



CALIFORNIA  
HEALTHCARE  
FOUNDATION



## **Implementing National Health Reform in California:** Changes to Public and Private Insurance

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# Implementing National Health Reform in California: Changes to Public and Private Insurance

*Prepared for*

CALIFORNIA HEALTHCARE FOUNDATION

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**Manatt Health Solutions** is the interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, a leading law and consulting firm. Clients look to Manatt Health Solutions for leading expertise in health care coverage and access, health information technology (health IT), health care financing and reimbursement, and health care restructuring. Manatt Health Solutions also provides strategic and business advice, policy analysis and research, project implementation, alliance building/advocacy, and government relations services. For more information, visit [www.manatt.com](http://www.manatt.com).

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## About the Foundation

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# I. Introduction

THE FEDERAL REFORM LEGISLATION KNOWN collectively as the Affordable Care Act (ACA) has a lofty goal: to transform the way health care is provided and paid for in the United States. Sweeping in scope, with an implementation timeline that spans nearly a decade, the new law will fundamentally alter the availability and structure of health insurance, bringing coverage for the first time to millions of Americans and creating new coverage options for millions more. Federal estimates indicate that 92 percent of people not yet eligible for Medicare could have access to coverage by 2016, compared to 81 percent today.<sup>1</sup>

The implementation of these reforms will be a massive undertaking requiring leadership, interagency and public-private collaboration, and a disciplined and aggressive planning process. Although the policy and legislation were crafted at the national level, their successful execution depends, in large part, on actions taken within the states, with much of the responsibility falling to state government.

California has long played a central role in supplying and regulating health insurance, through public programs such as Medi-Cal and the oversight of private insurance markets. Yet while the landscape is familiar, the broad extent of the new federal mandate is formidable: Under the combined legislation of the ACA—consisting of the Patient Protection and Affordable Care Act (PPACA) of 2010 and the Health Care and Education Reconciliation Act (HCERA) of 2010—the state’s responsibilities in both the public and private coverage spheres will grow considerably.<sup>2</sup> Some of the state’s major implementation responsibilities include:

- Expanding Medi-Cal and reconfiguring its eligibility standards;
- Creating a health insurance exchange; and
- Implementing a wide range of reforms to commercial markets, as mandated by the new law.

The purpose of this paper is to provide an initial assessment of the work ahead for California as the state and its partners implement the coverage-related provisions of the ACA. It identifies specific provisions that California either must or may implement, with a particular eye to the component tasks, decisions, and actions. The findings in this report have been informed by interviews with 16 leaders in health care policy and analysis, both private actors and public officials (see [Appendix](#)).

While each ACA provision differs in complexity, the steps necessary to implement them fall into several common categories:

- Monitoring, interpreting, and seeking to influence federal guidance;
- Facilitating interagency collaboration and planning;
- Identifying and securing financing for administrative and programmatic needs;
- Making and effecting state legislative and regulatory changes;
- Securing state plan amendments, waiver amendments, and other necessary federal approvals;

- Redesigning information technology (IT) systems; and
- Redesigning administrative systems.

In an effort to assist policymakers and stakeholders in navigating the legislation, each section of this analysis presents a summary outlining the provision discussed, its effective date, the responsible entities, and the decisions, tasks, and considerations facing California as it moves forward with implementation. Each summary ends with a short statement of “the bottom line” for the provision summarized.

Because the new law is subject to interpretation and regulatory clarification, this paper represents a starting point in a process that will evolve over the coming months and years. Moreover, the discussion that follows is focused solely on the reform act’s broad changes to public coverage programs and to the private health insurance market. In addition to those provisions, the ACA also promotes new care delivery and payment models designed to improve the quality and efficiency of care, encourages investment in population health and wellness, and improves administrative efficiency in the health care sector—all of which have their own implications for California.<sup>3</sup> Although these elements are not addressed here, important work lies ahead for public and private sector leaders to explore California’s options and opportunities, beyond those related to coverage, under the ACA.

## II. Public Coverage

THE AFFORDABLE CARE ACT RELIES ON the nation’s public health insurance programs, including Medicaid (Medi-Cal, operated by the state Department of Health Care Services [DHCS]) and the Children’s Health Insurance Plan (CHIP) (Healthy Families, operated by the Managed Risk Medical Insurance Board [MRMIB]), to serve as a foundation for enhancing health insurance coverage for people with low income. Most significantly, the ACA establishes a new national minimum Medicaid income eligibility level for individuals under the age of 65, extends authority and funding for the CHIP program, and calls for streamlined eligibility and enrollment procedures for both Medicaid and CHIP.

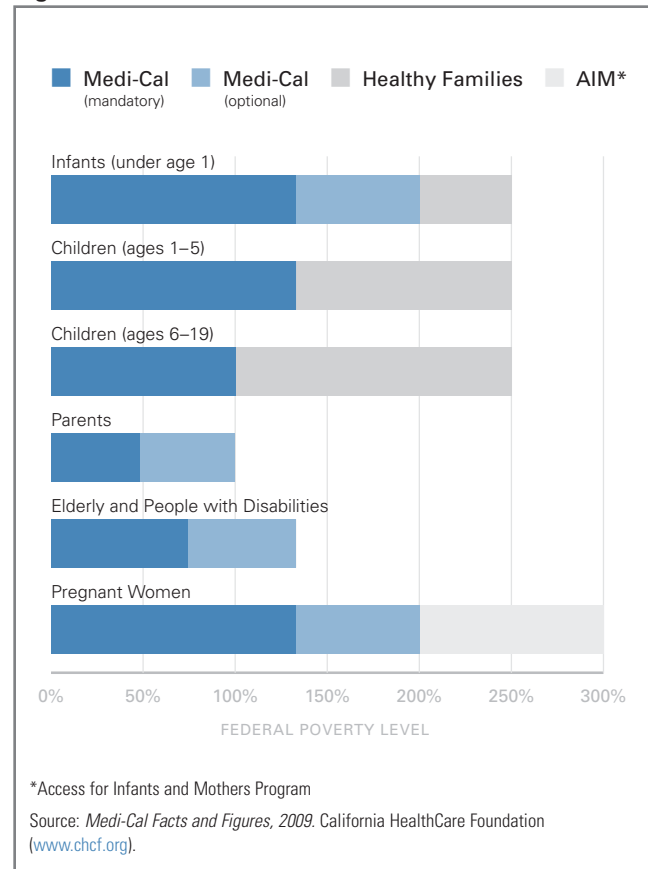
### Medi-Cal Expansion (§2001)<sup>4</sup>

Medi-Cal currently provides health coverage for nearly 7 million Californians, including children under age five in families whose income is up to 133 percent of the Federal Poverty Level (FPL), children six to 18 with family income up to 100 percent FPL, and parents with income up to 106 percent FPL (see Figure 1).<sup>5–6</sup> Childless adults who are not age 65 or disabled typically are not eligible for coverage under Medi-Cal, at any income level. Also, today as many as one in five Californians under age 65—between 900,000 and 1.4 million—are eligible for Medi-Cal or Healthy Families but are not enrolled.<sup>7</sup>

Federal reform mandates expansion of Medi-Cal coverage, estimated to increase total enrollment by more than 20 percent, or approximately 1.8 million individuals.<sup>8</sup> This would include approximately 1.4 million individuals who will be newly eligible for Medi-Cal (including some children currently covered

under Healthy Families), plus approximately 412,000 people who are already eligible and who are expected to seek coverage for the first time in response to the new federal mandate to obtain health insurance coverage.<sup>9</sup> In total, under the expanded enrollment Medi-Cal would cover nearly a quarter of the state’s population.<sup>10</sup>

**Figure 1. Income Limits**



### Coverage for Individuals with Income At or Below 133 Percent of FPL (§2001[a])

Effective 2014, the ACA expands Medi-Cal eligibility in two ways. First, it establishes a new national Medicaid eligibility threshold for all individuals under age 65, providing coverage for those with income up to 133 percent of FPL (see Table 1). Second, it requires states to provide coverage to current and former foster children up to age 26. Under this expansion, approximately 850,000 childless adults with income up to 133 percent of FPL will become newly eligible for Medi-Cal. Medi-Cal currently covers parents with income up to 106 percent of FPL; the federal expansion will make roughly 280,000 parents, with income of 106 percent to 133 percent of FPL, newly eligible for the program.<sup>11</sup> For children, new income eligibility levels will include those age six to 18 in families with income of 100 percent to 133 percent of FPL. This eligibility shift appears to require the state to transition an estimated 162,000 children from Healthy Families to Medi-Cal. The ACA also provides the state with the option to expand Medi-Cal eligibility earlier than 2014, but provides less generous federal support for doing so.<sup>12</sup>

**Table 1. Changes in Medi-Cal Coverage, Starting in 2014**

Available to individuals with income less than 133 percent of FPL<sup>13</sup>

- ▶ \$14,404—family unit of 1
- ▶ \$19,378—family unit of 2
- ▶ \$24,352—family unit of 3
- ▶ \$29,327—family unit of 4

### Medicaid Benchmark Benefits (§2001[c])

Under the ACA, California must provide the newly expanded Medi-Cal population with a “benchmark” benefit package.<sup>14</sup> These benchmark benefits may be less generous than the benefits available for individuals currently eligible for Medi-Cal coverage, but must be at least as generous as the narrower “essential health benefits” to be offered by private insurance plans through the new State Health Insurance Exchange (hereinafter, “the Exchange”) to be established under the new law by 2014 (discussed in Section III of this report). A comparison of these essential benefits with benefits for current Medi-Cal and Healthy Families enrollees illustrates the areas in which the essential benefits are less generous (see Table 2 on page 6). The state could, at its option:

- Seek the federal Department of Health and Human Services’ (HHS) approval to provide a more generous benchmark benefit package, and receive enhanced federal support for all services approved by HHS as part of the expanded benchmark benefit; or
- Choose to provide additional services over and above the approved benchmark package, but with such additional services not being eligible for federal matching dollars.

For children, California must ensure access to the full range of benefits guaranteed under Medicaid, which may require the creation of “wrap-around benefits” to supplement the benchmark package for children.<sup>15</sup>

### Federal Funding for Cost of Covering Newly Eligible Individuals (§2001[a][3])

Medi-Cal will receive enhanced federal funding to pay for newly eligible populations under the new law. The federal government generally matches state spending on Medi-Cal benefits at 50 cents on the

**Table 2. Essential Benefit Comparison**

BENEFITS	BENCHMARK/ESSENTIAL BENEFITS PACKAGE	MEDI-CAL BENEFIT PACKAGE	HEALTHY FAMILIES BENEFIT PACKAGE
Ambulatory Care	✓	✓	✓
Emergency Services	✓	✓	✓
Hospitalization	✓	✓	✓
Maternity and Newborn Care	✓	✓	✓
Mental Health and Substance Abuse Services	✓	✓	✓
Prescription Drugs	✓	✓	✓
Rehabilitative/Habilitative Services and Devices	✓	✓	✓
Laboratory Services	✓	✓	✓
Preventive and Wellness Services, including Chronic Disease Management	✓	✓	✓
Pediatric Services, including Oral/Vision Care	✓	✓	✓
Dental Services		✓ (children only)	✓
Vision Services		✓ <sup>16</sup>	✓
Long-Term Care		✓	
Medical Case Management		✓	
Podiatry Services		✓ (children only)	
Acupuncture		✓ (children only)	✓ (some plans)
Audiology and Hearing Aids		✓ (children only)	✓
Chiropractic		✓ (children only)	✓ (some plans)
Durable Medical Equipment		✓	✓
Medical Transportation		✓	✓
Orthotics and Prosthetics		✓	✓
Home Health Care		✓	✓
Skilled Nursing Care			✓
Biofeedback			✓ (some plans)
Elective Abortion			✓ (some plans)

Sources: Patient Protection and Affordable Care Act (P.L. 111–148) and modifications by the Health Care and Education Reconciliation Act of 2010 (P.L. 111–152).

dollar (increased to 62 cents on the dollar through December 31, 2010 due to the federal stimulus package). Starting in 2014, the federal government will pay 100 percent of costs for the expansion population, though this will decrease gradually over time to 90 percent in 2020 and beyond (see Table 3).<sup>17</sup> The state has the option to expand

eligibility prior to 2014, but will receive California's existing base match rate of 50 percent until 2014.<sup>18</sup>

Expanded Medi-Cal coverage, combined with the requirement that all individuals have insurance, is anticipated to have the single largest fiscal impact on the state resulting from the ACA. Based on congressional estimates, California could receive upwards of \$44.5 billion between 2014 and 2019 in federal support for newly eligible individuals.<sup>19</sup> However, starting in 2018, state Medi-Cal spending is expected to increase by \$2 billion to \$3 billion annually.<sup>20</sup> In addition to those added to Medi-Cal by expanded eligibility, the mandate that all individuals purchase or enroll in available health insurance coverage could bring into the Medi-Cal program up to 412,000 individuals who are currently eligible but not enrolled.<sup>21</sup> Enhanced federal funding will not be available for these new enrollees; the state will be responsible for picking up the customary 50 cents on the dollar for their costs.

**Table 3. Enhanced Federal Medical Assistance Percentages (FMAP)**

YEAR	STATE SHARE	FEDERAL SHARE
2014	0%	100%
2015	0%	100%
2016	0%	100%
2017	5%	95%
2018	6%	94%
2019	7%	93%
2020 and forward	10%	90%

Source: Manatt analysis of ACA.

### SUMMARY: Medicaid Expansion

**What Does It Say?** The Affordable Care Act sets a new, national Medicaid threshold at 133 percent of FPL. The newly eligible will receive a "benchmark" benefit package that must include the "essential" benefits required for insurance that will be offered in the Exchange, but may be less generous than Medi-Cal. The ACA provides full federal funding for the newly eligible populations for three years, gradually decreasing to cover 90 percent of the cost in 2020 and beyond.

**Effective Date** January 1, 2014, though California has the option to expand Medi-Cal income eligibility earlier.

**What Needs to Be Done?** Implementation of the expansion at the state level will require changes to state law, an amendment to California's State Plan, as well as a host of administrative actions including changes to the application and enrollment systems.

The state must define the "benchmark benefits," including "wrap-around benefits" for children.

The ACA appears to require the state to transition children ages six to 18 with family income of 100 percent to 133 percent of FPL from Healthy Families to Medi-Cal coverage.

**Who's Responsible?** Centers for Medicare & Medicaid Services (CMS), DHCS, MRMIB

**The Bottom Line** California could receive upwards of \$44.5 billion between 2014 and 2019 in federal support for those newly eligible for Medi-Cal, but will also face increased Medi-Cal costs due to both increased enrollment among those already eligible for public coverage and the ramping up of state matching requirements in later years.

## Changes in Eligibility and Enrollment Rules

In 2014, the ACA requires states to change their Medicaid and CHIP eligibility rules in three fundamental ways: (1) states must change the way income is counted for the purpose of determining eligibility; (2) states must eliminate the asset test for most populations; and (3) states must make a series of changes intended to improve the process for determining and maintaining eligibility for their public programs.

### Income-Counting Rules Replaced by Modified Adjusted Gross Income (MAGI) (§2002)

The ACA requires California to change the way it calculates income for the purpose of determining Medi-Cal and Healthy Families eligibility, with the goal of creating a single set of rules that will apply nationally to Medicaid, CHIP, and the Exchanges.

Today, Medicaid and CHIP allow applicants to deduct certain child care expenses, child support payments, the first \$90 of earned income, and other deductions at the state's discretion, before determining eligibility.<sup>22</sup> While these deductions have the effect of increasing eligibility, they also make the application process more complex. The ACA simplifies such income-counting rules by replacing them with a single federal standard articulated in federal tax law called “modified adjusted gross income”. To offset the loss of these deductions, the new methodology increases the adjusted gross income level by five percentage points for all Medicaid applicants. Thus, expanded eligibility under Medi-Cal, in effect, is automatically increased from 133 percent of FPL to 138 percent of FPL. Income will not be calculated on a MAGI basis for all individuals, however: Individuals who are 65 or over, disabled, medically needy (with high medical expenses), or deemed eligible for Medi-Cal as a

result of other programs, will not have their income calculated using the MAGI eligibility formula.

While transition to MAGI will simplify eligibility rules for many applicants, it will result in a less generous eligibility standard for some current Medi-Cal beneficiaries. Preliminary state analysis indicates that a number of Medi-Cal adults could lose Medi-Cal eligibility due to the application of MAGI to how their income is counted.<sup>23</sup> These beneficiaries are generally parents who receive Medi-Cal coverage through eligibility for California Work Opportunity and Responsibility to Kids (CalWORKS). These individuals would be able to obtain health insurance coverage through the Exchange, but this will have less generous benefits and substantially higher cost-sharing than Medi-Cal. Federal law prohibits children from losing coverage as a result of the transition to MAGI, but it appears to permit, and may even require, the MAGI standards to force some adults off Medi-Cal coverage.<sup>24</sup>

Prior to implementation of the new MAGI standards, California must submit to HHS—likely to CMS—the procedures that will be used to calculate income and the income eligibility thresholds under the new income calculation. This will require sorting through the existing eligibility categories and identifying those that will fall under the MAGI standards.

### Elimination of the Assets Test (§2002)

Medi-Cal eligibility rules currently require that most adults have less than \$2,000 to \$4,000 in assets, depending on family size; children are exempt from this requirement. The ACA requires that, beginning in 2014, states eliminate Medicaid assets tests for the same adults whose income will be calculated using MAGI (see previous section). That is, this change will not apply to Medi-Cal beneficiaries who are elderly, disabled, medically needy, or deemed eligible

for Medicaid as a result of other programs, such as Temporary Assistance for Needy Families (TANF). Because neither the Exchange nor Healthy Families has an assets test, this change will align and simplify the eligibility processes and enable as many as 16,000 adults to become newly eligible for Medi-Cal coverage.<sup>25</sup>

### Coverage for Legal Immigrants

The Affordable Care Act does not lift the five-year waiting period (“five-year bar”) for (non-pregnant) adult legal immigrants to enroll in federal, means-tested benefits like Medi-Cal.<sup>26</sup> However, as a result of the ACA, these legal immigrants will have other coverage options during the waiting period, available through the Exchange or the Basic Health Plan (see Section IV for discussion of the Basic Health Plan program).

- All legal immigrants will be able to access coverage under the Exchange, as well as applicable premium tax credits and cost-sharing reductions in the same manner as citizens. Though premium tax credits and cost-sharing reductions are generally only available for individuals whose income is between 100 percent and 400 percent of FPL, the ACA further allows for legal immigrants with income under 100 percent of FPL, and who are under the five-year bar, to access subsidies comparable to an individual with income of 100 percent of FPL.<sup>27</sup> (See Section III, Health Insurance Exchange.)
- All legal immigrants whose income is between 133 percent and 200 percent of FPL will be able to access Basic Health Plan coverage (if the state chooses to implement the Basic Health Plan). Though Basic Health Plan coverage is generally limited to people in the 133 percent to 200 percent of FPL income bracket, the ACA further allows legal immigrants under 133 percent of FPL, and who are under the five-year bar, to access Basic Health Plan coverage.<sup>28</sup>

### Enrollment Simplification (§§1413, 2201)

The ACA includes provisions aimed at simplifying eligibility and enrollment procedures for Medicaid and CHIP, and ensuring coordination with coverage available through newly created state Exchanges. By January 1, 2014, California must implement a series of procedures that simplify enrollment in Medi-Cal and Healthy Families and coordinate with the state’s Exchange, or risk losing federal Medi-Cal and Healthy Families funding. Required enrollment simplification and coordination procedures will include:

- Utilizing a single, streamlined application form for Medi-Cal, Healthy Families, subsidies for coverage through the Exchange, and the Basic Health Program (§1413(b));
- Establishing a Web site that permits individuals to apply to, enroll in, and renew enrollment in Medi-Cal, and to consent to enrollment or re-enrollment in such coverage through electronic signature (§2201, creating new Social Security Act §1943[b][1][A]);
- Ensuring that individuals who seek coverage through Medi-Cal, Healthy Families, or the Exchange are concurrently screened for eligibility for all three options (including Exchange coverage subsidies and the Basic Health Program) and referred to the appropriate program for enrollment, without having to submit additional or separate applications for each program (§2201, creating new Social Security Act §1943[b][1]), and §1413(b); and
- Establishing procedures for conducting outreach to and enrolling vulnerable populations, including children, homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities,

### **Enrollment Technology Standards and Protocols** (§1561)

By September 23, 2010, in consultation with the federal Health Information Technology (HIT) Policy Committee and the HIT Standards Committee, HHS must develop interoperable, secure standards and protocols that facilitate enrollment in federal and state programs. These standards and protocols must allow for:

- Electronic matching against existing federal and state data;
- Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility;
- Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals;
- Capability for individuals to apply, recertify, and manage their eligibility information online, including at home, at points of service, and at other community-based locations;
- Ability to expand the enrollment system to integrate new programs, rules, and functionalities, in order to operate at increased volume;
- Notification of eligibility, recertification, and other communications about eligibility via e-mail and cell phone; and
- Other functionalities necessary to provide eligibles with a streamlined enrollment process.

Funding is available to state and local governments for the development and adaptation of systems to meet these new standards and protocols. The Affordable Care Act specifies that state and local governments must submit applications outlining a plan to adopt and implement appropriate enrollment technology to secure funding, but it does not provide details on the application process, funding levels, any matching requirements, or timing. Presumably, this information will accompany further federal guidance and a funding announcement related to the provision.

rural populations, victims of abuse or trauma, individuals with mental health or substance abuse-related disorders, and individuals with HIV/AIDS (§2201, creating new Social Security Act §1943[f]).

Changes are required at the federal level in which HHS must (1) develop electronic information standards and protocols to facilitate enrollment and (2) establish a system to coordinate enrollment and eligibility determination and re-determination in Medicaid, CHIP, coverage (including applicable subsidies) through the Exchange, and the Basic Health Program, and to ensure that Medi-Cal- or Healthy Families-eligible individuals who apply for coverage through the Exchange are enrolled in the applicable public insurance program. Further federal guidance on how the federal system is to coordinate with state systems should significantly clarify and inform the implementation of these provisions.

DHCS has estimated an immediate cost of about \$1 billion to administer the changes to the Medi-Cal system that result from reform.<sup>29</sup> The state will need to develop and upgrade systems infrastructure including county consortia eligibility systems for Medi-Cal, CalWORKS and Food Stamps, state Medi-Cal eligibility systems for Medi-Cal, and the new insurance Exchange. Some funding is available through traditional federal Medi-Cal and Healthy Families support for administration, generally matched at 50 cents on the dollar. However, given its poor current fiscal condition, the state will face serious challenges in finding the state share of costs to draw down federal funding. The ACA also makes funding available to develop and adapt systems to the new simplified and streamlined enrollment standards and protocols, but details—such as funding levels, any matching requirements, the application process, and timing—are not yet available.

## SUMMARY: Changes in Eligibility and Enrollment Rules

**What Does It Say?** The Affordable Care Act mandates use of a new, simpler formula, based on MAGI, to calculate income eligibility in Medicaid and CHIP, and of simplified procedures that streamline and coordinate enrollment into public programs and plans in the state Exchange.

**Effective Date** January 1, 2014

**What Needs to Be Done?** CMS will issue guidance on the application of MAGI in state Medicaid and CHIP programs, intended to ensure that children do not lose Medicaid coverage in the transition to the new formula.

The state must make the transition to the MAGI formula and meet enrollment and eligibility simplification requirements in 2014.

**Who's Responsible?** CMS, DHCS

**The Bottom Line** While MAGI is a simpler income test to administer, it may result in less generous Medi-Cal eligibility standards, knocking some adults out of the program in 2014. Other eligibility simplification requirements in the ACA could make enrollment less burdensome for recipients and more streamlined across multiple programs, but will require significant human and financial resources to implement.

Finally, starting on January 1, 2014, the state will be permitted to expand hospital presumptive eligibility determinations beyond pregnant women and children to all Medi-Cal eligible populations. Presumptive eligibility allows individuals to temporarily receive Medi-Cal coverage based on an initial determination by a hospital while awaiting a formal eligibility determination by a Medi-Cal eligibility office.<sup>30</sup>

### **Maintenance of Effort (§§2001[gg], 2101[b])**

The Affordable Care Act establishes a maintenance of effort (MOE) requirement that prohibits states from imposing Medicaid or CHIP eligibility rules or enrollment methodologies or procedures that are more restrictive than eligibility and enrollment requirements in place on March 23, 2010 when the ACA was enacted. The MOE requirement will continue for adults until 2014, when HHS is to certify that a state's Exchange is fully operational, at which time states will be bound only by the new Medicaid income eligibility threshold of 133 percent of FPL. For children covered by Medi-Cal and

Healthy Families, the MOE will continue until October 1, 2019, at which time states may transition children to the state Exchange, but only upon a finding by HHS that comparable pediatric coverage is provided by participating qualified health plans. California would risk federal support for both programs, an estimated \$32 billion, if found to be in violation of MOE.<sup>31,32</sup>

The MOE requirement has immediate implications for California, prohibiting the state from enacting the Governor's 2010–11 Proposed Budget provision to reduce eligibility for Healthy Families, which had been estimated to generate savings of \$68 million.<sup>33</sup> (The governor withdrew this provision from the 2010–11 Revised Budget.)<sup>34</sup> As a result of the MOE, California will not be able to achieve budget cuts through narrowing income eligibility levels or imposing enrollment hurdles (e.g., requiring a face-to-face interview to apply for or renew coverage) in Medi-Cal or Healthy Families, or by reinstating mid-year status reports for Medi-Cal children.<sup>35</sup> However, the state would not be prohibited under federal law from seeking savings by

## SUMMARY: Maintenance of Effort

**What Does It Say?** The state must maintain eligibility levels and procedures in Medi-Cal and Healthy Families that are no more restrictive than rules in place on March 23, 2010.

**Effective Dates** Adults: March 23, 2010 through the date of HHS certification of a fully operational state Exchange.  
Children: March 23, 2010 through October 1, 2019.

**What Needs to Be Done?** CMS is expected to issue MOE guidance in the next several months.  
The state must withdraw or reject proposals to reduce Medi-Cal and Healthy Families eligibility and enrollment in light of the MOE requirement, or risk loss of federal Medicaid and CHIP funds.

**Who's Responsible?** CMS, MRMIB, DHCS, legislature/governor

**The Bottom Line** The MOE constrains California from extracting budget savings by making eligibility or enrollment process changes to Medi-Cal and Healthy Families.

reducing provider payments or restricting optional benefits in Medi-Cal. Although California is in the midst of a protracted budgetary crisis that has created enormous pressure to find cost reductions in Medi-Cal, these particular changes would likely be difficult to implement. The state already has among the lowest provider reimbursement rates in the nation, and is currently defending against a series of court challenges to recent rate cuts.<sup>36,37</sup> Also, last year California eliminated several categories of Medi-Cal optional benefits for adults, including dental, audiology, chiropractic, optometry, podiatry, psychology, and speech therapy services, leaving few optional benefits left to cut. However, California does continue to cover some optional benefits, including prescription drugs and home and community-based services.

### Changes to the Child Health Insurance Program (CHIP) (§§2101, 2102, 10203[c], 10203[d], HCERA §1004[b][2])

Healthy Families, California's CHIP, currently covers 873,850 children whose family income is above Medi-Cal income eligibility levels but below 250 percent of FPL.<sup>38</sup> Administered by the MRMIB, Healthy Families covers children who are California

residents and U.S. citizens, non-citizen nationals, or eligible qualified immigrants.<sup>39</sup>

The ACA makes a number of changes to Healthy Families: creates new eligibility parameters, related to Medi-Cal expansion; reauthorizes federal CHIP funding; enhances the state's Federal Medical Assistance Percentage (FMAP) for the program; imposes a MOE requirement; and outlines requirements to transition children to the state Exchange if federal CHIP funding is depleted after 2014. Key changes, as summarized below, have the following implications for Healthy Families:

- From 2010 through 2015, Healthy Families will operate with federal CHIP funding and under a MOE requirement. The program will have no changes in eligibility, other than the transition to Medi-Cal of children ages six to 18 whose family income is between 100 percent and 133 percent of FPL.
- From 2015 through 2019, Healthy Families will continue to operate under the MOE but federal funding for the program is uncertain. If Congress does not reauthorize CHIP funding, California is obligated under the ACA to transition Healthy Families children to comparable coverage in

the state Exchange when federal CHIP funding becomes insufficient.

- After 2019, the MOE expires and federal funding is uncertain. California will not be obligated to continue the Healthy Families program or comparable coverage in the state Exchange.

### Transition of Children from Healthy Families to Medi-Cal (§2001[a])

With the implementation of the new federal Medicaid eligibility threshold in 2014, roughly 162,000 children in California with family income from 100 percent to 133 percent of the FPL, who are currently covered by Healthy Families, will become eligible for the state's Medi-Cal program.<sup>40</sup> The ACA appears to require California to transition these children to Medi-Cal.

### Maintenance of Effort (§2101[b])

The Affordable Care Act imposes a MOE requirement that prohibits states from imposing eligibility rules and enrollment methodologies or procedures in their state CHIP programs that are more restrictive than eligibility and enrollment requirements in place on March 23, 2010, when the ACA was enacted. This MOE requirement is effective through September 30, 2019 and is a condition of continued federal funding for the state's Medi-Cal and Healthy Families programs. However, the CHIP MOE requirement does not prevent California from:

- Adopting income eligibility levels and enrollment procedures that are less restrictive than those in place on March 23, 2010;
- Imposing limitations on Healthy Families enrollment permitted under federal law, including enrollment caps and waiting lists, in order to limit program expenditures to those for which federal funding is available; and

- After September 30, 2015, enrolling Healthy Families eligible children into certified comparable coverage through the state Exchange.

### Federal Funding for Healthy Families

(§§2101[a], 10203)

The Affordable Care Act extends federal CHIP funding through September 30, 2015, consistent with current funding levels. The law also enhances the CHIP FMAP from October 1, 2015 through September 30, 2019 by increasing the federal share of Healthy Families costs by 23 percentage points, from a 65 percent to an 88 percent match. In order for this FMAP increase to have meaningful financial benefit to the state, CHIP funding would have to be reauthorized beyond 2015 and aggregate funding would have to be increased to take into account the new, higher FMAP rate. After 2015, the future of the Healthy Families program is uncertain; while the state will be operating under an ACA mandate to maintain Healthy Families income eligibility levels and benefits through 2019, this mandate is unfunded by the federal government after 2015.

### Exchange Coverage for Lower-Income Children (§2101)

The Affordable Care Act requires that, in the event of federal CHIP funding shortfalls, the state have procedures to transition Healthy Families-eligible children to alternate sources of coverage. Specifically, California would be required to have children's coverage available, through a plan offered in the state Exchange, that is comparable to Healthy Families in terms of both benefits and cost-sharing. The state's procedures to transition low-income children who are eligible for Healthy Families to new coverage would have to include screening for and enrolling eligible children in Medi-Cal and enrolling other children in a qualified health plan through the state Exchange,

## SUMMARY: Enhanced Federal Support for CHIP

**What Does It Say?** The Affordable Care Act establishes new eligibility parameters for Healthy Families related to the Medi-Cal expansion, authorizes two additional years of CHIP funding, enhances the FMAP for Healthy Families, and establishes an MOE requirement that the state has to meet to keep its federal Medi-Cal and CHIP funding.

**Effective Dates** March 23, 2010 through September 30, 2019: CHIP MOE in effect.  
September 30, 2015: Federal CHIP funding authorization end date.  
October 1, 2015: Federal matching for Healthy Families enhanced to 88 percent.  
October 1, 2015: State permitted to enroll Healthy Families-eligible children in comparable coverage through the state Exchange, as certified by HHS.  
By April 1, 2015: HHS to review and certify exchange coverage for children, to ensure that benefits and cost-sharing are comparable to state CHIP benefits.

**What Needs to Be Done?** The federal government will issue guidance on the MOE requirement in the near term, including regarding the relationship between the MOE and new Medi-Cal income eligibility levels which appear to require the state to transition children from Healthy Families to Medi-Cal.  
California must meet the federal MOE requirement. The state will also effect the transition of children from Healthy Families to Medi-Cal, related to the federal Medicaid expansion in 2014. The state will also have to ensure (if necessary) that Healthy Families comparable coverage is available through the Exchange until 2019.

**Who's Responsible?** CMS, MRMIB

**The Bottom Line** California cannot enact the initial Governor's 2010-11 Budget Proposal to reduce eligibility for Healthy Families—estimated to generate savings of \$68 million—without running afoul of MOE requirements and losing a much larger FMAP.<sup>41,42</sup>  
Through 2014, the Healthy Families program will operate with federal funding and under the MOE. But without renewed federal funding for CHIP after 2015, the future of the program is uncertain and the state risks financial exposure in light of its obligation to provide Healthy Families comparable coverage for children through 2019.

as certified by HHS. While there may be continuity and streamlining of benefits by having families enroll as units through the state Exchange, it is unclear whether California would be able to ensure Healthy Families comparable coverage—with more generous benefits than the “essential benefits package” and relatively low cost-sharing—for children in the state Exchange without federal financial support.

## Improving Coverage Coordination and Care Delivery for Dual-Eligible Beneficiaries

The Affordable Care Act includes a number of provisions related to integrating and coordinating care, including long-term care, for individuals who are covered by both Medicaid and Medicare (dual eligibles)—generally low-income seniors and people with disabilities. California has approximately 1.1 million dual eligibles enrolled in the Medi-Cal program.<sup>43</sup> While dual eligibles represent just 13 percent of total Medi-Cal beneficiaries, they generate 47 percent of total Medi-Cal expenditures annually, in part, because the dual eligibles represent

two-thirds of those who qualify as a result of age or disability.<sup>44</sup> As in many other states, financial and administrative responsibility for care for dual eligibles in California is fragmented, leading to significant access and quality issues for low-income seniors and people with disabilities.

California is in the process of developing its renewal of the Section 1115 waiver for hospital financing and uninsured care; the state's current waiver expires in August 2010. (Under the authority of Section 1115 of the Social Security Act, the federal government may waive certain Medicaid statutory requirements and states may receive federal matching funds for Medicaid services that would otherwise not be eligible for federal funding.) California's hospital financing and uninsured care waiver took effect in July 2005.<sup>45</sup> A primary goal of the waiver will be to better coordinate care for dual eligibles by establishing delivery systems that "incorporate a medical home system and care and disease management, as well as incentives that reward providers and beneficiaries for achieving the desired clinical, utilization, and cost-specific outcomes."<sup>46</sup> The state is also aiming to make coverage and delivery system changes that improve coordination between Medicare and Medi-Cal coverage through the waiver. The ACA contains a number of provisions that give California opportunities to expedite delivery system improvements for dual eligibles through enhanced federal funding and technical support, and additional opportunities to test innovative reimbursement and care delivery approaches outside of the 1115 waiver process.

### Five-Year Period for Dual Eligibles Demonstration Projects (§2601)

The ACA creates new demonstration authority for states to conduct five-year waivers related to dual-eligible beneficiaries under Section 1115 Research &

Demonstration Projects, Section 1915(b) Managed Care/Freedom of Choice Waivers, Section 1915(c) Home and Community-Based Services Waiver, and Section 1915(d) Waivers.

### Federal Coordinated Health Care Office (§2602)

For better integration of service delivery and payment mechanisms for dual eligibles, the ACA directs the establishment of the federal Coordinated Health Care Office within CMS to facilitate a working relationship between Medicare and Medicaid at the federal level and Medicaid offices at the state level. The new office is specifically charged with ensuring that these beneficiaries have better access to all services to which they are entitled and to improved quality of health care and long-term care services. Specific responsibilities of the Coordinated Health Care Office include:

- Providing states and other relevant parties with education and tools for developing programs that align Medicare and Medicaid benefits for dual eligibles;
- Supporting state efforts to coordinate and align acute and long-term care services with other Medicare benefits for dual eligibles;
- Supporting coordination of contracting and oversight by the states and CMS to support goals of the Office;
- Consulting and coordinating with the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commissions;
- Studying the provision of drug coverage for new full-benefit dual eligibles; and
- Monitoring and reporting total expenditures, health outcomes, and access to benefits for all dual eligibles.

## State Option to Provide Health Homes for Medi-Cal Enrollees with Chronic Conditions

(§2703)

Beginning on January 1, 2011, states will have the option to amend their Medicaid state plans to create health homes for enrolled people with chronic conditions, including dual eligibles. This program is designed to promote a coordinated, team-based approach to providing health care to individuals with multiple, chronic illnesses.

Through the program, eligible consumers select a provider or a team of health care professionals as their health home. The designated health home will provide comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; referral to community and social support services; and, as feasible, use health information technology to link such services. Eligible Medicaid beneficiaries include those that have:

- At least two chronic conditions;

- One chronic condition and are at risk of developing another; or
- At least one serious and persistent mental health condition.

Qualifying providers will have to meet standards established by HHS, including demonstrating that they have systems and infrastructure to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals. Teams of providers can be free-standing, virtual, or hospital-based, a community health center, a community mental health center, a clinic, a physician's office, or a physician group practice. Designated providers will be required to report to the state on all applicable quality measures in the state Medicaid program.

The state is to develop a mechanism to pay the health home, which may be tiered with respect to the clinical severity of each enrollee. States can use a variety of payment models for health home services, including per-member, per-month mechanisms, subject to approval by HHS. If a state chooses this option, the state plan amendment would have to

### SUMMARY: State Option to Provide Health Homes for Enrollees with Chronic Conditions

**What Does It Say?** The Affordable Care Act authorizes a new state plan option under which eligible Medicaid enrollees with chronic conditions, including dual eligibles, could designate a provider or health team as their health home. The health home would be responsible for providing comprehensive medical and care coordination services. States opting for the program would receive a 90 percent FMAP for the health home services provided during the first two years.

**Effective Date** January 1, 2011: State option becomes available and HHS may award planning grants to states for the purpose of developing a state plan amendment to create health homes.

**What Needs to Be Done?** CMS is expected to issue guidance to states on the new state option in the near-term. California should begin discussions with CMS to coordinate a January 2011 plan amendment for this program with the states' broader waiver activities and goals.

**Who's Responsible?** CMS, DHCS

**The Bottom Line** The program will bring enhanced federal dollars to California to more rapidly deploy delivery system improvements for dual eligibles.

describe the payment methodology, the state's plan for tracking avoidable hospital readmissions, and its plan for producing savings from improved chronic care coordination and management.

The ACA provides an enhanced match of 90 percent FMAP for all Medicaid costs for health home services provided to the enrollees for the first two years of program operation. Small planning grants may also be available to states beginning in 2011.

### Extension of Special Needs Plan Program

(§3205)

The Affordable Care Act extends program authority through December 31, 2013 for all three types of Special Needs Plans (SNP)—dual eligible, chronic care, and institutional care. In addition, the ACA requires all SNPs to be approved by the National Committee for Quality Assurance (NCQA), starting in 2012.

SNPs for dual eligibles will be able to operate for an additional two years without contracting with Medi-Cal because the authority to do so was extended until December 31, 2012. Starting in 2011, dual eligible SNPs which have a Medi-Cal contract could benefit from a “frailty payment” adjustment from HHS, comparable to the payment adjustment that Program of All-Inclusive Care for the Elderly (PACE) plans receive from HHS. The SNP frailty payment adjustment would be made to fully integrated SNPs that have a similar average level of frail beneficiaries as PACE plans and a contract with Medi-Cal. As a result of this additional payment, the Managed Care Division of DHCS may experience an increase in the number of dual eligible SNPs interested in obtaining a contract to integrate Medi-Cal benefits with Medicare benefits for their dual-eligible enrollees.

### Medicaid State Options and Demonstration Programs for Dual-Eligible Populations

The Affordable Care Act provides a host of new plan options and demonstration programs to encourage state innovation in payment reform and delivery system integration for Medicaid beneficiaries requiring long term care services, such as dual-eligible beneficiaries (see Table 4 on page 18). Forthcoming guidance from CMS on these programs should offer more insight into how these may best be leveraged in the context of its waiver renewal process, with an eye toward minimizing CMS red tape and maximizing the FMAP for delivery system innovations targeted to dual eligibles.

**Table 4. Medi-Cal State Options and Demonstration Programs Relating to Long Term Care Payment Reform and Delivery System Integration**

	DESCRIPTION	NEW FEDERAL FUNDS	EFFECTIVE DATE
Medicaid Community First Choice Option (§2401)	State plan amendment option to provide coverage of home and community-based attendant services and supports, such as assistance to accomplish activities of daily living, to those who meet the state’s nursing facility clinical eligibility standards.	6 percentage point FMAP increase	October 1, 2011
Home and Community-Based Services State Plan Options (§2402)	Simplifies provision of home and community-based services through a state plan option rather than by pursuing more difficult federal waiver authority. Provides a full range of Medicaid services to individuals whose income does not exceed 300 percent of the Supplemental Security Income (SSI) standard.	Regular FMAP	April 1, 2010
Balancing Incentive Payments Program (§10202(a))	Expands and diversifies Medicaid coverage for home and community-based long term services and makes structural changes to improve coordination and access to such services. Creates new financial incentives for states to shift Medicaid beneficiaries out of facilities and into home and community-based services.	2 to 5 percentage point FMAP increase Allocates up to \$3 billion for Medicaid home and community-based services.	October 1, 2011 through September 30, 2015
Hospitalization Care Integration Payment Bundling (§2704)	Five-year demonstration project limited to eight states to evaluate the use of bundled payment for integrated care for Medicaid beneficiaries. Focuses on specific episodes of care involving hospitalization and concurrent physician services where bundling payment may have the potential of improving quality of care while reducing costs.	Unclear, pending further federal guidance	January 1, 2012 through December 31, 2016
Medicaid Money Follows the Person Rebalancing Demonstration (§2403)	Demonstration established through the Deficit Reduction Act of 2005 (P.L. 109–171) to reduce reliance on institutional care and develop community-based systems of care. The ACA modifies eligibility rules to require that individuals reside in an inpatient facility for not less than 90 days.  California received \$130 million for California Community Transitions (CCT), for the five-year project term from 2007–2011. The project aims to transition 2,000 individuals from institutional to community-based settings in up to ten regions within the state.	The ACA extends the demonstration through September 30, 2016, bringing new aggregate federal funding of \$450 million each year for FY 2011–2016. The state may be able to access this funding to expand its current demonstration or to pursue further initiatives.	April 22, 2010

Sources: Manatt analysis of ACA; The Scan Foundation, Policy Brief No. 2. March 2010.

### III. Health Insurance Exchanges

A HEALTH INSURANCE EXCHANGE IS A marketplace for purchasing health insurance, which can be organized by a government agency or an independent organization. The Exchanges established by the Affordable Care Act include the American Health Benefit Exchange for individuals who want to enroll in a qualified health plan and the Small Business Health Options Program (SHOP) or “SHOP Exchange” for small employers, defined as businesses with up to 100 employees. The state has the option to define small employer using a 50-employee threshold prior to 2016. States are given the flexibility to operate geographic or regional Exchanges (referred to as “subsidiary Exchanges”) which may serve one or more counties, or other geographic or health insurance rating areas in the state. Starting in 2017, each state may allow, but not require, issuers of health insurance in the large group market in the state to offer qualified health plans through an Exchange.

California must establish separate Exchanges for individuals and small employers by 2014, or, if approved by HHS, implement a single Exchange that can serve the needs of both individual purchasers and small groups. If the state does not establish an Exchange, HHS will establish and operate one either directly or through an agreement with a not-for-profit entity (see Table 5 on page 20).

HHS will establish standards by which an Exchange could demonstrate that it would not compromise its ability to meet the needs of the small employer market if it merged the two Exchanges and formed a single risk pool. The standards will be based on a recognition of the different types of services that these two Exchanges need. For example, an Exchange

may need different resources to serve a high volume of individuals, some of whom may qualify for premium and cost-sharing subsidies and who will choose from a wide range of plans to meet their needs. In contrast, an Exchange would need different resources to serve small employers who may look to the Exchange for help in finding a plan that meets the needs of both the employees and the employer, including the employer’s potential to receive small business tax credits (see sidebar below).

#### **Small Business Tax Credits** (§1421)

Small employers who pay at least 50 percent of their employees’ health insurance will qualify for a 35 percent tax credit beginning in 2010 and continuing through 2013. The credit will be increased to 50 percent in 2014 if the employer plan is purchased on the new state Exchange. Tax-exempt organizations may qualify for the credit, although it is lower for them—25 percent through 2013 and 35 percent starting in 2014.

Small employers are defined in terms of the number of their full-time equivalents (FTE) and their average wage rate. The number of FTEs cannot be more than 25 and the average wage rate cannot be more than \$40,000, although that amount will increase each year based on inflation.

**Table 5. Affordable Care Act Requirements to Organize Health Insurance Inside and Outside of Exchanges**

HEALTH ISSUER OFFERS:	INSIDE EXCHANGE	OUTSIDE EXCHANGE	ACA PROVISION
<b>Separate Exchanges for the Individual and Small Group Markets</b>			
Qualified Plan in the <a href="#">Individual Market</a>	Yes	Yes	<i>Single Pool for Individual Market Required</i> Health plan must operate a single risk pool for individual market enrollees, both inside and outside of Exchange.
Qualified Plan in the <a href="#">Small Group Market</a>	Yes	Yes	<i>Single Pool for Small Group Market Required</i> Health plan must operate a single risk pool for small market enrollees, both inside and outside of Exchange.
<b>Single Exchange with Merger of Individual and Small Group Markets</b>			
Qualified Plans in <a href="#">Both the Individual and Small Group Market</a>	Yes	Yes	<i>Single Pool for Merged Markets (possible with state action)</i> State has the authority to require health plans to operate a single risk pool which merges the individual and small group market, both inside and outside of the Exchange.

Source: Manatt analysis of ACA.

Except for grandfathered plans, all health plans participating in an Exchange must operate a single risk pool without regard to the Exchange. That is, all of a health plan’s enrollees in either the individual or small group market must be treated as a single risk pool regardless of whether the enrollment occurred inside or outside of the Exchange. This single pool rule could have a wider impact if a state decides to merge the individual and small group Exchanges and the state requires that all fully insured health plans operate a single risk pool for their individual and small group subscribers regardless of whether the enrollment was inside or outside of the Exchange.

As part of organizing the health insurance market within the state, an Exchange will certify health plans it offers as “qualified health plans.” In addition, a state Exchange will operate a navigator program of public education and outreach to increase awareness about the Exchange and the health insurance subsidies. The Exchange will serve as a portal for qualifying individuals and small employers who are

directly seeking health insurance, or for agents or brokers who may act on their behalf.

A state Exchange will be responsible for administering the subsidies and the certification process by which the Department of Treasury will be notified that an individual is exempt from the individual mandate or the penalty for non-coverage, and for providing the employer identification information if an employer penalty needs to be applied. Individuals are exempt from the requirement to maintain health insurance in three instances: (1) an individual’s income is below \$9,350; (2) the lowest cost exchange plan exceeds 8 percent of his or her income; or (3) the individual has a recognized religious objection.

Federal regulations will prescribe various requirements for an Exchange (see Table 6). However, the ACA does allow the state flexibility with respect to governance, whether to establish one or more regional Exchanges, and whom the Exchange will serve (individuals and/or small businesses).

## Table 6. Exchange Functions

- Plan Certification** • Certify health plans as “qualified health plans” based on federal requirements.
- Premium Reviews** • Consider premium levels in determining whether to make a plan available through the Exchange.
- Outreach, Enrollment, and Exemptions** • Establish a navigator program to provide public education and outreach designed to promote awareness of the availability of qualified health plans and of the premium tax credits and cost-sharing reductions, and to facilitate enrollment in qualified health plans.
  - Screen individuals to determine if they qualify for coverage under Medi-Cal or Healthy Families and if so, enroll them in the program.
  - Assist individuals in determining if they qualify for premium and cost-sharing subsidies.
  - Certify if an individual is exempt from the individual mandate or the penalty and provide a list of individuals with such certification to the Secretary of the Treasury, as well as employer information when an employer penalty needs to be applied.
- Customer Support** • Maintain an Internet Web site where enrollees and prospective enrollees can obtain standardized information about the plans.
  - Operate a toll-free telephone hotline to respond to requests for assistance.
  - Establish and make available by electronic means a calculator to determine the actual cost of coverage after accounting for the subsidies.
- Quality Measures** • Assign a rating to each qualified plan offered through a state Exchange, based on criteria established by HHS.

All of the functions of the Exchange are limited to the qualified health plans operating within it. However, a state Exchange can take into account any excess of premium growth which the plan experiences outside the Exchange, as compared to the rate of such growth inside the Exchange, in determining whether to make a plan available.

### **Subsidies** (§§1401, 1402, 1411, 1412)

The Affordable Care Act requires HHS to establish procedures for advance determination of eligibility for Exchange participation, premium tax credits and reduced cost-sharing. In addition, procedures must include a process for certifying that an individual is exempt from the requirement to maintain essential minimum coverage.

The subsidies are based on a taxpayer’s monthly household income (as a percentage of FPL) compared to the monthly premium for the second-lowest cost plan within the “silver” tier of plans (see “Essential

Benefits,” on the next page for a description of tiers). Individuals with income of at least 100 percent but not more than 400 percent of FPL will receive a refundable tax credit for a percentage of the cost of premiums for a qualified health plan. Premium credit is scaled, using six income bands, so that premiums are less than 2 percent of income for consumers with income up to 133 percent of FPL while households with income of 300 to 400 percent of FPL would not pay more than 9.5 percent of income for health insurance.

The Exchange must establish an electronic calculator for consumers to determine the actual cost of coverage after any premium tax credit and cost-sharing reductions are applied. The tool will help purchasers to understand the actual costs of obtaining health insurance inside the Exchange.

Although there is a presumption that the advance determination of subsidies and the other enrollment-related processes described above will be performed

by the Exchange, the state has the option instead to operate the enrollment and eligibility determination program as part of either Medi-Cal or Healthy Families. The flexibility is provided as part of the enrollment simplification provisions.

Each state must operate the Exchange as part of a coordinated system with other “state health subsidy programs.” Specifically, through a single, streamlined form, individuals must be able to apply for enrollment and receive a determination of eligibility to participate (or continue to participate) in premium tax credits and cost-sharing reductions within the Exchange, the state Medicaid program, CHIP, and the new qualified basic health program.

California will have the option of delegating the advance determination of subsidy to Medi-Cal or Healthy Families if the state would be able to comply with new HHS requirements for ensuring reduced administrative costs, eligibility errors, and disruptions in coverage. If the Exchange will not perform the

actual determination, it will need to establish a contract with the state agency that does so.

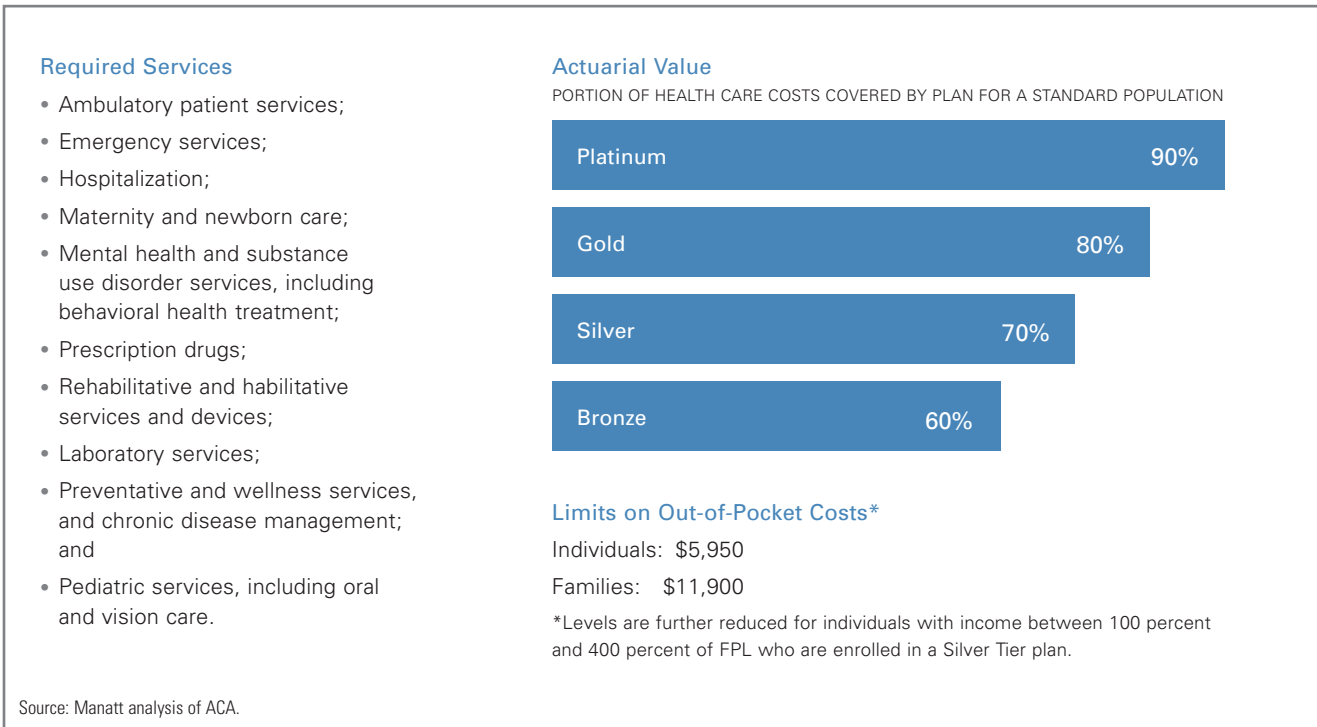
### Essential Benefits (§1302)

An “essential health benefits package” is defined as coverage that:

1. Provides for essential health benefits as defined by HHS, which must include at least certain specified general categories (see Figure 2);
2. Limits cost-sharing and deductibles for such coverage; and
3. Provides benefits that meet one of four defined categories of coverage.

In determining the scope of essential health benefits coverage, the HHS Secretary must ensure that coverage is equal to the typical coverage provided by an employer, and accords with other principles laid out in the act. The HHS Secretary is also

**Figure 2. Health Coverage through the Exchange: Essential Benefits Package**



directed to collaborate with the Secretary of Labor who will conduct a survey of employer-sponsored coverage to determine typical benefits.

There are four categories for essential benefits packages—Bronze (minimum coverage), Silver, Gold, and Platinum—that cover the same set of services but range in the value of benefits provided. Also, qualifying plans must offer a child-only policy for any of the four categories of benefits it offers.

The ACA also establishes a catastrophic coverage plan, primarily for individuals age 30 or younger, that complies with the essential health benefits package. A catastrophic plan provides coverage for all essential benefits once the cost limit has been reached, with preventive services and three primary care visits covered prior to reaching the out-of-pocket cost limit.

California has the flexibility to require its Exchange to offer benefits in addition to the essential health benefits. If the state opts to require more generous benefits, it will be required to defray the additional costs related to the expanded benefits when they are offered through the Exchange

### **Qualified Health Plans** (§1301)

HHS will develop a regulation that addresses the requirements that an Exchange will use in certifying qualified health plans. The ACA requires that “at a minimum” the qualified plans offered through an Exchange:

- Meet marketing requirements, and not use marketing practices or benefit designs that discourage enrollment by high-risk individuals;
- Ensure sufficient choice of providers, and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

- Include in the network essential community providers, where available, that serve predominately low-income, medically underserved individuals;<sup>47</sup>
- Be accredited with respect to local performance on clinical quality measures, patient experience ratings, and other accreditation program requirements;
- Implement a quality improvement strategy, which uses a payment structure that provides increased reimbursement or other incentives to hospitals and other healthcare providers and which improves health outcomes through quality reporting, case management, care coordination, chronic disease management and care, and medication compliance initiatives, including use of a medical home model;
- Use a “uniform enrollment form” developed by the National Association of Insurance Commissioners (NAIC) and certified by HHS;
- Use a standard format established for presenting health benefit plan options; and
- Provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on quality measures.

In some states, newly established CO-OP plans may be a source of qualified health plans offered through the state’s Exchange (see sidebar on the following page).

### **Consumer Operated and Oriented Plan (CO-OP) Program** (§1322)

The ACA provides authority for the development of Consumer Operated and Oriented Plans (CO-OPs), which are nonprofit, membership-driven health insurance organizations that will be able to offer qualified health plans to the individual and small group markets through a state Exchange. CO-OPs will be subject to the same federal standard qualification requirements that an Exchange will apply to all health plans. The membership focus of a CO-OP allows one or more community organizations to develop a health plan which meets the unique needs of its constituents.

The ACA appropriates \$6 billion for the CO-OP program and directs HHS to provide loans and grants to entities applying to become qualified nonprofit health insurance issuers. By June 23, 2010, the federal Comptroller General must form an advisory board with 15 members having qualifications similar to MedPAC members. No later than July 1, 2013, the HHS Secretary is required to award the loans and grants based on advisory board recommendations. The ACA directs the HHS to give preference in awards to applicants that will offer a qualified plan on a statewide basis. The ACA also directs HHS to ensure that there is funding to establish at least one CO-OP per state.

### **Scope of Exchanges** (§1311)

If California complies with the federal requirements to establish a state Exchange rather than relying on the federal fallback Exchange, it will need to enact conforming state legislation or issue regulations to implement it.

The state must make three key decisions concerning the operating charter of its Exchange.

1. The state must decide whether the Exchange will be an existing agency, a new state agency, or a nonprofit organization.
2. The state has the flexibility to establish subsidiary Exchanges if they serve geographically distinct areas and each area is at least as large as the rating area that will be used to establish fair health insurance premiums.<sup>48</sup>
3. The state must determine whether to operate separate Exchanges for individuals and small employers or to merge the individual and small group markets into a single risk pool and operate a single Exchange with two service lines. The state's decision must be based on an assessment of whether it has the resources necessary to meet the unique needs of the individual and small group markets. HHS will specify what resources are needed to address the unique needs of these two markets.

In order to meet the requirement to be self-sustaining by January 1, 2015, the state Exchange will need to develop a funding structure to support its operations. The ACA suggests an assessment or user fee for participating health insurance issuers, although the state is not limited to only those funding mechanisms.

## SUMMARY: Health Benefit Exchange

**What Does It Say?** The Health Benefit Exchange is the governmental agency or nonprofit entity established by a state, which organizes health insurance markets for individuals and small employers.\*

**Effective Dates** July 1, 2010: HHS must establish an Internet portal by which a resident of any state may identify affordable coverage insurance options within the state.

March 23, 2011: Exchange Planning and Establishment grants in amounts to be determined by HHS will be available to help fund states' Exchange-related activities. Planning grants may be renewed, subject to meeting performance criteria, but grant funding ends January 1, 2015.

January 1, 2014: Exchanges must be operational.

January 1, 2016: State discretion to limit the definition of "small business" to those with 50 or fewer employees expires.

January 1, 2017: State may allow qualified health plans in the large group market to be offered inside the Exchange.

**What Needs to Be Done?** **HHS must:**

- Establish, by regulation, criteria for the certification of qualified health plans;
- Develop a system that would rate qualified health plans in each benefit level on the basis of relative quality and price; and
- Establish enrollment periods which an Exchange will be required to offer, including an initial open enrollment period, an annual open enrollment period, special enrollment periods, and special monthly enrollment periods for Indians.

**California must:**

- Decide if the Exchange will be a state agency or an independent, nonprofit organization;
- Decide whether to limit the definition of small business to a 50-employee threshold;
- Enact any legislation and issue conforming regulations required to operate an Exchange, consistent with but not limited to the federal requirements;
- Apply for grant funding and technical assistance to help plan and establish the Exchange; and
- Anticipate the Exchange's need for operating capital in addition to the grants to establish the navigator program.<sup>49</sup>

**Who's Responsible?** HHS, governor, legislature

**The Bottom Line** Unless the state wants to rely on the federal fallback Exchange, it must start the planning process to develop a California Exchange. The Exchange requirements will be determined in large part by HHS, but the state has flexibility in some areas, including key decisions about its organizational form, whether to establish subsidiaries operating in some geographic areas or counties, and whether the individual and small employer Exchanges should be merged into a single risk pool.

Initial funding will be available in the form of federal Planning and Establishment Grants. However, the Exchange will need some working capital to support early-stage activities such as the navigator program to increase awareness prior to the start of the Exchange, and subsequently to support enrollment. The Exchange will be able to rely on the local navigator initiatives funded by the Patient Navigator Program, reauthorized by Section 3510 of the ACA with annual funding of \$4 million from 2011 through 2015. As of January 1, 2015, however, the Exchange will need to be self-sustaining and will need to charge assessments or user fees to participating health insurance issuers, or establish some other funding mechanism, to support its operations.

\*If a state chooses not to establish an Exchange, the HHS Secretary will directly or through an agreement with a not-for-profit entity, establish and operate an Exchange within the state.

## Technical and Financial Consumer Assistance

### Health Insurance Consumer Information (§1002)

The state, or a state-established Exchange, will be eligible to receive grant funds to expand existing or establish new offices of health insurance consumer assistance or health insurance ombudsman programs, which would be charged with responding to inquiries and complaints concerning health insurance coverage. A total of \$30 million in federal grant funding is available for this purpose during the first year (2011), with further funding subsequently available in amounts to be determined in the congressional appropriations process. The Congressional Budget Office (CBO) has estimated that a total of \$340 million will be available between 2011 and 2019, by estimating \$31 million for 2011 and calculating increasing annual funding based on estimated GDP growth, up to \$45 million in 2019.<sup>50</sup>

Both the California Department of Insurance (CDI) and the Department of Managed Health Care (DMHC) currently operate offices—CDI’s Ombudsman Office and DMHC’s Help Center—

that seem to align with the goals of the grant program. Whether these offices will be supported through the new funding will depend on a variety of factors: whether existing CDI and DMHC offices would qualify; how California chooses to configure the Exchange; and whether support would be more appropriately dedicated to an Exchange-level office or a community-based office. HHS guidance has not yet been released regarding these grant funds.

### Consumer Information Portal (§1103)

HHS must establish a mechanism to help consumers identify affordable health coverage options, including an Internet Web site, by July 1, 2010. The ACA places primary responsibility on HHS for the development of the resource, with a standardized format for information presented, though the Act stipulates that HHS do so in consultation with the states. In 2014, the Web site will be coordinated with the Web site the state is charged with developing under the Exchange. HHS issued interim final regulations, effective May 10, 2010, to begin implementation of the portal.<sup>51</sup>

#### SUMMARY: Health Insurance Consumer Assistance

**What Does It Say?** The state may be able to access federal funding to support an existing, or establish a new, consumer assistance office.

**Effective Date** March 23, 2010, though HHS guidance is not yet available.

**What Needs to Be Done?** The federal government will develop guidance on how the state may access funding, which could be in the form of a federal grants announcement.

California will need to determine whether it will request funding for an existing office or establish a new office, potentially through the state Exchange. If it chooses to dedicate funding to an existing office, the state could explore consolidating the CDI and DMHC offices, since the new office’s purview would cover health insurance broadly.

It is unclear how funds will be distributed, but California would need to successfully compete with other interested states for funds.

**Who’s Responsible?** HHS, CDI, DMHC, state Exchange entity

**The Bottom Line** The state could receive additional funding to support consumer assistance efforts.

## IV. Basic Health Program

THE AFFORDABLE CARE ACT (§1331) GIVES the state the option of establishing a Basic Health Program for low-income individuals under the age of 65 with income above the new Medicaid threshold of 133 percent of FPL and up to 200 percent of FPL. Legal immigrants with income below 133 percent of FPL who are not enrolled in Medi-Cal because of the five-year bar would also be eligible for Basic Health Program benefits if the state elects this option.

Those eligible for Basic Health Program coverage would otherwise be able to access coverage through the state Exchange, though some would qualify for affordability exemptions from the individual mandate and penalty for non-coverage and remain uninsured.

As implementation planning for the Medi-Cal expansion and creation of a state Exchange takes shape, California state regulators may consider whether a Basic Health Program is an effective means to provide an affordable coverage option for certain low-income state residents. A Basic Health Program could provide an affordable, comprehensive coverage option for very low-income legal immigrants who are ineligible for Medi-Cal, as well as for families with income just above the Medi-Cal threshold.<sup>52</sup> A Basic Health Program may be especially helpful in light of the number of parents that the state projects will lose current Medi-Cal coverage with the conversion to a MAGI eligibility test in 2014 (for more information on MAGI, see section starting on page 8).<sup>53</sup>

The ACA establishes caps on beneficiaries' monthly premiums and cost-sharing obligations, which vary based on income. Monthly premiums for the Basic Health Program are limited to the level of the second lowest cost coverage option (Silver Tier) offered in the state Exchange. Additionally, cost

sharing for beneficiaries with family income between 134 percent and 150 percent of FPL may not exceed the cost sharing required under the most generous coverage option in the state Exchange (Platinum Tier). Cost sharing for beneficiaries with family income between 151 percent and 200 percent of FPL may not exceed the cost sharing required under a state's Gold Tier (see Section III for a discussion of the categories of coverage in the Exchange).

The ACA requires the state to establish a competitive contracting process for a standard health plan, defined in the statute as a health benefits plan with which a state contracts to participate in the Basic Health Program. The law specifically directs that the state engage in the following practices (in addition to negotiation of premiums, cost sharing and benefits) in its contracting process:

- Negotiating with plans that offer: (a) care coordination and care management, especially for chronic conditions; (b) incentives for use of preventive services; and (c) establishment of provider/patient relationships that maximize patient involvement in health care decision making;
- Contracting with managed care systems or systems that offer attributes of managed care;
- Establishing quality of care and outcome measurement and reporting requirements; and
- Making multiple standard health plans available through the Basic Health Program.

Standard health plans must offer at least essential benefits in order to participate in a state's Basic

Health Program. Standard health plans may include licensed health maintenance organizations, licensed health insurance insurers, or networks of health care providers established to offer services under the Basic Health Program. The state may negotiate regional compacts with other states to cover eligible individuals in all participating states under contracted standard health programs.

The ACA requires HHS to transfer to states offering a Basic Health Program 95 percent of the tax credits and cost-sharing reductions that would have been provided to individuals enrolled in standard

health plans if they enroll in qualified health plans through the state Exchange. In turn, the state is required to establish a trust for deposit of federal Basic Health Program funds. The ACA requires that these trust funds be used only to reduce premiums and cost sharing for eligible individuals or to provide additional benefits.

HHS has responsibility for establishing the Basic Health Program through federal regulation, but Basic Health Program regulations are not expected to be promulgated in the near term.

#### SUMMARY: **Basic Health Program**

**What Does It Say?** The state has the option of creating a Basic Health Program for all people under age 65 with income from 134 percent to 200 percent of FPL, and to legal immigrants with income below 133 percent of FPL who are ineligible for Medi-Cal because of the five-year ban. Funding for the program would come from federal dollars that would otherwise have supported tax credits and cost-sharing reductions had these Californians enrolled in coverage through the state Exchange.

**Effective Date** January 1, 2014

**What Needs to Be Done?** The federal government will issue guidance on the Basic Health Program, but such guidance is probably not a high priority for the agency for at least the next year. California has the option to consider whether the Basic Health Program can provide an affordable, comprehensive coverage option for low-income families and legal immigrants. An assessment of tradeoffs among state costs, comprehensiveness of coverage, administrative ease, and consumer benefits could help inform whether to establish a Basic Health Plan.

**Who's Responsible?** HHS, CMS, DHCS, MRMIB

**The Bottom Line** The Basic Health Program is not a near term priority, but is worth exploration once federal guidance is available.

## V. Private Coverage

THE AFFORDABLE CARE ACT ENACTS PRIVATE health insurance reforms to address consumer barriers in accessing and maintaining comprehensive coverage. The new law also establishes insurance industry standards and consumer protection and assistance mechanisms that target coverage provided in the individual and small group markets, as well as some that apply more broadly to all private coverage models.

As a result, California will assume new responsibilities. New standards and requirements for health plans and insurers will require the state to harmonize its existing regulations and oversight activities with federal requirements in numerous areas including premium review and approval, plan financial reporting, product design, and network development. DMHC and CDI jointly regulate health insurance in the state: DMHC has authority over health maintenance organizations (HMO) and some preferred provider organizations (PPO) while CDI has authority over traditional insurance products and some PPOs.<sup>54</sup>

Some of the ACA's requirements become effective immediately or within the next six months while others are phased in over a longer term (through 2014). Practically speaking, however, even with many requirements that are effective immediately, the federal government will need to take additional action before the provisions can be implemented. In several instances, the ACA directs HHS to issue additional instructions or engage in formal rulemaking.<sup>55</sup> In other cases, while it is not specifically directed to do so, HHS could exercise its discretion to issue clarifying information. Additional federal guidance will not only help inform the state's

implementation of the new health reform law but will also help clarify how new insurance standards do and do not differ from current state standards.

### Provisions Affecting Individual and Small Group Private Coverage

#### Temporary High-Risk Pool Program (§1101).

The ACA establishes a \$5 billion temporary high-risk pool program to provide coverage for citizens and legal immigrants who have been uninsured for at least six months and have a preexisting condition.<sup>56</sup> California currently maintains a high-risk pool, known as the Major Risk Medical Insurance Program (MRMIP) which is operated by the state's MRMIB, although actual coverage is provided by contracted health plans, primarily Kaiser and Anthem Blue Cross. MRMIP has been operating since 1991 and reached its peak enrollment of over 27,000 in 1998. Its two major funding sources are the Cigarette and Tobacco Surtax Fund (Proposition 99) which covers one-third of program costs, and individual premiums which cover most of the other two-thirds. In 2008, MRMIP's enrollment was capped at 7,100 as a result of funding constraints, including a projected average annual decline of 3 percent for Proposition 99 revenue.

The new high-risk pool program is meant to serve as a temporary bridge to the establishment of the state Exchange; it will operate for approximately 42 months, assuming a July 1, 2010 start date. The state will be expected to transition the high-risk pool enrollees to the state Exchange by January 1, 2014, when the Exchange becomes operational.

HHS will develop procedures to transition eligible individuals enrolled in the high-risk pool to qualified health plans offered through a state Exchange. HHS is also authorized to extend coverage after the termination of the high-risk pool, if necessary to avoid an enrollee's loss of coverage.

California had several options for implementing the temporary high-risk pool program:

- Designate MRMIB as the entity that will operate the new temporary program, in tandem with MRMIP;
- Designate another state entity to operate the new high-risk pool, outside of MRMIB; or
- Fail to implement a temporary high-risk pool, meaning that HHS would operate the program, most likely through delegation to a contractor.

On April 29, 2010, Governor Schwarzenegger indicated to HHS Secretary Sebelius, through an official letter of intent, that California would operate its own temporary high-risk pool through the MRMIB.<sup>57</sup> HHS has indicated that it will allow states to use existing lists of benefits and criteria for defining preexisting conditions, as long as they are not inconsistent with the federal requirements. Because MRMIP is not a qualified high-risk pool, it is likely that both the benefits and the criteria would need to be modified for new high-risk enrollees. Nonetheless, the new federally funded risk pool is expected to operate alongside the state's current MRMIP high-risk pool (see Table 7 on page 31).

It is difficult to estimate the number of Californians who might benefit from the temporary high-risk pool, although it is likely to be significantly more than the enrollment cap of 7,100 for the state's current MRMIP risk pool, which has found that 40 percent of its subscribers had been uninsured six months or more. As a result, the federal criteria

that an individual must be without insurance for a six-month period is not likely to be a major limiting factor. In fact, California is thought to have somewhere between 400,000 and 850,000 medically uninsured residents.<sup>58</sup> The number that actually take advantage of the high-risk program will depend on many factors, including the level of benefits offered and premiums. The funds for the temporary pool will be allocated based on the state's population and cost profile, comparable to the CHIP allocation. The total pool of funds will be allocated each year in a manner which allows each qualified enrollee to be covered by the program until the end of December 2013.

### Coverage Expansion and Financing

HHS has clarified that the federal government will fund all costs which exceed the premiums received from individual enrollees in the high-risk pool. No state matching funds will be required. The costs of the temporary high-risk pool include administrative expenses required to develop and operate the program, as well as the costs of health insurance claims. HHS plans to establish an account through which each contracted state can draw down the benefit claims. Based on HHS's preliminary estimates, California could receive \$761 million over the 42 months of the pool's operation, or an annualized amount of \$218 million, which is more than a five-fold increase over the state's annual funding of MRMIP.<sup>59</sup> The estimated California allocation could fund coverage for more than 35,000 individuals for the entire 42-month period, assuming an average monthly premium of approximately \$600, which is the national average premium for high-risk pools in a Government Accountability Office (GAO) report.<sup>60</sup> The actual number will depend on two key factors:

- **Average enrollment period.** Enrollment is unlikely to occur for all enrollees at the same time, meaning that the average number of months of coverage for all enrollees will be less than the 42 months of the program’s operation.

- **Premiums.** The premiums may be more than the \$600 average in the GAO report because the ACA requires an actuarial value of 65 percent, which is likely to be higher than the coverage offered by most existing state risk pools. The remaining 35 percent reflects the average enrollee’s share, primarily for the cost-sharing

**Table 7. Comparison of MRMIP and New Temporary High-Risk Pool**

	MRMIP	TEMPORARY HIGH-RISK POOL
Eligibility Criteria	<ul style="list-style-type: none"> <li>• Resident of state</li> <li>• Demonstrate:               <ul style="list-style-type: none"> <li>• Rejection from a carrier in last 12 months; or</li> <li>• Offer of coverage with premiums equal to or exceeding MRMIPs; or</li> <li>• Termination by a carrier for reasons other than fraud or non-payment of premium</li> </ul> </li> <li>• Ineligible for Medicare, unless solely eligible because of End-Stage Renal Disease</li> <li>• Ineligible for or has exhausted COBRA or Cal COBRA</li> </ul>	<ul style="list-style-type: none"> <li>• Citizen or national of the U.S. or lawfully present in the U.S.</li> <li>• Have no creditable coverage in the last six months</li> <li>• Have a preexisting condition, as determined by the Secretary of HHS or as proposed by the state with HHS approval</li> </ul>
Rating Factors	<ul style="list-style-type: none"> <li>• Plan</li> <li>• Age of Subscriber</li> <li>• Individual or Family</li> <li>• Geographic Region</li> </ul>	<ul style="list-style-type: none"> <li>• Age of Subscriber (subject to a 4:1 limit)</li> <li>• Individual or Family</li> <li>• Geographic Region</li> <li>• Tobacco Use (subject to a 1.5:1 limit)</li> </ul>
Preexisting Conditions Restrictions/Waiting Periods	<ul style="list-style-type: none"> <li>• PPO product: three-month waiting period for services for preexisting conditions</li> <li>• HMO product: three-month post-enrollment waiting period during which no benefits are provided (subscriber does not pay premiums during this period)</li> </ul>	No waiting period for preexisting conditions
Deductible	\$500	To be determined (enrollee share of benefit costs cannot exceed 35 percent)
Annual Limit	\$75,000	
Out-of-Pocket Limit	\$2,500	\$5,950 for an individual; amount based on High Deductible Health Plan
Lifetime Benefit Limit	\$750,000	Pending federal guidance
Actuarial Value <small>(i.e., on average, the percent of total health care costs covered by the premium)</small>	Approximately 40 percent*	At least 65 percent

\*Estimate provided by MRMIP in personal communication with California HealthCare Foundation.

requirements up to the annual out-of-pocket limit. The premiums charged in the high-risk pool cannot exceed the state’s “standardized risk rate,” an amount that the state must calculate using reasonable actuarial methods.

Recognizing that there will be some uncertainties related to enrollment patterns, HHS intends to reassess the state high-risk pool allocations at some point within the program’s first two years. Similar to the process for CHIP, the reallocation will be based on an assessment of each state’s actual enrollment rates and spending experience. States with a high rate of medically uninsured are likely to pursue an aggressive first-year enrollment strategy to minimize their potential loss of federal funds in subsequent years if the early enrollment rates and spending experience causes HHS to reallocate funds among the states in the middle of the program’s operation.

### Maintenance of Effort and Plan Monitoring

In order to qualify for the new high-risk pool, the state is required to maintain the current level of effort associated with MRMIP, which is funded by the state. For California, which could be participating in the new program as early as July 1, 2010, the MOE requirement means that MRMIP’s funding must be maintained at the 2009 level.

In addition to MOE requirements, health insurance issuers and employment-based health plans are subject to sanctions for “dumping risk,” with HHS to develop criteria for determining if an individual has been discouraged from remaining enrolled in a plan based on the individual’s health status. As part of the high-risk pool solicitation, HHS has asked states to consider the following procedures for determining if an individual was discouraged from maintaining coverage:

- Questions on the high-risk pool application form about employment status of the applicant or family members, and questions as to whether anyone is assisting them with the premiums;

#### SUMMARY: Temporary High-Risk Pool Program

**What Does It Say?** The temporary high-risk pool program will be a source of health insurance coverage for U.S. citizens or nationals who have been uninsured for at least six months because of a preexisting condition. The program could start as early as July 1, 2010 and will continue until the end of 2013 when enrollees will transition to coverage through Medi-Cal or the state Exchange, based on a transition plan established by HHS and implemented by the state.

**Effective Date** July 1, 2010: California must be ready to begin operating the high-risk pool. HHS expects that an individual’s coverage will be effective within 15 days of submitting a complete enrollment request.

**What Has Been Done?** April 30, 2010: Governor Schwarzenegger expressed the state’s intent to operate the high-risk pool under contract with HHS.  
May 10, 2010: HHS issued a Solicitation for State Proposals to Operate Qualified High-Risk Pools.

**What Needs to Be Done?** California must submit its proposal in response to the HHS solicitation to operate the temporary high-risk pool (federal deadline not set as of this writing).

**Who’s Responsible?** HHS, governor, MRMIB, legislature

**The Bottom Line** California will be able to provide health insurance coverage to many more medically uninsured than is possible under MRMIP’s current funding constraints.

- Questions on the application form asking applicants to identify their most recent health coverage and the reasons for leaving or losing that coverage; and
- Requirement that enrollees report changes in their employment status, or that of a family member, during the course of enrollment.

The amount of the sanctions based on those who have been discouraged from remaining enrolled in an existing health plan will be based on the medical expenses that the high-risk pool program incurs as a result.

#### Temporary Reinsurance Programs (§§1341–2)

Two temporary reinsurance programs will be in place from the start of the Exchanges in 2014 until the end of 2016: the transitional reinsurance program and the federal risk corridor program. (In addition, a program to provide reinsurance for early retirees is also established; see sidebar below.) The transitional reinsurance program requires a state reinsurance entity to collect fees from all health insurers based

#### Reinsurance for Early Retirees (§1102)

As early as July 2010, employers—including state, county and local governments—can qualify for a total of \$5 billion in federal reinsurance payments to help them lower the health plan costs paid by early retirees, including premium contributions, deductibles and co-payments. In order to qualify for the payments, the employer must demonstrate that its retiree health plan has implemented programs and procedures to generate cost-savings related to chronic and high-cost conditions. The application process is similar to the Medicare Retiree Drug Subsidy program. Qualified plans will submit their claims to HHS, which will make reinsurance payments to the plans for claim costs which are between \$15,000 and \$90,000. HHS issued interim final regulations, which are effective June 1, 2010, to begin implementation of the program.<sup>61</sup>

on an amount set by HHS and to make reinsurance payments to plans in the individual market which have enrolled high-risk individuals. The risk corridor program involves payment adjustments between HHS and a health plan, which depend on an analysis of whether the plan's premiums are more or less than the allowed costs.

#### Transitional Reinsurance (§1341)

The transitional reinsurance program is designed to stabilize premiums in the individual market during the first three years of the new federal requirement to maintain minimum essential coverage. During this time, it may be difficult to estimate the average cost of an enrolled population because of the combined effect of the guaranteed issue requirement for health plans and the minimum coverage requirement for individuals. Some health plans may enroll a disproportionate number of individuals with preexisting conditions or risk factors who would not be able to afford coverage without the new federal subsidies, while other plans may have a disproportionate rate of healthy enrollees. Reinsurance will help to redistribute among the plans any disproportionate gains associated with low-risk enrollees as well as the losses associated with high-risk enrollees.

Nationwide, new health insurance issuers and health plans will be required to make contributions to a reinsurance pool which will total \$25 billion. Grandfathered health plans or issuers and self-insured ERISA plans are exempt from the reinsurance provision. The state reinsurance entity will determine the amount of reinsurance that each health insurer will pay based on the payment method selected by HHS, which will either be a specified percentage of premiums or claims costs, or a specified per capita amount. Regardless of the method, it would be applied to all major medical policies, both inside

and outside the Exchange, unless the plan or issuer was exempt. HHS will specify the fixed percentage or the per capita amount using a methodology whereby the total contributions across all states will total \$12 billion in 2014, \$8 billion in 2015, and \$5 billion in 2016.

The state reinsurance entity will make payments to insurers in the individual market that cover high-risk individuals. The payments will be based on a payment schedule for the range of high-risk conditions covered by the program, or using an alternative method recommended by the American Academy of Actuaries, that will encourage care coordination and care management programs. The high-risk conditions will be established by HHS based on: 1) a list of 50 to 100 conditions, defined by diagnosis or procedure codes, which are indicative of an individual with a preexisting high-risk condition, or 2) a comparable method recommended by the American Academy of Actuaries.

States have several options for establishing reinsurance entities, though they must be not-for-profit organizations. A state can establish a new independent reinsurance organization within the state or it can join with other states to establish a new independent entity available to all of the participating states. Alternatively, a state can choose to contract with one or more existing reinsurance entities to operate the program on its behalf. MRMIP is not a candidate to serve as a reinsurance entity, since it is a state agency rather than a nonprofit organization as required by law.

#### **Federal Risk Corridor Program** (§1342)

Health insurers in the individual and small group markets in California must participate in the federal risk corridor program if they offer a qualified health plan. The program will operate for the first three years of the state Exchange when plans may be less accurate in setting premiums because of the factors

#### **SUMMARY: Transitional Reinsurance Program for Individual Market in Each State**

**What Does It Say?** The transitional reinsurance program is designed to support health plans in the individual market that cover high-risk individuals. California will need to establish a reinsurance entity which will collect reinsurance contributions from all health plans that participate in the individual and group market, except for grandfathered plans. The fees will be based on a health insurance issuer's fully insured major medical products, regardless of whether they are offered inside the Exchange. HHS will determine if the reinsurance payments will be made based on a payment schedule for a list of 50 to 100 conditions or another method such as the risk adjustment methodology used in Medicare Advantage.

**Effective Date** January 1, 2014

**What Needs to Be Done?** HHS is responsible for defining how states will identify individuals with high-risk conditions and for determining the rate methodology that the state reinsurance entity will use to calculate each health insurer's reinsurance contributions.

California needs to decide if it wants to establish one or more reinsurance entities within the state or if it wants to establish a contract with an existing reinsurance entity. The only constraint is that the entity must be a not-for-profit organization.

**Who's Responsible?** HHS, DCI, MRMIB

**The Bottom Line** California needs to establish or contract with a reinsurance entity which will comply with federal standards and state laws and regulations regarding the Exchange. MRMIP would not qualify as the reinsurance entity because it is a state agency rather than a not-for-profit organization as required by law.

described in the section above. A risk corridor is a threshold that is based on a comparison of a plan's allowable costs to its target amount of revenue. Plans at the lower end of the risk corridor will return payments to HHS because their target rate exceeds their costs by more than 3 percent. Plans at the upper end will receive payments from HHS because their costs exceed their target rate by more than 3 percent.

The risk corridors or thresholds will be based on the methodology used in the Medicare Part D program, in which the plans with higher risk enrollees receive additional payments from the program while health plans with lower-risk enrollees make payments to the program.

The payment adjustment is calculated as the percentage of the plan's allowable costs measured against its target amount. The allowable costs are

the total amount of costs that the plan incurs in providing covered benefits, reduced by administrative expenses and any reinsurance from the temporary reinsurance fund or the state risk adjustment program. The target amount is the total annual premiums, including subsidies, minus administrative expenses.

Unlike the state reinsurance program, which makes payments only to plans in the individual market, the federal risk corridor payment adjustments will be made to qualified health plans in the small group market as well, if their costs are in the upper end of the risk corridor. While the risk corridor is a federal program, HHS may delegate the function to the state authority responsible for implementing the health insurance reform activities.

#### SUMMARY: **Federal Risk Corridors for Plans in Individual and Small Group Markets**

**What Does It Say?** Risk corridors will be calculated based on a comparison of a plan's allowable costs and its target amount, which is based on premiums.

Plans with low-risk corridors have allowable costs which are less than 97 percent of the target amount, indicating that they have been "overpaid" and will need to make a repayment to HHS, similar to a rebate.

Plans with high-risk corridors have allowable costs which exceed 103 percent of the target amount, indicating that they have been "underpaid" and will receive additional payments from HHS.

Qualified health plans in the individual and small group markets will be subject to positive or negative payment adjustments depending on the risk corridor calculation.

**Effective Date** The federal risk corridor payment adjustments will be effective for three years starting on January 1, 2014.

**What Needs to Be Done?** The Affordable Care Act does not specify how the payment adjustments will be made. HHS may establish a reconciliation process whereby a state agency or the Exchange would serve as an intermediary between HHS and the plans. Alternatively, it could follow the Medicare Part D model where the payment adjustments are between the plan and the federal government without any intermediary.

**Who's Responsible?** HHS

**The Bottom Line** HHS will rely on health plan data collected by the state to administer the risk corridor program. It is possible that HHS could delegate the payment adjustment function to the state.

## Permanent State Program for Risk Adjustment

(§1343)

California will be required to establish a risk adjustment program so that plans with high-risk enrollees will be compensated by plans with lower-risk enrollees, regardless of whether the plan is offered inside or outside of the state Exchange. The risk adjustment program will apply to all new fully insured health plans for the small group and individual markets. The program will not apply to grandfathered plans or to self-insured plans.

The risk adjustment methodology will be developed as part of a consultative process between the states and HHS, which is authorized to use criteria and methods similar to the “risk scores” used in the Medicare Advantage and Medicare Part D programs. This methodology uses an algorithm that creates an overall risk profile for various groupings of beneficiaries. For example, Medicare calculates geographic and health plan-specific risk scores to determine if there are differences in the relative risks of different Medicare populations.

The permanent risk adjustment program is based on a comparison of the “actuarial risk” of a health plan’s enrollees and the average risk profile across all plans and sources of health coverage in a state (not counting self-insured plans). If a health plan does not have many high-risk individuals, it would have a low risk score and would be defined as a “low actuarial risk plan.” In contrast, a “high actuarial risk plan” is likely to have many more high-risk enrollees compared to other plans. In order to limit the financial risks associated with adverse selection, this new state program would collect fees from low actuarial risk plans, which it would use to make payments to the high actuarial risk plans.

Since the risk adjustment program applies to qualified health plans inside and outside of the Exchange, the state will want to develop the program so that it coordinates with the state’s insurance and managed care regulatory agencies as well as with the new state Exchange.

### SUMMARY: Risk Adjustment State Program

**What Does It Say?** The state must establish a permanent program to adjust risk for qualified health plans in the small group and individual markets. Under the program, plans would be classified as low or high actuarial risk. Low actuarial risk plans would be assessed a fee which would provide funds the state would use to make payments to the high actuarial risk plans because they cover more individuals with high-risk conditions.

**Effective Date** The Affordable Care Act does not specify an effective date; however, CBO estimates include risk adjustment payments starting in 2014.

**What Needs to Be Done?** HHS must develop the criteria and establish the risk adjustment program, in consultation with the states. The ACA allows HHS to develop program criteria and methods similar to those used under the Medicare program. The state must then establish a program consistent with the criteria.

**Who’s Responsible?** HHS, state (likely CDI, DMHC)

**The Bottom Line** This is a significant change in the health insurance market since it is not limited to qualified health plans inside the state Exchange. This provision could have a financial impact on any fully insured health plan or health insurance issuer in the individual or small group market within the state.

**Table 8. Transitional Reinsurance, Risk Corridor, and Risk Adjustment Programs**

	TEMPORARY PROGRAMS (2014 – 2016)			PERMANENT RISK ADJUSTMENT PROGRAM (ESTIMATED 2014 OR LATER)	
	TRANSITIONAL REINSURANCE		FEDERAL RISK CORRIDOR	COLLECTIONS FROM LOW RISK PLANS	PAYMENTS TO HIGH RISK PLANS
	COLLECTIONS FROM ALL PLANS	PAYMENTS TO ALL PLANS	PAYMENT ADJUSTMENTS (POSITIVE AND NEGATIVE)		
Types of Plans*	<ul style="list-style-type: none"> <li>Individual</li> <li>Small Group, New Plan</li> </ul>	<ul style="list-style-type: none"> <li>Individual</li> </ul>	<ul style="list-style-type: none"> <li>Individual</li> <li>Small Group, New Plan</li> </ul>	<ul style="list-style-type: none"> <li>Individual</li> <li>Small Group, New Plan</li> </ul>	<ul style="list-style-type: none"> <li>Individual</li> <li>Small Group, New Plan</li> </ul>
Exchange Status of Plans	<ul style="list-style-type: none"> <li>Inside Exchange</li> <li>Outside Exchange (qualified and non-qualified plans)</li> </ul>	<ul style="list-style-type: none"> <li>Inside Exchange</li> </ul>	<ul style="list-style-type: none"> <li>Inside Exchange</li> <li>Outside Exchange (qualified plans only)</li> </ul>	<ul style="list-style-type: none"> <li>Inside Exchange</li> <li>Outside Exchange (qualified and non-qualified plans)</li> </ul>	<ul style="list-style-type: none"> <li>Inside Exchange</li> <li>Outside Exchange (qualified and non-qualified plans)</li> </ul>
Funding	\$25 billion		TBD	TBD	TBD
Organization	Nonprofit Reinsurance Entity		HHS	Determined by the State	

\*Grandfathered health plans and self-insured health plans are excluded from these programs.

## Changes Regarding All Private Coverage

### Premium Rate Review (§§1003, 10101(j))

Starting in 2010, California must institute an annual review process to identify “unreasonable” plan premium rate increases, a standard yet to be defined by HHS. The Affordable Care Act makes available a total of \$250 million to support state premium rate review efforts and for new “medical reimbursement centers”—to be established at academic and/or nonprofit institutions—that collect, analyze, and organize medical reimbursement information from health insurers. California could receive between \$1 million and \$5 million annually for five years, the exact amount to be based on a federal formula for state allocation of appropriated funds.<sup>62</sup> As a condition of receiving federal funding, California will need to provide HHS with information about premium increase trends in the state and recommend whether certain insurance plans should be excluded from participating in the state’s Exchange due to excessive or unjustified premium increases. In 2014,

the state must also begin ongoing monitoring of premium increases for plans, regardless of whether the health insurance coverage is offered in the Exchange or outside it.

Health insurers will be required to disclose to HHS, the state, and the public, the justification for a premium rate increase. Insurers with excessive or unjustified premium increases, as determined through the review process and applying standards set by HHS and applied by the state, may be excluded from participating in state Exchanges. The ACA does not otherwise authorize HHS or states to prevent implementation of plan rate increases and it is unclear at this time if HHS guidance can or will authorize federal or state modification of premium rates in the review process.

The premium rate review process is currently under development. The ACA places primary responsibility for that development on HHS, though it stipulates that HHS do so in consultation with the states. On April 14, 2010, HHS initiated this process and issued a notice requesting public feedback on

## SUMMARY: Premium Rate Review

**What Does It Say?** The state must review plan premium rates and report information to the federal government on an ongoing basis. The state may also provide funding to academic and nonprofit institutions to form medical reimbursement centers that collect, analyze, and organize medical reimbursement information from insurers.

**Effective Date** March 23, 2010

**What Needs to Be Done?** The federal government will develop guidance on the annual review process and parameters on the grant program to support states' premium rate review processes. California has the opportunity to work with federal partners in the guidance development process. California will also need to determine how current state premium rate review practices align with new federal requirements and if any changes (e.g., conforming state legislation) are necessary.

**Who's Responsible?** HHS, DOL, Treasury, DMHC, CDI

**The Bottom Line** The state needs to institute new premium rate review processes and could receive new federal funding to support these efforts.

current state rate review practices and requirements and on the formula for allocating grant funds.<sup>63</sup> On June 7, 2010, HHS announced the availability of \$51 million in a first round of grants from the \$250 million ACA dedicates to states to carry out this provision. In this first cycle, states will be able to receive \$1 million each if they submit satisfactory applications describing how they will use grant funds to develop or enhance the process of reviewing and approving, disapproving, or modifying health insurance premium requests.<sup>64</sup>

### New Insurance Standards

The Affordable Care Act establishes a number of new requirements for health plans and insurers. Unless otherwise noted below, these provisions apply to group health plans, including self-insured plans, and issuers offering individual and small group coverage both inside and outside the state Exchange. The ACA exempts existing group and individual coverage—“grandfathered health plans”—from a number of these new requirements.<sup>65</sup> Provisions that apply to grandfathered health plans are specifically highlighted below.

More guidance from the federal government related to standards and state enforcement authority will be necessary, but the state will likely need to harmonize current state requirements with the ACA health insurance standards. The state will also need to play an active role in monitoring and enforcing new standards. For both tasks, California may need to modify current or develop new administrative and oversight processes and pursue regulatory and legislative changes. Questions also remain with respect to the maintenance of grandfathered health plan status, and whether modifications in coverage features or issuer organizational structure could result in the end of grandfathered status.<sup>66</sup> It is unclear the extent to which these questions will be addressed in federal guidance, and if so, when.

**In the near term.** Starting with the first plan years following effective dates ranging from September 23, 2010 through December 31, 2010, health plans:

- Are prohibited from imposing lifetime limits on the dollar value for essential benefits provided to consumers (see “Essential Benefits” in Section III) and are only permitted to impose “restricted annual limits” on coverage. As of January 1,

2014, health plans will be prohibited from setting annual limits. In addition to new health plans and insurers, the lifetime limit prohibition applies to grandfathered health plans while the annual limits prohibition applies to grandfathered group health plans (§§1001 [PHSA §2711], 10101[a], 1251, HCERA §2301).<sup>67</sup>

**AREAS FOR FEDERAL GUIDANCE:** HHS must define the parameters for the interim standard of restricted annual limits.

- Are prohibited from terminating coverage of individuals except on grounds of fraud and abuse.<sup>68</sup> In addition to new health plans and insurers, this provision applies to grandfathered health plans (§§1001 [PHSA §2712], 1251, HCERA §2301).

**AREAS FOR FEDERAL GUIDANCE:** Though the ACA does not require any additional regulations, more guidance could be required to clarify “fraud” and “intentional misrepresentation of material fact,” the conditions that would permit health plans to terminate an individual’s coverage.

- Must provide coverage for a designated set of preventive health services (under existing federal guidelines) without cost-sharing. Examples of these services include immunizations and children’s preventive health screenings (§1001 [PHSA §2713]).

**AREAS FOR FEDERAL GUIDANCE:** HHS must establish an appropriate transition timeframe of at least a year between the issuance of new guidelines and expected adoption by health plans.

- Must extend coverage for children up to age 26, if the plan provides coverage for dependent children.<sup>69</sup> In addition to new health plans and insurers, this provision applies to grandfathered group health plans (§§1001 [PHSA §2714], 1251,

HCERA §2301). A related provision gives parents favorable tax treatment for coverage of adult children under age 27 (HCERA §1004[d][1]).<sup>70</sup>

**AREAS FOR FEDERAL GUIDANCE:** HHS, the Internal Revenue Service (IRS), the Department of the Treasury (Treasury), and the Department of Labor (DOL) jointly issued interim final regulations, effective July 12, 2010.<sup>71</sup> The public comment period closes on August 12, 2010. Federal guidance has already clarified some of the initial questions raised regarding this provision, such as articulating that such coverage: (1) is available up to a child’s 26th birthday and not through a child’s 26th year; (2) is not limited only to dependents meeting the income tax definition; and (3) is not required to be available to the spouse of an eligible child.

- Are prohibited from discriminating in the provision of health coverage or benefits in favor of highly compensated employees. These are rules that currently apply to self-insured plans and are being extended to group health plans (§§1001 [PHSA §2716], 10101[d]).
- Must submit annual reports to HHS on their activities and reimbursement structures related to quality improvement, hospital readmission prevention, patient safety, and wellness and health promotion (§§1001 [PHSA §2717], 10101[e]).

**AREAS FOR FEDERAL GUIDANCE:** HHS must develop reporting requirements and issue regulations on the criteria for evaluating whether reimbursement structures fulfill quality improvement, hospital readmission, patient safety, and wellness and health promotion goals. The deadline for HHS to promulgate these regulations is March 23, 2012.

- Must submit annual reports to HHS on the percentage of premiums spent by the plan on

clinical services and activities that improve health care quality, a term known in the insurance industry as “medical loss ratios.” If the reported medical loss ratio falls below minimum standards, insurers would be required to provide consumer rebates. The ACA specifies minimum medical loss ratios of 80 percent for individual and small group insurers and 85 percent for large group insurers, though the state has discretion to establish higher levels with HHS approval. In addition to new health plans and insurers, this provision applies to grandfathered health plans in the first plan year following enactment (§§1001 [PHSA §2718], 10101[f], 1251, HCERA §2301).

**AREAS FOR FEDERAL GUIDANCE:** The NAIC must develop guidelines for standard definitions in accounting for health care costs and calculation methodology for medical loss ratios, and HHS must certify these guidelines by the end of 2010. HHS must develop enforcement rules, which it has opted to do jointly with DOL and Treasury. On April 14, 2010, these three federal departments issued a notice requesting public feedback to inform the development of regulations.<sup>72</sup>

- Must implement internal claims appeals and external review processes. For internal claims appeals, health plans must initially comply with existing rules and then with any additional requirements that may be specified by DOL and HHS. For external review processes, health plans must comply either with state standards that meet minimum NAIC Uniform External Review Model Act consumer protections or, in the absence of state standards or for plans not regulated by the state, with standards to be established through HHS guidance (§§1001, 10101 [PHSA §2719], 10101[g]).

**AREAS FOR FEDERAL GUIDANCE:** HHS and DOL must establish internal claims appeal requirements. HHS must also establish external review process requirements.

**In the longer term.** Starting with the first plan years following effective dates, ranging from January 1, 2012 and beyond, health plans:

- Must provide benefits summary and coverage information to individuals, following a standardized format. In addition to applying to new health plans and insurers in 2012, this provision applies to grandfathered health plans and takes effect for them in the first plan year following ACA enactment (§§2715, 1251, HCERA §2301).

**AREAS FOR FEDERAL GUIDANCE:** HHS must develop a standardized format, in consultation with NAIC and a stakeholder workgroup, and issue the standards (including requirements concerning presentation and content) by March 23, 2011. HHS must also promulgate regulations providing standards for common health insurance and medical terms.

- Must issue insurance policies to interested individuals and employers (“guaranteed issue”) and continue to sell these policies (“guaranteed renewability”) regardless of health or risk status (effective January 1, 2014). Health plans may restrict enrollment timeframes by establishing open enrollment periods but must also establish special enrollment periods that would allow interested individuals to join or modify their coverage due to a “qualifying event” as addressed in existing law (e.g., change in marital status, loss of employment) (§1201 [PHSA §§2702, 2703]).

**AREAS FOR FEDERAL GUIDANCE:** HHS must issue regulations regarding requirements for the open enrollment and special enrollment periods.

- Are prohibited from withholding coverage due to a preexisting condition (a health condition present prior to a consumer seeking coverage). The ACA further specifies seven health status-related factors (such as claims experience, genetic information, and disability) that cannot be used in determining eligibility for coverage. (For children under 19, the protection is effective September 23, 2010.) In addition to applying to new health plans and insurers, the prohibition on withholding coverage due to a preexisting condition applies

to grandfathered group health plans (§§1201[2][a] [PHSA §§2704, 2705], 10103[e], HCERA §2301).

**AREAS FOR FEDERAL GUIDANCE:** HHS has the discretion to specify additional health status factors.

- Are prohibited from applying waiting periods for health coverage that exceed 90 days. This provision applies to all group health plans and all grandfathered health plans (§1201 [PHSA §2708], §1251, HCERA §2301).

**AREAS FOR FEDERAL GUIDANCE:** HHS may issue additional guidance regarding this requirement.

#### SUMMARY: **New Insurance Standards**

**What Does It Say?** Health plans regulated by the state are subject to a host of new requirements that become effective in the near term and in 2014.

**Effective Date** Plan years starting following effective dates ranging from September 23, 2010 to January 1, 2014.

**What Needs to Be Done?** The federal government and NAIC will develop guidance on a variety of requirements. California will need to analyze current insurance standards and the Affordable Care Act when federal parameters become clearer, to determine the extent to which legislative, administrative, or other changes may be necessary to harmonize with ACA standards.

**Who's Responsible?** HHS, DOL, Treasury, DMHC, CDI, legislature

**The Bottom Line** California could need to modify current or develop new administrative and oversight processes and pursue regulatory and legislative changes to harmonize current state requirements with ACA health insurance standards.

## VI. Waiver for State Innovation

CALIFORNIA MAY ASK PERMISSION FROM HHS and/or Treasury to waive certain requirements under the Affordable Care Act, substituting a state-designed coverage approach (§1332). If the state does so, its alternative program must:

- Provide coverage that is comparable to the essential benefits package and protections regarding consumers' out-of-pocket costs;
- Provide coverage to a comparable number of residents as in the absence of the waiver; and
- Not increase the federal deficit.

The state would have the opportunity to waive the provisions related to:

- Essential health benefits;
- Exchanges;
- Cost-sharing reductions;
- Premiums subsidies;
- Individual mandate for coverage; and
- Employer requirement for coverage.

The tax credits for premiums subsidies and cost-sharing reductions that would have been provided to individuals enrolled in qualified standard health plans offered through the state Exchange would be provided to the state to support its alternative program.

The state will have the option to apply for a five-year waiver for state innovation starting in 2017. In the interim, by September 23, 2010, HHS and Treasury are to issue regulations regarding the waiver application process. The ACA specifies certain required features of the waiver process, including requiring the state to engage in a public notice and comment process. The waiver process could very well be similar to current waiver processes applicable for Medi-Cal and Healthy Families, and the ACA specifically requires HHS to coordinate and consolidate these existing processes with the application process for the waiver for state innovation. The ACA even goes so far as to require that HHS develop a process that would allow the state to submit a single application for a waiver under this provision and Medi-Cal and Healthy Families, potentially allowing the state to test comprehensive approaches for expanding coverage.

Given that the ACA dictates that states would not be able to apply for a waiver sooner, it seems that the state will still need to be ready to implement major ACA provisions in 2014, even though the waiver option could raise some strategic considerations for the state in the long term.

**SUMMARY: Waiver for State Innovation**

**What Does It Say?** Starting in 2017, the state has the option of waiving certain major provisions in the Affordable Care Act related to essential benefits, the state Exchange, individual mandate, and employer requirements, and substituting state-designed policies.

**Effective Date** January 1, 2017

**What Needs to Be Done?** The federal government needs to issue guidance on the state innovation waiver application process.  
California will need to review federal guidance and consider whether the state has alternative policies it would like to test.

**Who's Responsible?** HHS, CMS, DHCS, governor, legislature

**The Bottom Line** The waiver for state innovation is not a near-term priority but may be an option for the state to test alternative state policies in later years.

## VII. Conclusion

IMPLEMENTATION OF FEDERAL HEALTH CARE reform would be daunting in the best of times. But California, like many states, is operating in an enormously challenging environment, with severe budget deficits projected for years to come, resources already stretched thin in the very state agencies key to implementation, and political transition at the highest levels of state government. Although the Affordable Care Act makes available some federal planning and implementation grants, neither the aggregate amount nor the amount of state awards for many of the areas is known at this time, leaving many to wonder whether the support will be adequate for the task (see Table 9, below). In addition, many areas necessary for state implementation—such as considerable policy and legal analysis—remain unfunded.

Implementation of health reform will unfold alongside the state’s comprehensive Medicaid waiver, slated for renewal this year. The goals articulated in the waiver—restructuring care delivery, strengthening

the safety net and reducing the number of the uninsured—reflect foundational elements for health reform implementation. The waiver request focuses on four target populations: seniors and persons with disabilities; children with special health care needs; people with behavioral health disorders or substance abuse requiring integration of care; and those who are dually eligible for Medi-Cal and Medicare. It remains to be seen what new programs and financing arrangements will emerge from state-federal negotiations around the waiver application. But the waiver’s focus on targeted groups, as well as California’s large undocumented population who will remain ineligible for programs under the waiver and under federal health reform, means that a significant number of residents will not benefit from coverage expansion either this year or in 2014. Therefore, continued support for the safety net, also included in the waiver renewal application, will remain a crucial priority for the state.

**Table 9. Federal Support Specified in the ACA for Implementation\***

	SUPPORTED ACTIVITIES	FEDERAL FUNDING LEVEL AND AVAILABILITY
Enrollment Technology Standards and Protocols (§1561)	Development and adaptation of systems to new simplified and streamlined enrollment standards and protocols	No funding level or timeframe specified
State Exchange (§1311 [a][1])	Planning and establishment of state Exchanges	No funding level specified; funding available between March 2011 and January 2015
Health Insurance Consumer Information (§1002)	Expansion of existing or establishment of new offices of health insurance consumer assistance or health insurance ombudsman programs	\$30 million in first year and such sums as necessary in future years; CBO estimates \$340 million of spending between 2011 and 2019.
Premium Rate Review (§§1003, 10101[i])	Establishment and operation of annual premium rate review process and medical reimbursement centers	\$250 million between October 2009 and September 2014

\*This chart represents sources of funding specified in PPACA solely for implementation activities related to new responsibilities. This chart does not include new funding available for Medicaid expansion or coverage of new benefits, nor does it include existing funding sources that may be accessed for implementation, such as Medicaid administrative funds.

In other ways, too, California's specific circumstances form an important backdrop for health reform implementation. The state's difficult fiscal position means that policymakers may be wary of potential new state costs resulting from increased enrollment of those already eligible for Medi-Cal. The state's already complicated insurance regulatory structure means that new programs and oversight mechanisms run the risk of adding to, rather than reducing, consumer confusion. In order to track and manage progress as implementation of the federal law unfolds, it will be important to monitor both desired outcomes and potential unintended consequences.

Despite these challenges and considerations, the ACA has the potential to have an enormously positive impact in California, reducing the state's uninsured population and improving the quality and accessibility of care. To realize this potential, California will need to draw on all available resources—taking full advantage of existing and new federal funding streams, as well as drawing upon the expertise of private stakeholders and subject matter experts within the state.

## Appendix: Interviewees

Shortly after enactment of the Affordable Care Act, Manatt Health Solutions engaged in a series of interviews with 16 leaders in health care policy and analysis, consisting of private actors and public officials in California.

Tahira Bazile, Senior Policy Analyst

California Primary Care Association

Kim Belshe, Secretary

California Department of Health and Human Services

Farra Bracht, Principal Policy and Fiscal Analyst

State of California Legislative Analyst's Office

Carmela Castellano-Garcia, President and Chief Executive Officer

California Primary Care Association

Lesley Cummings, Executive Director

California Managed Risk Medical Insurance Board

Duane Dauner, President and CEO

California Hospital Association

Toby Douglas, Deputy Director of Health Care Programs

California Department of Health Care Services

Cindy Ehnes, Director

California Department of Managed Health Care

Richard Figueroa, Health Care Advisor

Office of California Governor Arnold Schwarzenegger

Patrick Johnston, President and CEO

California Association of Health Plans

Howard Kahn, CEO

L.A. Care

David Link, Deputy Commissioner and Legislative Director

California Department of Insurance

David Panush

Office of California Senate President pro Tempore

Marjorie Schwartz

California State Assembly Health Committee

Melissa Stafford-Jones, President and CEO

California Association of Public Hospitals

Anthony Wright, Executive Director

Health Access California

## Endnotes

1. Health coverage figures of non-elderly residents in the 50 states and the District of Columbia, including unauthorized immigrants. Congressional Budget Office Letter to Speaker Pelosi, “Estimate of the Direct Spending and Revenue Effects of an Amendment in the Nature of a Substitute to H.R. 4872, the Reconciliation Act of 2010,” March 20, 2010.
2. The Patient Protection and Affordable Care Act is Public Law 111–148. The Health Care and Education Reconciliation Act of 2010 is Public Law 111–152.
3. For example, states will have the opportunity to compete for funding for demonstration projects and grants to promote quality and reduce the cost of care, including large-scale pilot programs on bundled payments, the development of community-based collaborative care networks, and programs establishing health homes for individuals with chronic conditions.
4. All citations are to sections of the PPACA unless otherwise noted.
5. *Medicaid Enrollment: June 2009 Data Snapshot*. Kaiser Family Foundation. February 2010 ([www.kff.org](http://www.kff.org)).
6. *Medicaid Income Eligibility, 2009*. Kaiser Family Foundation ([www.statehealthfacts.org](http://www.statehealthfacts.org)).
7. *California’s Uninsured*. California HealthCare Foundation. December 2009 ([www.chcf.org](http://www.chcf.org)). The precise number of people eligible but not enrolled is not captured through Current Population Survey, the data source for this report; percentage ranges presented in Chart 16 were the basis for numerical estimates presented here.
8. Analysis by the California Department of Health Care Services.
9. Ibid.
10. The estimate adjusts for the anticipated reduction in the number of adults who will lose Medi-Cal coverage because of eligibility-related changes.
11. See note 8.
12. §2001(a)(4).
13. Figures are calculated using most recently available levels, 2009 HHS Poverty Guidelines for the 48 contiguous states and the District of Columbia ([aspe.hhs.gov](http://aspe.hhs.gov)).
14. Benchmark benefits are defined in federal Medicaid law as benefits comparable to those offered through insurance provided to state or federal employees, insurance provided by the largest private HMO in the state, the actuarial equivalent of these options, or a plan approved by federal Medicaid officials (Social Security Act §1937. [42 U.S.C. 1396u-7]).
15. PPACA requires that the entire expansion population, including children, receive benchmark benefits. However, the Social Security Act specifies that children receiving benchmark benefits are still entitled to the full range of Medicaid benefits guaranteed to children under the Early and Periodic Screening, Diagnostic, and Treatment program. See Social Security Act §1937 [42 U.S.C. §1396u-7], State Medicaid Director’s Letter #06-008, “Section 6044 of the Deficit Reduction Act of 2005,” March 31, 2006, and State Medicaid Director’s Letter #10-005, “New Option for Covering Individuals Under Medicaid,” April 9, 2010.
16. Excluding optometry and optometric services.
17. §2101(a)(3), as amended by HCERA §1201(1)(B).
18. The increased FMAP that California has been receiving under the American Recovery and Reinvestment Act of 2009 would not be available for this new optional group. State Medicaid Director’s Letter #10-005, “New Option for Covering Individuals Under Medicaid,” April 9, 2010.
19. *The Benefits of Health Reform in California*. Special Report, Democratic Policy Committee, April 5, 2010 ([dpc.senate.gov](http://dpc.senate.gov)).
20. Skelton, G. “California Could Take Big Hit from Healthcare Overhaul.” *Los Angeles Times*. March 24, 2010 ([www.latimes.com](http://www.latimes.com)).
21. See note 8.
22. Social Security Act §1931.
23. See note 8.

24. Further federal guidance is necessary to clarify whether states may alter their eligibility standards to ensure adults do not lose existing coverage, as PPACA itself appears to give contradictory guidance on this point. Section 2002(a) provides that states are required to “establish income eligibility thresholds... using modified gross income and household income that are not less than the effective income eligibility levels that applied ... on the date of enactment [of PPACA].” However, the act goes on to say that current enrollees who lose eligibility are only “grandfathered” into coverage until their next eligibility determination. The act further specifies that children may not lose coverage due to MAGI, but does not mention adults.
25. *Simplifying Medi-Cal Enrollment: Options for the Assets Test*, California HealthCare Foundation, Medi-Cal Policy Institute. June 2003 ([www.chcf.org](http://www.chcf.org)).
26. 8 USC §1611.
28. Internal Revenue Code (1986) §§1401 (36B[c][1][B]) and 10105(b).
28. §§1331(e)(1)(B), 10104(o)(2).
29. Buchanan, W. “Health Care Law May Cost California Billions,” *San Francisco Chronicle*, March 28, 2010 ([articles.sfgate.com](http://articles.sfgate.com)).
30. §2202.
31. For Medi-Cal, the state is estimated to receive \$31.1 billion in federal funds in state Fiscal Year 2009–10. “Medi-Cal Program Estimate Summary, Fiscal Year 2009–10.” *Medi-Cal November 2009 Local Assistance Estimate for Fiscal Years 2009–10 and 2010–11* ([www.dhcs.ca.gov](http://www.dhcs.ca.gov)).
32. For the Healthy Families Program, the state is estimated to receive \$732 million in federal funds for state Fiscal Year 2009–10. *The 2010–11 Budget: Health and Social Services Budget Primer*. California Legislative Analyst’s Office ([www.lao.ca.gov](http://www.lao.ca.gov)).
33. “Summary of Significant Changes by Major Program Areas,” *Governor’s Proposed Budget Summary (2010–11)* ([www.ebudget.ca.gov](http://www.ebudget.ca.gov)).
34. “Summary of Significant Changes by Major Program Areas,” *Governor’s Revised Budget Summary (2010–11)* ([www.ebudget.ca.gov](http://www.ebudget.ca.gov)).
35. To ensure access to increased FMAP under the American Recovery and Reinvestment Act (P.L. 111-5), Senate Bill (SB) X3 24, Chapter 24, Statutes of 2009, amended Section 14005.25 of the Welfare & Institutions Code to suspend the MSR requirement, or reduction of Continued Eligibility for Children (CEC), from 12 months to six months during the time that the increased FMAP is available. The provisions of SB X3 24 took effect immediately and will continue until the Director of DHCS issues a declaration specifying that the increased FMAP is no longer available through the ARRA. DHCS will now need to consider the MOE requirements under PPACA.
36. Zuckerman, S., A. Williams, and K. Stockley. April 2009. “Trends in Medicaid Physician Fees, 2003–2009,” *Health Affairs* Web Exclusive 28 (3); w510–w519. *Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare*. California Health Care Foundation. April 2009 ([www.chcf.org](http://www.chcf.org)).
37. Rosenbaum, S. *Medicaid Payment Rate Lawsuits: Evolving Court Views Mean Uncertain Future for Medi-Cal*. California HealthCare Foundation. October 2009 ([www.chcf.org](http://www.chcf.org)).
38. Enrollment as of February 2010. Source: Managed Risk Medical Insurance Board ([www.mrmib.ca.gov](http://www.mrmib.ca.gov)).
39. *Children’s Health Coverage Facts and Figures, 2009*. California HealthCare Foundation. November 2009 ([www.chcf.org](http://www.chcf.org)).
40. See note 8.
41. See note 33.
42. See note 34.
43. *State Of California’s Concept For A Comprehensive Section 1115 Waiver To Replace The Current Medi-Cal Hospital/Uninsured Care Demonstration Project*. California Department of Health Care Services. December 16, 2009 ([www.dhcs.ca.gov](http://www.dhcs.ca.gov)).
44. Kaiser Family Foundation. *State Health Facts* ([statehealthfacts.kff.org](http://statehealthfacts.kff.org)).

45. For more information, see *Medicaid Section 1115 Demonstration Waivers: Comparing California, Massachusetts, and New York*. California HealthCare Foundation. October 2009 ([www.chcf.org](http://www.chcf.org)).
46. Ibid.
47. Essential community providers are those such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by section 221 of Public Law 111–8.
48. The state will define geographic area(s) which the Secretary will use in calculating premiums.
49. A total of \$3.5 million in federal grant funding is available for federal Fiscal Year 2010, with subsequent funding available but in amounts subject to the congressional appropriations process. CBO has estimated a total of \$20 million will be available between 2011 and 2015, by applying a \$4 million estimate for 2011 and increasing annual funding available based on GDP growth. *Letter to the Honorable Jerry Lewis (R-CA)*, Congressional Budget Office, May 11, 2010.
50. *Letter to the Honorable Jerry Lewis (R-CA)*, Congressional Budget Office, May 11, 2010.
51. 75 Fed. Reg. 24470–24482.
52. The estimate is based on information from the Urban Institute and the Kaiser Family Foundation, which indicates that 14 percent of the uninsured would qualify for premium and cost-sharing subsidies in the Exchange.
53. See note 8.
54. *Making Sense of Managed Care Regulation in California*. California HealthCare Foundation. November 2001 ([www.chcf.org](http://www.chcf.org)).
55. HHS may carry out responsibilities in collaboration with other federal agencies, for example the DOL or Treasury, as well as in consultation with the NAIC.
56. HHS will establish a list of, or the criteria for determining, a preexisting condition, although it will provide some flexibility to the states in this regard.
57. “Gov. Schwarzenegger Announces State will Contract with Federal Government to Cover High-Risk, Uninsured Californians,” *Press Release*, April 29, 2010 ([gov.ca.gov](http://gov.ca.gov)).
58. Estimates of the total number of California residents who are uninsured because of a preexisting condition range from 200,000 (quoted in *Sacramento Bee*) to more than 850,000 based on a GAO study for the 2005–2007 period. MRMIP materials refer to 400,000 Californians as being “medically uninsurable.”
59. *Fact Sheet – Temporary High Risk Pool Program*. U.S. Department of Health and Human Services ([www.hhs.gov](http://www.hhs.gov)).
60. GAO reported a 2006 national average premium for high risk pools of \$450 in 2006, which was inflated by 10 percent each year to develop a 2010 rate.
61. 75 Fed. Reg. 24450–24470.
62. Public Health Service Act §2794(c), U.S. Code, Title 42, as created by PPACA §1003.
63. 75 Fed. Reg. 19335–19338.
64. “Grants to States for Health Insurance Premium Review-Cycle I,” Funding Opportunity Number: RFA-FD-10-999 ([www.grants.gov](http://www.grants.gov)).
65. §1251, P.L. 111–152 §2301.
66. Fernandez, B. *Grandfathered Health Plans Under PPACA*. Congressional Research Service, April 7, 2010.
67. See note 62.
68. Dropping of sick individuals from coverage, known as rescission, has been a significant focus of DMHC and CDI. Both agencies have conducted investigations of California’s five largest insurers, leading to settlements that imposed fines and corrective action plans on insurers. Through these investigations, the state agencies reportedly found that more than 6,000 Californians had their coverage rescinded by the five insurers between 2004 and 2008. Referenced in background material for “Department of Managed Health Care and Department of Insurance Rescission Settlement Agreements,” *Hearing before the California State Assembly Committee on Accountability and Administrative Review*, March 10, 2010 ([www.assembly.ca.gov](http://www.assembly.ca.gov)).

69. While the provision is not effective until September 23, 2010, several large insurers have indicated they will extend this coverage immediately. “HHS Secretary Kathleen Sebelius on Growing List of Insurers That Will Provide Coverage for Young Adults under Age 26.” *Press Release*, U.S. Department of Health and Human Services, April 20, 2010 ([www.hhs.gov](http://www.hhs.gov)).
70. April 27, 2010, IRS Notice 2010-38, regarding the tax treatment provision, notes that the dependent coverage provision does not exactly parallel the tax treatment provision in some respects.
71. 75 Fed. Reg. 27122–27140.
72. 75 Fed. Reg. 19297–19302.



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