when they lose a job or undergo another life transition, such as divorce or aging out of a parent's coverage. In addition, Californians who already participate in categorical public programs that provide services but not full coverage should be pre-enrolled in Medi-Cal or the Exchange.

California will still have a great need for a strong safety net system post-ACA

A strong safety net of health care providers will still be needed to provide care for the predicted 2.3 million uninsured Californians with household incomes at or below 200 percent of the Federal Poverty Level.

Programs needed for Californians left with no affordable coverage option

In addition to securing the health care safety net, California should maintain and expand programs for individuals without an offer of affordable coverage. Existing programs for the uninsured, such as Family PACT for family planning services, should be sustained and new programs should be explored.

INTRODUCTION

The Affordable Care Act (ACA) will greatly expand health insurance coverage in California. Beginning in 2014, millions of low- and middle-income Californians will gain access to coverage under the expansion of Medi-Cal and through premium and cost sharing subsidies offered through the California Health Benefit Exchange (the Exchange). The ACA requirement that individuals maintain minimum coverage or pay a tax penalty will also increase enrollment. As a result of these coverage expansions, between 1.8 and 2.7 million Californians are predicted to gain coverage by 2019, depending on the extensiveness of outreach and enrollment strategies. However, between 3.1 and 4.0 million Californians are predicted to remain uninsured.

In this report, we use the California Simulation of Insurance Markets (CalSIM) model, version 1.8, to characterize the demographics, geographic distribution, eligibility for coverage and applicability of the minimum coverage requirements of Californians who are predicted to remain uninsured after full implementation of the ACA in 2019. This report focuses on Californians under age 65.

We analyzed the number of remaining uninsured under two scenarios. The base scenario estimates take up of coverage in the Exchange using the best evidence on individual decision-making from the health economics literature. We assume that Medi-Cal take up for newly eligible uninsured individuals will continue at the current take up rate of 61

percent,¹ while previously eligible individuals will take up at a 10 percent rate. These take up rates are applied to all Californians under the base scenario, except that Limited English Proficient (LEP) Californians, defined as those speaking English less than very well, are assumed to be less likely to enroll based on available evidence.²

In developing the enhanced scenario, we assume that eligibility determination is simplified, strong outreach and education is conducted, ‘no wrong door’ enrollment is implemented, outreach and enrollment are culturally sensitive and language appropriate, and the use of pre-enrollment strategies is maximized. This scenario assumes 75 percent take up of Medi-Cal for newly eligible individuals who were previously uninsured. It assumes 40 percent Medi-Cal take up for previously eligible but uninsured Californians, following the Urban Institute/Kaiser Family Foundation enhanced participation estimate.³ It also assumes 75 percent take up of uninsured adults eligible for subsidies in the Exchange.

The take-up rates we assume under the enhanced scenario are not an upper limit. While there will always be some eligible individuals who do not enroll in any program, including those who are eligible transitionally for only short periods of time, evidence from other states and other programs suggests that California could do even better than 75 percent take-up among those newly eligible for Medicaid and uninsured who are eligible

Eligibility for Medi-Cal and Exchange Subsidies under the ACA

In 2014, Medi-Cal will be expanded to eligible Californians with household incomes up to 138 percent of the Federal Poverty Level (\$15,415 for an individual and \$31,809 for a family of four in 2012), including childless adults who will be eligible for Medi-Cal for the first time based solely on income. Eligible families with incomes up to 400 percent of the Federal Poverty Level (\$44,680 for an individual and \$92,200 for a family of four in 2012) who do not have an offer of affordable job-based coverage and are not eligible for Medi-Cal or Medicare or other public coverage, will become eligible for premium tax credits and cost sharing subsidies for coverage purchased through the Exchange.

for subsidized coverage in the Exchange. Medicaid take-up rates for currently eligible adults are already as high as 80 percent in Massachusetts and 88 percent in Washington DC.⁴ In California, 85 percent of non-elderly adults who are offered job-based coverage enroll.⁵ Take up of Medicare Part B is around 96 percent nationally.⁶

This report primarily focuses on the Californians who are predicted to remain uninsured under the base scenario as this is the more conservative set of estimates. As noted, the base scenario assumes Medi-Cal take-up rates at the current level for

California of 61 percent. The eligibility and enrollment simplifications required under federal regulations implementing the ACA, coupled with the plans the state and the Exchange have already developed for outreach and enrollment, should enable California to surpass those rates. In order to show the potential impact of more robust outreach and enrollment efforts, the number of remaining uninsured under the enhanced scenario is shown in Exhibit 2, and eligibility for coverage and characteristics of the uninsured under that scenario are shown in Exhibits 11b and 12 in the Appendix.

FINDINGS

Many Californians will gain coverage under ACA due to expanded eligibility

Exhibit 1 shows the coverage gains that are predicted under the ACA in 2019 for Californians who would have otherwise been uninsured. Of the 5.8 million Californians who would be uninsured in 2019 without the ACA, 880,000 are predicted to be newly eligible for Medi-Cal, 880,000 are predicted to already be eligible for Medi-Cal and 1.6 million are predicted to be eligible for subsidized coverage in the Exchange. Of these, 640,000 to 1.0 million are predicted to newly enroll in Medi-Cal and 790,000 to 1.2 million are predicted to enroll in the Exchange with subsidies.

Additional Californians who are currently enrolled in the individual market or unaffordable job-based plans are also predicted to newly enroll in more affordable coverage options, for a predicted total of 1.0 to 1.4 million Californians newly enrolled in Medi-Cal and 1.7 to 2.1 million enrolled in subsidized coverage in the Exchange in 2019 (data not shown).

The number of uninsured Californians falls to 4.0 million under the ACA base scenario and is nearly one million lower (3.1 million) under the enhanced scenario, demonstrating the importance of outreach and enrollment efforts (Exhibit 2, page 8).

Exhibit 1. Insurance coverage with the ACA for the 5.8 million Californians under age 65 who would be uninsured without the ACA, 2019

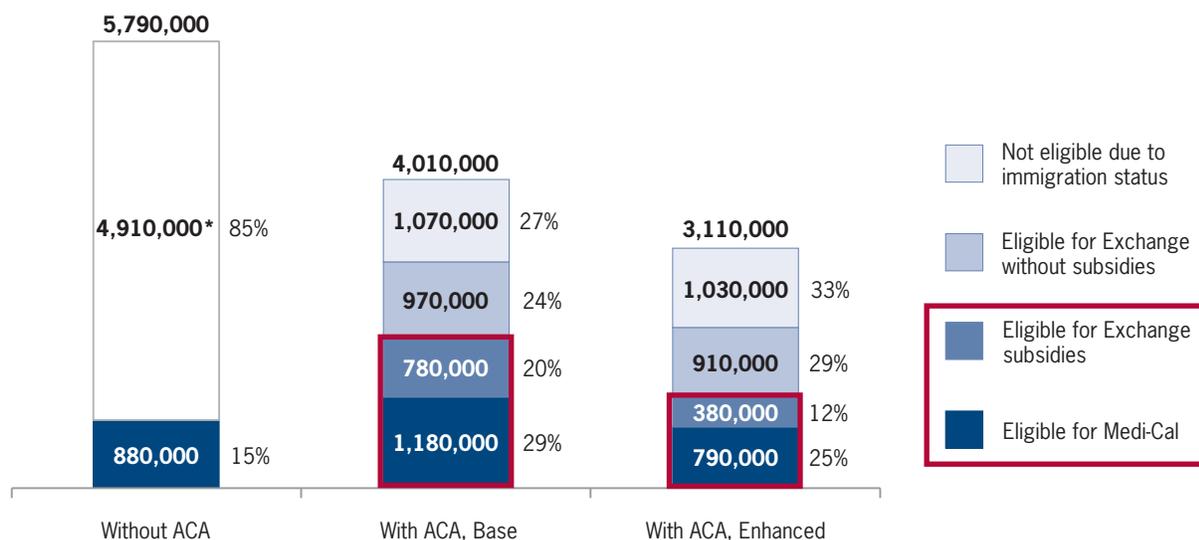
Insurance coverage with the ACA	Employer-sponsored insurance	Newly eligible for Medi-Cal	Previously eligible for Medi-Cal	Exchange with subsidies	Unsubsidized Exchange/individual market
Eligible*	850,000	880,000	880,000	1,590,000	NA**
Enrollment, base scenario	220,000	550,000	90,000	790,000	510,000
Enrollment, enhanced scenario	220,000	670,000	350,000	1,210,000	580,000

Source: UC Berkeley–UCLA CalSIM model, Version 1.8

* Individuals may be eligible for more than one type of coverage.

** All individuals are eligible to purchase insurance in the individual market.

Exhibit 2. Uninsured Californians under age 65, with and without the ACA, 2019



Source: UC Berkeley–UCLA CalSIM model, Version 1.8
 * Not eligible for Medi-Cal or subsidies without ACA.

As a result of these coverage expansions, between 89 and 91 percent of non-elderly Californians are predicted to have health coverage under the ACA, compared to 84 percent without the law.⁷

Many Californians eligible for coverage could remain unenrolled

Under the base scenario, 2.0 million Californians, or half of all remaining uninsured, are predicted to be eligible for Medi-Cal⁸ or Exchange subsidies but remain unenrolled. With greater outreach and retention efforts under the enhanced scenario, the number of uninsured who are eligible for no-cost coverage or subsidized drops to 1.2 million.

Almost three-quarters of the remaining uninsured are predicted to be lawfully present residents (Exhibit 2).

Eligibility for coverage of the remaining uninsured is shown by income,⁹ age, self-reported health status, race and ethnicity, English proficiency, family structure and region in Exhibits 6 and Exhibits 11a and 11b in the Appendix.

Current barriers to enrollment in Medicaid and the State Children’s Health Insurance Program nationally include lack of awareness of the programs or eligibility standards, difficult application or re-enrollment processes, burdensome documentation requirements, and stigma associated with enrolling in the programs. The ACA addresses some barriers to enrollment by simplifying enrollment and re-enrollment processes, increasing the use of existing government data sources to determine eligibility and encouraging the creation of ‘no wrong door’ for enrollment. Other barriers could cause Californians who are eligible for Exchange subsidies to remain uninsured, some of which depend on decisions made by the Exchange. For example, Californians may be unaware of their options in the Exchange, may encounter challenges in the application process or may be unable to afford subsidized coverage.

Californians eligible for Medi-Cal are able to enroll in coverage when they show up for care at a safety net hospital or clinic or another provider. Medi-Cal may retroactively cover medical expenses incurred over the previous 90 days. However, it is important

for eligible individuals to sign up in advance of needing care because individuals who enroll in Medi-Cal will choose or be assigned to a medical home and may be more likely to seek preventive or primary care. Research on the Oregon Medicaid program for previously uninsured low-income adults found that, compared to similar adults who were not selected by lottery to apply for Medicaid, “people with Medicaid coverage were 70% more likely to report having a regular place of care and 55% more likely to report having a usual doctor; Medicaid coverage also increased the use of preventive care such as mammograms (by 60%) and cholesterol monitoring (by 20%).”¹⁰

Californians eligible for subsidies in the Exchange will apply during the annual open enrollment period.¹¹ When an individual loses minimum essential coverage, gains or becomes a dependent through marriage, birth or adoption, gains lawful immigration status, or experiences other triggering events outlined in regulations, he or she will qualify for a special enrollment period at the time of the change in circumstances. Individuals will not be able to enroll in Exchange coverage outside of these enrollment periods, making it important that Exchange-eligible individuals are aware of their coverage options and the process for enrolling because they cannot wait until they need care to enroll.

Majority of remaining uninsured Californians predicted to be exempt from tax penalties

Under the ACA, individuals who do not have minimum essential coverage will be required to pay a tax penalty beginning in 2014. The penalty will be waived if the cost of available coverage exceeds eight percent of household income, if an individual’s income is below the federal tax-filing threshold, if an individual is ineligible for coverage due to immigration status or if an individual meets other criteria for exemption described in the ACA. Approximately 1.1 million Californians, 28 percent of the remaining uninsured or 3 percent of all Californians, are predicted to owe a tax penalty in 2019 due to not having minimum essential coverage.¹²

In total, 72 percent of the remaining uninsured in California, or nearly 2.9 million, are predicted to be exempt from the penalties in 2019 (Exhibit 3).

Exhibit 3. Individual penalty and exemptions for remaining uninsured, Californians under age 65, base scenario, 2019

Eligibility for benefits	Exempt from penalty	Subject to penalty	Total
Exempt due to immigration status	1,070,000		
Exempt due to low income	990,000		
Exempt due to no affordable coverage	820,000		
Total	2,880,000	1,130,000	4,010,000
Percentage	72%	28%	100%

Source: UC Berkeley–UCLA CalSIM model, Version 1.8

Many remaining uninsured Californians predicted to lack an affordable coverage offer

More than 1.5 million uninsured Californians, or nearly 40 percent of the remaining uninsured, are predicted to lack an offer of affordable coverage (Exhibit 4), defined under the minimum coverage requirements of the ACA as costing a family eight percent of income or less. These Californians are predicted to lack an offer of affordable coverage after implementation of the ACA for several reasons.

First, undocumented immigrants are ineligible for Medi-Cal or coverage in the Exchange.

Second, families with incomes between 250 and 400 percent of the Federal Poverty Level are eligible for subsidized coverage in the Exchange, but premiums will be capped at 8.05-9.5 percent of household income, exceeding the standard of affordability under the minimum coverage requirement. Families with incomes of more than 400 percent of the Federal Poverty Level will not be eligible for subsidies in the Exchange. Eligible

Exhibit 4. Availability of affordable coverage to remaining uninsured by income (federal poverty level), Californians under age 65, base scenario, 2019

Availability of affordable coverage (<8% income)	0-138% FPL	139-200% FPL	201-250% FPL	251-400% FPL	401% + FPL	Total
Has an offer of affordable coverage	1,230,000	470,000	300,000	210,000	250,000	2,460,000
No offer of affordable coverage	500,000	100,000	70,000	370,000	520,000	1,550,000
Total	1,720,000	570,000	370,000	580,000	770,000	4,010,000
Percentage with no offer of affordable coverage	29%	18%	19%	64%	67%	39%

Source: UC Berkeley-UCLA CalSIM model, Version 1.8

individuals below 250 percent of the Federal Poverty Level are offered Medi-Cal or Exchange coverage with premiums costing less than eight percent of income, which largely explains why these uninsured individuals are much more likely to have an offer of affordable coverage (75% of uninsured) than those with income above 250 percent of the Federal Poverty Level (34% of uninsured) (Exhibit 4).

The majority of Californians above 400 percent of the Federal Poverty Level who are predicted to remain uninsured with no offer of affordable coverage are ages 45 to 64. In the individual market, older individuals will be charged higher premiums than their younger counterparts, though the age-based variation in premiums will be reduced under the ACA compared to the current California individual market.

Finally, under draft federal regulations, some Californians with incomes below 400 percent of the Federal Poverty Level will lack an offer of affordable coverage because family members will be ineligible for subsidized coverage in the Exchange if an employee is offered affordable self-only coverage by an employer, even if family coverage is unaffordable.¹³ The CalSIM model and all of the estimates in this report are based on the assumption that these regulations are finalized as proposed.

Majority of remaining uninsured Californians predicted to be Latino or Limited English Proficient

According to the Kaiser Family Foundation, people of color are more likely to lack health coverage because they “are more likely to be low-income than whites, and less likely to have health coverage through an employer, in part because they are more likely to be unemployed, and when employed, they are more likely to work low-wage jobs, which are less likely to offer coverage.”¹⁴ Racial and ethnic minority groups are predicted to comprise 66 percent of non-elderly Californians in 2020¹⁵ and 82 percent of the remaining uninsured under the ACA in 2019. The rate of decline in uninsurance under the ACA is predicted to be greatest among African Americans and Whites and lowest among Latinos and Asians, but the overall distribution of uninsured across race and ethnicity groups is not expected to change significantly under the ACA (Exhibit 5, page 11).

Latinos are predicted to represent an especially large share of the remaining uninsured: two-thirds (66%) in 2019 (Exhibit 5). By comparison, Latinos are predicted to comprise approximately 45 percent of non-elderly Californians in 2020.¹⁶

Speaking a language other than English has been shown to result in barriers to coverage. A national survey found that lack of language-appropriate materials hindered Medicaid enrollment among Spanish-speaking parents.¹⁷ Eligible Limited English Proficient (LEP) Californians are projected to

Exhibit 5. Race and ethnicity and English proficiency of the uninsured with and without the ACA, Californians under age 65, 2019

	Without ACA		With ACA, base		Percentage change
Total	5,790,000		4,010,000		-31%
Race and Ethnicity					
Latino	3,710,000	64%	2,660,000	66%	-28%
Asian, not Latino	620,000	11%	450,000	11%	-27%
African American, not Latino	210,000	4%	110,000	3%	-48%
White, not Latino	1,160,000	20%	730,000	18%	-37%
Other, multi-racial, not Latino	100,000	2%	60,000	1%	-40%
English Proficiency					
Age 18+, Speaks English at least very well	2,500,000	43%	1,400,000	35%	-44%
Age 18+, Limited English proficiency	2,730,000	47%	2,040,000	51%	-25%

Source: UC Berkeley–UCLA CalSIM model, Version 1.8

be less likely to enroll in coverage than non-LEP Californians in the base scenario, based on available evidence. Therefore, the decline in uninsurance is predicted to be greater among Californians who speak English at least very well (44%) than among LEP Californians (25%). While the overall number of uninsured LEP and non-LEP Californian adults will decrease significantly, the share of uninsured who are LEP will increase under the ACA. Nearly three out of five adults who are predicted to remain uninsured are LEP, while the remainder of the uninsured adult population will consist of native English speakers or adults who speak English very well (Exhibit 5). An additional 570,000 uninsured Californians are predicted to be children with all levels of English proficiency (data not shown).

Spanish is the most common language (other than English) spoken at home by LEP Californians who are projected to enroll in the Exchange in 2019 (80%); other common languages spoken are Chinese, Vietnamese and Korean.¹⁸

California already has experience with language-appropriate outreach and enrollment in its Medi-Cal and Healthy Families programs that it can draw upon in implementing the ACA. The Medi-Cal program currently provides notices and information

in 13 threshold languages: English, Spanish, Vietnamese, Chinese, Korean, Tagalog, Russian, Armenian, Khmer, Arabic, Farsi, Hmong and Laos.

The vast majority of uninsured who are not eligible for coverage due to immigration status are predicted to be Latino (95%) and LEP (80% of adults). However, we also predict that a majority of uninsured Californians who are eligible for no-cost or subsidized coverage but remain unenrolled will be Latino (64%) and LEP (54% of adults) (Exhibit 6, page 12).

Six out of ten remaining uninsured predicted to reside in Southern California

Residents of Los Angeles and other Southern California counties (Orange, San Diego, San Bernardino, Riverside and Imperial) are predicted to make up 55 percent of California’s population in 2019, but a disproportionate 62 percent of the remaining uninsured due to a higher predicted rate of uninsurance. Thirteen percent of Los Angeles County residents and 12 percent of residents of other Southern California counties are predicted to remain uninsured while in the rest of California we predict that an average of 9 percent of the population will remain uninsured (Exhibit 7, page 12).

Exhibit 6. Eligibility for benefits of remaining uninsured by race and ethnicity and English proficiency, Californians under age 65, *base scenario*, 2019

	Not eligible due to immigration status	Eligible for Medi-Cal	Eligible for Exchange subsidies	Eligible for Exchange without subsidies	Total
Race and Ethnicity					
Latino	1,020,000	740,000	520,000	380,000	2,660,000
Asian, not Latino	40,000	90,000	70,000	250,000	450,000
African American, not Latino	–	60,000	20,000	30,000	110,000
White, not Latino	10,000	260,000	170,000	280,000	730,000
Other, multi-racial, not Latino	–	30,000	10,000	20,000	60,000
English Proficiency					
Age 18+, Speaks English at least very well	200,000	400,000	330,000	470,000	1,400,000
Age 18+, Limited English proficiency	820,000	420,000	420,000	380,000	2,040,000

Source: UC Berkeley–UCLA CalSIM model, Version 1.8

Exhibit 7. Total remaining uninsured by region and county, Californians under age 65, *base scenario*, 2019

Region/county	Remaining uninsured	Projected total population	Uninsured share of county population	Share of uninsured within each region/county
All California	4,010,000	35,810,000	11%	100%
Northern California and Sierra Counties	120,000	1,240,000	10%	3%
Greater Bay Area	570,000	6,840,000	8%	14%
Santa Clara County	140,000	1,740,000	8%	4%
Alameda County	120,000	1,470,000	8%	3%
Sacramento Area	150,000	2,010,000	7%	4%
San Joaquin Valley	410,000	3,780,000	11%	10%
Fresno County	100,000	900,000	11%	2%
Central Coast	220,000	2,110,000	11%	6%
Ventura County	70,000	780,000	9%	2%
Los Angeles	1,280,000	9,780,000	13%	32%
Other Southern California	1,220,000	10,050,000	12%	30%
Orange County	370,000	2,970,000	13%	9%
San Diego County	290,000	2,960,000	10%	7%
San Bernardino County	280,000	1,970,000	14%	7%
Riverside County	270,000	1,990,000	13%	7%

Source: UC Berkeley–UCLA CalSIM model, Version 1.8

Note: Not all counties are listed due to sample sizes. For definitions of regions see Exhibit 7-2 Regions in California, CHIS 2009 Methodology Report Series #5, page 7-7, http://www.chis.ucla.edu/pdf/CHIS2009_method5.pdf.

Eligibility for benefits among the remaining uninsured is also predicted to vary by region. For example, the predicted share of uninsured individuals who will be eligible for Medi-Cal varies significantly, from 23 percent of the uninsured in the Greater Bay Area to 42 percent in the Northern California and Sierra Counties. The share of uninsured individuals eligible for the Exchange without subsidies varies from 17 percent of the uninsured in the San Joaquin Valley and Northern California and Sierra Counties to 33 percent in the Greater Bay Area, while the share eligible for subsidies in the Exchange is relatively consistent across regions (16 to 20 percent of the uninsured; see Exhibit 11a in the appendix).

Most remaining uninsured Californians will be low-income

We predict that 57 percent of the remaining uninsured under the ACA in 2019 will be in families with incomes at or below 200 percent of the Federal Poverty Level (\$22,340 for an individual and \$46,100 for a family of four in 2012) (Exhibit 9). This income threshold is significant because most

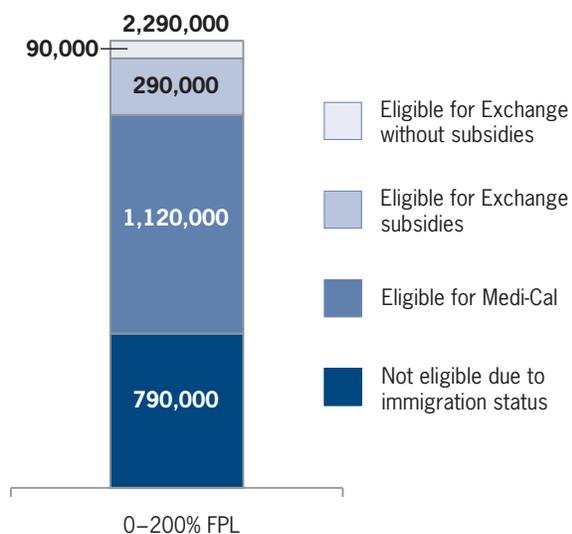
of the uninsured users of the health care safety net system of public hospitals, community and government clinics that primarily serve the uninsured and public program enrollees have incomes at or below 200 percent of the Federal Poverty Level,¹⁹ though some Californians with incomes over this threshold also use the safety net.

Nearly 2.3 million Californians with incomes at or below 200 percent of the Federal Poverty Level are predicted to remain uninsured and rely on the safety net after the ACA is fully implemented in 2019. This includes over 1.1 million Californians who are eligible for Medi-Cal but remain unenrolled, 290,000 who are eligible for Exchange subsidies but remain unenrolled, 90,000 who are eligible for the Exchange without subsidies and 790,000 who are not eligible for coverage due to their immigration status (Exhibit 8).

Other characteristics of remaining uninsured Californians

In Exhibit 9 (page 14), we show how other characteristics of the uninsured would differ with and without the ACA in 2019.

Exhibit 8. Likely safety net users, remaining uninsured at or below 200% FPL, Californians under age 65, base scenario, 2019



Source: UC Berkeley–UCLA CalSIM model, Version 1.8

- Income:** The total number of uninsured is predicted to decline across all income categories under the ACA, but the largest declines are among Californians with incomes between 100 and 400 percent of the Federal Poverty Level, with smaller declines below and above that income range.
- Gender:** The gender distribution of the uninsured is not predicted to change significantly under the ACA.
- Age:** The number of uninsured Californians in all age groups is predicted to decline under the ACA, but uninsured Californians in 2019 are predicted to be slightly younger, on average, than those who would be uninsured without the ACA. The Medi-Cal coverage expansion mostly affects adults, resulting in a greater percentage decline in uninsurance among adults (34%) than children (8%), coupled with already high rates of insurance coverage among children (94% were insured in 2009²⁰).

Exhibit 9. Characteristics of the uninsured with and without the ACA, Californians under age 65, 2019

	Without ACA		With ACA, base		Percentage change
Total	5,790,000		4,010,000		-31%
Income					
Less than 100% FPL	1,600,000	28%	1,310,000	33%	-18%
101–138% FPL	730,000	13%	410,000	10%	-44%
139–200% FPL	1,020,000	18%	570,000	14%	-44%
201–250% FPL	580,000	10%	370,000	9%	-36%
251–400% FPL	880,000	15%	580,000	14%	-34%
401% or more	980,000	17%	770,000	19%	-21%
Gender					
Male	2,990,000	52%	2,060,000	51%	-31%
Female	2,800,000	48%	1,950,000	49%	-30%
Age					
0–18 years	650,000	11%	600,000	15%	-8%
19–29 years	1,690,000	29%	1,020,000	25%	-40%
30–64 years	3,450,000	60%	2,390,000	60%	-31%
Self-Reported Health Status					
Excellent, very good, or good	4,790,000	83%	3,410,000	85%	-29%
Fair or poor	1,000,000	17%	610,000	15%	-39%
Family Structure					
Single adult	2,270,000	39%	1,360,000	34%	-40%
All others (children, parent, or married)	3,520,000	61%	2,650,000	66%	-25%

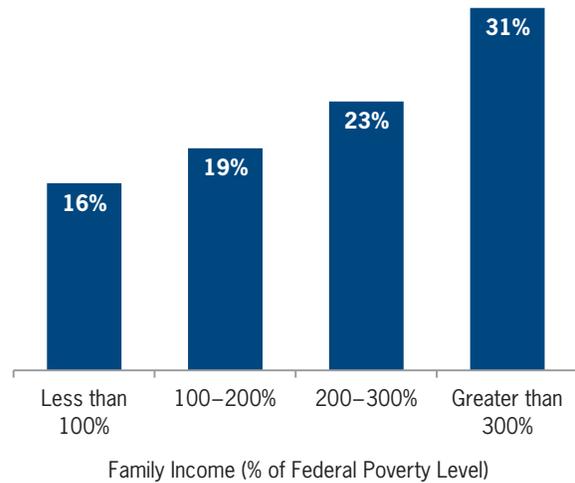
Source: UC Berkeley–UCLA CalSIM model, Version 1.8

- Health status:** We predict no major change in self-reported health status among the uninsured with and without the law. Uninsurance is predicted to decline more among Californians with fair or poor health status (39%) than for those with excellent or very good health status (29%) because individuals with fair or poor health status are more likely to enroll in coverage when they become eligible. Despite this variation, only a slightly higher percentage of uninsured Californians would report excellent or very good health status with the ACA than without the ACA. This predicted experience is consistent with the experience in Massachusetts, where no clear pattern in self-reported health status was observed after the state implemented its own health care reform in 2006.²¹
- Family structure:** Single adults are predicted to comprise a smaller share of the uninsured after the ACA is implemented (34% with the ACA and 39% without) due to the expansion of Medi-Cal to low-income childless adults.

Appreciable share of remaining uninsured Californians will lack coverage for short time periods

Regardless of how robust outreach and enrollment efforts are under the ACA, a certain number of individuals who are uninsured for short time periods will remain after the ACA is implemented, often because they are between jobs. Research suggests that more than one-fifth of Americans who are uninsured at any point during the year are uninsured for five months or less,²² though this percentage is likely to change after the ACA is implemented. An analysis by the Urban Institute using data from the 2002 National Survey of America's Families found that higher-income uninsured individuals had shorter bouts of uninsurance than lower-income individuals (Exhibit 10).

Exhibit 10. Percent of uninsured with a short spell of uninsurance, by income level, 2001–2002*



Source: Urban Institute, 2004

* Percent of all non-elderly individuals who were uninsured at any point during previous year with duration of uninsurance of 5 months or less.

RECOMMENDATIONS

Outreach and enrollment efforts needed to minimize the number of remaining uninsured

Half of Californians who are predicted to remain uninsured will be eligible for Medi-Cal or subsidies in the Exchange. The exact share of eligible Californians who enroll in coverage could depend on a number of factors, including the to-be-determined scope of the Medi-Cal benefit package for newly-eligible adults²³ and the affordability of plans in the Exchange. However, research indicates that effective outreach and enrollment strategies are one significant factor that can drive increased take up of coverage.²⁴ States can increase take up by ensuring that outreach and enrollment efforts are language appropriate and culturally competent, targeting outreach efforts to populations with a high share of remaining uninsured, pre-enrolling individuals who already participate in other categorical public programs that provide services but

not full coverage and connecting individuals to coverage when they lose insurance due to a life transition. More robust outreach and enrollment efforts would be predicted to reduce the number of uninsured who are eligible for Medi-Cal or Exchange subsidies by nearly 800,000 in 2019 compared to the base scenario (Exhibit 2, page 8).

Outreach to Latinos will be especially important

Latinos are predicted to make up two-thirds of all remaining uninsured Californians in 2019 and the majority of uninsured who are eligible for Medi-Cal or Exchange subsidies but remain unenrolled. As the state, the Exchange and community organizations make plans to inform Californians of the new coverage options, and develop enrollment systems and processes, strategies should be customized to address the high share of Latinos who are predicted to remain uninsured. With culturally

California's Plan for Marketing and Outreach under the ACA

The California Exchange, Department of Health Care Services, and Managed Risk Medical Insurance Board have already sponsored a plan for using marketing, outreach and education to maximize enrollment of Californians eligible for Medi-Cal or coverage in the Exchange.²⁵ The plan takes into account that the majority of the uninsured are predicted to be Latino and that California has at least 13 threshold languages in which outreach is needed. One of the guiding principles of the plan is that it considers “where eligible populations live, work and play.” The plan also considers rebranding Medi-Cal to encourage enrollment. Under the plan, outreach will begin in January 2013 to make Californians aware of the new coverage options that will be available.

sensitive outreach and enrollment efforts under the enhanced scenario, we predict that 570,000 fewer Latinos who are eligible for Medi-Cal or Exchange subsidies would remain uninsured in 2019 compared to under the base scenario (Exhibits 6 and 11b).²⁶

Language-appropriate outreach and enrollment are critical

Three out of five California adults remaining uninsured are predicted to be Limited English Proficient (LEP) in 2019. LEP Californians are also predicted to make up the majority of the uninsured who are eligible for Medi-Cal or Exchange subsidies, making language appropriate outreach and enrollment efforts critical to take-up of these coverage options. It is important that outreach efforts are conducted in all threshold languages. California can build upon its existing experience with language-appropriate outreach and enrollment in its Medi-Cal and Healthy Families programs. If language appropriate outreach and enrollment efforts are undertaken, we predict that 440,000 fewer LEP Californians who are eligible for Medi-Cal or Exchange subsidies would be uninsured compared to under the base scenario (Exhibits 6 and 11b).

Focused outreach efforts are needed in Southern California

Outreach efforts in Los Angeles and other Southern California counties are especially important due to higher predicted rates of uninsurance in those regions. Focused efforts in those regions could reach 2.5 million Californians who are

predicted to remain uninsured. Variations in eligibility for coverage by region also underscore the importance of customizing outreach efforts by region.

Measures needed to minimize short-term uninsurance

Some individuals will always be uninsured for short periods, but the number of individuals in this category could be reduced through outreach and enrollment efforts focused on individuals undergoing life transitions because individuals often lose health coverage during those transitions. The Exchange service centers, counties, assistors and navigators will play an important role in helping Californians navigate these life events and ensure that they maintain coverage.

In addition, Californians often come into contact with other public institutions as they experience a change in life circumstances. At these connection points, uninsured Californians could be notified of their potential eligibility for Medi-Cal or the Exchange and provided with information on how to enroll.²⁷ California Assembly Bill 792, recently passed by the state legislature, would require insurers and courts to provide notices informing Californians of their coverage options and how to obtain coverage when they dis-enroll from an individual or group plan, or file for divorce, separation or adoption. There are many other examples of public institutions that could connect Californians to coverage when they undergo life transitions, such as the California Employment Development

Department when individuals apply for unemployment insurance, the Department of Motor Vehicles when they change address, or public colleges when students enroll or graduate.

It is important to link Californians who lose coverage to appropriate resources to secure new insurance coverage quickly so that they avoid tax penalties unnecessarily. In recognition of the prevalence of short bouts of uninsurance, the ACA allows a three-month grace period under which individuals who lack coverage will not owe any tax penalties. Individuals who are uninsured for more than three continuous months in a year will owe a penalty for all of the months they lacked coverage. The ACA allows only one three-month grace period per tax year.

Addressing this type of uninsurance is important as research has shown that even short spells of uninsurance can have negative health consequences.²⁸

California will still have a great need for a strong safety net system post-ACA

With three to four million residents remaining uninsured, California will still have a critical need to maintain and strengthen the health care safety net system of public hospitals, community and government clinics and other providers, even after the ACA is fully implemented. More than half of remaining uninsured individuals are predicted to have incomes at or below 200 percent of the Federal Poverty Level, the typical income range of safety net users. The safety net also serves a high share of uninsured LEP individuals and people of color. Strengthening the safety net will help ensure that care is available for these Californians who are more likely to remain uninsured, but a strong safety net system will need to be there for all Californians. These considerations should be taken into account as policy decisions affecting the safety net are made, such as the provision of federal and state grants to fund operations of community clinics, the distribution of realignment funds, and the allotment of Disproportionate Share Hospital (DSH) subsidies.

Programs needed for Californians left with no affordable coverage option

In addition to adequately funding the safety net, California should maintain and develop programs for individuals with no affordable coverage option. Nearly 40 percent of the remaining uninsured are predicted to have no offer of affordable coverage. Existing state and local programs for the uninsured, including state-funded populations, should be maintained and strengthened. For example, due to their inability to afford coverage through the Exchange or ineligibility for Medi-Cal, many uninsured Californians will continue to rely on programs such as Family PACT for family planning services and Every Woman Counts for services to prevent, detect, diagnose and treat breast and cervical cancer. The locally-funded Healthy Kids programs provide coverage to children who are not eligible for public programs due to income or immigration status, but demand for these county-based programs currently exceeds the funding. Programs similar to Healthy Kids for adults or non-insurance programs like Healthy San Francisco should also be considered. Exploration of programs that would fill in the coverage gaps for Californians left with no affordable option should be considered at both the state and county levels.

CONCLUSIONS

While the ACA will expand coverage to millions of uninsured Californians, three to four million could remain uninsured in 2019. Some may remain uninsured because they lack an offer of affordable coverage, some because they lose coverage for short periods of time as life circumstances change and others because they encounter barriers to enrollment or are not aware of their options. Most of the remaining uninsured will be exempt from the tax penalty; though some will choose to pay the penalty rather than purchasing coverage.

Efforts are needed to maximize enrollment. Half of the remaining uninsured are predicted to be eligible for Medi-Cal or subsidies in the Exchange in 2019. Many of these individuals are already enrolled in state health or social services programs or already have connections to public institutions. Additionally, individuals often connect with public institutions or services when they undergo a life transition such as losing a job, filing for divorce or aging out of a parent's coverage. Outreach efforts

should take advantage of these connection points to notify these individuals of their new ACA coverage options. Planning for outreach and enrollment efforts should take into account that Latinos are predicted to make up two-thirds of the remaining uninsured, LEP individuals are predicted to constitute nearly 60 percent of uninsured adults and over 60 percent of the uninsured are predicted to reside in Southern California.

Significant demand for safety net providers in California will remain after the ACA is fully implemented. We predict that 2.3 million individuals with incomes at or below 200 percent of the Federal Poverty Level will remain uninsured and rely on the safety net in 2019. Adequate funding of the safety net is critical to ensuring that these individuals have access to care. Finally, state and local programs should be maintained and developed for the predicted 1.5 million remaining uninsured Californians who will not have an affordable coverage option available.

Appendix 1: Additional Exhibits

Exhibit 11a. Eligibility for benefits of remaining uninsured, Californians under age 65, base scenario, 2019

	Not eligible due to immigration status	Eligible for Medi-Cal	Eligible for Exchange subsidies	Eligible for Exchange without subsidies	Total
Income					
Less than 100% FPL	440,000	840,000	40,000	–	1,310,000
101–138% FPL	200,000	190,000	20,000	–	410,000
139–200% FPL	160,000	90,000	230,000	90,000	570,000
201–250% FPL	110,000	60,000	180,000	30,000	370,000
251–400% FPL	100,000	–	320,000	160,000	580,000
401% or more	70,000	–	–	700,000	770,000
Age					
0–18 years	50,000	370,000	40,000	130,000	600,000
19–29 years	320,000	260,000	260,000	180,000	1,020,000
30–64 years	700,000	550,000	480,000	660,000	2,390,000
Self-Reported Health Status					
Excellent, very good, or good	820,000	1,010,000	690,000	880,000	3,410,000
Fair or poor	250,000	170,000	90,000	90,000	610,000
Family Structure					
Single adult	430,000	290,000	400,000	250,000	1,360,000
All others (children, parent, or married)	650,000	890,000	390,000	730,000	2,650,000
Region					
Northern California and Sierra Counties	20,000	50,000	20,000	20,000	120,000
Greater Bay Area	160,000	130,000	90,000	190,000	570,000
Sacramento Area	20,000	60,000	30,000	40,000	150,000
San Joaquin Valley	110,000	140,000	80,000	70,000	410,000
Central Coast	70,000	60,000	40,000	50,000	220,000
Los Angeles	380,000	340,000	250,000	310,000	1,280,000
Other Southern California	330,000	360,000	230,000	310,000	1,220,000

Source: UC Berkeley–UCLA CalSIM model, Version 1.8

Note: See Exhibit 6 for eligibility for benefits by race and ethnicity and English proficiency.

Exhibit 11b. Eligibility for benefits of remaining uninsured, Californians under age 65, *enhanced scenario*, 2019

	Not eligible due to immigration status	Eligible for Medi-Cal	Eligible for Exchange subsidies	Eligible for Exchange without subsidies	Total
Income					
Less than 100% FPL	430,000	570,000	–	–	1,000,000
101–138% FPL	190,000	120,000	–	–	310,000
139–200% FPL	150,000	60,000	70,000	80,000	360,000
201–250% FPL	110,000	40,000	90,000	20,000	260,000
251–400% FPL	100,000	–	210,000	150,000	450,000
401% or more	60,000	–	–	650,000	720,000
Age					
0–18 years	50,000	260,000	40,000	130,000	490,000
19–29 years	310,000	160,000	140,000	160,000	770,000
30–64 years	670,000	370,000	190,000	620,000	1,850,000
Self-Reported Health Status					
Excellent, very good, or good	790,000	680,000	350,000	830,000	2,650,000
Fair or poor	240,000	110,000	20,000	80,000	460,000
Race and Ethnicity					
Latino	980,000	470,000	220,000	340,000	2,010,000
Asian, not Latino	40,000	60,000	40,000	230,000	370,000
African American, not Latino	–	40,000	10,000	30,000	90,000
White, not Latino	10,000	190,000	100,000	280,000	590,000
Other, multi-racial, not Latino	–	20,000	10,000	20,000	50,000
English Proficiency					
Age 18+, Speaks English at least very well	200,000	280,000	190,000	460,000	1,130,000
Age 18+, Limited English proficiency	790,000	250,000	150,000	320,000	1,510,000
Family Structure					
Single adult	400,000	180,000	210,000	230,000	1,020,000
All others (children, parent or married)	630,000	610,000	170,000	680,000	2,090,000
Region					
Northern California and Sierra Counties	20,000	40,000	10,000	20,000	90,000
Greater Bay Area	150,000	90,000	50,000	170,000	460,000
Sacramento Area	20,000	40,000	10,000	30,000	120,000
San Joaquin Valley	110,000	100,000	40,000	60,000	310,000
Central Coast	70,000	40,000	20,000	50,000	180,000
Los Angeles	360,000	230,000	110,000	280,000	980,000
Other Southern California	310,000	240,000	110,000	280,000	950,000

Source: UC Berkeley–UCLA CalSIM model, Version 1.8

Exhibit 12. Characteristics of the remaining uninsured, Californians under age 65, *enhanced scenario*, 2019

	With ACA, enhanced	
Total	3,110,000	
Income		
Less than 100% FPL	1,000,000	32%
101–138% FPL	310,000	10%
139–200% FPL	360,000	12%
201–250% FPL	260,000	8%
251–400% FPL	450,000	15%
401% or more	720,000	23%
Gender		
Male	1,590,000	51%
Female	1,510,000	49%
Age		
0–18 years	490,000	16%
19–29 years	770,000	25%
30–64 years	1,850,000	36%
Self-Reported Health Status		
Excellent, very good, or good	2,650,000	85%
Fair or poor	460,000	15%
Race and Ethnicity		
Latino	2,010,000	65%
Asian, not Latino	370,000	12%
African American, not Latino	90,000	3%
White, not Latino	590,000	19%
Other, multi-racial, not Latino	50,000	2%
English Proficiency		
Age 18+, Speaks English at least very well	1,130,000	37%
Age 18+, Limited English proficiency	1,510,000	49%
Family Structure		
Single adult	1,020,000	33%
All others (children, parent or married)	2,090,000	67%

Source: UC Berkeley–UCLA CalSIM model, Version 1.8

Appendix 2: Methodology

The California Simulation of Insurance Markets (CalSIM) model is designed to estimate the impact of various elements of the ACA on employer decisions to offer insurance coverage and individual decisions to obtain coverage in California. The CalSIM model uses four data sources: the 2004–2008 Medical Expenditure Panel Survey Household Component (MEPS-HC) public use data files, the 2009 California Health Interview Survey (CHIS), California Employment Development Department (EDD) 2007 wage distribution, insurance offer, and firm size data, and the 2010 California Employer Health Benefits Survey (CEHBS). CHIS, EDD, and

CEHBS provide weights and wage distributions that adjust the nationally-representative MEPS data to build a California-specific model. Once re-weighted, the MEPS-HC respondents are then assumed to represent the population of California.

The California Simulation of Insurance Markets (CalSIM) model was created by the UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research with funding from the California Endowment. For further information, please visit http://www.healthpolicy.ucla.edu/pubs/files/calsim_methods.pdf.

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- ⁵ 2009 California Health Interview Survey.
- ⁶ Sommers BD, Kronick R, Finegold K, Po R, Schwartz K and Glied S. Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act. U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Issue Brief. March 2012.
- ⁷ We estimate that California’s 2019 population will be 35.8 million in 2019 based on population data from the 2009 California Health Interview Survey inflated by 7.57 percent predicted annual Medicaid enrollment growth without the ACA, consistent with assumptions in the CalSIM.
- ⁸ Throughout this report, when we refer to individuals eligible or enrolled in Medi-Cal in 2019, we are including children in families with incomes up to 250 percent of the Federal Poverty Level who will be transitioned into Medi-Cal beginning in 2013.
- ⁹ Throughout this report, when we refer to income, we are typically referring to household income, which is the determinant of federal poverty level and eligibility for Medi-Cal or Exchange subsidies and applicability of the minimum coverage essential requirement under the ACA.
- ¹⁰ Baicker K and Finkelstein A. The Effects of Medicaid Coverage—Learning from the Oregon Medicaid Experiment. *New England Journal of Medicine*. Volume 365, Number 8, pages 683-685, August 25, 2011.
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- ¹² We estimate that California’s 2019 population will be 35.8 million in 2019 based on population data from the 2009 California Health Interview Survey inflated by 7.57 percent predicted annual Medicaid enrollment growth without the ACA, consistent with assumptions in the CalSIM. The number of Californians who will be subject to the penalty is a high-end estimate because it does not take into account that some Californians will be exempt from the penalty due to the three-month grace period.
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¹⁹ Among uninsured non-elderly Californians whose usual source of care is a community clinic, government clinic or community hospital, 72 percent have incomes that are under 200 percent of the Federal Poverty Level (2009 California Health Interview Survey). More than four out of five patients at Federally Qualified Health Centers are in this income range (California Primary Care Association, Profile of Community Clinics and Health Centers, 2012).

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²⁶ This is based on the CalSIM assumption that the use of language appropriate materials and outreach under the enhanced scenario would equalize enrollment levels for Limited English Proficient (LEP) and non-LEP Californians.

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Federal Health Care Reform and California Counties Behavioral Health



FEDERAL HEALTH CARE REFORM & BEHAVIORAL HEALTH

PRESENTATION TO CSAC INSTITUTE FOR EXCELLENCE IN
COUNTY GOVERNMENT
MAY 16, 2013

Suzanne Tavano, Ph.D.
Consultant
California Mental Health Directors Association

PRESENTATION OVERVIEW

- ❖ Brief Overview of California's Public Mental Health System
 - ❖ Brief Overview of California's Public Substance Use Disorder Treatment System
 - ❖ The ACA & Mental Health and Substance Use Disorders
 - ❖ Opportunities for MH & SUD
 - ❖ Parity
 - ❖ Outstanding Questions and Considerations
- 

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CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM

- ❖ Under the provisions of our Medicaid Title 42, Section 1915(b) “freedom of choice” waiver covering the mandatory enrollment of eligible Medi-Cal beneficiaries in the Mental Health Plans (MHPs) for specialty mental health, emergency and hospital services, California’s county MHPs are considered prepaid inpatient health plans.
- ❖ California’s MHPs are responsible for assuring 24 hour, seven day/week access to emergency, hospital and post-stabilization care for the covered psychiatric conditions for Medi-Cal beneficiaries.
- ❖ In addition, California has two SPAs that increase the scope of outpatient, crisis and residential and inpatient mental health coverage provided to Medi-Cal beneficiaries when medically necessary, by the MHP.
- ❖ California’s Approved State Plan Amendments:
 - Targeted case management for persons with mental illness.
 - Mental health services available under the Rehabilitation Option, broadening the range of personnel and locations that were available to provide services to eligible beneficiaries.

CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM

- ❖ MHPs are subject to CFR Title 42, Part 438 Managed Care requirements which specify additional access, beneficiary protection and quality management requirements that the MHP must conform to.
- ❖ Both federal and state code and regulation specify that there is to be a contract between the state and the MHP/PIHP specifying the conditions under which the managed care program will operate.
- ❖ The regulations and contract also specify requirements for the coordination of health and mental health treatment between the county and the state contracted health plans, including that an MOU be in place between the county and each health plan specifying the process for timely referral and treatment.

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MAJOR MENTAL HEALTH MILESTONES

- ❖ 1969: Community Mental Health Services Act, Deinstitutionalization, Short/Doyle Act
- ❖ 1984: AB 3632 (Special Education Mandate)
- ❖ 1991: Realignment 1991
- ❖ 1993: Medi-Cal Rehabilitation Option
- ❖ 1995-97: Medi-Cal Specialty Mental Health Consolidation
- ❖ 2004: Prop. 63 – Mental Health Services Act
- ❖ 2008: Federal Mental Health Parity
- ❖ 2009-10 Federal Health Care Reform/CA 1115 Waiver
- ❖ 2011: AB 100/MHSA Changes
- ❖ 2011: Repeal of AB 3632
- ❖ 2011: Realignment 2011/Public Safety Realignment

CALIFORNIA'S PUBLIC SUBSTANCE USE DISORDER SYSTEM

- ❖ In California, the public system of care for the prevention and treatment of SUD is overseen by a single state agency, but is administered by counties, which either provide services directly or (in most cases) contract with private providers for services.
- ❖ Public treatment of SUD is predominantly provided in separate specialty services programs, some of which are based on social-model recovery (i.e. 12-step), and others which offer medication-assisted treatment (i.e. methadone maintenance).
- ❖ SUD treatment is typically provided by staff members who are state-certified but not professionally licensed.

Federal Health Care Reform and California Counties Behavioral Health

CALIFORNIA'S PUBLIC SUBSTANCE USE DISORDER SYSTEM

- ❖ Traditional sources of funding for public SUD services:
 - Federal Substance Abuse Prevention & Treatment Block Grant
 - FFP for Drug Medi-Cal
 - State General Fund (now Realignment funding) for:
 - Drug Medi-Cal Match
 - Perinatal Services
 - Drug Court Treatment Programs
- ❖ Drug Medi-Cal (D/MC) was originally a set of benefits within Short-Doyle Medi-Cal. The two systems separated in the late seventies, but still today are linked in the billing process at the state level.

THE ACA & MENTAL HEALTH AND SUBSTANCE USE DISORDERS

- ❖ The ACA explicitly includes mental health and substance use disorder services, including behavioral health treatment, as one of ten categories of service that must be covered as **essential health benefits**.
- ❖ The ACA also mandates that mental health and substance use disorder benchmark coverage must be provided at **parity**, compliant with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (2008).
- ❖ The Low Income Health Program (LIHP), established under California's 1115(a) "Bridge to Reform" waiver, requires a **minimum mental health benefit** for the MCE population in implementing counties. SUD benefits are not required. However, several counties have opted to include expanded MH or SUD services in the benefit package for LIHP enrollees.
- ❖ As part of California's 1115 Waiver requirements, California must develop and submit to CMS a **behavioral health needs assessment and service plan** to prepare for the 2014 Medicaid expansion.

Federal Health Care Reform and California Counties

Behavioral Health

OPPORTUNITIES

- ❖ Given the low rate of service utilization among uninsured adults with mental health and substance use disorder needs, the expansion of health insurance coverage through health care reform could **increase access to and utilization of mental health and substance use disorder services** for many uninsured adults in California.
- ❖ Half a million uninsured California adults with mental health needs will become eligible for health insurance coverage in 2014.*
- ❖ The ACA offers an extraordinary opportunity to provide access to rehabilitative and recovery-oriented mental health services to individuals **before they become disabled**. Qualified adults without a disability will for the first time have access to mental health services through the Medi-Cal program or subsidized insurance.

**UCLA Center for Health Policy Research (November 2012), Health Policy Fact Sheet, "Half a Million Uninsured California Adults with Mental Health Needs Are Eligible for Health Coverage Expansions."*

PARITY

- ❖ Prior to 1996, health insurance coverage for mental illnesses has historically been **less generous** than that for other physical health illnesses.
- ❖ This has generally been reflected either by a **complete lack of coverage** of a particular mental health condition or by a **differential structuring** of coverage terms for mental health benefits relative to benefits for medical/surgical services (e.g. lower annual/lifetime dollar limits, treatment limitations, increased cost-sharing)
- ❖ Mental health parity is a response to this **disparity in insurance coverage**, and generally refers to the concept that health insurance coverage for mental health services should be offered on par with covered medical and surgical benefits.

Federal Health Care Reform and California Counties Behavioral Health

BRIEF HISTORY OF PARITY

- ❖ The **Mental Health Parity Act of 1996** was the first federal mental health parity law, primarily addressing annual/aggregate lifetime dollar limits.
- ❖ California has had **state parity laws** in place since 2000 (Mental Health Parity Act of 1999 – SB 88) requiring private insurers to cover treatment of specific severe mental illnesses, and to do so on the same terms and conditions applied to the treatment of other illnesses.
- ❖ The **Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008** expands the scope of MH parity requirements at the federal level and includes SUD within its scope.
- ❖ An Interim **Final Rule** was published in February 2010 outlining many of the relevant quantitative and non-quantitative limitations
- ❖ The **ACA** extended the reach of some of the federal parity requirements to **all benchmark & benchmark equivalent plans**. Specifically, MH/SUD benefits must have parity with medical/surgical benefits with respect to financial requirements & treatment limitations.
- ❖ The ACA also creates a **coverage mandate** for MH/SUD services as one of the 10 required EHB categories.

PARITY

- ❖ Specifically, **the ACA expands the reach of federal MH/SUD parity law to 3 main types of plans**: 1) QHPs, 2) Medicaid non-managed care benchmark and benchmark-equivalent plans, and 3) plans offered through the individual market.
- ❖ The ACA **requires Medicaid benchmark plans to provide MH & SUD services at parity** with other covered medical and surgical services, in accordance with MHPAEA (i.e. treatment limitations and financial requirements imposed on MH/SUD services cannot be more restrictive than those imposed on other covered medical and surgical benefits).
- ❖ **Medicaid managed care plans (non-benchmark) are also required to comply with MHPAEA.**
- ❖ MHPAEA, which preexists the ACA, contained an exemption for small employers. **The ACA extends the requirements of MHPAEA to small group plans.** Plans offered through the small group and individual market will need to not only cover mental health and substance use disorder services but also provide those services at parity with medical and surgical benefits.

Federal Health Care Reform and California Counties Behavioral Health

PARITY

- ❖ It is anticipated that HHS will promulgate **additional rule-making** on mental health and addiction parity shortly.
- ❖ Some speculate that the forthcoming guidance may simply finalize the interim final rules released in February 2010. However, many hope that the final parity guidance will be more substantive than the interim final rule (i.e. **address service exclusions**).
- ❖ CMS released a State Health Official letter on January 16, 2013 on the **application of MHPAEA to Medicaid MCOs, CHIP, and benchmark plans**. The letter additionally includes some limited discussion of “Prepaid Inpatient Hospital Plans” (PIHPs) and “Prepaid Ambulatory Health Plans” (PAHPs) and their role in providing a more limited set of state plan services, including in some instances through a “carve-out arrangement.” CMS urges states with these arrangements to **apply the principles of parity across the whole Medicaid managed care delivery system** when mental health and substance use disorders services are offered through a carve-out arrangement.
- ❖ According to CMS, **additional guidance is forthcoming regarding carve-out arrangements.”**

ALTERNATIVE BENEFIT PLAN OPTIONS

- ❖ Mercer Government Human Services Consulting, under contract with the California Healthcare Foundation, conducted an analysis of Alternative Benefit Plan (ABP) options to consider for newly enrolled Medi-Cal beneficiaries under the ACA.
- ❖ This analysis was not broadly available to stakeholders or open to much public feedback, but in draft form was submitted by DHCS to CMS on 4/1/13 as an interim report to substitute for California’s Behavioral Health Service Plan. DHCS committed to submitting the actual Service Plan to CMS by October 1, 2013.
- ❖ In the May Revise released on 5/14/13, there was some clarification of the ABP for the newly enrolled Optional Expansion population. As stated in the May Revise, newly enrolled (as determined by the threshold MAGI test for eligibility) beneficiaries will be eligible for the same range of mental health benefits as the current Mandatory population, inclusive of “county-administered comprehensive specialty mental health services.” Substance use disorder services for the expansion population will be the same as available through the “county supported substance use disorder services.”

Federal Health Care Reform and California Counties

Behavioral Health

ALTERNATIVE BENEFIT PLAN OPTIONS

- ❖ Of note is the difference in terminology between mental health and substance use disorder services. For specialty mental health services, “county-administered” indicates benefits are managed by the county mental health plan inclusive of selection and certification of providers, establishment of rates, authorization of services, etc. Services and costs can be managed at the local level. However, the term “county-supported” in reference to services provided by the county under Drug Medi-Cal indicates these benefits will not be exclusively managed at the local level, but in some combination with the state.
- ❖ It is further noted in the May Revise that “at a county option, both existing enrollees and new eligibles, may receive an enhanced benefit package for substance use disorders.” While an opportunity to increase very needed services, there may be financial considerations for counties in absence of reform of the current Drug Med-Cal program.

CAL MEDICONNECT

- ❖ CMS and DHCS executed a MOU in March, 2013 allowing implementation of the Dual Eligibles program, newly titled Cal MediConnect, as a key element of California’s Coordinated Care Initiative (CCI). This project for integrated management of Medi-Cal and Medicare benefits is to demonstrate the value of coordinating benefits available to the dually eligible population (primarily older adults and adults with disabilities) and the treatment provided by health and behavioral health providers.
- ❖ This demonstration will be in eight counties: Alameda, Santa Clara, San Mateo, Los Angeles, Orange, San Bernardino, Riverside and San Diego. In each, the county mental health plan will be the provider of specialty mental health services, in coordination with the health plans providing health care.
- ❖ Last week, DHCS announced that implementation of Cal MediConnect is postponed from a start date of 10/1/13 to no sooner than 1/1/14. The number of potential enrollees in this demonstration has been reduced to a total of 456,000 with no more than 200,000 enrolling in Los Angeles.

Federal Health Care Reform and California Counties Behavioral Health

OUTSTANDING QUESTIONS & CONSIDERATIONS

- 1) What will the mental health and SUD benefits be for newly eligible individuals qualifying under the expansion and what will the delivery system(s) be?
- 2) How will qualified health plans in the Exchange be held accountable for meeting MH/SUD parity standards?
- 3) How will individuals covered through the Exchange access specialty rehab mental health services if medically indicated?
- 4) How will the methadone exclusion in the benchmark coverage offered in the individual & small group market impact the county SUD system?
- 5) How will continuity of care be ensured for individuals with mental health needs churning between the expansion and Covered California?
- 6) To what extent will new streamlined eligibility determination processes identify and enroll new currently eligible beneficiaries?
- 7) How will county MHPs and health plans take advantage of changing landscape and new opportunities to better coordinate and integrate care for individuals with specialty mental health needs?

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For additional resources on ACA implications for CA's public mental health system, go to: <http://www.cmhda.org/go/publicpolicy/healthcarereformresources.aspx>

Health Advocate

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Understanding the Difference Between Medicaid and EHB Benchmarks: How These Systems Work and Interact

Prepared by: [Jina Dhillon](#) and [Michelle Lilienfeld](#)

Key Resources

In January and March 2012, NHeLP submitted comments on HHS' Essential Health Benefits Bulletin and Frequently Asked Questions, which can be found [here](#) and [here](#) respectively. NHeLP's earlier comments on this topic can be found [here](#).

Also, see NHeLP's Overview to the Upcoming Supreme Court Decision on the ACA found [here](#).

Upcoming comment deadlines:

- State Plan HCBS, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice; due 7/2/12.
- Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of QHPs; due 7/5/12.
- Notice of Opportunity to Provide Comments - Reauthorization of Ryan White HIV/AIDS Program; due 7/31/12.

As health reform implementation moves forward, two health insurance “benchmark” systems are emerging as the critical determinants of the care and services that millions of individuals will receive beginning in 2014.¹ The first is the Medicaid benchmark, which already exists.² The second is the new Essential Health Benefits (EHB) benchmark, which sets the standard for benefits packages that individuals and employees of small businesses will receive through the Exchanges, Basic Health Plans, and other coverage options established by the Affordable Care Act (ACA).

This article provides an overview of the Medicaid and EHB benchmarks, and briefly describes some of the interactions between the two. NHeLP will release further analyses of these interactions in coming months.

WHO WILL GET THESE BENCHMARK BENEFITS?

Medicaid benchmark:

Medicaid benchmark plans have existed since the Deficit Reduction Act of 2005 allowed states the option of developing alternative Medicaid benefits packages for certain Medicaid-eligible individuals. Only a few states have selected this option, but the ACA brings new focus to Medicaid benchmarks because most of the newly eligible Medicaid expansion population will receive Medicaid benchmark coverage as of 2014.

The Medicaid Act exempts certain populations from benchmark coverage, so states cannot require beneficiaries within the following groups to enroll in Medicaid benchmarks:

- pregnant women;
- individuals who are blind or have a disability;
- individuals who are dually eligible for Medicaid and Medicare;
- terminally ill hospice patients;
- individuals who are eligible on the basis of hospitalization;
- individuals who are medically frail or have special medical needs;
- individuals qualifying for long term care services;
- children in foster care receiving child welfare services and children receiving foster care or adoption assistance;

¹ A benchmark is the standard by which benefits are measured or defined.

² This includes benchmark-equivalent plans, which are discussed later in this article.

- TANF and 1931 parents (i.e., individuals who would have been eligible for Aid to Families with Dependent Children before the program was abolished on July 16, 1996);
- women in the breast or cervical cancer program;
- limited services beneficiaries who qualify for Medicaid based on tuberculosis or who qualify for emergency services only; and
- medically needy or spend-down populations.

Although they cannot require exempt individuals to enroll in Medicaid benchmarks, states may offer these individuals the option to do so.

Essential Health Benefits benchmark:

In December 2011, the Department of Health and Human Services (HHS) released an Essential Health Benefits Bulletin defining the EHB standard as an EHB benchmark plan that includes the ACA's ten statutory categories of benefits (see Figure 2). Each state will select an EHB benchmark, which will serve as the basis of the benefits package offered to those in the Exchange, Basic Health Plans, and non-grandfathered plans sold in the small group and individual markets.³ As a result, the EHB benchmark will set the scope of benefits that many individuals and employees of small businesses will receive in the private market.

WHAT ARE THE STATE'S OPTIONS FOR SELECTING A BENCHMARK PLAN?

Medicaid benchmark:

The Medicaid Act defines Medicaid benchmark plans as:

1. the standard Blue Cross/Blue Shield preferred provider option (PPO) under the Federal Employee Health Benefit Plan;
2. any generally-available state employee plan in the state;
3. the HMO plan with the largest commercial, non-Medicaid enrollment in the state; or
4. Secretary-approved coverage (which can include the state's existing Medicaid benefit package).

There is also a fifth option. States may design or select a benchmark-equivalent plan as long as it includes benefits within each of the following categories:

- inpatient and outpatient hospital services;
- physicians' surgical and medical services;
- laboratory and x-ray services;
- prescription drugs;
- mental health services;
- well-baby and well-child care (including immunizations); and
- "other appropriate preventive services" designated by the Secretary of HHS.⁴

Benchmark-equivalent coverage must have an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark plans listed above. To the extent the benchmark plan selected for comparison purposes includes vision and/or hearing services, the benchmark-equivalent package must also include these services at an actuarial value that is at least 75% of the actuarial value of the vision and/or hearing services in the benchmark plan.

³ A non-grandfathered plan is a plan that must implement the changes required by health care reform because it came into existence after the law passed (March 23, 2010) or was in existence before the law but made significant changes causing it to lose its grandfathered status.

⁴ There is some overlap between these benchmark-equivalent categories of benefits and the ten statutory categories of benefits for EHB (see Figure 2 for a list of the EHB categories).

Of the few states currently offering Medicaid benchmark coverage, most have selected option #4, Secretary-approved coverage (i.e., any other health benefits coverage that the Secretary determines, upon application by a state, provides appropriate coverage for the population that will receive those benefits). The Secretary-approved coverage is limited to benefits available under benchmark coverage or the standard full Medicaid coverage package.

Essential Health Benefits benchmark:

States can select their EHB benchmark from among ten options:

- the three (3) largest federal employee plans;
- three (3) largest state employee plans;
- three (3) largest small group plans in the state; or
- the largest commercial HMO operating in the state.

Once the state selects a plan, it must supplement it as needed to include all ten EHB statutory categories of benefits (see Figure 2).

Figure 1: Comparison of benchmark plans for EHB and Medicaid

Type of Plan	Essential Health Benefits (EHB) Benchmark Plans ⁵	Medicaid Benchmark Plans
Federal Employee Health Benefit Program (FEHBP)	1 of 3 largest	Standard BC/BS PPO
State Employee Coverage	1 of 3 largest	plan that is generally available to state employees
Small Group Plan	1 of 3 largest	n/a
Largest Commercial HMO in the State	✓	✓
Secretary-Approved Coverage	n/a	✓
Benchmark Equivalent Coverage	n/a	✓

ARE THERE SPECIFIC SERVICES THAT MUST BE INCLUDED?

Medicaid benchmark:

All Medicaid benchmarks must include: 1) family planning services and supplies; and 2) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under age 21.

Beginning in 2014, pursuant to the ACA, Medicaid benchmark coverage also must provide at least the EHBs (see Figure 2).

Figure 2: The plan selected as the EHB benchmark must include coverage of ten statutorily-designated categories of benefits:

- | | |
|---|---|
| <ul style="list-style-type: none"> • ambulatory patient services; • emergency services; • hospitalization; • maternity and newborn care; • mental health and substance use disorder services, including behavioral health treatment; | <ul style="list-style-type: none"> • prescription drugs; • rehabilitative and habilitative services and devices; • laboratory services; • preventive and wellness services (including chronic disease management); and • pediatric services, including oral and vision care. |
|---|---|

⁵ Based on enrollment data from the first quarter of 2012.

Essential Health Benefits benchmark:

If a state chooses an EHB benchmark plan that is missing any of these categories, the state must supplement the benchmark to include that category of benefits. If a state chooses an EHB benchmark plan that is subject to state health insurance mandates (e.g., a small group market plan), those mandates become part of the EHB benchmark at no additional cost to the state until 2016.⁶ If a state does not choose an EHB benchmark plan that is subject to mandates (e.g., a Federal Employee Health Benefit Plan), the state must pay the additional costs associated with mandated services. In 2016, HHS will revisit coverage of state mandates in the EHB benchmark.

INTERACTION BETWEEN MEDICAID AND EHB BENCHMARKS

Further guidance on how states should proceed is needed to assess how these two benchmarks will interact. In the meantime, it is important for advocates to understand how these benchmark systems work, identify the options available in their states, and closely monitor state implementation to identify opportunities for advocacy and education.

CONCLUSION

NHeLP will continue to monitor the interactions and challenges described above, and advocates should closely monitor the implementation of these benchmark standards in their states. This monitoring should include:

- Making sure states understand that the EHB requirement enhances, but does not replace, existing Medicaid benchmark requirements.
- Analyzing the importance of aligning benefit coverage offered to different populations (e.g., the Medicaid expansion population and current Medicaid-covered populations).
- Requesting future guidance on how states will know if their Medicaid benchmark appropriately covers the EHBs and, if necessary, how to supplement.
- Ensuring that important state mandates are included as part of the EHB at no additional cost to the state beyond 2016.

NHeLP has already prepared several comments on the underlying principles of the EHB, available on our [website](#). We will continue to post information and analyses, so please visit our website regularly for more information.

⁶ Mandated benefits are benefits that health insurance companies or health plans are required to provide. Since private insurance regulation has historically been the responsibility of the states, most mandated benefits are established by state legislatures, and are therefore state mandates. Some common mandated benefits are substance abuse treatment, maternity minimum stay, and mammography screening.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

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Affordable Care Act Implementation: County Eligibility Operations

The Affordable Care Act (ACA) and subsequent regulations will have far-reaching impacts on the eligibility rules and requirements for Medi-Cal, which is administered by county human services departments under state law. With less than a year to go before implementation, much has been decided and much remains unknown regarding these rules changes.

Role of Counties in Eligibility Operations Post-2014

- Counties will continue to receive applications from customers via multiple pathways: In person, Online, By Mail, By Phone, and will process those applications for both Medi-Cal and the new coverage offered through the California Health Benefit Exchange (a.k.a. Covered California).
- Participating counties will accept “warm hand offs” from the Covered California service center, and assist callers needing eligibility determinations who are potentially Medi-Cal eligible.
- Counties will receive and process applications submitted on line or by mail to Covered California that are incomplete or need additional work and who appear to be Medi-Cal eligible.
- Counties will handle all ongoing case management activities for Medi-Cal customers.

Some Known Changes Affecting Eligibility

- Medi-Cal Structure: The ACA changes who is considered to be a household and how income is calculated. Both will now largely follow the tax filing process, such that persons who file on the same tax return are considered a household, and income is based on the Modified Adjusted Gross Income (known as MAGI), which is derived from a person’s tax return.
- Eligibility Simplifications: The ACA makes a number of mandatory eligibility simplifications for Medi-Cal, including the elimination of asset tests and extra reporting (such as the current mid-year status report that most parents must submit).
- Individual Mandate: Last year the Supreme Court upheld the requirement for individuals to maintain health insurance (subject to affordability provisions). This means that more people will be seeking coverage. It could result in an increase in enrollment of those who are eligible under current Medi-Cal rules, but who have not enrolled.

Key Unknowns Affecting Eligibility Operations

- Volumes: A major unknown is how many people will really apply for the expanded coverage. CWDA has worked with the Department of Health Care Services and researchers from UC Berkeley to develop an estimator of caseload increases as a result of ACA. That tool was recently released and counties are now able to use it to make some estimates of local volumes. However, these are just estimates at this point based on many underlying assumptions.

- Success of Electronic Verifications: While federal and state data sources will be aggregated into “hubs” that can be checked for verification of items such as income and citizenship, it is not known whether these sources will be recent and robust enough to avoid requesting additional information and verifications from customers. The more inconsistencies exist, the less simple the process will be.
- Benefit Package for Expansion Group: Today, about 1.5 million Medi-Cal recipients are eligible on the basis of disability. While eligibility rules such as the asset test will remain in place for this population, they could also qualify for services using the new, simpler MAGI-based rules. However, if the benefit package adopted for the MAGI Medi-Cal population is less robust than the current Medi-Cal benefits, many persons with disabilities may still wish to be evaluated for non-MAGI-based coverage due to its better benefits. This will reduce simplicity.

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CMHDA-CADPAAC HEALTH CARE REFORM PRINCIPLES Jointly Adopted 12-13-12

On March 23, 2010, President Obama signed into law the comprehensive health care reform legislation promising to extend coverage to 33 million Americans – the Patient Protection and Affordable Care Act (ACA). Of note to the behavioral health community, the ACA explicitly includes mental health and substance use disorder services, including behavioral health treatment, as one of ten categories of service that must be covered as essential health benefits. Furthermore, the ACA also mandates that mental health and substance use disorder benchmark coverage must be provided at parity, compliant with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (2008). Individuals with mental illness and substance use disorders have the opportunity to significantly benefit from the health care law, as insufficient insurance health care coverage for these conditions has traditionally prevented countless people from obtaining needed treatment. If applied correctly, the health care reform law has the opportunity to ensure that clients, families and communities struggling with mental illness and substance use disorders have access to culturally competent prevention and treatment opportunities. Research suggests that without addressing the treatment needs of persons with serious mental health and substance use disorders, it may be very difficult to achieve the three critical healthcare reform objectives articulated by the Institute for Healthcare Improvement's Triple Aim:

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce, or at least control, the per capita cost of total healthcare

The following are some of the opportunities for this population under the ACA:

- Given the low rate of service utilization among uninsured adults with mental health and substance use disorder needs, the expansion of health insurance coverage through health care reform could increase access to and utilization of mental health and substance use disorder services for many uninsured adults in California.
- Half a million uninsured California adults with mental health needs will become eligible for health insurance coverage in 2014.¹
- Qualified adults will for the first time have access to mental health and substance use disorder services through the Medi-Cal program or subsidized insurance without having a disability.

Given the tremendous opportunities that the ACA affords this population, CMHDA and CADPAAC believe that California's implementation of the ACA should be grounded in the

¹ UCLA Center for Health Policy Research (November 2012), Health Policy Fact Sheet, "Half a Million Uninsured California Adults with Mental Health Needs Are Eligible for Health Coverage Expansions."

following principles to ensure access to the highest quality mental health and substance use disorder services for these populations and achieve health care reform objectives:

- 1) **Health equity must be integrated into all aspects of ACA implementation.** This includes addressing systematic disparities in health status related to race, ethnicity, gender, sexual orientation, income and geography. People of color and people living in rural areas are more likely to be low-income, uninsured, and without access to employer-based health insurance², and therefore have the most to gain from the ACA.
- 2) **Mental health and substance use disorder systems must be equity partners with physical health care systems.** Parity between mental health and substance use disorder and other medical systems and services must be realized at every level.
- 3) **Recovery and resiliency-driven services that are culturally and linguistically appropriate must be the standard for covered mental health and substance use benefits available to California’s Medicaid Expansion population.** This includes coverage of consumer/client- and family-directed case management and behavioral health rehabilitation services in the community that reflect the cultural, ethnic and racial diversity of mental health and substance use consumers/clients, and that address each consumer/client’s individual needs.
- 4) **Access to mental health and substance use disorder services for both the Medicaid Expansion population and the Covered California population should be based upon established medical/clinical necessity criteria for specialty mental health services and substance use services – e.g. Medi-Cal criteria and evidence-based American Society of Addiction Medicine (ASAM) placement criteria.** This is essential to ensure seamless continuity of care and consistent access to services regardless of change in economic status or type of health care coverage. There is also a strong business case supported by research that demonstrates that efficiencies in care and improved outcomes occur when patient needs are well matched with the most appropriate, medically necessary and least restrictive/costly level of care.
- 5) **Education, prevention and early intervention for mental health and substance use disorders must be fully integrated as part of the spectrum of reimbursable services in any benefit package provided to the Medicaid Expansion population, or individuals insured through Covered California.** The prevention of disease is a central tenet of the ACA; this should apply no less to mental health and substance use disorder services as it does for physical health. Research and experience have proven that education, prevention and early intervention for mental health and substance use disorders play an essential role in population health, client outcomes and cost containment. Such services may include screening in primary care, media and public awareness campaigns, suicide prevention and peer-delivered services.
- 6) **Specialty mental health and substance use disorder services provided in field, home and community-based settings must be available and reimbursable under all coverage programs and opportunities.** Effectively addressing the rehabilitative needs of children, youth, adults and older adults with serious mental illness and

² National Health Law Program (August 21, 2012), 10 Reasons the Medicaid Expansion Helps to Address Health Disparities.

substance use disorders requires assertive, proactive, culturally and linguistically appropriate outreach in a variety of settings by specialty and community providers who have the expertise in engaging individuals at the earliest possible point in an episode of mental illness and/or substance use.

- 7) **Mental health and substance use benefit packages must promote high quality, patient-centered and cost-effective care, and continue to support the existing safety net.** This includes, but is not limited to, services not traditionally provided in the medical arena and/or covered by Medicaid, such as many homeless outreach services, mobile response programs, services to children and youth in specialized foster care, supports for housing stability, recovery maintenance homes, field-based services, etc. These services are critical in addressing social determinants of health and are an integral component of California's specialty mental health and substance use disorder systems.
- 8) **Safety net funding for residually uninsured populations must be preserved.** As healthcare reforms take hold and insurance coverage gradually expands, we must ensure that a shifting or reduction in safety net funding does not diminish access to mental health and substance use disorder services for residually uninsured populations. In particular, approximately 11% (58,600) of today's uninsured Californians with mental health needs will not be eligible under the ACA due to immigration status³. This means increasing the efficiency of federal funds reimbursement, preserving realignment revenue and federal block grant funding for County mental health and substance use disorder services and ensuring that the State does not reduce Medi-Cal eligibility or benefits. The size and impact of the residual population, including those ineligible for programs due to placement in an Institute for Mental Disease (IMD), will likely be realized only over time once the ACA policies and programs are fully implemented. Any diversion of funds from these health care delivery systems before a full assessment of the near-term and longer-term impacts of the ACA are determined and analyzed would offer a recipe for undermining the very systems the State will need to rely on to service the expanded Medi-Cal and other publicly sponsored populations. Financing systems may need to be reformed to better align payment policies with care coordination and quality improvement goals and objectives.
- 9) **Support for policies that address the workforce composition, development and expansion to address the needs of the Medicaid expansion and Covered California populations is critical, including pathways to employment, competencies for peer support, etc.** This includes the utilization of non-licensed providers and peer support to most effectively and efficiently meet the needs of consumers/clients with mental health and substance use disorders.
- 10) **Coordination of mental health, substance use and primary care is essential to ensuring quality care and realizing cost savings.** The aim of the ACA is to ultimately reduce the cost of healthcare delivery to the entire population. In order to more effectively care for the whole person, there must be more seamless coordination between system partners. This includes reducing barriers to the exchange of information necessary to appropriately coordinate care, improve quality, and address confidentiality.

³ UCLA Center for Health Policy Research (November 2012), Health Policy Fact Sheet, "Half a Million Uninsured California Adults with Mental Health Needs Are Eligible for Health Coverage Expansions."



CalSIM

California Simulation of Insurance Markets

The California Simulation of Insurance Markets (CalSIM) model is designed to estimate the impacts of various elements of the Affordable Care Act on employer decisions to offer insurance coverage and individual decisions to obtain coverage in California. It was developed by the UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research, with generous funding provided by The California Endowment.

FACT SHEET • JUNE 2012

Predicted Increase in Medi-Cal Enrollment under the Affordable Care Act: Regional and County Estimates

Between 1.2 and 1.6 million more Californians will have coverage through Medi-Cal in 2019 due to the Affordable Care Act

Ken Jacobs, Dave Graham-Squire, Gerald F. Kominski, Dylan H. Roby, Nadereh Pourat, Christina M. Kinane, Greg Watson, Daphna Gans, and Jack Needleman

The Affordable Care Act (ACA) will expand access to health coverage across California. Californians with household incomes up to 138 percent of the Federal Poverty Level (\$14,856 for an individual and \$31,809 for a family of four in 2012) will be eligible for Medi-Cal starting in January 2014 under the law. Childless adults will be eligible for Medi-Cal for the first time based on income alone, while the income thresholds will be increased for parents and children ages 6–19. The new law will also significantly simplify program enrollment and retention, including eliminating asset tests for those who are eligible solely due to their income.¹ As a result, between 1.2 and 1.6 million more Californians are predicted to be enrolled in Medi-Cal in 2019 than otherwise would have been under current law. (See [*Nine Out of Ten Non-Elderly Californians Will Be Insured When the Affordable Care Act is Fully Implemented*](#)).

An estimated 1.4 million Californians under age 65 will be newly eligible for Medi-Cal in 2014 due to the ACA. Of the newly eligible, 730,000 are predicted to take up the program by 2019 under our base scenario, and 900,000 under our enhanced scenario, which involves extensive outreach and multiple consumer-friendly enrollment pathways. In addition, 1.3 million Californians are currently eligible for Medi-Cal, but not enrolled. About 100,000 of those currently eligible but not enrolled are predicted to take up coverage under our base scenario, while 300,000 will take up under our enhanced scenario.²

Medi-Cal enrollment will expand in every county across the state. Los Angeles and the remaining Southern California counties are predicted to each account for more than 30 percent of the new enrollees. The San Joaquin Valley will have a higher share of new enrollees (14 percent under the base scenario) compared to its population size (10.4 percent of the state's population), while the Greater Bay Area will have a smaller share of new enrollees (11.4 percent) compared to its size (19.3 percent of the state's population).

Exhibit 1. Predicted Increase in Medi-Cal Enrollment due to the ACA, Californians under Age 65, by Region and County, 2019

Region/County	Baseline Without Increases due to ACA	Increased Enrollment Base Scenario		Increased Enrollment Enhanced Scenario	
		Predicted Enrollees	Percent of State Total	Predicted Enrollees	Percent of State Total
Northern California and Sierra Counties	250,000	50,000	4.4%	60,000	3.9%
Greater Bay Area	740,000	130,000	11.4%	180,000	11.7%
Santa Clara	190,000	30,000	2.6%	40,000	2.6%
Alameda	190,000	30,000	2.6%	40,000	2.6%
Sacramento Area	250,000	60,000	5.2%	80,000	5.2%
San Joaquin Valley	990,000	160,000	14.0%	210,000	13.7%
Fresno	270,000	30,000	2.6%	40,000	2.6%
Central Coast	330,000	60,000	5.2%	80,000	5.2%
Ventura	90,000	30,000	2.6%	30,000	2.0%
Los Angeles	1,990,000	350,000	30.6%	460,000	30.0%
Other Southern California	1,330,000	350,000	30.6%	470,000	30.6%
Orange	410,000	90,000	7.9%	110,000	7.2%
San Diego	310,000	90,000	7.9%	120,000	7.8%
San Bernardino	340,000	80,000	7.0%	110,000	7.2%
Riverside	230,000	90,000	7.9%	110,000	7.2%

Source: UC Berkeley–UCLA CalSIM model, version 1.7.

Note: Not all counties are listed due to sample sizes. For definitions of regions see Table 7-2 Regions in California, CHIS 2009 Methodology Report Series #5, page 7-7, http://www.chis.ucla.edu/pdf/CHIS2009_method5.pdf.

Data Sources and Methodology

We used the California Simulation of Insurance Markets (CalSIM) model, version 1.7, to predict changes in health coverage in California under the ACA. The model is designed to estimate the impacts of various elements of the ACA on employer decisions to offer insurance coverage and individual decisions to obtain coverage in California. For further information on the CalSIM methodology, please visit http://www.healthpolicy.ucla.edu/pubs/files/calsim_methods.pdf.

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Endnotes

¹ Asset tests remain for individuals applying for other Medicaid eligibility categories, including the elderly and disabled.

² For more details see Exhibits 12–17, Kominski et al., *Health Insurance Coverage in California under the Affordable Care Act*, June 2012.

1991 Health Realignment

History of programs leading up to 1991 Realignment

- 1971: Creation of state-only Medically Indigent Adult (MIA) Medi-Cal Category (100% State funds since no federal matching dollars were available, with a county share of cost in the early years).
- 1979: Creation of the AB 8 program to help prevent erosion of local health services in the aftermath of Proposition 13. MOE placed on counties as a condition of receiving AB 8 funds, and requirement of annual reporting to the state on how AB 8 funds were used.
- 1982: Transfer of state-only MIA program back to the counties; creation of Medically Indigent Services Program (MISP) for medium to large counties and County Medical Services Program (CMSP) for small counties.
- 1991/92: Realignment. Health Programs rolled into the Health Account included:
- AB 8
 - MISP/CMSP
 - Local Health Services (public health services for 12 smallest counties)
 - State Legalization Impact Assistance Grants (SLIAG)

County-by-county formula created by adding up each county's share of the above programs, and calculating a percentage of the aggregate.

Requirements on Use of Health Realignment Funds

Health Realignment Funds must be deposited into each county's local health trust fund.

Each county must also deposit its individual Maintenance of Effort (MOE) into its local health trust fund. The county MOE is a specific dollar amount (\$341 million statewide total) set in statute (Welfare and Institutions Code Section 17608.10).

A county can only expend local health trust funds for indigent health or public health services (W&I 17609.01).

Unlike under the old AB 8 program, counties are not required to report to the state how Health Realignment funds are expended.

The flexibility provided by Health Realignment allows county health departments to target resources to address local community health needs, including health care access for underserved populations and communicable and chronic disease prevention.

How much in Health Realignment do Counties receive?

- 75% of the Health Realignment Account comes from Vehicle License Fees (VLF)
- Prior to the recession, VLF was a strong, stable funding source
- VLF revenues since 2006-07 have declined by almost 25%

Health Realignment Accounts	FY 11/12
VLF	\$996,048,479
Sales Tax	\$351,716,342
Total	\$1,347,764,821



Glossary of Key Health Reform Terms

The complex and challenging process of implementation of the recently passed health reform law—the Patient Protection and Affordable Care Act (PPACA)—has begun. This glossary is intended to serve as a resource for understanding the concepts included in the reform legislation as well as in the debate surrounding implementation. It provides simple and straightforward definitions of key terms that were part of the health reform debate and continue to be part of the national dialogue as implementation moves forward.

Access: The ability to obtain needed medical care. Access to care is often affected by the availability of insurance, the cost of the care, and the geographic location of providers.

Accountable Care Organization (ACO): A network of health care providers that band together to provide the full continuum of health care services for patients. The network would receive a payment for all care provided to a patient, and would be held accountable for the quality and cost of care. New pilot programs in Medicare and Medicaid included in the health reform law would provide financial incentives for these organizations to improve quality and reduce costs by allowing them to share in any savings achieved as a result of these efforts.

Actuarial Equivalent: A health benefit plan that offers similar coverage to a standard benefit plan. Actuarially equivalent plans will not necessarily have the same premiums, cost-sharing requirements, or even benefits; however, the expected spending by insurers for the different plans will be the same.

Actuarial Value: A measure of the average value of benefits in a health insurance plan. It is calculated as the percentage of benefit costs a health insurance plan expects to pay for a standard population, using standard assumptions and taking into account cost-sharing provisions. Placing an average value on health plan benefits allows different health plans to be compared. The value only includes expected benefit costs paid by the plan and not premium costs paid by the enrollee. It also represents an average for a population, and would not necessarily reflect the actual cost-sharing experience of an individual.

Adverse Selection: People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.

Annual Benefit Limit: Insurers place a ceiling on the amount of claims they will pay in a given year for an individual. Individuals would then have to pay the full cost for any claims incurred above this ceiling during the course of the year. Beginning in 2010, annual benefit limits will be restricted and will be prohibited in 2014 under health reform.

Association Health Plan: Health insurance plans that are offered to members of an association. These plans are marketed to individual association members, as well as small business members. How these plans are structured, who they sell to, and whether they are state-based or national associations determines whether they are subject to state or federal regulation, or both, or are largely exempt from regulations.

Basic Health Plan: Beginning in 2014, the health reform law will give states the option of creating a basic health plan to provide coverage to individuals with incomes between 133 and 200 percent of poverty in lieu of having these individuals enroll in the health insurance exchange and receive premium subsidies. The plan would exist outside of the health insurance exchange and include the essential health benefits as defined by the health reform law. Cost-sharing under this plan would also be limited. If states choose to offer this plan, the federal government will provide states 95 percent of what it would have paid to subsidize these enrollees in the health insurance exchange.

Benefit Package: The set of services, such as physician visits, hospitalizations, prescription drugs, that are covered by an insurance policy or health plan. The benefit package will specify any cost-sharing requirements for services, limits on particular services, and annual or lifetime spending limits.

Capitation: A method of paying for health care services under which providers receive a set payment for each person or “covered life” instead of receiving payment based on the number of services provided or the costs of the services rendered. These payments can be adjusted based on the demographic characteristics, such as age and gender, or the expected costs of the members.

Case Management: The process of coordinating medical care provided to patients with specific diagnoses or those with high health care needs. These functions are performed by case managers who can be physicians, nurses, or social workers.

Catastrophic Coverage: A coverage option with limited benefits and a high deductible (the amount of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services), intended to protect against medical bankruptcy due to an unforeseen illness or injury. These plans are usually geared toward young adults in relatively good health. While catastrophic plans do not generally cover preventive care, catastrophic coverage plans under health reform will be required to exempt some preventive care services from the deductible.

Children's Health Insurance Program (CHIP): Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP but federal CHIP funds are capped.

Chronic Care Management: The coordination of both health care and supportive services to improve the health status of patients with chronic conditions, such as diabetes and asthma. These programs focus on evidence-based interventions and rely on patient education to improve patients' self-management skills. The goals of these programs are to improve the quality of health care provided to these patients and to reduce costs.

Community Living Assistance Services and Supports (CLASS) Program: The CLASS program establishes a national voluntary insurance program for purchasing non-medical services and supports necessary for individuals with functional limitations to maintain community residence. Enrollment will begin January 1, 2011 and will target working adults who will be able to make voluntary premium contributions either through payroll deductions through their employer or directly. The first benefits will be paid out to eligible beneficiaries in 2016.

COBRA: When employees lose their jobs, they are able to continue their employer-sponsored coverage for up to 18 months through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under the original legislation, individuals were required to pay the full premium to continue their insurance through COBRA. The American Recovery and Reinvestment Act (ARRA) provides a temporary subsidy of 65% of the premium cost for the purchase of COBRA coverage to people who have lost their job between September 1, 2008 and May 31, 2010.

Co-insurance: A method of cost-sharing in health insurance plans in which the plan member is required to pay a defined percentage of their medical costs after the deductible has been met.

Community Rating: A method for setting premium rates for health insurance plans under which all policy holders are charged the same premium for the same coverage. "Modified community rating" generally refers to a rating method under which health insuring organizations are permitted to vary premiums based on specified demographic characteristics (e.g. age, gender, location), but cannot vary premiums based on the health status or claims history of policy holders. Under health reform, beginning in 2014, health plans will be required to adopt modified community rating. Variations in premiums will only be allowed for differences in geography, family structure, age (limited to a 3 to 1 ratio) and tobacco use (limited to a 1.5 to 1 ratio).

Comparative Effectiveness Research: A field of research that analyzes the impact of different options for treating a given condition in a particular group of patients. These analyses may focus only on the medical risks and benefits of each treatment or may also consider the costs and benefits of particular treatment options.

Consumer-Directed Health Plans: Consumer-directed health plans seek to increase consumer awareness about health care costs and provide incentives for consumers to consider costs when making health care decisions. These health plans usually have a high deductible accompanied by a consumer-controlled savings account for health care services. There are two types of savings accounts: Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs).

Co-payment: A fixed dollar amount paid by an individual at the time of receiving a covered health care service from a participating provider. The required fee varies by the service provided and by the health plan.

Cost Containment: A set of strategies aimed at controlling the level or rate of growth of health care costs. These measures encompass a myriad of activities that focus on reducing overutilization of health services, addressing provider reimbursement issues, eliminating waste, and increasing efficiency in the health care system.

Cost-Sharing: A feature of health plans where beneficiaries are required to pay a portion of the costs of their care. Examples of costs include co-payments, coinsurance and annual deductibles.

Cost Shifting: Increasing revenues from some payers to offset losses or lower reimbursement from other payers, such as government payers and the uninsured.

Countercyclical: Medicaid is a countercyclical program in that it expands to meet increasing need when the economy is in decline. During an economic downturn, more people become eligible for and enroll in the Medicaid program when they lose their jobs and their access to health insurance. As enrollment grows, program costs also rise.

Deductible: A feature of health plans in which consumers are responsible for health care costs up to a specified dollar amount. After the deductible has been paid, the health insurance plan begins to pay for health care services. Under health reform, beginning in 2014, deductibles for new plans sold in the small group insurance market will be limited to \$2,000 for individual policies and \$4,000 for family policies.

Disproportionate Share Hospital (DSH) Payments: Payments made by Medicare or a state's Medicaid program to hospitals designated as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicare and Medicaid beneficiaries. With respect to Medicaid DSH, states have some discretion in determining how much eligible hospitals receive, but the amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute. Health reform will reduce the amount of both Medicare and Medicaid DSH funds distributed by the federal government over time as more people become insured.

Doughnut Hole: A gap in prescription drug coverage under Medicare Part D, where beneficiaries enrolled in Part D plans pay 100% of their prescription drug costs after their total drug spending exceeds an initial coverage limit until they qualify for catastrophic coverage. Under the standard Part D benefit, Medicare covers 75% of total drug spending below the initial coverage limit (\$2,830 in 2010), and 95% of spending above the catastrophic level (\$6,440 in 2010). These thresholds are indexed to increase over time. The doughnut hole or coverage gap specifically refers to the range between these two levels (\$3,610 in 2010) in which beneficiaries are responsible for all costs incurred for prescription drugs. The coverage gap will be gradually phased out under health reform, so that by 2020, beneficiaries will only be responsible for 25% of all prescription drug costs up to the catastrophic level.

Dual Eligibles: A term used to describe an individual who is eligible for Medicare and for some level of Medicaid benefits. Most dual eligibles qualify for full Medicaid benefits including nursing home services, and Medicaid pays their Medicare premiums and cost sharing. For other duals, often those with slightly higher incomes (up to 120% of poverty), Medicaid provides the "Medicare Savings Programs" through which enrollees receive assistance with Medicare premiums, deductibles, and other cost sharing requirements. To promote better coordination of Medicare and Medicaid services for dual eligibles, the health reform law creates a new Federal Coordinated Health Care Office within the Centers for Medicare & Medicaid Services.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services: One of the services that states are required to include in their basic benefits package for all Medicaid-eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions, as well as vision, hearing, and dental problems. Services also include follow-up diagnostic and treatment services to correct conditions identified during a screening, without regard to whether the state Medicaid plan covers those services for adult beneficiaries.

Electronic Health Record/Electronic Medical Records: Computerized records of a patient's health information including medical, demographic, and administrative data. This record can be created and stored within one health care organization or it can be shared across health care organizations and delivery sites.

Employee Retirement Income Security Act of 1974 (ERISA): Legislation enacted in 1974 to protect workers from the loss of benefits provided through the workplace. ERISA does not require employers to establish any type of employee benefit plan, but contains requirements applicable to the administration of the plan when a plan is established. The requirements of ERISA apply to most private employee benefit plans established or maintained by an employer, an employee organization, or both.

Employer Health Care Tax Credit: An incentive mechanism designed to encourage employers, usually small employers, to offer health insurance to their employees. The tax credit enables employers to deduct an amount, usually a percentage of the contribution they make toward their employees' premiums, from the federal taxes they owe. These tax credits are typically refundable so they are available to non-profit organizations that do not pay federal taxes. The health reform law includes a tax credit for small employers that provide health coverage to their employees. The tax credit is available to employers with 25 or fewer employees and average annual wages of less than \$50,000.

Employer Mandate: An approach that would require all employers, or at least all employers meeting size or revenue thresholds, to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of their employees. Currently, Hawaii is the only state in the US to have an employer mandate.

Employer Pay-or-Play: An approach that would require employers to offer and pay for health benefits on behalf of their employees, or to pay a specified dollar amount or percentage of payroll into a designated public fund. The fund would provide a source of financing for coverage for those who do not have employment-based coverage. Currently, two states, Massachusetts and Vermont, and the City of San Francisco impose pay-or-play requirements on employers.

Entitlement Program: Federal programs, such as Medicare and Medicaid, for which people who meet eligibility criteria have a federal right to benefits. Changes to eligibility criteria and benefits require legislation. The federal government is required to spend the funds necessary to provide benefits for individuals in these programs, unlike discretionary programs for which spending is set by Congress through the appropriations process. Enrollment in these programs cannot be capped and neither states nor the federal government may establish waiting lists.

Episode of Care: An episode of care refers to all the treatments and services related to the treatment of a condition. For acute conditions (such as a concussion or a bone fracture), the episode refers to all treatment and services from the onset of the condition to its resolution. For chronic conditions, the episode refers to all services and treatments received over a given period of time, commonly one year. Some payment reform proposals include basing payment on episodes of care, rather than on each service rendered. The intent is to increase the accountability of the provider for the care of the patient. The health reform law calls for pilot programs to test this method of payment reform in Medicare and Medicaid.

Essential Health Benefits: A benchmark level of benefits created by the health reform law that is meant to ensure a health plan provides a comprehensive set of services. Plans both within and outside of the health insurance exchange will be required to offer at least this level of coverage. Cost-sharing will be limited to the current HSA limits (\$5,950 for individuals and \$11,900 for families). The Secretary of Health and Human Services will be required to define and annually update the benefit package.

Experience Rating: A method of setting premiums for health insurance policies based on the claims history of an individual or group. Experience rating will be prohibited under the health reform law beginning in 2014.

Federal Employee Health Benefits Program (FEHBP): A program that provides health insurance to employees of the U.S. federal government. Federal employees choose from a menu of plans that include fee-for-service plans, plans with a point of service option, and health maintenance organization plans. There are more than 170 plans offered; a combination of national plans, agency-specific plans, and more than 150 HMOs serving only specific geographic regions. The various plans compete for enrollment as employees can compare the costs, benefits, and features of different plans.

Federal Medical Assistance Percentage (FMAP): The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50% to 76% depending upon a state's per capita income; on average, across all states, the federal government pays 57% of the costs of Medicaid. The American Recovery and Reinvestment Act (ARRA) provides a temporary increase in the FMAP through December 31, 2010, and additional legislation partially extends this funding through June 30, 2011.

Federal Poverty Level (FPL): The federal government's working definition of poverty that is used as the reference point to determine the number of people with income below poverty and the income standard for eligibility for public programs. The federal government uses two different definitions of poverty. The U.S. Census poverty threshold is used as the basis for official poverty population statistics, such as the percentage of people living in poverty. The poverty guidelines, released by the U.S. Department of Health and Human Services (HHS), are used to determine eligibility for public programs and subsidies. For 2009, the Census weighted average poverty threshold for a family of four was \$21,947 and HHS poverty guideline was \$22,050.

Fee-for-Service: A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement.

Grandfathered Plan: A health plan that was in place on March 23, 2010, when the health reform law was enacted, is exempt from complying with some parts of the health reform law, so long as the plan does not make significant changes to its policy, such as eliminating or reducing benefits to treat a specific disease or condition, significantly increasing cost-sharing, or reducing the employer contribution toward the premium, among others. Once a health plan makes such a change to their policy, it becomes subject to all the requirements of health reform.

Group Health Insurance: Health insurance that is offered to a group of people, such as employees of a company. The majority of Americans have group health insurance through their employer or their spouse's employer.

Guarantee Issue/Renewal: Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason. Beginning in 2014, the health reform law will require guarantee issue and renewability.

Health Care Cooperative (CO-OP): A non-profit, member-run health insurance organization, governed by a board of directors elected by its members. Co-ops provide insurance coverage to individuals and small businesses and can operate at state, regional, and national levels.

Health Information Technology: Systems and technologies that enable health care organizations and providers to gather, store, and share information electronically.

Health Insurance Exchange/Connector: An arrangement through which insurers offer smaller employers and individuals health insurance plans for purchase. Under health reform, state-based health insurance exchanges will be established to set standards for what benefits are to be covered, how much insurers can charge, and the rules insurers must follow in order to participate in the insurance market. Individuals and small employers will then be able to select their coverage within this organized arrangement. An example of this arrangement is the Commonwealth Connector, created in Massachusetts in 2006. The state-based exchanges under health reform are legislated to begin operation in 2014.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Through the Health Insurance Portability and Accountability Act of 1996, individuals can maintain coverage while changing jobs or for a temporary period of unemployment without a waiting period. Individuals in many states who lose group health coverage after a loss of employment have access to coverage through high-risk pools, with no pre-existing condition exclusion periods. HIPAA also sets standards that address the security and privacy of personal health data.

Health Reimbursement Arrangement (HRA): A tax-exempt account that can be used to pay for current or future qualified health expenses. HRAs are established benefit plans funded solely by employer contributions, with no limits on the amount an employer can contribute. HRAs are often paired with a high-deductible health plan, but do not have to be.

Health Savings Account (HSA): A tax-exempt savings account that can be used to pay for current or future qualified medical expenses. Employers may make HSAs available to their employees or individuals can obtain HSAs from most financial institutions. Employers and employees can contribute to the plan. In order to open an HSA, an individual must have health coverage under an HSA-qualified high-deductible health plan. These HSA-qualified high-deductible health plans must have deductibles (the amount of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services) of at least \$1,200 for an individual and \$2,400 for a family in 2010.

High-Deductible Health Plan: Health insurance plans that have higher deductibles (the amount of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services), but lower premiums than traditional plans. Qualified high-deductible plans that may be combined with a health savings account must have a deductible of at least \$1,200 for single coverage and \$2,400 for family coverage in 2010.

High-Risk Pool: State programs designed to provide health insurance to residents who are considered medically uninsurable and are unable to buy coverage in the individual market. As of early 2009, high-risk pools operated in 34 states but varied by eligibility requirements, cost-sharing requirements, availability of premium subsidies, and funding sources. The health reform law creates temporary high risk pools in each state (referred to as the Pre-existing Condition Insurance Plan) to provide coverage for those with pre-existing conditions who are uninsured. These temporary pools will provide coverage until 2014.

Income-Related Premium: Premiums for Medicare Part B and Part D that apply to higher-income Medicare beneficiaries. The Medicare Modernization Act of 2003 established an income-related Part B premium that took effect in 2007, requiring higher-income Medicare beneficiaries to pay a greater share of average Part B costs (35% to 80%, depending on their income). Beneficiaries are required to pay the income-related Part B premium if their income is equal to or greater than \$85,000 for an individual and \$170,000 for a couple in 2010. The health reform law freezes the threshold for the income-related Part B premium at 2010 levels through 2019, effective in 2011. The health reform law also creates an income-related Part D premium, effective in 2011, using the same surcharge percentages (35% to 80%) and income thresholds (\$85,000 for an individual and \$170,000 for a couple in 2010) as for Part B. Similar to the Part B premium provision, the income thresholds for the Part D income-related premium are not indexed to increase annually.

Independent Payment Advisory Board: A board of 15 members appointed by the President and confirmed by the Senate for six year terms. The board is tasked with submitting proposals to Congress to reduce Medicare spending by specified amounts if the projected per beneficiary spending exceeds the target growth rate. If the Board fails to submit a proposal, the Secretary of the Department of Health and Human Services is required to develop a detailed proposal to achieve the required level of Medicare savings. The Secretary is required to implement the Board's (or Secretary's) proposals, unless Congress adopts alternative proposals that result in the same amount of savings. The Board is prohibited from submitting proposals that would ration care, increase taxes, change Medicare benefits or eligibility, increase beneficiary premiums and cost-sharing requirements, or reduce low-income subsidies under Part D.

Individual Insurance Market: The market where individuals who do not have group (usually employer-based) coverage purchase private health insurance. This market is also referred to as the non-group market.

Individual Mandate: A requirement that all individuals obtain health insurance. Massachusetts was the first state to impose an individual mandate that all adults have health insurance. There is an individual mandate to obtain health insurance in the health reform law that applies to all Americans with some hardship and income-based exemptions beginning in 2014.

Lifetime Benefit Maximum: A cap on the amount of money insurers will pay toward the cost of health care services over the lifetime of the insurance policy. Lifetime benefits maximums are prohibited under health reform.

Long-Term Care: Services that include those needed by people to live independently in the community, such as home health and personal care, as well as services provided in institutional settings such as nursing homes. Medicaid is the primary payer for long-term care. Many of these services are not covered by Medicare or private insurance. The health reform law includes several new options in Medicaid for states to expand the availability of home and community-based long-term care services and creates the new Community Living Assistance Services and Supports (CLASS) program to assist individuals with functional limitations in purchasing supportive services so they can maintain community residence.

Managed Care: A health delivery system that seeks to control access to and utilization of health care services both to limit health care costs and to improve the quality of the care provided. Managed care arrangements typically rely on primary care physicians to act as "gatekeepers" and manage the care their patients receive.

Mandatory Benefits: Certain benefits or services, such as mental health services, substance abuse treatment, and breast reconstruction following a mastectomy, that state-licensed health insuring organizations are required to cover in their health insurance plans. The number and type of these mandatory benefits vary across states.

Medicaid: Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a federal entitlement program that provides health and long-term care coverage to certain categories of low-income Americans. States design their own Medicaid programs within broad federal guidelines including setting eligibility levels. Medicaid plays a key role in the U.S. health care system, filling large gaps in the health insurance system, financing long-term care coverage, and helping to sustain the safety-net providers that serve the uninsured. The health reform law expands Medicaid eligibility to non-elderly individuals (children pregnant women, parents, and adults without dependent children) with incomes up to 133% of poverty, establishing uniform eligibility for adults and children across all states by 2014.

Medicaid Waivers: Authority granted by the Secretary of Health and Human Services to allow a state to continue receiving federal Medicaid matching funds even though it is no longer in compliance with certain requirements of the Medicaid statute. States can use waivers to implement home and community-based services programs, managed care, and to expand coverage to populations who are not otherwise eligible for Medicaid.

Medical Home or Health Home: A health care setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to non-emergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care.

Medical Loss Ratio (MLR): The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits. The health reform law requires insurers in the large group market to have an MLR of 85% and insurers in the small group and individual markets to have an MLR of 80%.

Medical Underwriting: The process of determining whether or not to accept an applicant for health care coverage based on their medical history. This process determines what the terms of coverage will be, including the premium cost, and any pre-existing condition exclusions. Medical underwriting will be prohibited under health reform beginning in 2014.

- Medicare:** Enacted in 1965 under Title XVIII of the Social Security Act, Medicare is a federal entitlement program that provides health insurance coverage to 45 million people, including people age 65 and older, and younger people with permanent disabilities, end-stage renal disease, and Lou Gehrig's disease.
- Medicare Advantage:** Also referred to as Medicare Part C, the Medicare Advantage program allows Medicare beneficiaries to choose to receive their Medicare benefits through a private insurance plan rather than the traditional fee-for-service program. Payments to Medicare Advantage plans made by Medicare, which were on average 9% higher than the costs of the traditional fee-for-service program in 2010, will be reduced under health reform, bringing them closer to the average costs of care under the traditional fee-for-service program.
- Minimum Creditable Coverage:** The minimum level of benefits that must be included in a health insurance plan in order for an individual to be considered insured. Minimum creditable coverage standards have been established in Massachusetts as part of that state's health reform law.
- Out-of-Pocket Costs:** Health care costs, such as deductibles, co-payments, and co-insurance that are not covered by insurance. Out-of-pocket costs do not include premium costs.
- Out-of-Pocket Maximum:** A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium. The health reform law requires new plans offered beginning in 2014 to include an out-of-pocket maximum set at the current HSA level or \$5,950 for an individual policy or \$11,900 for a family policy in 2010.
- Pay for Performance:** A health care payment system in which providers receive incentives for meeting or exceeding quality and cost benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.
- Payment Bundling:** A form of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service rendered. Total care provided for an episode of illness may include both acute and post-acute care. The health reform law establishes pilot programs in Medicare and Medicaid to pay a bundled payment for episodes of care involving hospitalizations.
- Portability of Coverage:** Rules created by the Health Insurance Portability and Accountability Act (HIPAA) allowing people to obtain coverage as they move from job to job or in and out of employment. Individuals changing jobs are guaranteed coverage with the new employer without a waiting period. In addition, insurers must waive any pre-existing condition exclusions for individuals who were previously covered within a specified time period. Portable coverage can also be health coverage that is not connected to an employer, allowing individuals to keep their coverage when they have a change in employment.
- Pre-existing Condition Exclusions:** An exclusion from coverage of an illness or medical condition for which a person had received a diagnosis or treatment within a specified period of time prior to becoming insured. Health care providers can exclude benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage. Pre-existing condition exclusions are prohibited by the health reform law beginning in 2010 for children and in 2014 for adults.
- Premium:** The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers and individuals.
- Premium Subsidies:** A fixed amount of money or a designated percentage of the premium cost that is provided to help people purchase health coverage. Premium subsidies are usually provided on a sliding scale based on an individual's or family's income. The health reform law provides premium subsidies through refundable pre-tax credits to individuals with incomes between 133% and 400% of the federal poverty level who purchase policies through the health insurance exchanges beginning in 2014.
- Preventive Care:** Health care that emphasizes the early detection and treatment of diseases. The focus on prevention is intended to keep people healthier for longer, thus reducing health care costs over the long term. The health reform law requires new qualified health plans and Medicare to provide coverage without cost-sharing for certain preventive services. The law also includes incentives for states to offer the same coverage in their Medicaid programs.
- Primary Care Provider:** A provider, usually a physician specializing in internal medicine, family practice, or pediatrics (but can also be a nurse practitioner, physician assistant or even a health care clinic), who is responsible for providing primary care and coordinating other necessary health care services for patients.
- Provider Payment Rates:** The total payment a provider, hospital, or community health center receives when they provide medical services to a patient. Providers are compensated for patient care using a set of defined rates based on illness category and the type of service administered.

Public Plan Option: A proposal to create a new insurance plan administered and funded by federal or state government that would be offered along with private plans in a newly created health insurance exchange.

Purchasing Pool: Health insurance providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should balance low and high risk individuals such that expected costs for the pool are reasonably predictable for the insurer and relatively stable over time.

Qualified Health Plan: Refers to insurance plans that have been certified as meeting a minimum benchmark of benefits (i.e. the essential health benefits) under health reform. This will allow consumers to verify that the plan they have purchased will meet at least the minimum requirements of the individual mandate.

Reinsurance: Reinsurance is insurance for insurance companies and employers that self-insure their employees' medical costs. Through government-funded reinsurance programs, federal or state governments pay for a portion of the high costs experienced by insurers. By limiting insurers' exposure to very high health costs, reinsurance programs enable insurers to lower the premiums they charge to employers and individuals. This type of program is a form of subsidy to the insurer that lowers the premium cost for all purchasers. The Healthy New York program and the Healthcare Group of Arizona are examples of state reinsurance programs. The health reform law provides for a temporary federal reinsurance program for employers that insure early retirees over age 55 who are not eligible for Medicare.

Rescission: Also referred to as "post-claims underwriting," this is a practice in the individual insurance market where an approved policy is rescinded by the insurer, often after a large claim has been filed, on the grounds that the individual misrepresented their health history on their initial application. The condition not disclosed to the insurer can be unrelated to the current claim. This practice occurs in the individual market because, unlike the large group/ employer market, until the passage of health reform, there were no restrictions against insurers for underwriting or denying coverage based on pre-existing conditions. Under health reform, insurers will only be able to rescind policies in cases of fraud.

Risk Adjustment: The process of increasing or reducing payments to health plans to reflect higher or lower than expected spending. Risk adjusting is designed to compensate health plans that enroll an older and sicker population as a way to discourage plans from selecting only healthier enrollees.

Safety Net: Health care providers who deliver health care services to patients regardless of their ability to pay. These providers may consist of public hospital systems, community health centers, local health departments, and other providers who serve a disproportionate share of uninsured and low-income patients.

Section 125 Plan: A section 125 plan allows employees to receive specified benefits, including health benefits, on a pre-tax basis. Section 125 plans enable employees to pay for health insurance premiums on a pre-tax basis, whether the insurance is provided by the employer or purchased directly in the individual market.

Self-Insured Plan: A plan where the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employer sponsored self-insured plans typically contract with a third-party administrator or insurer to provide administrative services for the plan.

Single-Payer System: A health care system in which a single entity pays for health care services. This entity collects health care fees and pays for all health care costs, but is not involved in the delivery of health care.

Small Group Market: Firms with 2-50 employees can purchase health insurance for their employees through this market, which is regulated by states.

Socialized Medicine: A health care system in which the government operates and administers health care facilities and employs health care professionals.

Tax Credit: A tax credit is an amount that a person/family can subtract from the amount of income tax that they owe. If a tax credit is refundable, the taxpayer can receive a payment from the government to the extent that the amount of the credit is greater than the amount of tax they would otherwise owe.

Tax Deduction: A deduction is an amount that a person/family can subtract from their adjusted gross income when calculating the amount of tax that they owe. Generally, people who itemize their deductions can deduct the portion of their medical expenses, including health insurance premiums, that exceeds 7.5% of their adjusted gross income. Under health reform, the threshold for deducting medical expenses increases to 10% in 2013 (this increase is waived for individuals 65 and older for tax years 2013-2016).

Tax Preference for Employer-Sponsored Insurance: Under the current tax code, the amount that employers contribute to health benefits are excluded, without limit, from most workers' taxable income and any contributions made by employees toward the premium cost for health insurance are made on a tax-free basis. In contrast, individuals currently who do not receive health insurance through an employer may only deduct the amount of their total health care expenses that exceeds 7.5% of their adjusted gross income.

Uncompensated Care: A measure of the costs of health care services that are provided but not paid for by the patient or by insurance. Health care providers incur some of this cost along with the federal government.

Underinsured: People who have health insurance but who face out-of-pocket health care costs or limits on benefits that may affect their ability to access or pay for health care services.

Universal Coverage: A system that provides health coverage to all residents. One mechanism for achieving universal coverage (or near-universal coverage) used under health reform is the individual mandate. Single-payer proposals would also provide universal coverage.

Value-Based Purchasing: A payment reform under which hospitals and other providers are provided bonuses based upon their performance against quality measures. The health reform law establishes a value-based purchasing program in Medicare for hospitals and requires the development of similar programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers, and the testing of pilot programs for other providers, including psychiatric hospitals, long-term care hospitals, rehabilitation hospitals, and hospice programs.

Wellness Plan/Program: Employment-based program to promote health and prevent chronic disease. Goals of these programs include: reducing health care costs, sustaining and improving employee health and productivity, and reducing absenteeism due to illness.

For additional information on the implementation of health reform, please see:

Summary of New Health Reform Law. April 2010. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. Available at: www.kff.org/healthreform/upload/8061.pdf

Health Reform Implementation Timeline. April 2010. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. Available at: www.kff.org/healthreform/upload/8060.pdf .

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