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California State Senate

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BUDGET AND FISCAL REVIEW

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Agenda

February 21, 2013
10:00 a.m. or upon adjournment of Session
Room 4203

Evaluating State and County Risks and Responsibilities for Medi-Cal Simplification and Expansion under the Affordable Care Act

I. Overview of Administration's Proposals (10 minutes)

- Michael Wilkening, Undersecretary, California Health and Human Services Agency

II. Legislative Analyst's Comments (15 minutes)

- Mac Taylor, Legislative Analyst

III. What is the Affordable Care Act's Impact on Medi-Cal and California? (15 minutes)

- Ken Jacobs, Chair, UC Berkeley Labor Center

IV. How to Evaluate State and County Risks and Responsibilities for the Medi-Cal Expansion? (10 minutes per panelist)

- Dr. Mitchell Katz, Director, Los Angeles County Department of Health Services
- Lee Kemper, Director of Policy and Planning, County Medical Services Program Governing Board
- Melissa Stafford Jones, President CEO, California Association of Public Hospitals and Health Systems
- Ken Yeager, Supervisor, Santa Clara County Board of Supervisors, on behalf of the California State Association of Counties
- Patricia Ryan, Executive Director, California Mental Health Directors Association

V. Who Are the Remaining Uninsured? (10 minutes per panelist)

- Anthony Wright, Executive Director, Health Access California
- Sarah de Guia, Director of Government Affairs, California Pan-Ethnic Health Network

VI. Public Comment

Evaluating State and County Risks and Responsibilities for Medi-Cal Simplification and Expansion under the Affordable Care Act

HEALTH CARE REFORM

The federal Patient Protection and Affordable Care Act (ACA) increases access to private and public health care coverage. Under the ACA, most U.S. citizens and legal residents will be required to have health insurance beginning in 2014. It is estimated that 4.7 million Californians who were uninsured during some part of 2009 will be eligible for health coverage under the ACA. The ACA increases access through various mechanisms including:

- ***California's Health Benefit Exchange (Covered California).*** The creation of health benefit exchanges. In California, the health benefit exchange is called Covered California. Covered California is a new insurance marketplace that will offer an opportunity to purchase affordable health insurance using federally funded tax subsidies for millions of Californians with incomes of up to 400 percent of the federal poverty level (FPL).

- ***Medi-Cal Streamlining Eligibility and Retention.*** The streamlining of eligibility (e.g., establishing a new income standard based on Modified Gross Income—MAGI and the elimination of the asset test), enrollment, and retention rules for persons already eligible for Medicaid (Medi-Cal in California). The cost associated with this new caseload will be generally split equally between the state and federal government.

- ***Expanding Coverage to Low-Income Adults through Medi-Cal.*** The expansion of Medi-Cal coverage to adults with incomes up to 138 percent of the FPL. Under the ACA, the federal government will pay for 100 percent of the costs for this population for the first three years (2014-2016) with funding gradually decreasing to 90 percent in 2020.

There are several key aspects of ACA implementation for which federal guidance has not yet been issued including the methodology for claiming enhanced federal funding for the newly eligible Medi-Cal population.

The Governor convened an extraordinary session that began on January 28, 2013, to consider and act upon legislation necessary to implement the ACA. SBX1 1 (Hernandez and Steinberg) and ABX1 1 (Perez) have been introduced to implement the ACA's Medi-Cal simplification provisions and the state-based expansion of Medi-Cal to low-income adults with incomes up to 138 percent of the FPL. These bills are identical as the Legislature is working collaboratively on these vehicles. The policy decisions made via SBX1 1 and ABX1 1 will have a direct bearing on fiscal estimates and assumptions discussed at today's hearing.

OVERVIEW OF GOVERNOR'S BUDGET[1]

The Governor's budget includes the following thoughts related to the ACA:

- ***Increase in Medi-Cal Caseload of Persons Already Eligible.*** The Administration has included a "placeholder" of $350 million General Fund in 2013-14 and $700 million General Fund annually thereafter for the increase in caseload associated with persons already eligible for Medi-Cal actually enrolling (as a result of Medi-Cal streamlining and the individual mandate under the ACA and the extensive marketing by the Exchange).

  At the time of this writing, caseload and fiscal assumptions for this placeholder funding had not been shared with the Legislature.

- ***Intent to Expand Medi-Cal to Newly Eligible Low-Income Adults.*** The Administration has expressed its intent to expand Medi-Cal to adults with incomes up to 138 percent of the FPL as allowed under the ACA. It has proposed two options for this expansion, a state-based option and a county-based option.

  The Administration has not provided any caseload or fiscal estimates for this expansion because it has linked this expansion to an evaluation of how the state and counties should share the risks and responsibilities associated with expanding Medi-Cal coverage to this population as this population was formerly covered by county indigent health programs.

STATE AND COUNTY RISKS AND RESPONSIBILITIES

As discussed above, the Administration has linked the expansion of Medi-Cal to individuals with incomes up to 138 percent of the FPL to the discussion of how the state and counties should share the financial risks and responsibilities to provide Medi-Cal coverage to this population.

The following key considerations, discussed in more detail below, will impact this discussion:

- County Spending on Indigent Care is Unknown, But Likely Insufficient
- Rate at which Individuals Take-Up Coverage Affects Number of Uninsured
- Level of County Savings to be "Captured" as Indigent Transition to Coverage is Unclear
- Counties Will Still Provide Care to the Remaining Uninsured
- Counties Have Made Varied Investments in Safety-Net Systems
- New State Sources of Funding Could be Available for Expansion
- Unpredictability of Health Care Markets under ACA Necessitates Checkpoints

The Administration has suggested that under the state-based option, counties would assume programmatic and fiscal responsibility for human services programs (e.g., child care and CalWORKs) as the state takes on the costs for health care coverage for this previously medically indigent population.

The Administration and counties have been meeting on these topics the last few weeks; however, there is no public timeline or roadmap to come to a decision.

Given that the state is operating under a very tight timeline for these changes (this expansion begins January 1, 2014), it is critical that a decision be made as soon as possible on the details of implementing this expansion. If the state does not meet the January 1, 2014 timeline, hundreds of millions of dollars in federal funding could be lost and the opportunity to provide comprehensive health coverage to California's uninsured could be delayed. It is important to note again that the first three years of the Medi-Cal expansion to low-income adults is 100 percent covered with federal funds.

County Spending on Indigent Care is Unknown, But Likely Insufficient

Concerns have been expressed that existing indigent health care varies by county and it is generally recognized as being underfunded. For example, Fresno County contracts with Community Medical Centers (CMC) for its county indigent care program. Under this contract, Fresno County pays a fixed annual payment to CMC to provide care regardless of actual program enrollment. CMC has reported that its expenditures on indigent care have risen more dramatically than the fixed annual payment and it has growing losses on this contract.[2]

California's counties, per Welfare and Institutions Code Section 17000, are the health care providers of last resort for county indigent with no other source of health coverage. Counties implement this responsibility in several different ways:

1. They provide the care in their own hospitals and clinics,
2. They pay for care delivered in private hospitals, clinics and doctor's offices,
3. They provide outpatient care in their own clinics and pay for private hospital care, or
4. They collectively pay private providers for care to the county indigent in 35 small counties (County Medical Services Program counties).

County indigent health is generally funded with 1991 Realignment funds, county general fund, as well as with support from the state (e.g., Proposition 99 funds and federal Maternal Child and Adolescent Health Funds). Additionally, counties with hospitals that serve high numbers of uninsured and Medi-Cal enrollees have access to federal Disproportionate Share Hospital Funds.

The state does not have a clear picture as to the level of spending on county indigent care programs. A clear and agreed upon understanding of these expenditures could serve as a starting point for the discussion on how some of these costs may shift to the Medi-Cal program under the ACA. As the LAO found in its 2001 report evaluating 1991 Realignment:

> Specifically, there is no state system to collect data regarding each county's (1) total expenditures for indigent care by fund source, or (2) total expenditures by fund source for each major spending category--public health, indigent inpatient care, and indigent outpatient care. The lack of this data leaves the state unable to answer fundamental questions regarding the provision of health services in each county and hampers the state's ability to devise effective health financing policies and budgets.

In the Governor's Budget Summary, the Administration estimated that counties spend between $3 billion to $4 billion annually on health care costs (and that this spending varies significantly by county). This estimate included $1.5 billion from the 1991 Health Realignment Account, $1 billion in county maintenance of effort (the 1991 realignment of funding for county health services retained the concept of a county's level of effort for the provision of health services), and was informed by other reporting sources and data submitted to DHCS.

It is likely that this estimate is high. First, it appears that federal funds were included in this estimate (it was intended that this estimate capture only non-federal spending). Second, that the county maintenance of effort (MOE) amount was more than actual county MOE. The Administration has indicated that it is working with the counties to develop a more refined estimate; however, it has not been conveyed when this information will be available.

Rate at which Individuals Take-Up Coverage Affects Number of Uninsured

Even though the expansion of Medi-Cal to low-income adults and the subsidies to purchase health coverage through the Exchange are effective January 1, 2014, the rate at which individuals actually obtain coverage (i.e., the "take-up" rate) is unclear. For example, will there be a spike in enrollment in the first year or will it take a few years to enroll eligible individuals before stable caseloads are achieved. These questions directly impact the fiscal implications of this discussion.

A recent report[3] by the UCLA Center for Health Policy Research and UC Berkeley Labor Center found that under a Base scenario the take-up rate for the newly eligible into Medi-Cal would continue at Medi-Cal's current rate of 61 percent and would be 10 percent for the already eligible. Under the Enhanced scenario, this report estimates that the take-up rate for the newly eligible would be 75 percent and 40 percent for the already eligible. See table that follows for predicted increase in Medi-Cal enrollment.

Predicted Increase in Medi-Cal Enrollment

Year	Scenario	Already Eligible	Newly Eligible	Total
2014	Base	200,000	480,000	680,000
	Enhanced	440,000	780,000	1,220,000
2016	Base	230,000	630,000	860,000
	Enhanced	490,000	880,000	1,370,000
2019	Base	240,000	750,000	990,000
	Enhanced	510,000	910,000	1,420,000

Research[4] indicates that provisions in the ACA may improve the current take-up rate (61 percent) in Medi-Cal. For example, the individual mandate could encourage individuals to learn about all their insurance options and enroll in Medi-Cal (without such a mandate, uninsured individuals would likely only seek care when medical services were needed). Consequently, it is feasible that enrollment into Medi-Cal may reach the estimates under the Enhanced scenario. However, this improved take-up rate is highly dependent on Medi-Cal's outreach, enrollment, and retention efforts.

Level of County Savings to be "Captured" as Indigent Transition to Coverage is Unclear

Over time, as Medi-Cal expansion phases in and more people are covered, counties will realize savings as individuals who were formerly covered by county health programs are now covered by Medi-Cal or purchase health coverage through the Exchange. However, not all of these county savings should be necessarily directed toward funding the Medi-Cal expansion.

It is critical to recognize, that many counties may need to develop and expand their safety-net infrastructure as there may be pent up demand and a need for increased capacity as more people seek services and coverage.

According to regional market reports commissioned by the California HealthCare Foundation, with increasingly strained county budgets since 2008 (the beginning of the recession), in counties without public hospitals and clinics, there appears to be little local funding and other support to build safety-net capacity and infrastructure. For example, since 2008, Sacramento County has closed five of its six clinics that serve county indigent due to budget shortfalls (and Sacramento's reluctance to encourage the development of nonprofit clinics), and as a result uninsured persons seeking care reportedly wait longer for care or seek care in emergency rooms.

Public health services are also funded with 1991 Realignment funds and are used "to preserve and protect the public health" of the county as required by Health and Safety Code Section 101025. These funds need to be maintained as the ACA's coverage expansions will not replace the need for public health services.

Finally, it is critical to recognize that counties with public hospitals, in particular, have fixed costs as safety-net providers. Consequently, a direct shift of these county savings (on indigent care) could jeopardize the ability of these safety-net providers to serve not only the uninsured but also those with private coverage who seek trauma services, for example, at county hospitals.

It should also be noted that hospitals which receive federal Disproportionate Share Hospital (DSH) payments will see a reduction in these payments per the ACA (the Governor's budget includes a placeholder reduction of about $100 million for DSH and DSH replacement payments).

Counties Will Still Provide Care to the Remaining Uninsured

It is projected that between three and four million Californians will remain uninsured in 2019. Of this, almost three-quarters of the remaining uninsured will be U.S. citizens or lawfully present immigrants and two-thirds will be Latino.[5]

The number of remaining uninsured is dependent on factors, such as:

- ***Outreach, Enrollment, and Retention Efforts by Medi-Cal and Exchange.*** Of the estimated uninsured in 2019, between 1.2 and 2 million of these individuals could be eligible for Medi-Cal or Exchange subsidies. This number is highly dependent on Medi-Cal's and the Exchange's outreach, enrollment, and retention efforts. Accordingly, every effort should be made to target outreach and simplify enrollment into Medi-Cal and the Exchange so that all eligible individuals secure comprehensive health coverage. This makes sense from both a policy and fiscal perspective as more people would gain coverage and the costs of this coverage would mostly not be borne by the state or counties.

- ***Affordability of Coverage in Exchange.*** Although individuals with incomes between 138 percent and 400 percent of the FPL may be eligible for Exchange subsidies to purchase health coverage, the affordability of this coverage may prevent individuals from actually obtaining coverage.

Under current law, counties will remain responsible for providing county indigent care for the remaining uninsured persons. Consequently, it will be necessary to maintain a level of funding for those remaining uninsured who seek care under county indigent programs.

Finally, it is noteworthy that the 1991 realignment of funding for county health services retained the concept of a county's level of effort for the provision of health services. This was included to ensure that counties maintained a certain level of local funding for health programs (i.e., that realignment funds did not supplant local funding for health programs). A similar mechanism to ensure that counties maintain funding on county health services is likely worthwhile.

Counties Have Made Varied Investments in Safety-Net Systems

The impact of the Medi-Cal expansion to low-income adults on counties will be different depending on how each county provides indigent health care services. For example, counties that own and operate public hospitals, health systems and clinics are important safety-net providers and are different from counties that contract out (e.g., a CMSP county) entirely for the provision of indigent health care services.

It is anticipated that counties with public hospitals will experience growth in Medi-Cal enrollees under health care reform, both from the providers' existing uninsured patients obtaining coverage and from newly insured patients who may not have used safety-net providers before;

however, they also expect increased competition for these patients. Consequently, it is unclear how this health market dynamic will impact safety-net providers.

It is also important to remember that some counties have made significant investments in their safety-net systems and are providing comprehensive coverage to uninsured individuals and improving clinical outcomes; while others have provided a threadbare medical access and coverage.

For example, not all counties have implemented the Low Income Health Program (LIHP) and some LIHPs only offer minimal services. There are over 515,000 individuals enrolled in 17 LIHPs, covering 51 counties. Each LIHP may have different income eligibility requirements and cover varying levels of benefits. The LIHP is authorized under a federal waiver and is intended to provide an opportunity for county health departments to improve coverage, increase access to care, pay for uncompensated services, identify persons eligible for care under the ACA, and build the right delivery systems for the uninsured population. LIHPs are funded with a 50:50 match of existing county health spending for the newly eligible and federal funds. The terms of this waiver limit operations of LIHP to December 31, 2013.

Those counties that have made an investment in their system should not be penalized.

New State Sources of Funding Could be Available for Expansion

New ongoing state funding sources are potentially available to finance this expansion. These include:

- ***Direct Gross Premium Tax (GPT) to Expansion Instead of Budget Reserve.*** The Governor's budget proposes to reauthorize the gross premiums tax on Medi-Cal managed care plans permanently on a retroactive basis starting July 1, 2012. The Administration proposes to continue to use 50 percent of the gross premium tax revenue to draw down federal funds and make plans whole and 50 percent (about $230 million annually) of the revenue to offset General Fund spending. Instead, all or a portion of the funds set aside to offset General Fund savings could be directed to the expansion.

- ***Increase in Gross Premium Tax (GPT) Revenue on Managed Care Plans from Increased Medi-Cal Enrollment Due to Expansion.*** The Administration's estimated GPT revenues do not include the impact of the Medi-Cal expansion (related to health care reform) as a result of the increase in enrollment of individuals into Medi-Cal managed care. Accordingly, GPT revenues will be higher than projected in the Governor's budget as more people will be covered by Medi-Cal managed care. These increased revenues could be directed to fund this expansion (instead of used for General Fund savings).

- ***Increased State Tax Revenue as a Result of ACA.*** It is estimated that for every new dollar the federal government spends on Medi-Cal, 5.4 cents in state General Fund tax revenue will be generated. As a result, in 2014, it is predicted that $111 million to $190 million in new General Fund tax revenue, increasing to potentially over $240 million in

2019[6] could be realized. These new revenues (after the Proposition 98 share is considered) could be used to finance this expansion.

- ***State Savings on State-Only Health Programs.*** Expenditures for various smaller state health care programs (e.g., the Breast and Cervical Cancer Treatment Program and the Genetically Handicapped Persons Program (GHPP)) should decline overtime as people transition to comprehensive coverage. However, it is important to remember that many Californians will continue to rely on these programs as they may not be eligible for Medi-Cal, may not be able to afford coverage through the Exchange, or require specialized services (e.g., services provided under GHPP) that may not be available in the individual market. Consequently, these state programs will need to be maintained.

Unpredictability of Health Care Markets under ACA Necessitates Checkpoints

Health care markets will change dramatically under the ACA. The predictability of how individuals, plans, providers, and others will behave with regard to Medi-Cal and the Exchange is uncertain. The impact and full realization of these changes may not occur for years. Accordingly, it is important to develop short- and long-term checkpoints to evaluate the assumptions and methodology that may be used to develop an agreement on the financing of this expansion.

This discussion provides the opportunity to build in reporting mechanisms, such as data reporting requirements on county indigent care programs and expenditures and on the numbers of remaining uninsured (by county), which will provide information to assess how these systems change over time and how the state and counties should share responsibility for financing this expansion.

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[1] For background information and more information on the Governor's health-related proposals, please see the Senate Budget and Fiscal Review's Overview of the 2013-14 Budget Bill:
http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/overview/Overviewof2013Budget.pdf

[2] Joy Grossman, Peter Cunningham, and Lucy Stark of the Center for Studying Health System Change, "Fresno: Health Providers Expand Capacity, but Health Reform Preparation Lags," California HealthCare Foundation, Regional Markets Issue Brief, December 2012.

[3] Laurel Lucia, Ken Jacobs, Greg Watson, Miranda Dietz, and Dylan Roby, "Medi-Cal Expansion under the Affordable Care Act: Significant Increase in Coverage with Minimal Cost to the State," UCLA Center for Health Policy Research and UC Berkeley Labor Center, January 2013.

[4] Alan Krueger and Ilyana Kuziemko, "The Demand for Health Insurance Among Uninsured Americans: Results of a Survey Experiment and Implications for Policy," Princeton University, April 2011.

[5] Laurel Lucia, Ken Jacobs, Miranda Dietz, Dave Graham-Squire, Nadereh Pourat, and Dylan Roby, "After Millions of Californians Gain Health Coverage under the Affordable Care Act, who will Remain Uninsured?"

[6] Laurel Lucia, Ken Jacobs, Greg Watson, Miranda Dietz, and Dylan Roby, "Medi-Cal Expansion under the Affordable Care Act: Significant Increase in Coverage with Minimal Cost to the State," UCLA Center for Health Policy Research and UC Berkeley Labor Center, January 2013.

Health Care Reform

Background

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

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

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

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

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

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

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

Private Insurance Market Reforms to Increase Access

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

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

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

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

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

California Health Benefit Exchange (Covered California)

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

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

Mandatory Medicaid Expansion

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

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

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

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

Medi-Cal "Bridge to Reform" Waiver

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

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

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

Implementing the Optional Expansion

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

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

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

State-Based Expansion

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

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

County-Based Expansion

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

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

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

Outstanding Issues

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

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

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Medi-Cal

BACKGROUND:

Proposed Medi-Cal Funding and Enrollment. The Department of Health Care Services administers the Medi-Cal program (California's Medicaid health care program). This program pays for a variety of medical services for children and adults with limited income and resources.

The Governor proposes total expenditures of $59.8 billion ($15.3 billion General Fund) which reflects a General Fund increase of $354 million or 2.4 percent above the Budget Act of 2012. Generally, each dollar spent on health care for a Medi-Cal enrollee is matched with one dollar from the federal government.

Caseload is anticipated to increase by about 485,500 for a total of about 8.7 million[1] average monthly eligibles primarily due to the transition of children from the Healthy Families Program to Medi-Cal. Of this total, approximately 4.6 million are children.

According to the Administration, Medi-Cal provides health insurance coverage to about 21.7 percent of Californians. Of the total Medi-Cal eligibles about 33 percent, or 2.9 million people, are categorically-linked to Medi-Cal through enrollment in public cash grant assistance programs (i.e., SSI/SSP or CalWORKs). Almost all Medi-Cal eligibles fall into four broad categories of people: (1) aged, blind or disabled; (2) families with children; (3) children only; and (4) pregnant women.

Currently, Medi-Cal eligibility is generally based upon family relationship, family income level, asset limits, age, citizenship, and California residency status. Other eligibility factors can include medical condition (such as pregnancy or medical emergency), share-of-cost payments (i.e., spending down to eligibility), and factors that are related to a particular eligibility category.

GOVERNOR'S PROPOSAL:

In comparison to the last few years, the budget does not include major reductions to the Medi-Cal program. Key proposals are discussed below.

Health Care Reform. The budget includes $350 million General Fund for 2013-14 (for six months) and projects $700 million General Fund annually thereafter as placeholder for the costs of providing coverage to individuals who are already eligible for Medi-Cal but not presently

[1] This caseload estimate does not include new enrollees expected with the implementation of Medi-Cal expansion under health care reform.

enrolled. The Administration also proposes to expand Medi-Cal to adults with incomes up to 138 percent of FPL. The budget presents two options to do this (a state-based option and a county-based option) and does not include any fiscal estimates for these costs. These proposals are discussed in further detail later in this chapter.

Hospital Quality Assurance Fee Extension. The Governor proposes an extension of the hospital quality assurance fee, which will sunset on December 31, 2013. This fee provides funds for supplemental payments to hospitals and offsets the costs of health care coverage for children. The revenues generated from this fee are proposed to offset $310 million in General Fund expenditures for the Medi-Cal program. These General Fund savings are included as part of the Administration's $1 billion budget reserve. As with past extensions of this fee, it is proposed that the budget score the savings resulting from this fee and that the extension of this fee be a policy bill.

Gross Premium Tax Reauthorization. The Administration proposes the reauthorization of the Gross Premium Tax on Medi-Cal managed care plans on a permanent basis. Reauthorizing this tax would generate General Fund savings of $131 million in 2012-13 (applied to the Healthy Families Program) and $232 million in 2013-14. The Administration proposes to continue to use 50 percent of the gross premium tax revenue to draw down federal funds and, in turn, make plans whole and 50 percent of the revenue to offset General Fund spending. These General Fund savings are also included as part of the Administration's $1 billion budget reserve. This proposal is discussed in more detail later in this chapter.

Coordinated Care Initiative/Duals Demonstration Project. The budget includes $170.7 million General Fund savings in 2013-14 and estimates future annual savings of $523.3 million General Fund as a result of this initiative. This is a reduction in savings of $356.7 million General Fund in the budget year compared to what was estimated at the time of the 2012 Budget Act (due to the factors discussed below).

The 2012 budget authorized the Coordinated Care Initiative (CCI), by which persons eligible for both Medicare and Medi-Cal (dual eligibles) would receive medical, behavioral, long-term supports and services, and home- and community-based services coordinated through a single health plan in eight demonstration counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara). Budget year savings have been revised compared to previous estimates as the population estimated to be included in CCI has decreased, the scheduled phasing for the enrollment in CCI has been delayed until September 2013, and the state has not yet developed a Memorandum of Understanding with the federal CMS to implement CCI. DHCS indicates that delay in timeline means that the first notices that any enrollees would receive about this transition would come no earlier than June 2013.

Limit Annual Open Enrollment for Medi-Cal Enrollees. A reduction of $1 million General Fund is assumed by limiting Medi-Cal enrollees who are families and children (i.e., persons who are not seniors or persons with disabilities) to an annual open enrollment, in lieu of being able to change plans more frequently throughout the year. This proposal requires trailer bill legislation.

Medi-Cal Managed Care Efficiencies. The Administration includes a decrease of $135 million General Fund in the Medi-Cal program as a result of implementing additional efficiencies in managed Care. DHCS proposes to look for new ways to improve quality and the efficiency of the health care delivery system and develop payment systems that promote quality of care and improve health outcomes.

Provider Rate Reductions. AB 97 (Chapter 3, Statutes of 2011) enacted provider rate reductions beginning June 1, 2011. However, DHCS was prevented from implementing many of the reductions due to court injunctions. The budget assumes positive resolution of the court injunctions in March 2013, resulting in General Fund savings of $488 million in 2013-14. On January 28, 2013, provider groups filed a request for a rehearing of this case.

The budget proposes to begin collection of the retroactive rate reductions (back to June 1, 2011) from the enjoined fee-for-service providers starting on September 2013.

Legally the Administration cannot retroactively recoup this rate reduction on managed care plans; however, there is a separate Managed Care Efficiencies proposal (discussed above) that is intended to achieve a similar amount of savings applied to managed care plans.

Healthy Families Program Transition. The budget reflects $129,000 General Fund savings in 2012-13 and $42.6 million General Fund savings in 2013-14 as a result of the transition of children from the Healthy Families Program to Medi-Cal. This is a reduction in General Fund savings of almost $13 million in 2012-13 as a result of a slower transition of these children to Medi-Cal and an increase in Medi-Cal managed care capitation payments for these children. This estimate also assumes that the gross premium tax on Medi-Cal managed care plans is reauthorized in the current year and that a portion of the revenues ($131 million) derived from this tax is directed to the Managed Risk Medical Insurance Board.

Withdrawal of Pharmacy Copayment from Last Year. The 2012 Budget Act included the implementation of a copayment for prescription drugs. It was estimated that this proposal would achieve $13 million General Fund savings. The Administration has withdrawn this implementation of this copayment and the corresponding General Fund savings are not included. DHCS indicates that this copayment was not workable.

ISSUES TO CONSIDER:

Continued Oversight of Prior Year Proposals. While there are major new health proposals in the budget, it is important for the Legislature to continue to monitor the implementation of prior year budget proposals. These include:

- *Healthy Families Transition.* The federal CMS approved the state's proposal to transition children from the Healthy Families Program (HFP) to Medi-Cal on December 31, 2012. The first phase (Phase 1a) of transition occurred on January 1, 2013 and included about 200,000 children. To date, it appears that the transition has generally

gone smoothly, as it was only for children in HFP plans that matched Medi-Cal plans and whose provider network was determined adequate for transition.

On February 15, 2013, the first monitoring report of this transition is due to the Legislature. This report will include information on health plan grievances related to access to care, continuity of care requests and outcomes, and changes to provider networks (including provider enrollment and disenrollment). Additionally, it should be noted that CMS has required federal approval for each of the phases prior to implementation of the phase and demonstration of successful implementation of the previous phase is required prior subsequent phased implementation.

Each subsequent phase will present opportunities for oversight as the level of plan and provider overlap decreases and the risk of children losing access to care and services increases.

- *Duals Demonstration/Coordinated Care Initiative.* Enacted last year, the Coordinated Care Initiative integrated medical, behavioral, long-term supports and services, and home- and community-based services coordinated through a single Medi-Cal health plan in eight demonstration counties. The 2012 budget had assumed a June 1, 2013 implementation date and 50:50 shared savings with the federal Medicare program. The state has not yet heard back from the federal CMS on an agreement regarding the shared savings or a six-month lock-in enrollment period for participants. Statute requires that in the event DHCS has not received, by February 1, 2013, federal approval, or notification indicating pending approval, then effective March 1, 2013, the provisions of the dual demonstration project, enrollment of dual beneficiaries into Medi-Cal managed care, and long-term supports and services integration become inoperative. At the time of this report, the Legislature had not received notice of federal approval.

  This initiative is a substantive undertaking and affects the lives of over 500,000 dual eligibles. As discussions and planning continue, it is important to ensure that standards are in place to ensure that managed care plans are ready for the integration of medical, behavioral, long-term supports and services, and home- and community-based services and that enrollees, providers, and community organizations are well-educated on this transition.

Medi-Cal Managed Care Efficiencies Proposal Lacks Details. According to the Administration, legislation to implement the changes necessary to achieve $135 million General Fund savings from Medi-Cal managed care is not necessary because these changes would be implemented as part of the managed care rate setting process. DHCS has no specific proposals on how to achieve these efficiencies and does not propose to engage stakeholders or the Legislature prior to implementation of this substantial reduction to managed care rates.

Medi-Cal – Health Care Reform

BACKGROUND:

Health Care Reform. The federal Patient Protection and Affordable Care Act (ACA) (health care reform) increases access to private and public health care coverage. Under the ACA, most U.S. citizens and legal residents will be required to have health insurance beginning in 2014. It is estimated that 4.7 million Californians who were uninsured during some part of 2009 will be eligible for health coverage under the ACA. The ACA increases access through various mechanisms including:

- *California's Health Benefit Exchange (Covered California).* The creation of health benefit exchanges. In California, the health benefit exchange is called Covered California. Covered California is a new insurance marketplace that will offer an opportunity to purchase affordable health insurance using federally funded tax subsidies for millions of Californians with incomes up to 400 percent of the federal poverty level (FPL). The open enrollment period will begin October 1, 2013 and coverage begins January 1, 2014. Covered California has many program elements focused on ensuring its premiums are as affordable as possible.

- *Medi-Cal Streamlining Eligibility and Retention.* The streamlining of eligibility, enrollment, and retention rules for persons already eligible for Medicaid (Medi-Cal in California). The cost associated with this new caseload will be generally split equally between the state and federal government. These changes are effective January 1, 2014.

- *Expanding Coverage to Low-Income Adults through Medi-Cal.* The expansion of Medi-Cal coverage to adults with incomes up to 138 percent of FPL. (Generally, these are childless adults who are nonelderly and nondisabled.) Under the ACA, the federal government will pay for 100 percent of the costs for this population for the first three years (2014-2016) with funding gradually decreasing to 90 percent in 2020. See table below for specific federal matching rate by calendar year. This change is effective January 1, 2014.

Federal Matching Rate for Medi-Cal Expansion to Adults with Incomes Up to 138 Percent of FPL

Calendar Year	Federal Match*
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and thereafter	90%

*Applies to only health care services, not administrative costs.

On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of the ACA; however, it found that the ACA's provision allowing the federal government to remove all federal Medicaid (Medi-Cal in California) funding for states that do not expand Medicaid coverage to 138 percent of FPL was unconstitutional. The Court treated the ACA's expansion of the Medicaid program as if it were a new program and determined that the federal government could not condition funds for the existing Medicaid program on participation in the "new program" created by the ACA. This ruling effectively made the Medicaid expansion to low income adults optional for the states.

Impact of Medi-Cal Expansion in California. A recent report[2] quantifying how the ACA may impact the Medi-Cal program was released in January 2013 by the UCLA Center for Health Policy Research and the UC Berkeley Labor Center. This report finds that expanding Medi-Cal will have "far-reaching benefits for the health outcomes of Californians, providers, and the California economy."

This report estimates that about 2.5 million Californians are currently income eligible for Medi-Cal but not yet enrolled.[3] Of these already eligible, 200,000 to 440,000 will enroll into Medi-Cal in 2014, growing to 240,000 to 510,000 in 2019.

It also estimates that more than 1.4 million[4] Californians will be newly eligible for Medi-Cal and that between 480,000 and 780,000 of these individuals would enroll in Medi-Cal in 2014, growing to up to 910,000 by 2019. See the table that follows for more details on these estimates.

[2] Laurel Lucia, Ken Jacobs, Greg Watson, Miranda Dietz, and Dylan Roby, "Medi-Cal Expansion under the Affordable Care Act: Significant Increase in Coverage with Minimal Cost to the State," UCLA Center for Health Policy Research and UC Berkeley Labor Center, January 2013.
[3] Of the 2.5 million Californians that are currently income eligible for Medi-Cal, 35 percent are uninsured, 11 percent are covered by the individual market, and 54 percent have employer sponsored insurance.
[4] Of the 1.4 million Californians newly eligible for Medi-Cal, 60 percent are uninsured, 17 percent are covered by the individual market, and 23 percent have employer sponsored insurance.

Predicted Increase in Medi-Cal Enrollment

Year	Scenario*	Already Eligible	Newly Eligible	Total
2014	Base	200,000	480,000	680,000
	Enhanced	440,000	780,000	1,220,000
2016	Base	230,000	630,000	860,000
	Enhanced	490,000	880,000	1,370,000
2019	Base	240,000	750,000	990,000
	Enhanced	510,000	910,000	1,420,000

*Base Scenario assumes a 10 percent take-up rate for the Already Eligible and 40 percent for the Newly Eligible. Enhanced Scenario assumes a 61 percent take-up rate for the Already Eligible and a 75 percent take-up rate for the Newly Eligible.

Additionally, the report finds that the federal government will pay for at least 85 percent of the total new Medi-Cal spending between 2014 and 2019. This includes funding for those that are already eligible and the newly eligible. It is projected that the Medi-Cal expansion will bring in between $2.1 billion and $3.5 billion in new federal Medi-Cal dollars to California in 2014.

Low Income Health Program. The Low Income Health Program (LIHP) is a voluntary, county-run program to provide a Medicaid-like coverage to low-income individuals who are uninsured. There are 17 LIHPs in operation, covering 51 counties, and each LIHP can have different income eligibility requirements. The County Medical Services Program (CMSP) LIHP includes 35 counties.

The LIHP is authorized under the state's Section 1115 Medicaid Waiver. The 1115 waiver provides a bridge to implement the ACA and an opportunity for county health departments to improve coverage, increase access to care, pay for uncompensated services, identify persons eligible for care under the ACA, and build the right delivery systems for a uninsured population with a 50:50 match of existing county health spending for the newly eligible and federal funds. The terms of this waiver limit operations of LIHP to December 31, 2013.

The LIHP consists of two programs: Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). MCE will provide coverage for very low-income adults with incomes under 138% of FPL, and its federal funding through the waiver is uncapped. HCCI is coverage for low-to-moderate income adults with incomes between 138 and 200% of FPL, and its expenditures are capped. See the table that follows for LIHP enrollment information.

Low Income Health Program (LIHP), October 2012 Monthly Enrollment

LIHP	Medicaid Coverage Expansion			Health Care Coverage Initiative			Total LIHP Enrolled
	Start Date	Upper Income Limit	Number Enrolled	Start Date	Upper Income Limit	Number Enrolled	
Alameda	07/01/2011	133% of FPL	37,940	07/01/2011	200% of FPL	8,591	46,531
CMSP (County Medical Services Program)	01/01/2012	100	56,564			0	56,564
Contra Costa	07/01/2011	133	9,763	07/01/2011	200	2,026	11,789
Kern	07/01/2011	100	6,023			416*	6,439
Los Angeles	07/01/2011	133	205,257			185*	205,442
Orange	07/01/2011	133	33,855	07/01/2011	200	9,775	43,630
Placer	08/01/2012	100	1,908			0	1,908
Riverside	01/01/2012	133	23,893			0	23,893
Sacramento	11/01/2012	67	0**			0	0
San Bernardino	01/01/2012	100	24,659			0	24,659
San Diego	07/01/2011	133	32,794			89*	32,883
San Francisco	07/01/2011	25	9,386			1,085*	10,471
San Joaquin	06/01/2012	80	1,502			0	1,502
San Mateo	07/01/2011	133	8,452			197*	8,649
Santa Clara	07/01/2011	75	12,242			763*	13,005
Santa Cruz	01/01/2012	100	2,196			0	2,196
Ventura	07/01/2011	133	8,418	07/01/2011	200	2,892	11,310
TOTAL			**474,852**			**26,019**	**500,871**

*These programs are not currently operating an HCCI, the enrollment numbers reflect legacy program caseload.
**Sacramento implemented on 11/1/2012 and did not have enrollment in October.

It is anticipated that Monterey will implement a LIHP in February 2013. DHCS is working with Tulare towards implementation in March 2013. Both Stanislaus and Santa Barbara LIHPs are pending and implementation dates have not been established, these LIHPs will likely not be established due to the diminishing implementation timeframe. Fresno, Merced, and San Luis Obispo have withdrawn their interest in creating a LIHP.

How Counties Provide Uncompensated Care. California's counties, per Welfare and Institutions Code Section 17000, are the health care providers of last resort for county indigent with no other source of health coverage. Counties implement this responsibility in several different ways: (1) they provide the care in their own hospitals and clinics, (2) they pay for care delivered in private hospitals, clinics and doctor's offices, (3) they provide outpatient care in their own clinics and pay for private hospital care, or (4) they collectively pay private providers for care to the county indigent in 35 small counties (CMSP counties).

County indigent health is generally funded with 1991 Realignment funds, county general fund, as well as with support from the state (e.g., Proposition 99 funds and federal Maternal Child and Adolescent Health Funds). Additionally, counties with hospitals that serve high numbers of uninsured and Medi-Cal enrollees have access to federal Disproportionate Share Hospital Funds.

GOVERNOR'S PROPOSAL:

Special Session. The Governor convened an extraordinary session that began on January 28, 2013 to consider and act upon legislation necessary to implement the ACA. Senate Bill 1X 1 (Hernandez and Steinberg) has been introduced to implement the ACA's Medi-Cal streamlining provisions and the expansion of Medi-Cal to low-income adults.

Already Eligible. The budget includes $350 million General Fund for 2013-14 (for six months) and projects $700 million General Fund annually thereafter as placeholder for the costs of providing coverage to individuals who are currently eligible for Medi-Cal but not presently enrolled (referred to as "already eligible"). The Administration's projected caseload estimates on the number of the already eligible individuals who would enroll are not yet available.

It is expected that these currently eligible individuals will enroll in Medi-Cal because of streamlining in eligibility (establishing a new income standard based on the Modified Gross Income—MAGI; the elimination of the asset and disability tests) and redeterminations that would make it easier for individuals to enroll and remain on Medi-Cal; the individual mandate (under the ACA) that requires most individuals to obtain health coverage; and the extensive marketing by Covered California (California's health benefit exchange) about health care coverage options. The Administration considers this group of individuals the "mandatory expansion."

Newly Eligible Adults with Incomes Up to 138 Percent of FPL. The Administration proposes to expand Medi-Cal to adults with incomes up to 138 percent of FPL (referred to as "newly eligible"). The budget presents two options to do this and does not include any fiscal estimates for these costs. (The 138 percent of FPL is $15,415 for individual or $26,344 for family of three in 2012.) The Administration refers to this expansion as the "optional expansion."

These two options are:

- *State-Based Option.* The first option is a state-based Medi-Cal expansion that would build upon the existing state-administered Medi-Cal program and managed care delivery system.

- *County-Based Option.* The second option is a county-based Medi-Cal expansion that would build upon the Low Income Health Program (LIHP). This option would require waiver of federal requirements. Under this option, counties would have operational and fiscal responsibility for implementing this expansion. These responsibilities include: (1)

establishing networks of providers to deliver health care services, (2) setting payment rates to providers, and (3) processing claims billed by providers.

Under both of these options, the benefit package proposed by the Administration would be comparable to what is available today in Medi-Cal, but would exclude long-term care coverage (both institutional care and home- and community-based programs). In order to receive long-term care coverage, the individual would have to qualify under the state's current eligibility rules (i.e., would have to meet asset and disability requirements). Under the county-based option, counties could offer additional benefits, except for long-term care.

The Administration indicates that it has presented these options as a framework to begin discussions with counties and stakeholders, including the Legislature, on how the state and local governments should share the risks and costs associated with expanding public health coverage to this population.

According to the Administration, counties are spending between $3 billion and $4 billion annually on health care costs, this spending varies significantly by county. This estimate includes $1.5 billion from the 1991 Health Realignment Account, $1 billion in county maintenance of effort (the 1991 realignment of funding for county health services retained the concept of a county's level of effort for the provision of health services), and was informed by County Medical Services Program, the Medically Indigent Care Reporting System, and data provided by counties to DHCS for claiming under the Medicaid Waiver for the uninsured. Additionally, counties that own and operate hospitals also use local funds to fund the non-federal share of Medi-Cal for inpatient Medi-Cal services provided in their facilities.

ISSUES TO CONSIDER:

Medi-Cal Expansion Brings Many Benefits to State. As ruled by the U.S. Supreme Court, the expansion of Medicaid to low-income adults is an optional provision of the ACA. The Administration has recognized the benefits of expanding Medi-Cal coverage to low-income childless adults. These benefits include: (1) providing health coverage to more of the state's uninsured population, (2) an influx of federal funding to the state to support this expansion of health coverage, and (3) general economic benefits to the state, such as job creation.

Already Eligible Caseload Estimates Unavailable from Administration. The Administration has not yet provided its estimates on the number of persons who are already eligible for Medi-Cal and are projected to enroll on or after January 1, 2014. Without these numbers it is difficult to evaluate the basis for the placeholder $350 million General Fund for 2013-14 (for six months) and $700 million General Fund for 2014-15 (and ongoing) included in the budget.

Newly Eligible – State and County Costs Uncertain. The Administration also has not provided any caseload or fiscal estimates on the newly eligible individuals expected to enroll in Medi-Cal.

Nor does the Administration have a timeline or proposal on how the state and counties should share the risks and costs associated with expanding public health coverage to this population.

In determining these costs and risks, it will be important to consider the following factors:

- How quickly will individuals obtain coverage and access to services?
- What level of savings will be realized by the counties as individuals who were formerly covered by county indigent health programs are now covered by Medi-Cal?
- What will be the remaining county obligations to provide care to those individuals who do not qualify for Medi-Cal?
- What will be the nonfederal costs of providing this coverage (as the federal matching rate declines starting in 2017)?
- What short- and long-term checkpoints should be considered to evaluate the assumptions and methodology on how the state and counties should share the risks and costs of this expansion?

These factors will need to be considered differently depending on how each county provides indigent health care services. For example, counties that own and operate public hospitals, health systems and clinics are important safety-net providers and are different from counties that contract out (e.g., a CMSP county) entirely for the provision of indigent health care services.

County-based Option Not Viable. Medi-Cal is currently a state-based program administered by DHCS. The county-based option is not viable option for many reasons including:

- *Inefficient.* Implementation of this expansion at the county level would take a significant amount of work and would be inefficient as each county would have to develop or contract out for fiscal (e.g., claiming) and operational activities and would have to develop its own provider networks. The state already has these processes established for the state Medi-Cal program and could implement this expansion using existing contracts.

- *Varied Implementation*. Although all counties would have to expand coverage on the same date and for the same population, this option could lead to varied implementation by counties. As exemplified by LIHP, counties have developed different provider networks and have taken a varied interest in providing coverage for the uninsured population. A state-based option would help ensure timely and consistent statewide implementation and access to coverage.

- *Families Could Be Split Across Programs*. Under this option, there could be a situation in which children in a family would be covered by the state-based Medi-Cal program and the parents in the family would be covered by the county-based Medi-Cal program. This could mean that one family is covered by multiple health plans and providers. Additionally, women who become pregnant would switch programs at the time of pregnancy. A state-based option would eliminate any potential for fragmentation and churning between the Medi-Cal programs.

- *Not All Counties Operate LIHPs*. The Administration argues that under the county-based option, counties could build upon their LIHPs. However, not all counties have implemented LIHPs. Consequently, those counties without LIHPs would likely need a

significant amount of time to develop health coverage programs for this expansion population.

- *Unclear if County-Based Option Would Get Federal Approval.* The Administration has indicated that it is unclear if the federal government would approve implementation of this expansion at the county level instead of at the state level.

Exclusion of Home- and Community-Based Services in Medi-Cal Benefit Package. As discussed above, the Administration proposes that long-term supports and services (LTSS), both institutional care and home- and community-based services (HCBS), be excluded from the Medi-Cal benefit package for the already eligible and the newly eligible who enroll in Medi-Cal on and after January 1, 2014.

The Administration argues that this Medi-Cal benefit package should not include LTSS because these individuals have qualified without an asset or disability test and that these individuals could, for example, have assets that could be liquidated to cover the costs of LTSS. (Under the ACA's efforts to streamline eligibility and enrollment, the current Medi-Cal asset and disability tests are eliminated.) The Administration indicates that these individuals would be eligible for LTSS if they qualify under the current asset and disability rules.

By not including LTSS, home- and community-based services in particular, in the Medi-Cal benefit package for the newly eligible individuals, the state is forgoing a higher federal matching rate (100 percent for the first three years and no lower than 90 percent in the out years) for these benefits. If these newly eligible individuals qualify under the asset and disability tests, the state would be responsible for 50 percent of the costs. Consequently, it could make sense to include these benefits as the federal government would be contributing at a significantly higher matching rate. The Administration has not presented any fiscal estimates justifying the exclusion of these benefits from the Medi-Cal benefit package.

Additionally, the exclusion of HCBS, at the very least, appears counter to DHCS's Coordinated Care Initiative (discussed earlier) intended to coordinate medical, behavioral, long-term supports and services, and home- and community-based services through a single health plan and; consequently, achieve net savings in the Medi-Cal program (through a reduction in inpatient care, for example).

No Estimate on the Savings from Other State Health Programs. As individuals become eligible and enroll in comprehensive health coverage (either through Medi-Cal or Covered California), it is expected that the state would realize cost savings in various smaller health care programs (e.g., the Breast and Cervical Cancer Treatment Program and the Family Planning, Access, and Care Program). The LAO estimates about $100 million in reduced General Fund costs in 2013-14 and ongoing reductions of about $200 million, but notes that there is a significant amount of uncertainty surrounding these estimates as the fiscal effects will largely depend on future policy decisions about the modification of these programs in response the Medicaid expansion.

Short Timeline for Implementation of these Expansions. Given that the state is operating under a very tight timeline for these changes (this expansion begins January 1, 2014), it is critical that a decision be made as soon as possible on the details of implementing this expansion. If the state does not meet the January 1, 2014 timeline, hundreds of millions of dollars in federal funding could be lost.

Federal Guidance on Key Issues Still Outstanding. There are several key aspects of ACA implementation for which federal guidance has not yet been issued including the methodology for claiming enhanced federal funding for the newly eligible Medi-Cal population.

Medi-Cal – Gross Premiums Tax

BACKGROUND:

Managed Care Organization Fee. In 2005, California enacted a quality improvement fee (QIF) on Medi-Cal managed care organizations.[5] Based on federal rules, the fee was assessed on all premiums paid to legal entities providing health coverage to Medi-Cal enrollees. When the fee was established, 75 percent of the revenue generated was matched with federal funds and used for payments to managed care organizations and the remaining 25 percent was retained by the state General Fund. Under this arrangement, the managed care organizations received a rate adjustment (i.e., on the net, health plans gained).

Effective October 1, 2007, as part of the implementation of the state's new managed care rate methodology, this arrangement changed and 50 percent of the revenue generated by the QIF was matched with federal funds and used for payments to managed care organizations and the remaining 50 percent was retained by the state General Fund.[6] Under this allocation, managed care plans were made whole in that they were reimbursed the amount of QIF they paid, but no longer realized a net benefit.

Changes in federal law resulted in this fee sunsetting on October 1, 2009 as it no longer complied with federal requirements. New federal law required that provider fees be "broad based" and uniformly imposed throughout a jurisdiction, meaning that they cannot be levied on a subgroup of providers, such as only those enrolled in Medicaid programs.

Gross Premiums Tax (GPT). Assembly Bill 1422 (Chapter 157, Bass, Statutes of 2009) extended the 2.35 percent premium tax imposed on all types of insurance to include all comprehensive health plans contracting with Medi-Cal. The revenues from this tax were directed to fund health coverage for children through the Healthy Families Program, provide a cost-of-living increase to health plans participating in Healthy Families, and increase Medi-Cal capitation rates to health plans. Under this arrangement, 50 percent of the revenue was matched with federal funds to make health plans whole and 50 percent of the revenue was used to maintain the Healthy Families Program. This tax expired December 31, 2010 and was extended twice until it expired on June 30, 2012.

It should be noted that because the GPT is an existing tax on a broad group of insurers, the overwhelming majority of which are not health care insurers, it can be extended to Medi-Cal managed care plans without being considered a fee under federal law. As such, the state does

[5] Assembly Bill 1762 (Committee on Budget, Chapter 230, Statutes of 2003)
[6] "Financing Medi-Cal's Future: The Growing Role of Health Care-Related Provider Fees and Taxes," California HealthCare Foundation, November 2009.

not have to meet federal requirements for provider fees to obtain federal matching funds, using this source of revenues as the state match.

Last Year's Proposal. Last year, the Administration proposed to permanently extend the GPT. It was estimated that about $187 million from the GPT would be directed to the Healthy Families Program (and that Medi-Cal managed care plans would receive a rate adjustment to make them whole). The Senate Budget and Fiscal Review Committee approved a two-year extension of this tax; however, this proposal was not voted on by the Legislature. Consequently, this tax expired on July 1, 2012.

The 2012 Budget Act assumed reauthorization of the GPT, and, based on this assumption appropriated no General Fund to cover the Healthy Families Program. On January 7, 2013, the Administration notified the Joint Legislative Budget Committee of an unanticipated cost funding request of $15 million General Fund from the Managed Risk Medical Insurance Board. These requested funds would be used to cover the capitation and administrative vendor costs for the month of December 2012 for the Healthy Families Program.

GOVERNOR'S PROPOSAL:

Permanently Extend Gross Premiums Tax. The Administration proposes to reauthorize the gross premiums tax on Medi-Cal managed care plans permanently on a retroactive basis starting July 1, 2012. Reauthorizing this tax would generate General Fund savings of $131 million in 2012-13 and $232 million in 2013-14. The Administration proposes to continue to use 50 percent of the gross premium tax revenue to draw down federal funds and make plans whole and 50 percent of the revenue to offset General Fund spending.

It should be noted that one of the components of the Administration's proposed $1 billion reserve, is $364 million from the gross premiums tax ($131 million from 2012-13 and $232 million from 2013-14).

ISSUES TO CONSIDER:

Gross Premium Tax Brings In Additional Federal Funding to State. With the expiration of the GPT, the state is forgoing hundreds of millions of dollars in additional federal funding for the Medi-Cal program as the revenue from the gross premiums tax can be used as a match for federal funding for Medi-Cal.

State Has One of Lowest Capitation Rates in Country. Medi-Cal capitation rates are among the lowest Medicaid rates in the country.[7] With the implementation of the ACA's Medicaid

[7] "Public Partner: The California Health Benefit Exchange Aligned with Medi-Cal," California HealthCare Foundation, October 2011.

expansion, discussed earlier, it will be important to ensure that Medi-Cal rates are at a level to ensure provider participation in the program in order to ensure access to services. Consequently, as part of these discussions it will be important to consider the cumulative impact of the AB 97 rate reductions, the managed care efficiencies proposal, and Medi-Cal expansion when evaluating this reauthorization and the allocation of the revenues generated from this tax. For example, should the revenues from the GPT be used to offset General Fund expenditures in Medi-Cal or should they be used to increase rates to Medi-Cal managed care plans given their important role in the Medi-Cal expansion. As noted above, when the QIF was first assessed on managed care organizations, it was used to provide a rate increase to managed care plans.

GPT Revenue Does Not Account for Medi-Cal Expansion. The Administration's estimated GPT revenues do not include the impact of the Medi-Cal expansion (related to health care reform). Accordingly, GPT revenues will be higher (likely in the tens of millions) than projected in the Governor's budget as more people will be covered by Medi-Cal managed care.

Permanent Extension Makes Evaluation Difficult. A permanent extension of this tax would make it difficult to periodically evaluate its effectiveness and its impact on Medi-Cal managed care.

The 2013-14 Budget:

Examining the State and County Roles in the Medi-Cal Expansion

MAC TAYLOR • LEGISLATIVE ANALYST • FEBRUARY 2013

LAO

EXECUTIVE SUMMARY

Federal Health Care Reform Includes Optional Medi-Cal Expansion. Under the Patient Protection and Affordable Care Act (ACA), also known as federal health care reform, the state has the option to expand its Medicaid Program (known as Medi-Cal) to cover over one million low-income adults who are currently ineligible. For three years, beginning January 1, 2014, the federal government will pay almost all the costs associated with the expansion. Beginning January 1, 2017, the federal share of costs associated with the expansion would be decreased over a three-year period until the state pays for 10 percent of the expansion and the federal government pays the remaining 90 percent. Currently the counties have the fiscal and programmatic responsibility for the care for the low-income adult population that would be covered by the expansion.

Governor Proposes to Adopt Expansion and Offers Two Options to Implement It. The Governor proposes to adopt the optional Medi-Cal expansion and proposes two options to implement the expansion beginning January 1, 2014: (1) a county-based approach under which counties would assume fiscal and programmatic responsibility for the provision of health services to the expansion population or (2) a state-based approach under which the state would expand its existing state-administered Medi-Cal Program to cover the expansion population.

LAO Assessment. The expansion would likely have significant policy benefits, including improved health outcomes for the newly eligible Medi-Cal population. In the short term, fiscal savings to the state as a whole would far outweigh the nonfederal costs associated with providing health care to the expansion population. After a decade, when the enhanced federal matching rate is reduced from 100 percent to 90 percent, we estimate that overall savings to the state as a whole (state and local governments) would likely continue to outweigh costs. Despite the significant uncertainty about the long-term costs and savings associated with the expansion, on balance, we believe the policy merits of the expansion and the fiscal benefits that are likely to accrue to the state as a whole outweigh the costs and potential fiscal risks. We recommend the state adopt the optional expansion.

We also find that the state is in a better position than the counties to effectively organize and coordinate the delivery of health services to the newly eligible population—potentially resulting in improved health outcomes and administrative efficiencies. As a practical matter, we also believe the state is better positioned than the counties to successfully implement an expansion by January 1, 2014. We recommend the Legislature adopt a state-based expansion, shifting the fiscal and programmatic responsibility of providing health care to the expansion population from counties to the state.

Given this shift of responsibility, we further find that implementation of a state-based approach results in the need for a reexamination of state-county funding arrangements for indigent health care. Accordingly, we recommend the Legislature redirect a portion of funding currently allocated to counties under 1991 realignment for indigent health.

INTRODUCTION

Beginning January 1, 2014, the ACA gives state Medicaid programs the option to expand health coverage to most adults under age 65—including childless adults—with incomes at or below 133 percent of the federal poverty level (FPL) who are not currently eligible. In California, counties generally have the fiscal and programmatic responsibility for providing health care to this population. The federal matching rate for coverage of this expansion population will be 100 percent for the first three years, but will decline between 2017 and 2020, with the state or counties eventually bearing 10 percent of the additional cost of health care services for the expansion population.

The Governor has proposed to adopt the optional expansion. He has also outlined two distinct approaches to implementing the expansion—a state-based approach and a county-based approach—but has not indicated a preference for either approach. Under both approaches, the Governor indicates that the expansion will require a reassessment of the state-local fiscal relationship.

In this report, we provide the Legislature with recommendations on three major issues related to the optional Medicaid expansion.

- Should the state adopt the optional Medicaid expansion?
- Should the state adopt the state-based or county-based approach?
- What changes to the state-county fiscal relationship would be appropriate under the expansion and how should they be implemented?

BACKGROUND

The existing allocation of federal, state, and local responsibilities and funding for health programs is complex. Below, we discuss: (1) the major programs administered by state and local governments that provide health services to low-income populations in California, (2) provisions of the ACA that have significant effects on these state and local programs, and (3) recent actions the state and counties have taken toward implementing the ACA.

Overview of Medi-Cal

Medi-Cal Is California's Primary Health Coverage Program for Low-Income Individuals. Medicaid is a joint federal-state program that provides health coverage to certain low-income populations. The program is voluntary for states. In California, the Medicaid program is administered by the state Department of Health Care Services (DHCS), and is known as Medi-Cal. Currently, Medi-Cal provides health care services to over eight million qualified low-income persons—including families with children, pregnant women, seniors, and persons with disabilities. The income threshold used to determine eligibility varies. For some groups, such as parents, the income threshold is about 100 percent FPL. (In 2012, the FPL is $11,170 per year for an individual and $23,050 for a family of four.) For other groups, the income threshold is significantly higher—reaching up to 200 percent FPL for pregnant women and 250 percent FPL for children (when the transition

of the state's Healthy Families Program (HFP) into Medi-Cal is complete in 2013). Generally, a low-income childless adult who is not elderly or disabled does not qualify for Medi-Cal under current eligibility standards. As discussed in more detail below, the ACA gives California the option to significantly expand eligibility for the Medi-Cal Program beginning January 1, 2014, mainly to low-income childless adults, as well as some parents.

Medi-Cal Costs Split Between the State and Federal Government. The federal government pays for a share of the cost of each state's Medicaid program. The percentage of program costs funded with federal funds is known as the federal medical assistance percentage (or "federal match"). The Medi-Cal Program currently—and historically—receives a 50 percent federal match for most services, meaning that the program generally receives one dollar of federal funds for each state dollar it spends on those services. The federal government also provides an enhanced federal match for certain program costs, such as certain types of health services and the implementation of information technology systems.

The federal government only pays for emergency and pregnancy-related services for certain populations that meet all current eligibility standards with the exception of certain immigration status requirements—including undocumented individuals and qualified aliens who have been in the country for less than five years (newly qualified aliens). In California, newly qualified aliens are eligible to receive full Medi-Cal benefits and the costs of the additional benefits are funded entirely with state General Fund monies. Medi-Cal does not pay for nonemergency and nonpregnancy-related services for undocumented individuals.

The Medi-Cal Delivery System. There are two main Medi-Cal systems for the delivery of health care: fee-for-service (FFS) and managed care. In the FFS system, a health care provider receives an individual payment for each service provided to a Medi-Cal enrollee. The FFS enrollees generally may obtain services from any provider who has agreed to accept Medi-Cal payments. In Medi-Cal managed care, DHCS contracts with certain managed care plans, also known as health maintenance organizations or "plans," to provide health care coverage for Medi-Cal beneficiaries residing in certain counties. Plan enrollees may obtain services from providers who accept payments from the plan, also known as a plan's "provider network." Medi-Cal reimburses the plans on a "capitated" basis with a predetermined amount per person, per month and the plans reimburse providers for health care services delivered to enrollees.

Overview of County Health Services

Counties provide a wide variety of health services in California, including physical health care for medically indigent adults—or low-income individuals who cannot afford health insurance coverage and who are not eligible for Medi-Cal. Throughout this report, we focus on the counties' role in providing *physical* health care services to the medically indigent—also known as indigent health care. Counties are also the primary providers of public health services and behavioral health services for low-income individuals in California. For more information on counties' role in the provision of public health and behavioral health services, please see the nearby box.

The State-County Relationship and Indigent Health Care in California

For most of the state's history, counties have provided safety-net health care services to low-income individuals who do not have health insurance coverage—commonly referred to as the

medically indigent. Counties' indigent health responsibilities were statutorily established in the 1930s, with the enactment of Welfare and Institutions Code (WIC) Section 17000, which generally requires counties to provide health care to medically indigent individuals. With the establishment of the Medi-Cal Program in 1966, some county responsibilities for providing health care for low-income Californians shifted to the federal government and state. However, counties remained responsible for providing health care to medically indigent individuals who are not eligible for Medi-Cal or other state health programs—a population that consists primarily of childless, non-elderly adults. Many counties also provide indigent health services to undocumented individuals, although this is not specifically required by WIC Section 17000.

Over the years, the roles of the state and counties in providing health care to the medically indigent have been redefined several times. Below, we discuss the major historical developments that shaped the relationship between the state and counties in the delivery of indigent health care.

Medi-Cal Eligibility Expanded to Certain Medically Indigent Adults (MIAs). In 1971, the state enacted a package of reforms to the Medi-Cal Program. As part of this package, the state

Counties Provide Other Important Health Services

Counties provide and finance a wide variety of health services in addition to physical health care for the medically indigent, including mental health services, substance use treatment, and public health services.

Mental Health Services. Counties are the primary providers of mental health services to the medically indigent (to the extent resources are available). Counties also provide mental health services to Medi-Cal enrollees, primarily for serious mental disorders that require treatment by licensed mental health care specialists such as psychiatrists. Services include medication support, case management, prevention programs, and crisis intervention. Counties are responsible for paying the nonfederal share of these specialty mental health treatments provided to Medi-Cal enrollees. The nonfederal share of funding for mental health services comes from various sources, including 1991 Realignment, Proposition 63 (Mental Health Services Act), 2011 Realignment, and county General Fund revenues.

Substance Use Treatment. Counties are the primary providers of substance abuse treatment services to the medically indigent (to the extent resources are available). Counties also provide substance abuse treatment services to Medi-Cal enrollees. The Drug Medi-Cal program offers services that include: outpatient drug free clinics and the Narcotic Treatment Program. Counties are responsible for paying the nonfederal share of drug and alcohol treatment provided to Medi-Cal enrollees. The nonfederal share of funding for substance use treatment services comes from various sources, including 1991 Realignment, 2011 Realignment, and county General Fund revenues.

Public Health Services. Many public health programs and services are delivered at the local level by county public health departments. These programs address public health issues, such as communicable disease control, environmental health, smoking cessation programs, childhood exposure to lead, and family planning services.

extended Medi-Cal eligibility to childless adults as a state-only program—shifting the responsibility of providing health care to this population from counties to the state. In conjunction, counties were required to assume a share of cost for the Medi-Cal Program. Following this shift of childless adults to Medi-Cal, county obligations under WIC Section 17000 decreased substantially. However, counties continued to incur costs for services provided to undocumented individuals and others unable to qualify for Medi-Cal.

Two Constitutional Amendments Substantially Altered State-County Relationship. In the late 1970s, voters approved two amendments to the State Constitution which substantially altered the state-local relationship: Proposition 13 (1978) and Proposition 4 (1979). Proposition 13 immediately reduced local government property tax revenues by more than 60 percent. Proposition 4 generally requires the state to reimburse local governments if the state mandates that local governments provide a new program or a higher level of service.

State Provided Aid to Counties Following Proposition 13. In response to the significant decline in local government revenues resulting from Proposition 13, the state took a variety of actions to provide fiscal relief to local governments. In 1979, the Legislature enacted Chapter 282, Statutes of 1979 (AB 8, L. Greene), which, among other things, provided fiscal relief to counties by: (1) eliminating the county share of cost for Medi-Cal and (2) establishing annual subventions to counties to support county public health programs and indigent health care. As a condition of receiving state aid for health programs under AB 8, counties were required to spend a specified amount of county purpose general revenues on county public health and indigent health programs.

MIAs Removed From Medi-Cal. In 1982, facing rising costs in the Medi-Cal Program and a significant budget deficit, the Legislature eliminated Medi-Cal eligibility for childless adults. Under WIC 17000, health care responsibilities for childless adults once again fell to the counties. To support county costs of providing health care to individuals no longer eligible for Medi-Cal, the Legislature established two new programs: (1) Medically Indigent Services Program (MISP), which provided state funding to support indigent health costs in larger counties, and (2) County Medical Services Program (CMSP), which allowed smaller counties to contract with the state to provide indigent health care. Both MISP and CMSP were funded with annual appropriations from the General Fund. In order to receive state funds under MISP or CMSP, counties were required to continue meeting the provisions in AB 8 related to the expenditure of county general purpose revenue on public health and indigent health programs.

State Enacted a Major Change to State-County Relationship. In 1991, the state enacted a major change in the state and local government relationship, known as realignment. The 1991 realignment package: (1) transferred several programs from the state to the counties, including health and mental health programs; (2) changed the way state and county costs are shared for social services and health programs; and (3) increased the sales tax and vehicle license fee (VLF) and dedicated these increased revenues for the increased financial obligations of counties. Under realignment, the original revenue allocations to counties were based on the amount of funding each county received for the realigned programs from the state just prior to realignment. Annual growth in realignment revenues is allocated based on a separate set of formulas, primarily intended to prioritize funding for costs due to increased caseload and to equalize funding levels across counties.

1991 Realignment Modified Indigent Health Funding. The 1991 realignment package dedicated a portion of the increased sales tax and VLF revenues to fund AB 8 health payments, MISP, and CMSP—eliminating state General Fund support for these programs. Consistent with county expenditure requirements under AB 8, the 1991 realignment package required counties to maintain a minimum level of expenditure—a maintenance-of-effort (MOE)—on public health and indigent health programs.

County Medically Indigent Programs Vary Significantly

Currently, the manner in which each county finances and delivers health care to the medically indigent varies across the state. Counties have flexibility with respect to the services provided, the populations served, the method of delivering services, and the funding used to provide services. Figure 1 describes three broad categories of county-based programs that have provided coverage to MIAs in recent years. This section focuses on the characteristics of county medically indigent programs. We discuss the federally funded waiver programs later in this report.

Counties Vary in How They Deliver Services to Medically Indigent Individuals. The manner in which counties deliver health services to the medically indigent varies from county to county. Counties are often characterized by the degree to which they directly provide health care services to the medically indigent population. For example, counties generally fall into one of the following categories:

- ***Provider Counties***—MISP counties that own and operate inpatient hospitals and clinics that provide care to essentially all individuals, whether or not they have health coverage. Currently, there are 12 provider counties, including some of the most populous counties in California, such as Los Angeles County.

- ***Payer Counties***—MISP counties that pay for medically indigent care services through contracts with private or University of California (UC) hospitals, community clinics, and/or private

Figure 1

County-Based Indigent Health Programs

Program	Description
Medically Indigent Programs	***Longstanding County Programs That Pay for Health Services for Some Medically Indigent Adults.*** Characteristics of each county's medically indigent program vary substantially, including the maximum income level and residency requirements necessary for eligibility.
Coverage Initiatives	***Federally Funded Programs Authorized in Ten Counties Under a 2005 Medicaid Waiver.*** Beginning in 2007, counties were eligible for 50 percent federal funding for care provided to medically indigent adults enrolled in the Coverage Initiative. In return, counties were required to meet certain federal requirements related to improved system integration, quality, and coordination of care. In 2011, these programs were replaced by the Low Income Health Programs (LIHPs) authorized under the new Bridge to Reform waiver.
LIHPs	***The Bridge to Reform Waiver Built Upon the Existing Coverage Initiatives in the Ten Counties by Authorizing Optional County-Based LIHPs in Every County, Beginning in July 2011.*** Most, but not all, counties currently operate a LIHP. Many counties that operate a LIHP have a separate medically indigent program for adults who are not eligible for the LIHP.

physicians. These counties generally do not own or operate facilities that provide physical health care services.

- ***Hybrid Counties***—The MISP counties that do not operate a hospital, but that operate outpatient clinics that provide care to low-income populations. These counties also have contracts with hospitals and, in some cases, other community clinics and/or private physicians.

- ***CMSP Counties.*** As discussed above, a group of 35 rural and/or small counties that pays for medical care to MIAs in participating counties. The CMSP currently contracts with a third-party administrator (Anthem Blue Cross) to organize the delivery of health care services to certain medically indigent populations in these counties.

Figure 2 illustrates the degree to which each county directly provides care to its MIA population.

Historically, medically indigent programs have provided episodic care, with little emphasis on primary care services, preventative care, and care coordination. For example, some payer counties simply reimburse providers for services provided to individuals who show up at the hospital with an immediate need for care. In provider counties, many of the medically indigent program enrollees are indigent individuals who show up at the hospital emergency room with an illness or injury in need of treatment. In recent years, some counties have begun to place a greater emphasis on actively enrolling medically indigent individuals in the program as a way to emphasize preventative and primary care services.

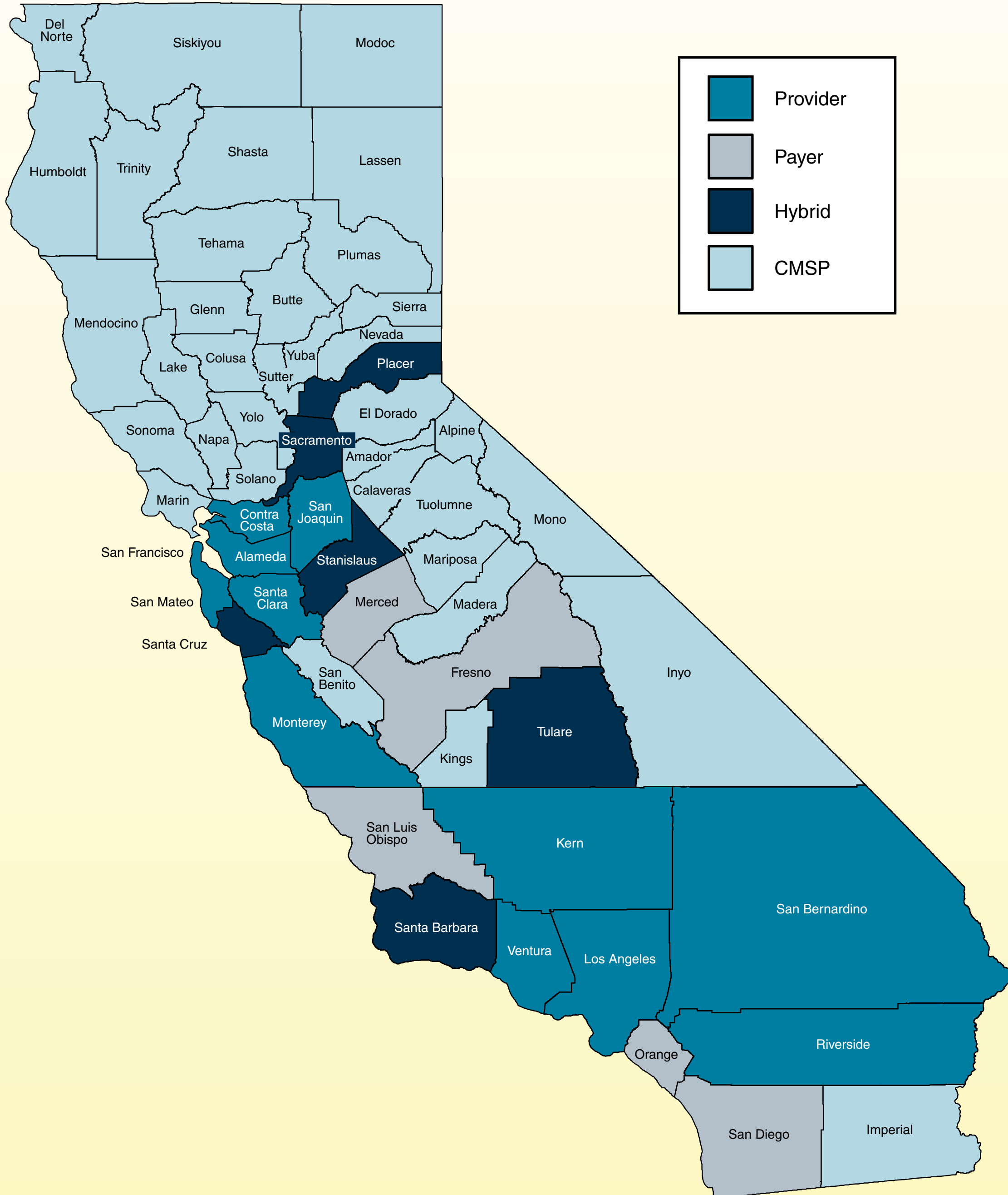
Significant Differences in Eligibility for Medically Indigent Programs. Generally, potential enrollees are screened for Medi-Cal eligibility before they are determined eligible for medically indigent programs. Eligibility differs among counties in several ways, including the maximum income threshold and immigration status requirements. For example, some counties do not cover services for undocumented individuals, other counties cover limited services for undocumented individuals (such as emergency services), while other counties provide full services to undocumented individuals. Most medically indigent programs provided coverage to citizens and legal residents with incomes up to 200 percent FPL. However, several counties had income thresholds either above or below 200 percent FPL. In one county, the maximum income threshold was 63 percent FPL.

Counties Use Various Sources of Funding to Pay for Care for the Medically Indigent. In addition to 1991 health realignment funding described above, counties use a variety of funding sources to pay for medically indigent costs. Some of the most common sources of nonfederal funds are described in Figure 3 (see page 12). In many instances, counties have flexibility to use these funds on different types of services and populations. For example, a county may use a mix of 1991 health realignment funds, county general funds, and mental health realignment funds to provide services to MIAs.

In addition, provider counties receive a wide variety of supplemental payments from the federal government, including Medicaid Disproportionate Share Hospital (DSH) payments and other payments associated with California's Medicaid Section 1115 Waiver (discussed in more detail below). These funds are meant to at least partially offset uncompensated care costs, such as costs associated with providing care to the uninsured and care for which the county does not receive enough payment to fully cover its costs.

Figure 2

County Systems for Delivery of Care to Medically Indigent Adults Vary Widely



Source: Based on data compiled for report produced by California HealthCare Foundation in 2011.
CMSP = County Medical Services Program.

Counties Are Major Safety-Net Providers

County-operated hospitals and clinics are a major part of the health care safety net. The health care safety net may be broadly defined as the health care providers—both public and private—that, as part of their core mission, provide services to all patients regardless of ability to pay or legal status. There are many different types of safety-net providers, including county-hospitals, private safety-net hospitals (such as Children's Hospitals), county clinics, and rural health clinics. Generally, these providers serve a high percentage of individuals enrolled in Medi-Cal, county-based indigent health programs, and the uninsured. The financing structure for these providers is complex and they depend on a wide variety of funding sources. For example, under the terms of the Section 1115 waiver, counties are financially responsible for the nonfederal share of Medi-Cal inpatient services delivered to certain Medi-Cal enrollees. However, the waiver also provides a significant amount of federal funding that is intended to help ease the burden of uncompensated care costs for these hospitals.

Figure 3

Examples of Nonfederal Funding Sources Used to Pay for Care for the Medically Indigent

- ✓ ***1991 Health Realignment Funds.*** Vehicle license fee (VLF) and state sales tax revenues that are allocated to the health account of each county.
- ✓ ***1991/2011 Mental Health Realignment.*** The VLF and state sales tax revenues that are allocated to the mental health account of each county.
- ✓ ***Tobacco Master Settlement Funds.*** A portion of funds paid by tobacco companies under the Master Settlement Agreement between the states and certain tobacco companies is allocated to counties.
- ✓ ***County General Funds.*** The public funds of the county primarily from tax revenues.

Overview of the ACA

The ACA, also referred to as federal health care reform, is far-reaching legislation that makes significant changes to health care coverage and delivery in California. The ACA is, in part, designed to create a health coverage purchasing continuum that makes it easier for persons to access, purchase, and maintain health care coverage. As individuals' incomes rise and fall; as they become employed, change employers, or become unemployed; and as they age, they are to have access to different sources of coverage along the coverage continuum. Creating this continuum requires the modification of existing government programs and integration of these programs with new coverage options created by ACA. For more information on the various provisions in the ACA that potentially affect California state health programs, please see our May 2010 report, *The Patient Protection and Affordable Care Act: An Overview of Its Potential Impact on State Health Programs*. Below, we discuss some of the major ACA provisions that have fiscal implications for state and local governments. We note that there are numerous other provisions of the ACA that will affect state and county finances—both directly and indirectly—that we have not described here.

Provisions Encourage Individuals to Purchase Health Coverage

Creates Penalties for Certain Individuals Without Health Insurance Coverage. Beginning January 1, 2014, the ACA requires most U.S. citizens and legal residents to have

health insurance coverage or pay a penalty. This requirement is commonly known as the individual mandate. Certain individuals are exempt from the individual mandate, including those exempt from filing federal taxes due to their low-income status. A significant portion of the Medicaid population has income below the federal tax filing threshold and would be exempt from the individual mandate. The ACA also gives the federal Secretary of Health and Human Services (Secretary) some flexibility to establish other financial hardship exemptions. In light of the recent Supreme Court ruling, as discussed below, the Secretary indicates that she would use this authority to exempt additional low-income individuals in those states that chose not to implement the optional Medicaid expansion.

Establishes Health Benefit Exchanges With Federal Subsidies to Purchase Coverage. The ACA establishes entities called Health Benefit Exchanges. Through these exchanges, individuals and small businesses will be able to research, compare, check their eligibility for, and purchase health coverage. In California, citizens and legal residents with family income between 100 percent and 400 percent FPL who do not qualify for Medi-Cal will be eligible for federal subsidies to purchase health coverage through the California Health Benefit Exchange (also known as the Exchange or Covered California) that is currently under development.

Allows for Optional Medicaid Expansion to Adult Populations

Authorizes Medicaid Expansion up to 133 Percent FPL. The ACA gives states the option to significantly expand their Medicaid programs, with the federal government paying for a large majority of the additional costs. Beginning January 1, 2014, federal law allows state Medicaid programs to expand coverage to most adults under age 65—including childless adults—with incomes at or below 133 percent of the FPL who are not currently eligible. (After taking into account a technical adjustment to eligibility required under the federal law, the income limit is, in effect, 138 percent of the FPL.) Generally, this population includes nonpregnant, nondisabled childless adults. In addition, some parents with incomes between 100 percent and 133 percent FPL would become eligible. Similar to other Medi-Cal eligibility categories, undocumented immigrants would only be eligible for limited services, such as emergency services. As shown in Figure 4, the federal matching rate for coverage of this expansion population will be 100 percent for the first three years, but will decline between 2017 and 2020, with the state eventually bearing 10 percent of the additional cost of health care services for the expansion population.

Recent Supreme Court Ruling Makes Medicaid Expansion Optional for States. Originally, the ACA included a provision that would allow the federal government to withhold a state's Medicaid funding if the state did not adopt the expansion—effectively making the Medicaid expansion mandatory. A recent U.S. Supreme Court ruling found the mandatory Medicaid expansion unconstitutional and struck down this provision

Figure 4

Federal Matching Rate for Health Care Services Provided to Medicaid Expansion Population

Calendar Year	Federal Match
2014	100%
2015	100
2016	100
2017	95
2018	94
2019	93
2020 and thereafter	90

of the ACA—effectively making the Medicaid expansion optional for states. Subsequent federal guidance confirmed that the Medicaid expansion is now truly voluntary—meaning states may choose to adopt or eliminate the coverage expansion at any time. Recent guidance from the federal government also indicates that states may not partially adopt the Medicaid expansion. In other words, states may either adopt the expansion up to 133 percent FPL or not adopt the expansion at all. For example, states may not adopt the expansion only for adults up to 100 percent FPL.

Makes Changes to Medi-Cal Eligibility and Enrollment

Changes Methodology Used to Determine Financial Eligibility. Beginning January 1, 2014, the ACA makes changes to the methodology used to calculate income when determining Medicaid program eligibility for most beneficiaries—excluding certain populations, such as seniors and persons with disabilities. Currently, the methodology used to determine financial eligibility for Medicaid is complex—often involving verification of an applicant's assets and accounting for a variety of income deductions and exemptions. The ACA generally simplifies the standards used to determine financial eligibility. The two major changes to the methodology are:

- Requiring the use of a new methodology to calculate income, known as Modified Adjusted Gross Income (MAGI). As part of this change, various deductions to applicant income that are now permissible would end.
- Asset tests will no longer be used to determine eligibility.

Changes to Outreach and Enrollment Processes. In addition to the eligibility changes identified above, the ACA also includes provisions aimed at streamlining the enrollment processes and coordinating with other entities that will offer subsidized health insurance coverage to low- and moderate-income persons. For example, persons may be determined eligible for Medi-Cal after applying through a website operated by the Exchange. The state is required to use available electronic data sources, such as tax information from the Internal Revenue Service, to determine eligibility prior to asking for additional information from the applicant. The Exchange will also be conducting outreach activities aimed at enrolling uninsured individuals in health coverage, including Medi-Cal.

Reduces Medicaid Hospital Funding

The ACA requires over several years an $18.1 billion total reduction in federal funding nationwide for DSH allocations, which now go to hospitals that serve a disproportionate share of Medicaid beneficiaries and the uninsured. The fiscal impact of this change will be felt mainly by counties that operate DSH-supported hospitals.

Overview of Federal Waivers That Promote Coverage Expansion

The state and counties have, in effect, already taken significant steps toward implementing the optional expansion under ACA. Much of that progress was facilitated by the state's Section 1115 Medicaid Demonstration Waivers that provided federal funding for, among other things, county-based indgent health programs. (These allow states to waive federal Medicaid requirements in order to have the flexibility to modify their Medicaid programs in ways that are favorable to beneficiaries.) In 2005, the federal government approved the first of two 1115 waivers in California—hereafter referred to as "the previous waiver." In November 2010, several months after passage of ACA, the federal government approved the next waiver—called California's "Bridge

to Reform" waiver—hereafter referred to as "the waiver." Below, we discuss some of the significant components of the waivers and how they relate to funding and care for the medically indigent.

Previous Waiver Authorized Coverage Initiatives in Ten Counties. Among other things, the previous waiver authorized county-operated Coverage Initiatives in ten counties to provide medical care to low-income adults. In 2007-08, the following counties began operating Coverage Initiatives: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. Counties operating Coverage Initiatives received 50 percent federal funding for care provided to enrollees. In return, counties were required to meet certain federal requirements related to improved system integration, quality, and coordination of care. The general goal of the Coverage Initiatives was to assign individuals to a "medical home" in an effort to shift care away from more expensive episodic care to a more coordinated system of care to improve access, quality of care, and efficiency.

Bridge to Reform Waiver Authorized Low Income Health Programs (LIHPs). The Bridge to Reform waiver built upon and expanded the existing Coverage Initiatives in the ten counties by authorizing optional county-based LIHPs in every county. County LIHPs are split into two different types of coverage groups.

- ***Medicaid Coverage Expansion (MCE).*** Counties may offer coverage to low-income adults up to 133 percent FPL who would become eligible under ACA for Medi-Cal in 2014. Counties have the option to establish their MCE income eligibility thresholds below 133 percent FPL.

- ***Health Care Coverage Initiative (HCCI).*** If a county provides coverage to the MCE population up to 133 percent FPL, it has the option to operate a HCCI that offers coverage to adults with incomes between 133 percent and 200 percent FPL.

Currently, most counties are operating—or plan to operate—LIHPs that provide coverage to low-income populations, many of whom would qualify for Medi-Cal under the expansion. As shown in Figure 5 (see next page), the characteristics of each LIHP—such as income threshold—vary from county to county. In addition, counties began implementing LIHPs at different times over the course of the last couple of years and currently several counties have not implemented a LIHP.

Counties that operate a LIHP receive 50 percent federal matching funds for services provided to LIHP enrollees. (Counties pay for the nonfederal share.) In return, a county must comply with certain federal requirements, such as minimum covered benefits and provider network adequacy. As discussed in more detail below, the LIHPs share some similar characteristics with Medi-Cal, but there are also significant differences. Many counties that operate a LIHP also operate a separate medically indigent program for adults who are not eligible for the LIHP, including undocumented immigrants and uninsured individuals with incomes too high to qualify for the LIHP.

Waiver Provides Additional Federal Funding for State Programs and Public Hospitals. In addition to the LIHPs, the waiver made over $7 billion in federal Medicaid matching funds available over a five-year period to offset state costs for certain state health programs and provide funding to public hospitals intended to help preserve and improve the county-based health care safety net. For example, as much as $2 billion may be used to offset state General Fund costs for certain state health programs, such as the Genetically Handicapped Persons Program (GHPP) and the California Children's Services Program (CCS), over the five-year period. Another $1.9 billion may be used to offset some of

the uncompensated care costs that public hospitals incur when treating the uninsured. The waiver also established a new $3.4 billion Delivery System Reform Incentive Pool (DSRIP) that is used to encourage infrastructure development, innovative models of care delivery, improved care for certain diseases, and more broad improvements in public hospital care.

GOVERNOR'S PROPOSAL

The administration has stated its commitment to adopting the optional Medicaid expansion authorized under ACA beginning January 1, 2014. The Governor's budget summary document presents two distinct approaches—a state-based expansion and a county-based expansion. However, the administration neither indicates which approach it prefers nor provides an estimate of the fiscal effects on the state for either approach. Accordingly, the budget does not reflect any costs or savings related to the optional Medi-Cal expansion. The Governor's budget summary notes that counties will realize savings associated with MIAs becoming eligible

Figure 5

County Low Income Health Program (LIHP) Characteristics Vary

	Upper-Income Limit (Percent of FPL)	Implementation Date	Monthly Enrollment[a] (As of October 2012)		
			MCE	HCCI[b]	Total
Alameda[c]	200%	7/1/2011	37,900	8,600	46,500
Contra Costa[c]	200	1/2/2012	9,800	2,000	11,800
CMSP	100	7/1/2011	56,600	—	56,600
Kern[c]	100	7/1/2011	6,000	—	6,000
Los Angeles[c]	133	7/1/2011	205,300	—	205,300
Monterey	100	N/A	—	—	—
Orange[c]	200	7/1/2011	33,900	9,800	43,700
Placer	100	8/1/2012	1,900	—	1,900
Riverside	133	1/1/2012	23,900	—	23,900
Sacramento	67	11/1/2012	—	—	—
San Bernardino	100	1/1/2012	24,700	—	24,700
San Diego[c]	133	7/1/2011	32,800	—	32,800
San Francisco[c]	25	7/1/2011	9,400	—	9,400
San Joaquin	80	6/1/2012	1,500	—	1,500
San Mateo[c]	133	7/1/2011	8,500	—	8,500
Santa Clara[c]	75	7/1/2011	12,200	—	12,200
Santa Cruz	100	1/1/2012	2,200	—	2,200
Tulare	75	N/A	—	—	—
Ventura[c]	200	7/1/2011	8,400	2,900	11,300
Totals			**475,000**	**23,300**	**498,300**

[a] Numbers reflect rounding.
[b] Does not include 2,800 continuing enrollees under the prior Coverage Initiative.
[c] Counties that operated Coverage Initiatives under the previous waiver.
Note: Fresno, Stanislaus, San Luis Obispo, Santa Barbara, and Merced counties do not plan to operate LIHPs.
FPL = federal poverty level; MCE = Medicaid Coverage Expansion (only enrollees up to 133 percent FPL);
HCCI = Health Care Coverage Initiative (only enrollees 133 percent FPL to 200 percent FPL); CMSP = County Medical Services Program;
N/A = not yet implemented as of November 2012.

for Medi-Cal under the expansion. It further asserts that state implementation of ACA will require it to assess how much of these county savings "should be redirected to pay for the shift in health care costs to the state." While the administration has not clarified how this redirection would occur, it suggests possible changes in the state-county fiscal relationship.

State-Based Expansion Approach. Under the state-based expansion approach, the state would build upon the existing state-administered Medi-Cal Program and managed care delivery system. Aside from long-term care, covered benefits for the expansion population would be similar to benefits available to the currently eligible population. According to the administration, this option would require a discussion with the counties around the appropriate state and local relationship in the funding and delivery of health care, and what additional programs the counties should be responsible for if the state assumes the majority of the nonfederal health care costs for the expansion population. (Currently, the counties are generally responsible for paying for the nonfederal share of health care costs for the expansion population.) Under the Governor's proposed state-based approach, the counties would assume programmatic and fiscal responsibility for various human services programs, such as subsidized child care.

County-Based Expansion Approach. Under this approach, the counties would have operational and fiscal responsibility for implementing the Medi-Cal expansion. The financial responsibility for the nonfederal share of Medi-Cal costs for the expansion population would belong with the counties. Operational responsibilities include some functions currently performed by the state and Medi-Cal managed care plans to administer the program such as:

- Establishing networks of providers to deliver health care services.
- Setting payment rates to providers.
- Processing claims billed by providers.

Counties could build upon their existing medically indigent programs and LIHPs to operate the expansion. The county-based expansion would meet statewide eligibility standards and cover a minimum benefits package similar to coverage requirements for health plans offered on the Exchange. Counties would also have the option of covering additional benefits (other than long-term care) for the expansion population. The administration indicates this approach would likely require federal approval.

LAO ASSESSMENT

The optional Medi-Cal expansion presents a number of important fiscal and policy considerations for the Legislature. Below, we provide our assessment of (1) the major policy benefits of the expansion, (2) the major fiscal effects—on both the cost and savings fronts—an expansion would have on state and local governments, (3) whether or not, on balance, the state should adopt the expansion, (4) what approach should be taken to implement the expansion if adopted, and (5) what types of changes to the state-local fiscal relationship would be appropriate under such an adopted expansion.

Expansion Has Significant Policy Benefits

Coverage Expansion Has Benefits for Certain Low-Income Adults

Perhaps the primary policy merits of adopting the expansion relate to the benefits associated with increasing the number of Californians with health coverage—specifically low-income adults who are citizens and legal residents.

Expansion Would Increase Health Coverage for Low-Income Adults. While it is certain that a number of individuals currently without health coverage would ultimately obtain coverage under the expansion, there is significant uncertainty regarding this number. While some of the newly eligible Medi-Cal enrollees currently receive health coverage from county-based programs, including county indigent programs or LIHPs, indigent adults with incomes below 133 percent FPL yet too high to qualify for coverage in some counties would gain access to health coverage under the expansion. In addition, in many cases, the coordination of the services delivered would potentially be much better under the Medi-Cal Program (discussed in more detail below).

Estimates of the newly eligible population range from 1.4 million to nearly 3 million individuals. Under the expansion, and other provisions of the ACA that are intended to encourage individuals to obtain health coverage, estimates suggest that roughly 50 percent to 75 percent of the newly eligible population would likely *enroll* in Medi-Cal. Based on our review of the literature, we believe the expansion would result in about 1.2 million new Medi-Cal enrollees by 2017. Plausible estimates, however, range from 750,000 to about 2 million newly eligible Medi-Cal enrollees.

Health Coverage Has Significant Benefits for Enrollees. Generally, obtaining health coverage increases an individual's access to health care services. Enhanced access to health care services may lead to improved health outcomes for the newly covered population. For example, individuals with health coverage are more likely to seek primary and preventative health care—services that are likely to result in improved long-term health outcomes. In addition, there is evidence that a coverage expansion for low-income adults would result in lower overall out-of-pocket medical expenditures and medical debt for the newly covered populations, as well as better self-reported health.

Expansion Would Reduce Uncompensated Care Costs

The expansion would likely reduce the total amount of uncompensated health care provided in California. In addition to the significant fiscal effects on counties (which we discuss in more detail below), many health care providers—including private hospitals, clinics, and physicians—often provide care for which they receive no direct reimbursement. For example, according to data from the Office of Statewide Health Planning and Development (OSHPD), California hospitals provide over $1 billion annually in "charity care"—services provided for which the hospital receives no direct reimbursement. In some cases, providers receive substantial supplemental payments from the federal or state government that help offset some of these uncompensated care costs. Under an expansion, over a million individuals may obtain Medi-Cal coverage—thereby reducing the overall amount of uncompensated care provided in California. A reduction in total uncompensated care costs may reduce some of the associated financial burden on health care providers and other payers for health care services.

Expansion Would Have Major Fiscal Effects on State and Local Governments

The optional expansion would have major fiscal effects on state and local governments, regardless of whether a state-based or county-based approach were adopted. We describe these impacts below.

Expansion Costs Are Likely Minor in the Short Term, but Potentially Significant in the Long Term

Expansion Costs Are Subject to Substantial Uncertainty. Estimates of the costs to provide services to the expansion population are subject to considerable uncertainty. Numerous national and state-level studies have attempted to estimate the number of additional enrollees and related government costs that would result from the Medicaid expansion—with significantly varying results. In addition to the typical challenges associated with projecting costs in the Medi-Cal Program—such as projecting underlying caseload growth and medical inflation—several additional major factors contribute to the overall uncertainty when projecting expansion costs, including:

- ***Eligible Expansion Population.*** The total number of individuals who would become eligible for the Medi-Cal Program under the expansion is subject to significant uncertainty.

- ***Take-Up Rates.*** The percent of eligible individuals who would actually enroll in the expanded program—often referred to as the "take-up rate"—depends on a variety of factors, including behavioral responses to the individual mandate, the effectiveness of outreach activities, and the degree to which a simplified application process reduces barriers to enrollment.

- ***Per Capita Cost of Coverage.*** The cost of providing health coverage to the expansion population largely depends on the health characteristics of the newly enrolled population. There are limited data that can be used to precisely estimate the cost to provide health care services to the expansion population since most of these individuals were previously ineligible for Medi-Cal.

- ***Remaining State and Federal Decisions Contribute to Uncertainty.*** Remaining state policy decisions could impact the cost of the expansion. For example, it is still unclear exactly which benefits package would be provided to the expansion population—a decision which affects costs. At the federal level, a reduction in the federal matching rate for the expansion population as a method to reduce federal deficits would increase the nonfederal share of costs and potentially significantly increase nonfederal costs.

To illustrate the broad range of potential Medi-Cal expansion costs, we estimated costs over a ten-year period under three scenarios, each involving a different set of assumptions regarding the eligible population, take-up rates, and average cost per new enrollee, as seen in Figure 6 (see next page). (We note that these are estimates of the cost of providing health care services to the expansion population. They do not include administrative costs.) The potential for the particular assumptions used in each of these three scenarios is based on our review of a wide variety of studies and reports, including: (1) models that attempt to predict the size of the expansion population, (2) previous studies analyzing Medicaid take-up rates in California and across the country, (3) information on costs to provide services to nondisabled adults

currently in the Medi-Cal Program, and (4) preliminary cost information from county-run Coverage Initiaves and LIHPs.

We consider the moderate-cost scenario the most likely of the three scenarios presented. In our view, the low- and high-cost scenarios are plausible, but not likely.

Short-Term Nonfederal Cost of Expansion Would Be Minor. Under all three scenarios illustrated in Figure 6, there would be no costs to the state as a whole through 2015-16 because the federal government would pay 100 percent of the cost of health services. Under the moderate-cost scenario, the state as a whole would begin to incur costs in the low hundreds of millions of dollars starting in 2016-17 as the federal matching rate begins to decline.

Estimated Long-Term Costs of Health Services Vary Widely, but May Be Substantial. Under our moderate-cost scenario, nonfederal expansion costs increase to over $600 million annually beginning in 2020-21 when the state as a whole would become responsible for 10 percent of the costs. Under the alternative low- and high-cost scenarios, nonfederal expansion costs could be as low as $300 million or as high as $1.3 billion annually beginning in 2020-21. Under all three scenarios, the federal government would pay about 94 percent of the expansion costs over the ten-year period, with state or counties paying the remaining 6 percent.

Uncertain, but Relatively Minor Costs for Eligibility Determinations. It is important to note that while an enhanced federal match would be applied to the *health care services* provided to the Medi-Cal expansion population, this enhanced federal match is not available for some *administrative costs*, such as costs associated with

Figure 6
Range of Estimated Annual Medi-Cal Costs for Expansion Population Under the ACA[a]

(Dollars in Millions)

State Fiscal Year	Low-Cost Assumptions			Moderate-Cost Assumptions			High-Cost Assumptions		
	Total Cost	Federal Funds	Nonfederal Funds	Total Cost	Federal Funds	Nonfederal Funds	Total Cost	Federal Funds	Nonfederal Funds
2013-14	$694	$694	—	$1,339	$1,339	—	$2,844	$2,844	—
2014-15	1,790	1,790	—	3,470	3,470	—	7,426	7,426	—
2015-16	2,167	2,167	—	4,222	4,222	—	9,125	9,125	—
2016-17	2,408	2,348	$60	4,714	4,596	$118	10,290	10,032	$257
2017-18	2,546	2,406	140	5,009	4,733	275	11,043	10,436	607
2018-19	2,697	2,522	175	5,332	4,985	347	11,872	11,101	772
2019-20	2,853	2,610	242	5,668	5,186	482	12,746	11,662	1,083
2020-21	3,026	2,723	303	6,042	5,438	604	13,722	12,350	1,372
2021-22	3,213	2,892	321	6,448	5,803	645	14,789	13,310	1,479
2022-23	3,403	3,063	340	6,862	6,176	686	15,894	14,305	1,589
Key Assumptions									
Eligible population in 2014	1.4 million			1.8 million			2.8 million		
Average take-up rates[b]	50%			65%			75%		
Annual average cost per new enrollee in 2014	$3,000			$3,500			$4,000		

[a] Estimates do not include administrative costs.
[b] The "take-up rate" is the percent of eligible individuals who actually enroll. Estimates assume a steady take-up rate by July 1, 2016.
ACA = Patient Protection and Affordable Care Act.

conducting eligibility determinations. (There is, however, an enhanced federal match for changes to technological systems that need to be made in order to conduct Medicaid eligibility determinations under the ACA.) Therefore, the state as a whole would pay the traditional 50 percent cost-share for some of the additional costs of determining eligibility for the expansion population. The conversion to MAGI eligibility and other changes that streamline the eligibility processes would likely result in some efficiencies and lower per capita eligibility costs. However, some of the details of the eligibility determination process under the ACA are still being determined at the state and federal levels. These unresolved policy decisions and implementation details make the future costs for eligibility determinations for the expansion population highly uncertain.

County Savings on Indigent Health Care Would Likely Outweigh Expansion Costs, for at Least a Decade

Significant Federal Funding Would Offset County Costs for Certain MIAs. As discussed above, health care that is currently provided to the expansion population is largely funded by counties. The expansion would leverage a significant amount of federal funding to provide care to the medically indigent population that would become eligible for Medi-Cal. Generally, this population is currently the programmatic and fiscal responsibility of counties. The total number of individuals who are currently enrolled in county-based programs who would become eligible for Medi-Cal under the expansion is uncertain because the income thresholds and residency requirements used in these county programs vary. However, based on our preliminary estimates, almost 600,000 individuals who are currently enrolled in county-based programs would transition to Medi-Cal under an expansion. Once enrolled in Medi-Cal, the enhanced federal funding available for health services provided to these individuals would almost entirely offset current county costs in the near term and mostly offset county costs in the long term.

Data Limitations Make County Savings Estimates Subject to Considerable Uncertainty. Poor data availability makes estimating county savings difficult. The state does not currently collect data on county spending for MIAs. Perhaps more importantly, there is no single source of information that can be used to precisely estimate county spending on the portion of the medically indigent population that would become newly eligible for Medi-Cal.

Preliminary Analysis Indicates County Savings Likely Range From $800 Million to $1.2 Billion. In our view, the MCEs provide a reasonable starting point for estimating current county spending on the expansion population. The number of MCE enrollees is well known, as shown in Figure 5. Unfortunately, it will take at least a couple of years for counties to complete the process of calculating, reporting, and reconciling costs for health care services provided to MCE enrollees. In the absence of reliable cost information for current MCE enrollees, we used per-enrollee cost information from the Coverage Initiatives to develop a proxy for per-enrollee MCE costs. A preliminary evaluation of the Coverage Initiatives conducted by the UCLA Center for Health Policy Research indicates that average per-enrollee costs were $3,861 and $3,312 annually in the first and second years of implementation, respectively. We note, however, that, as a proxy for MCE costs, the per-enrollee cost information from the preliminary evaluation of the Coverage Initiatives has a few significant limitations, including:

- ***Cost Estimates Are Based on Preliminary Reports From Counties.*** Although the Coverage Initiatives began operating in 2007-08, the publicly available cost information is still preliminary and subject to final reconciliation. In addition, some counties may not have reported cost information that they knew was ineligible for federal reimbursement.

- ***Some Coverage Initiatives Targeted High-Risk Populations.*** In a few counties, enrollment for the Coverage Initiatives was targeted toward high-risk populations with chronic conditions, such as diabetes and hypertension, or individuals with urgent medical conditions. The MCEs generally focus enrollment on a broader population that likely has fewer health risks and lower per-enrollee costs.

- ***Coverage Initiatives Had Fewer Federal Requirements.*** Under the terms of the new waiver, the MCEs must meet certain requirements that were not part of the Coverage Initiatives, such as the requirement to provide HIV/AIDS drugs. The additional MCE requirements will likely result in higher per-enrollee costs, all else equal.

Given these limitations, we used a somewhat broader range of per-enrollee cost from $3,000 to $4,000 annually (total funds) to estimate MCE costs. Using this range of per-enrollee costs, we estimate that counties' nonfederal spending on MCE enrollees as of October 2012 is likely between $700 million and $950 million annually.

Additionally, a portion of the expansion population is not eligible for an MCE but is currently enrolled in a medically indigent program in a county that either: (1) does not operate an MCE or (2) operates an MCE with a maximum income threshold below 133 percent FPL. After including a rough estimate of additional spending in county medically indigent programs, we estimate that current nonfederal spending on health care services for the expansion population likely ranges from $800 million to $1.2 billion. While we recognize that this estimated range is based on limited available data, we believe it provides a reasonable basis for ongoing discussions related to reduced county spending under the expansion.

Savings to Counties Would Likely Outweigh Nonfederal Costs, for at Least a Decade. Our preliminary estimates indicate that the direct county savings associated with adopting the expansion likely range from $800 million to $1.2 billion annually. This amount of county savings exceeds our estimates of the most likely annual nonfederal costs associated with providing health care to the expansion population through 2022-23, as shown in Figure 6.

Other Significant Fiscal Benefits to the State and Counties

County savings related to the shift of adults from county-based programs into a mostly federally funded Medi-Cal is the most significant fiscal benefit to the state or local governments under an expansion. However, we discuss other significant fiscal benefits that would likely accrue to the state and counties under an expansion.

State May Realize Savings in Certain Health Programs. The expansion would likely reduce state costs in certain state-administered health programs that focus on particular illnesses or diseases, such as GHPP and the

Breast and Cervical Cancer Treatment Program (BCCTP). Some individuals currently enrolled in these programs would become newly eligible for Medi-Cal and the state would receive the enhanced federal matching rate. The net fiscal effect on these types of state programs would depend on future policy decisions about the potential modification or elimination of these existing programs, but state savings could be in the low hundreds of millions of dollars annually.

Reduced State and County Costs for Inmate Medical Services. A Medi-Cal eligibility expansion could result in significant savings from reduced inmate medical services costs. While federal law generally excludes individuals who are inmates being held involuntarily in an institutional setting (such as in county jails and state prisons) from the Medicaid program, there is an important exception to this rule. Specifically, inmates who are referred off-site for inpatient care lasting at least 24 hours are not excluded from participation in the Medicaid program if they otherwise meet the program's eligibility requirements. In other words, when jail or prison inmates receive such care at a hospital, nursing facility, or other facility that is outside of the correctional system, they can be enrolled into Medi-Cal and a federal match can be applied to the state's cost of the entire duration of their inpatient stay at the Medi-Cal rate. Most inmates are low-income childless adults and thus many would be part of a Medi-Cal expansion population. Under an expansion, state General Fund savings for prison inmates who would become newly eligible for Medi-Cal is potentially over $60 million annually. For more information on potential correctional savings from a Medi-Cal eligibility expansion, please refer to our recent report, *The 2013-14 Budget: Obtaining Federal Funds for Inmate Medical Care—A Status Report.*

Recommend the Legislature Adopt the Medi-Cal Expansion

The optional Medi-Cal expansion gives California the opportunity to leverage a significant amount of federal funding to pay for health care for certain low-income adults. The expansion would have significant policy benefits, including improved health outcomes for the newly eligible Medi-Cal population. In the short term, fiscal savings to the counties and the state would far outweigh the nonfederal costs associated with providing health care to the expansion population. After several years, when the enhanced federal matching rate is reduced from 100 percent to 90 percent, we estimate that overall savings to the counties and state would likely continue to outweigh costs.

We note that there is a significant uncertainty about the actual costs and savings associated with the expansion. First, the number of adults who would actually enroll in Medi-Cal and the cost to provide services to the new enrollees is highly uncertain. In addition, there is a risk that the federal government would reduce the federal matching rate and, thereby, increase the nonfederal share of cost for providing services to the expansion population. This fiscal risk is somewhat mitigated by the fact that California would be able to opt out of the expansion in the future.

On balance, we believe the policy merits of the expansion and fiscal benefits that are likely to accrue to state and county governments outweigh its costs and potential fiscal risks. Therefore, we recommend the state adopt the optional expansion. Below, we provide our assessment of the two implementation approaches outlined by the Governor and what changes to the state-county fiscal relationship would be appropriate under an expansion.

State-Based Approach Presents Major Policy and Implementation Advantages

The administration indicates that it is considering two approaches to the Medi-Cal expansion: a state-controlled or a county-controlled program. Decisions regarding the assignment of responsibility for governmental programs invariably are complex and pose difficult questions regarding the fundamental purpose of programs and the advantages of state versus local control. (We discuss the conceptual advantages of state versus local control over any given program in the nearby box.)

In approaching the decision between state and county control over Medi-Cal for the expansion population, we recommend that the Legislature focus on promoting the best health outcomes and program efficiency—and sort out the fiscal issues afterwards. Underlying this view is a belief that government's job is to provide public services and programs to its residents, and that government's ability to raise or reallocate revenue is solely a means to the end of providing these services and programs. We also recommend that the Legislature assign program financial responsibility and program authority to the same level of government. Under this approach, efficiency and accountability is promoted because the level of government that determines whether a program is offered pays its resulting bills.

Should the State or Counties Control the Medi-Cal Expansion? In our view, with respect to the delivery of physical health care services to the expansion population, a state-controlled Medi-Cal system makes the most sense for two primary reasons. First, most of the traditional advantages of county-controlled programs (greater ability to experiment with service delivery, modify programs to meet local needs, et cetera) are probably not possible because the federal

Factors to Consider in Assigning Responsibility for a Governmental Program

Which Programs Should the State Control? If statewide uniformity is vital because service level variation would impede the achievement of overriding state objectives, conflict with federal requirements, or could create incentives for people to move across county borders, state control of the program typically is the better option. In addition, state control is more appropriate for programs where the costs or benefits of a program are not restricted geographically, and thus individual counties might underinvest in a program because the county does not see the full impact of its actions. Finally, state control over income support programs (including health care for the indigent) makes sense, because it allows the redistribution of income to reflect the resources of the entire state, as opposed to the resources of a specific county.

Which Programs Should Counties Control? County control over programs offers different advantages. Counties have greater ability to adjust programs to meet the needs of their communities and experiment to determine which efforts improve program outcomes. Also, when budget constraints are significant, counties are in a better position to discern what works in their community and preserve the activities yielding the best outcomes. Thus, when program innovation, responsiveness to community interests, and efficiency are critical, it makes sense to assign the program to counties.

government likely will require a high degree of uniformity in the delivery of these services. Second, as described in greater detail below, the delivery of health care services to low-income individuals and families would probably be more organized and coordinated under a state controlled system—thereby leading to improved health outcomes for enrollees and potential administrative efficiencies.

State-Based Approach Would Reduce Program Fragmentation

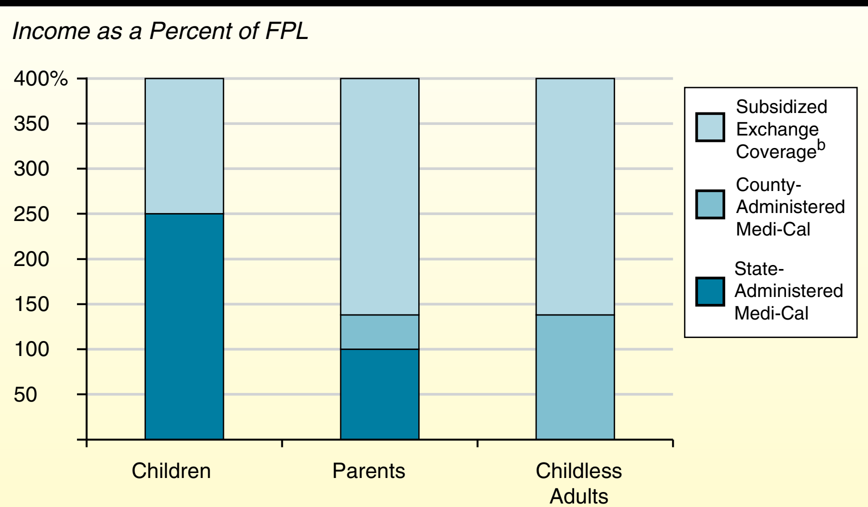
Under the state-based approach, the DHCS and the Exchange would administer the two major free or publically subsidized health coverage options available to non-elderly low- and moderate-income persons—state-administered Medi-Cal (for the currently eligible and expansion populations) and subsidized coverage offered on the Exchange. Under a county-based expansion, coverage available to the expansion population would likely differ from the state-administered Medi-Cal Program in several significant ways—including offering different benefit packages, provider networks, and provider rates. As shown in Figure 7, a county-based approach would effectively create a third major health coverage program—county-administered Medi-Cal—for the expansion population. (Hereafter, we use the term "county-administered Medi-Cal" to describe the county-administered programs that would provide physical health care services to the Medi-Cal expansion population under the Governor's county-based approach.)

Operating a consolidated state-administered Medi-Cal Program for low-income populations under the state-based approach—rather than operating separate state- and county-administered programs under the county-based approach—would have several significant advantages. We discuss some of the primary advantages below.

Consolidated State-Administered Medi-Cal Program Would Decrease Churning. Low-income households frequently experience changes in income or household composition that cause individuals to gain or lose eligibility for different health coverage programs, potentially causing them to have to change health plans and/or providers—a phenomenon often known as "churning." Churning has the potential to disrupt coverage, adversely affect health outcomes, and increase administrative costs. A state-based approach would likely result in less churning than a county-based approach because, under a county-based approach, adults with incomes below

Figure 7

Publicly Funded or Subsidized Health Coverage Available Under a County-Based Expansion[a]



[a] Coverage options for U.S. citizens.
[b] Subsidized exchange coverage only available if person is not offered affordable job-based coverage.
FPL = federal poverty level.

133 percent FPL would potentially have to switch programs when income or household composition change. For example, a parent whose income increases from 90 percent FPL to 110 percent FPL may have to switch from the state-administered program to the county-administered program. On the other hand, if a childless adult with income below 100 percent FPL has a child, she might have to switch from the county-administered coverage to state-administered coverage. In both of the above examples, the individuals would not have to switch health plans or providers under a state-based approach.

More Parents Would Share Coverage With Their Children Under a State-Based Approach. Families that obtain coverage from the same source may find it easier to navigate the health care delivery system and access appropriate medical care. Under a state-based approach, essentially all parents and children under 133 percent FPL would be eligible for state-administered Medi-Cal. Alternatively, under the county-based approach, parents with incomes from 100 percent FPL to 133 percent FPL would potentially be eligible for county-administered Medi-Cal and their children would be eligible for state-administered Medi-Cal.

State-Based Approach Would Potentially Reduce Administrative Complexity and Duplication. Creating a new county-administered Medi-Cal Program would run counter to recent state efforts to consolidate health coverage programs for low-income populations. For example, California is in the process of consolidating its two largest health coverage programs for low-income families and children, Medi-Cal and HFP—a change that is partially intended to streamline and simplify the administration of health coverage programs prior to ACA implementation in 2014. The county-based approach has the potential to create additional administrative complexity by creating a new county-administered Medi-Cal Program in each county that would have to coordinate its activities with the state-administered Medi-Cal Program and the Exchange. In addition, as discussed in more detail below, many counties would have to build the infrastructure needed to conduct many of the administrative activities that are already performed by DHCS and Medi-Cal managed care plans—including contracting with providers and/or health plans, setting provider rates, and processing claims.

State-Based Approach Leverages Existing Systems for Organizing and Coordinating Care

The two expansion approaches outlined by the administration would likely create very different systems for organizing and coordinating care delivered to the expansion population. It is our understanding that, under the state-based approach, the state would attempt to contract with Medi-Cal managed care plans to arrange for the delivery of care to all new enrollees. For example, managed care plans would perform the following functions:

- Establish networks of providers to deliver health care services.
- Set payment rates to providers.
- Process claims billed by providers.

Under the county-based approach, counties would be responsible for performing these same tasks. The administration indicates that counties would build on their existing medically indigent programs and LIHPs to deliver care to the expansion population.

Medi-Cal Managed Care Plans Have Significant Experience Organizing and Coordinating Care. In 2012-13, approximately 5.4 million out of over eight million Medi-Cal enrollees are expected to receive care from Medi-Cal managed care plans. In most large

counties, these plans have significant experience coordinating care for low-income populations, including an established process for assigning enrollees to a primary care provider and emphasizing preventative care as a way to avoid more serious medical conditions that result in unnecessary hospitalizations. In addition, managed care plans also have significant experience with the administrative activities that are typical of an organized care delivery system.

While Certain Counties Have Made Progress Developing Organized Systems of Care . . . Historically, many county medically indigent programs provided fragmented and episodic care, with limited care coordination and little emphasis on primary care or preventative care. However, in recent years, some counties have improved their systems for delivering care. For example, through the Coverage Initiatives, some counties made significant progress developing provider networks, assessing access to specialists, managing referrals, offering disease management programs, and building an infrastructure to promote and monitor quality. Many of these counties were able to leverage existing health systems and local managed care plans, as well as create new relationships with private providers to accomplish these goals. Under the LIHPs, these counties have an opportunity to build upon the progress under the Coverage Initiatives, and new counties operating LIHPs have opportunities to achieve similar progress toward building organized and coordinated systems of care.

. . . Significant Challenges Remain. Despite the improvements made in certain county delivery systems under the Coverage Initiatives, significant obstacles to implementing the county-based expansion statewide remain. We have serious concerns about counties' capacity to successfully implement a coverage expansion of this magnitude by January 1, 2014. Many counties started operating LIHPs within the last couple of years and some counties do not currently operate LIHPs. At this point, it is unclear how much progress recently established LIHPs have made in establishing provider networks and coordinating care. In addition, despite improvements in care delivery made under the Coverage Initiatives, many of these counties may lack the administrative resources needed to implement the expansion by January 1, 2014, such as the ability to quickly secure contracts with additional providers to serve the additional enrollees and develop the capacity to process a large number of additional claims. Some counties may be able to leverage existing relationships with their local managed care plans or other third-party administrators to perform these activities. However, in our view, many counties lack the existing relationships and infrastructure necessary to effectively implement these changes, particularly in the short term.

County-Based Approach Faces Other Implementation Obstacles

What if Certain Counties Are Unwilling or Unable to Adopt the Expansion? As discussed above, many counties may lack the infrastructure necessary to implement an expansion by January 1, 2014. Under the county-based option, the administration indicates that there would be statewide eligibility standards, but only counties would offer coverage to the expansion population—a state-administered program for the expansion population would not exist. At this time, it is unclear how the county-based expansion would be implemented statewide if certain counties are either unwilling or incapable of implementing the expansion.

Federal Approval of County-Based Approach Is Uncertain. The administration indicates that

the county-based approach would require federal approval of a waiver. At this point, many of the details about the county-based approach are unclear so it is difficult to comment with much confidence on the likelihood of obtaining federal approval for such an approach. However, we believe there is a risk that the state might not receive federal approval. The LIHPs were established under California's Bridge to Reform waiver under the assumption that LIHP enrollees would transition to the state-administered Medi-Cal Program on January 1, 2014. The conditions of the waiver require the state to complete a detailed plan to transition LIHP enrollees to Medi-Cal and the Exchange on January 1, 2014. A county-based approach would require an amendment to the existing waiver and represent a significant change in policy from what was previously approved by the federal government.

Implementation Timelines for County-Based Approach Appear Unrealistic. We believe implementation of the county-based approach by January 1, 2014 may be unrealistic. In addition to the significant amount of work at the county level needed to prepare for a county-based expansion, successful implementation by January 1, 2014 depends on quick action from both the state and the federal government on major issues. As discussed above, there is currently very little detail about the structure of a county-based approach and how it would be implemented. The Legislature would need to resolve a number of major policy and fiscal issues prior to passing legislation adopting the county-based expansion. Furthermore, after legislation is passed, the state would need to secure federal approval of a waiver. The process of submitting a waiver and receiving federal approval often takes several months, especially for a proposal of this scope.

Implementation Challenges Under State-Based Expansion Are Less Severe. Many of the implementation obstacles that we identified above would not exist under a state-based approach. However, a significant amount of effort prior to January 1, 2014 would still be required. For example, Medi-Cal managed care plans would need to prepare for roughly one million additional Medi-Cal enrollees. This would likely require securing new provider contracts in order to have an adequate network of providers to accommodate the additional enrollment. Given the significant experience managing care for the Medi-Cal population and recent transitions of additional enrollees into managed care, these plans are likely better equipped to handle the task of expanding their provider network to handle additional enrollees than the counties. The state would also need to continue to plan and implement the successful transition of MCE enrollees from county-based coverage under a LIHP into Medi-Cal managed care plans. While these activities would require a significant amount of effort, we believe a state-based expansion has a much greater likelihood of being successfully implemented by January 1, 2014 than a county-based expansion.

Optional Expansion Should Prompt Reassessment of County Indigent Health Financing

As discussed earlier, for most of California's history, counties have been responsible for providing health care to MIAs. The state assumed this responsibility for about a decade in the 1970s, but transferred it back in 1982. The state's 1982 program transfer occurred shortly after voters approved two amendments to the Constitution: (1) Proposition 13, which reduced local government authority to raise the property tax (a major source of county revenue) and (2) Proposition 4, requiring the state to reimburse local governments for mandated new programs or responsibilities. Given these constitutional changes, two new programs

were created—MISP and CMSP—to provide state funding to offset county costs resulting from the 1982 shift of responsibility for MIAs. The MISP and CMSP were supported with annual appropriations from the state General Fund until 1991, when the state—as part of the 1991 realignment—created a dedicated ongoing funding source for county indigent health programs, as well as new county responsibilities for mental health and social service programs. Under 1991 realignment, counties received roughly the same amount of resources for indigent health programs as they previously received from the state General Fund, but had more flexibility in allocating these funds to meet local priorities. Consistent with past conditions regarding the receipt of state aid for health programs, the 1991 realignment legislation required counties to meet MOE requirements by spending a specified amount of county general purpose revenues on indigent health and public health programs.

As we discussed previously, we believe the state is best positioned to operate the optional expansion and, therefore, recommend a state-based approach to implement the optional expansion. The state-based optional expansion would shift the responsibility for providing health care to MIAs back to the state—significantly altering the state-county relationship that was established in 1982 and provided ongoing funding under 1991 realignment. This shift of responsibility under the optional expansion would create new state costs and reduce the need for county expenditures on indigent health programs. Given these significant changes in state and county responsibilities and finances, it is reasonable for the Legislature to consider related changes to the 1991 realignment plan. Specifically, the Legislature may wish to consider whether 1991 realignment funding, as well as the county MOE expenditure requirements for county indigent health programs, should be modified. Additionally, it is reasonable to consider whether the distribution of the remaining 1991 health realignment funds should be updated to reflect significant changes in county responsibilities created by the optional expansion and the ACA. This section provides advice to the Legislature in considering potential changes to 1991 realignment in response to the state-based expansion.

Optional Expansion Reverses Realignment of Indigent Health Responsibilities. As part of the 1991 realignment, the state provided a dedicated funding stream to counties for indigent health and public health. If the optional expansion is adopted, a significant portion of county indigent health obligations will be shifted back to the state. In light of this change in responsibilities, it would be reasonable for the Legislature to consider reallocating a corresponding amount of realignment funding to offset the state's costs for the Medicaid expansion or other state priorities and for this reallocation to occur on the same timeline as the shift of responsibilities to the state.

How Much Realignment Funding Should Be Reallocated? In general, we feel it would be reasonable for the Legislature to consider reallocating the portion of 1991 health realignment funding associated with providing health care to the expansion population. However, data on county indigent health expenditures are very limited—significantly complicating the Legislature's task of determining the appropriate amount of health realignment funding to reallocate. Our review of the available county financial data suggests that counties currently spend between $800 million and $1.2 billion from all nonfederal funding sources to provide health care to the expansion population. Although a majority of these expenditures are supported by 1991 health realignment dollars, data limitations preclude us from estimating the extent to which county general purpose revenues or other funding

sources also pay for services for the expansion population. An alternative point of reference is the portion of total health realignment funds provided counties in 1991 attributable to MISP and CMSP indigent care programs—which served populations very similar to the expansion population. In 1991, realignment funding for MISP and CMSP comprised about 46 percent of total health realignment funding (about $700 million in 2013-13). Given data limitations, in our view, this amount is the best available starting point for the Legislature as it considers the amount of realignment funds to reallocate for the benefit of the state. If the Legislature were to reallocate this amount, county programs serving the remaining uninsured population and public health programs would continue to receive annually slightly more than half of total 1991 realignment health funds (about $800 million in 2013-14)—an amount roughly equivalent to historical funding levels for these programs. However, for the reasons discussed below, the Legislature may wish to consider leaving a higher level of 1991 realignment funds with counties.

Other County Costs Merit Consideration. The Legislature may wish to consider a smaller change to county realignment funding than suggested by our above analysis for two primary reasons. First, under the ACA, provider counties are expected to face a variety of changes that potentially threaten the financial viability of county hospitals, such as significant decreases in federal funding in the coming years. To the extent preservation of the current infrastructure of county hospitals and clinics is desired, the Legislature may wish to consider leaving higher levels of realignment funding with provider counties—at least for the next few years to ease the transition of these counties to a post-ACA environment. Second, although the optional expansion would remove a significant portion of county indigent health obligations, counties would continue to have responsibility for all the other programs funded under 1991 realignment, including social services and mental health programs. Over the last two decades many developments have affected the cost of administering these programs, in some cases increasing the cost of these responsibilities for counties. By and large, the state has not revised 1991 realignment funding in recognition of these past events. In light of this, the Legislature may wish to consider allowing counties to use some freed-up indigent health realignment funds to support other 1991 realignment responsibilities.

Allocating Changes to Realignment Funding Amongst Counties. In addition to determining the amount of aggregate realignment funding that should be reallocated, the Legislature would need to determine how the resulting reduction in the amount of realignment funds allocated for indigent health would be distributed among the counties. This decision is complicated by limitations in available county financial data that make it difficult to determine the amount of realignment dollars each county spends on the expansion population. Additionally, as discussed in more detail below, the effect of the optional expansion varies significantly across counties. Consequently, apportioning reductions in health realignment funding among the counties would be very difficult. The Legislature may wish to consider a simple method of apportioning the reductions, such as distributing amounts based on: (1) county shares of 1991 realignment health funding or (2) county shares of new Medi-Cal enrollees under the optional expansion. However, the Legislature should consider working in concert with the counties to develop apportionment formulas more reflective of varying circumstances across counties.

Legislature Should Consider Reducing County MOE Requirements. Although county indigent health programs are primarily funded

with 1991 realignment funds, counties supplement indigent health programs with funding from other revenue sources, including county general purpose revenue. As a condition of receiving indigent health realignment funds, counties are required to meet MOE requirements by spending a specified amount of county general purpose revenue on indigent health and public health programs. In recognition of county contributions to indigent health programs, it would be reasonable for the Legislature to consider reducing county MOE requirements. This would allow counties to use these county revenues for other purposes.

Implementing Changes to 1991 Realignment Funding

After determining the appropriate amount of realignment funding to be used to offset state costs, the Legislature would need to select a mechanism to effectuate the change. Below, we discuss two possible approaches: (1) depositing transferred realignment funds in the General Fund and (2) shifting state programmatic and fiscal responsibilities to counties, creating offsetting savings for the state. Each of these approaches has benefits and drawbacks. However, on balance, we suggest the Legislature use a simple version of the second approach—shift some state program costs to counties—to effectively transfer county indigent health savings to the state. This approach is discussed further below. We caution the Legislature that all of the approaches we discuss in this section present some risk of complications with provisions of the Constitution—the most significant of which we summarize in Figure 8. Ultimately, the Legislature may wish to consider submitting its plan to voters for approval, in order to reduce the risk of future legal challenges.

Shifted Realignment Funds Could Be Deposited in General Fund. The most straightforward method of using realignment revenues to offset state costs would be to deposit these revenues into the General Fund. This approach would be relatively simple, easy to understand, and provide legislative discretion over the allocation of the transferred realignment funds. However, this approach could present two complications:

Figure 8

Major Provisions of the State Constitution That Complicate Changes to State-County Relationship

Constitutional Amendment	Year	Major Provisions
Proposition 4	1979	• Requires the state to reimburse local governments if the state mandates that they provide a new program or higher level of service.
Proposition 98	1988	• Establishes a minimum state funding guarantee for K-12 schools and community colleges. • Specifies that the minimum funding guarantee is based on several inputs including K-12 average daily attendance, per capita personal income, and per capita General Fund revenue.
Proposition 1A	2004	• Restricts the state's ability to reduce or change the allocation of local government revenues from the property tax, sales tax, and vehicle license fee (VLF). • Requires VLF revenues raised under a 0.65 percent rate to be distributed to local governments. • Defines as a state reimbursable mandate certain changes in local government shares of program costs.
Proposition 22	2010	• Reduces the state's authority to use or redirect taxes levied by local governments.

- ***Resources Would Count Towards the Proposition 98 Guarantee.*** Because the state has considered 1991 realignment funds to be local revenues, the state historically has not counted 1991 realignment revenues for purposes of calculating the Proposition 98 minimum funding guarantee. If some realignment revenues were deposited to the General Fund and available for general state purposes, these funds would count towards calculating the education minimum funding guarantee. Thus, a portion of the shifted realignment revenue would benefit K-14 education and not be available to pay the state's costs related to the optional expansion.

- ***Revision of Entire 1991 Realignment Package Needed.*** The 1991 realignment funding package includes VLF and sales tax revenues and uses varying formulas to distribute these funds across programs. Under the current funding structure, VLF revenues comprise the majority of funds allocated to counties for indigent health. The Constitution requires that these VLF revenues be allocated to local governments and does not allow them to be deposited to the state's General Fund. To avoid complications with this provision of the Constitution, the state could change the program allocation of VLF and sales tax realignment resources so that sales tax revenues were transferred to the General Fund. Such a change could have a negative effect on the realignment programs currently funded with sales tax revenues, however, because the sales tax historically has grown at a faster rate than the VLF.

County Fiscal Responsibilities Could Be Increased. Instead of depositing some 1991 realignment funds into the General Fund, the administration proposes shifting to counties some state fiscal and programmatic responsibilities—such as child care and social service programs. Counties would pay for these costs using the 1991 realignment resources formerly used for indigent health. This approach would reduce state costs without directly depositing the local realignment funds into the General Fund, thereby decreasing potential Proposition 98 complications. The administration's proposal to shift fiscal and programmatic responsibilities to counties, however, raises several significant issues. Specifically, we believe such an approach:

- ***Adds Complexity to an Already Complicated Decision.*** Evaluating programs as to their suitability for state-county realignment is extremely involved and requires significant deliberation by the Legislature and discussions with the administration, counties, and program stakeholders. For example, the Governor has suggested child care responsibilities be realigned to counties. Realigning this program would require the Legislature to review its current multifaceted delivery system, as well as the state's historical interest in setting eligibility and quality standards and provider rates. Given the multitude of issues the Legislature would face in implementing the optional expansion, we suggest the state avoid introducing additional issues—such as complicated shifts of authority over unrelated programs—into discussions of the optional expansion.

- ***Raises State Mandate Concerns.*** The Constitution generally requires the state

to reimburse local governments if it mandates that local governments provide a new program, pay an increased share of a program's cost, or provide a higher level of service. Forecasting the future costs of a program is very difficult, especially for caseload-driven programs such as child care and social service programs. For this reason, in future years it would be difficult to ensure that the freed-up realignment funds were sufficient to cover the costs of new county responsibilities on a county-by-county basis. If funding fell short of the new county responsibilities, the state could be liable to claims for mandate reimbursements, creating new state costs.

- ***Lacks Flexibility.*** In many respects, the effect of the ACA and the optional expansion on state and county finances is not clear. A major shift of programmatic responsibilities to counties, as proposed by the administration, likely would be difficult to rescale or reverse. In our view, it would be advisable for the Legislature to reserve some flexibility in its modifications to the 1991 realignment package so that it could respond to unforeseen developments.

1991 Realignment Indigent Health Funds Could Pay Some CalWORKs Costs. As an alternative to making major changes to county fiscal and program responsibilities, we suggest the Legislature consider building upon a mechanism that was used in the 2011 state-county realignment plan. (This recent realignment has many similarities with the 1991 plan, but also includes criminal justice programs.) Specifically, under the 2011 realignment plan, some of its funds are used to pay mental health responsibilities that were realigned to counties in 1991. This, in turn, frees up some 1991 realignment funds to be used for other purposes. The 2011 realignment plan requires that the freed-up 1991 realignment funds be used to help pay California Work Opportunity and Responsibility to Kids (CalWORKs) grant costs in each county. (CalWORKs is a state program that provides cash assistance and welfare-to-work services to low-income families.) Using these 1991 realignment funds to pay CalWORKs grant costs offsets state spending for this program on a dollar-for-dollar basis. It is important to note that this approach does not fundamentally increase county financial responsibility for supporting CalWORKs. Rather, 2011 realignment simply requires that any displaced 1991 realignment funds be used for the purposes of paying CalWORKs grants. The Legislature could use this approach in implementing the Medicaid expansion—that is, redirect funds provided under 1991 realignment for indigent health to an account to help pay CalWORKs grant costs in the county. This approach would not change the authority or programmatic responsibility for CalWORKs or any other program and, therefore, would be simpler to implement, less likely to raise mandate reimbursement concerns, and afford more flexibility to the Legislature than the Governor's approach.

How Should Remaining Health Realignment Funds Be Distributed Among Counties?

Some Counties Will Have Significant Indigent Costs Remaining. Despite the savings in health programs for MIAs, some counties would continue to have significant costs for medically indigent populations after the expansion, including: (1) services to undocumented individuals, (2) services to MIAs with incomes above 133 percent FPL, and (3) fixed costs associated with continuing to operate county health facilities, such as hospitals or clinics. For example, according to estimates from the UC Berkeley

and UCLA "CalSIM" model shown in Figure 9, about 2.2 million to 2.8 million individuals are expected to remain uninsured and ineligible for Medi-Cal after the major provisions of the ACA are implemented, including the optional expansion. Some of the remaining uninsured will be ineligible for public coverage due to their immigration status. In addition, a significant number of people will remain uninsured, even though many of them are eligible to purchase subsidized or unsubsidized health coverage on the Exchange. The number of uninsured individuals who fall into the latter group will largely depend on the affordability of health insurance coverage offered on the Exchange.

According to these same estimates, about 800,000 to 1.2 million additional uninsured individuals will be eligible for Medi-Cal, but not enrolled in the program. Despite not being enrolled in the program, Medi-Cal eligible individuals are eligible for three-month retroactive coverage. In other words, if an eligible individual becomes sick and accesses services from a county health facility, the county may help the eligible individual enroll in Medi-Cal. If that person is subsequently enrolled in the program, the county can receive Medi-Cal payment for services retroactively.

Remaining Indigent Costs Will Vary Substantially From County to County. Remaining indigent health costs will vary substantially from county to county. For example, a payer county that does not cover undocumented immigrants or individuals with income above 133 FPL would potentially have no remaining indigent health costs. Alternatively, a provider county that operates a hospital and provides care to undocumented immigrants and uninsured individuals above 133 FPL would have significant costs remaining. We note that although many of the remaining county indigent health costs—such as providing services to undocumented immigrants and operating county health facilities—are not a requirement under WIC 17000, these are activities that the Legislature may consider a priority.

Recommend the Legislature Develop a Process to Update Health Realignment Allocation. The optional expansion would fundamentally change California's indigent health care

Figure 9

Millions of People Projected to Be Uninsured and Ineligible for Medi-Cal Under the ACA in 2017

(In Thousands)

	Estimates of Remaining Uninsured, but Ineligible for Medi-Cal		
	Eligible for Exchange Coverage[a]	Ineligible for Public Coverage Due to Immigration Status	Totals[b]
Base Scenario			
Income (percent of FPL)			
0-133%	74	575	649
139-200	351	152	503
201-300	462	171	633
301+	910	114	1,024
Totals	**1,795**	**1,013**	**2,808**
Enhanced Scenario[c]			
Income (percent of FPL)			
0-133%	5	562	567
139-200	133	142	280
201-300	276	158	434
301+	789	105	894
Totals	**1,208**	**966**	**2,174**

[a] Reflects individuals eligible for Exchange coverage, but who do not purchase that coverage.
[b] Estimates do not include individuals eligible for Medi-Cal, but who do not enroll.
[c] Enhanced Scenario assumes a higher take-up rate than the Base Scenario.
Source: University of California, CalSIM Version 1.8.
ACA = Patient Protection and Affordable Care Act and FPL = federal poverty level.

system. Consequently, the indigent health obligations remaining for counties following the optional expansion are not likely to resemble the decades-old indigent health obligations on which the allocation of 1991 realignment health funds is currently based. For this reason, we recommend the Legislature revisit the allocation of the 1991 realignment health funds that are to remain with counties in order to better align funding allocations with modern county responsibilities. As the effects of the ACA and the optional expansion on counties are varied and not clear at this time, we suggest the Legislature create a process to facilitate a dialogue between the state and counties over the next few years, with the goal of revising the allocation of 1991 realignment health funds as the effects of the ACA become more clear.

RECOMMENDATIONS

Adopt the Optional Medi-Cal Expansion. We recommend the Legislature adopt the optional Medi-Cal expansion. The expansion would greatly increase the number of low-income adults in California with health coverage, thereby potentially improving health outcomes for this population. Most of the costs of the expansion would be paid for by the federal government and nonfederal costs for providing services to the expansion population are likely to be relatively minor in the first few years. In addition, although long-term nonfederal costs will likely be several hundred million dollars annually in several years, the large majority of total costs will likely continue to be federally funded. In addition, these costs will likely be entirely offset by significant reductions in state and county costs, including reduced county costs for MIAs, over the next decade.

We note that there are several factors that make estimating the nonfederal costs associated with the expansion subject to considerable uncertainty. For example, there is a risk that the federal government would reduce the federal matching rate for the expansion population—thereby increasing nonfederal costs. However, we also note that the expansion is optional for states and California could opt out if future costs become too high.

Adopt a State-Based Approach. We recommend the Legislature adopt a state-based approach to the optional Medi-Cal expansion. Based on our initial understanding of the two expansion approaches outlined by the Governor, we believe the state is the level of government best positioned to successfully implement the expansion in a way that improves health outcomes for beneficiaries and reduces administrative complexity. The state could leverage the existing Medi-Cal managed care delivery system to organize and coordinate the delivery of care for the newly eligible population. In addition, counties would not have to build the infrastructure needed to perform some of the administrative activities that are already being performed by the state-administered Medi-Cal Program and/or Medi-Cal managed care plans. We also have serious doubts about whether the county-based approach could be successfully implemented statewide by January 1, 2014.

Redirect a Portion of 1991 Realignment Funding to Reflect Shift in Responsibility. The Medi-Cal expansion would shift the responsibility for providing health care coverage for most MIAs from counties to the state. Given this major shift in program responsibility, we recommend the Legislature make related changes to the funding the state provides counties for these services. Specifically, we recommend the Legislature redirect some of the funding counties receive under 1991 realignment to reflect this shift in responsibility.

Redirect an Amount That Reflects Current Fiscal Responsibilities. When determining an amount of realignment funding to redirect, we recommend the Legislature use as a starting point the portion of health realignment funds (about 46 percent) historically associated with MISP and CMSP—programs which serve populations very similar to the expansion population.

Consider Reducing the Amount to Redirect in Recognition of Remaining County Responsibilities. In recognition of residual county obligations and overlapping state-county priorities, we recommend the Legislature consider shifting less than suggested above. For example, to the extent preservation of the current infrastructure of public hospitals and clinics is desired, the Legislature may wish to consider leaving higher levels of realignment funding with provider counties—at least for the next few years to ease the transition of these counties to a post-ACA environment. In addition, although the optional expansion would remove a significant portion of county indigent health obligations, counties would continue to have responsibility for other programs funded under 1991 realignment. The Legislature may wish to consider allowing counties to use some freed-up indigent health realignment funds to support remaining 1991 realignment program responsibilities.

Use Redirected Realignment Funds to Reduce State CalWORKs Grant Costs. We recommend the Legislature direct counties to use freed-up 1991 indigent health realignment funds to reduce state costs to pay CalWORKs grants. This approach would not change the CalWORKs program or realign program responsibilities and, therefore, would be simpler to implement and afford more flexibility to the Legislature than the Governor's approach. We caution the Legislature that any significant change in state-local finance, including this approach, presents some risk of complications with various provisions of the Constitution. Ultimately, the Legislature may wish to consider submitting its plan to voters for approval, in order to reduce the risk of future legal challenges.

Consider Reducing County MOE Requirements. We recommend the Legislature consider reducing county MOE requirements established under 1991 realignment. This would allow counties to use these county revenues for other purposes.

Develop Process for Allocating Changes to Realignment Funding Amongst Counties. The effect of the optional expansion and the ACA likely would vary significantly across counties. We recommend the Legislature consider working in concert with the counties to determine how the reduction in the amount of 1991 realignment funds for indigent health would be distributed among the counties.

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CalSIM
California Simulation of Insurance Markets

What is the Affordable Care Act's Impact on Medi-Cal and California?

Ken Jacobs
UC Berkeley Center for Labor Research and Education
February 2013

California Simulation of Insurance Markets (CalSIM)

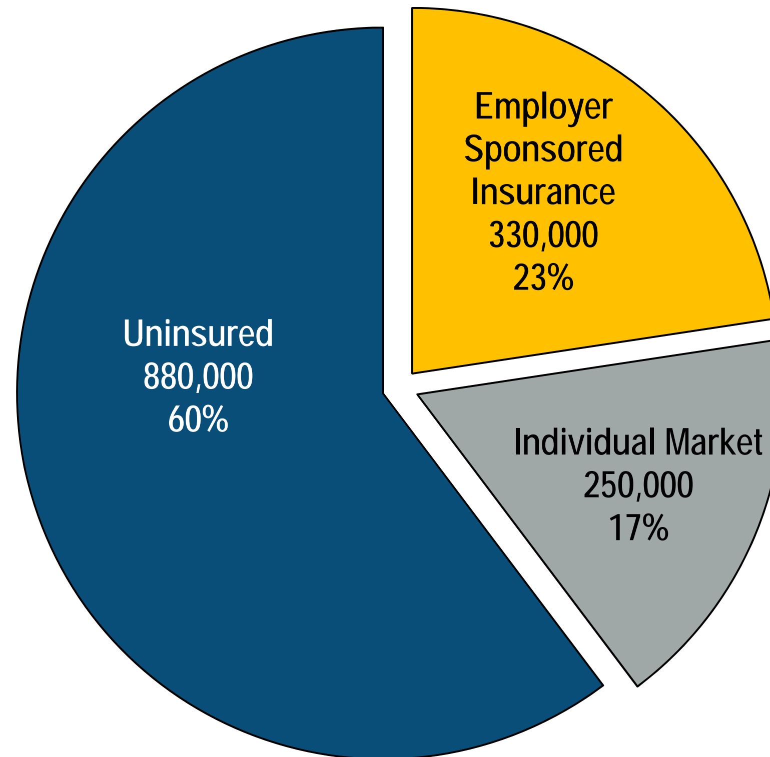
- Developed by UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research with support from The California Endowment
- Enrollment estimates produced for Covered California
- Predicts the impact of the Affordable Care Act (ACA) on employer decisions to offer coverage and individual decisions to obtain coverage in California
- Uses public data sources—mostly state-specific, including California Health Interview Survey

Medi-Cal Expansion (Newly Eligible)

- Adults under age 65 with income below 138% Federal Poverty Level (~$15,000 single individual, ~$32,000 for a family of four)
- More than 1.4 million eligible in 2014-2019
- Roughly 75% adults without children living at home
- 750,000-910,000 expected to enroll by 2019

1.46 million Californians Will Be Newly Eligible for Medi-Cal

Newly Eligible for Medi-Cal
by Source of Insurance without the ACA, 2019

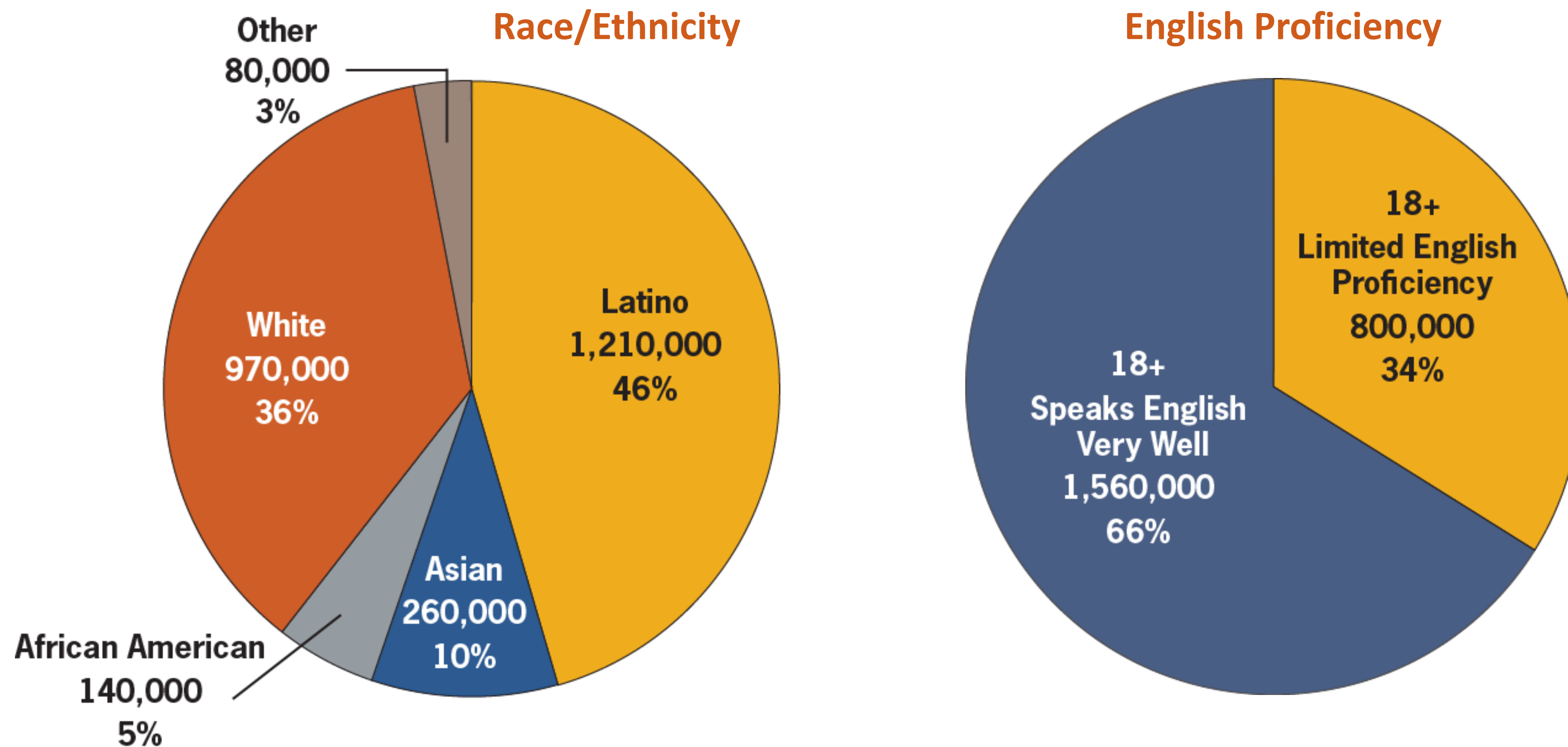


Total Eligible: 1,460,000

Source: UC Berkeley-UCLA CalSIM model, version 1.8

Nearly half of the newly eligible will be Latino

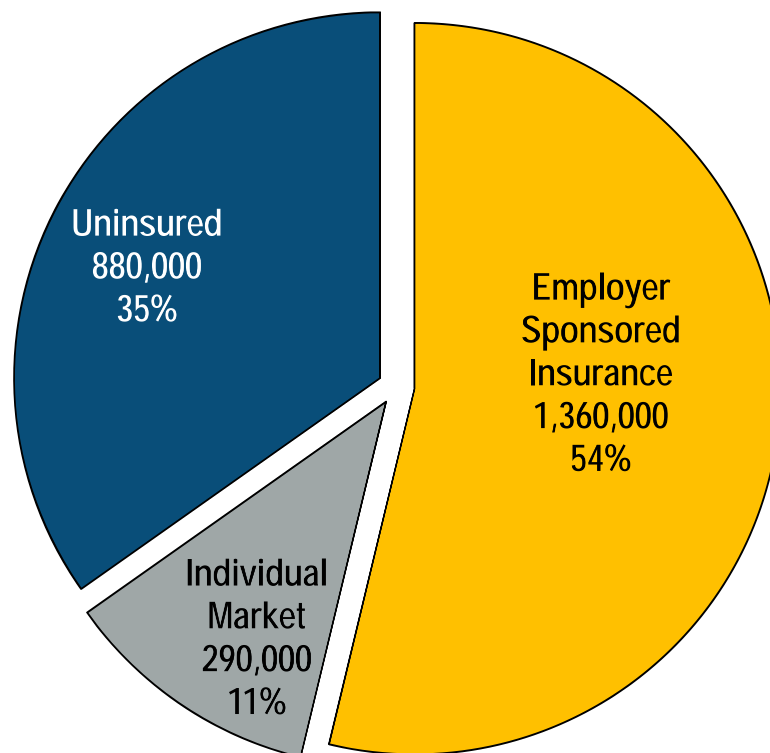
Californians under Age 65 Predicted to Take Up Covered California Subsidies or Medi-Cal (newly-eligible and already eligible but not enrolled), Base Scenario, 2019



Source: UC Berkeley-UCLA CalSIM model, version 1.8

The Majority of Those Eligible for Medi-Cal, but Not Enrolled, Have Another Source of Coverage

Eligible for Medi-Cal but Not Enrolled by Source of Insurance without the ACA, 2019



Total Eligible: 2,530,000

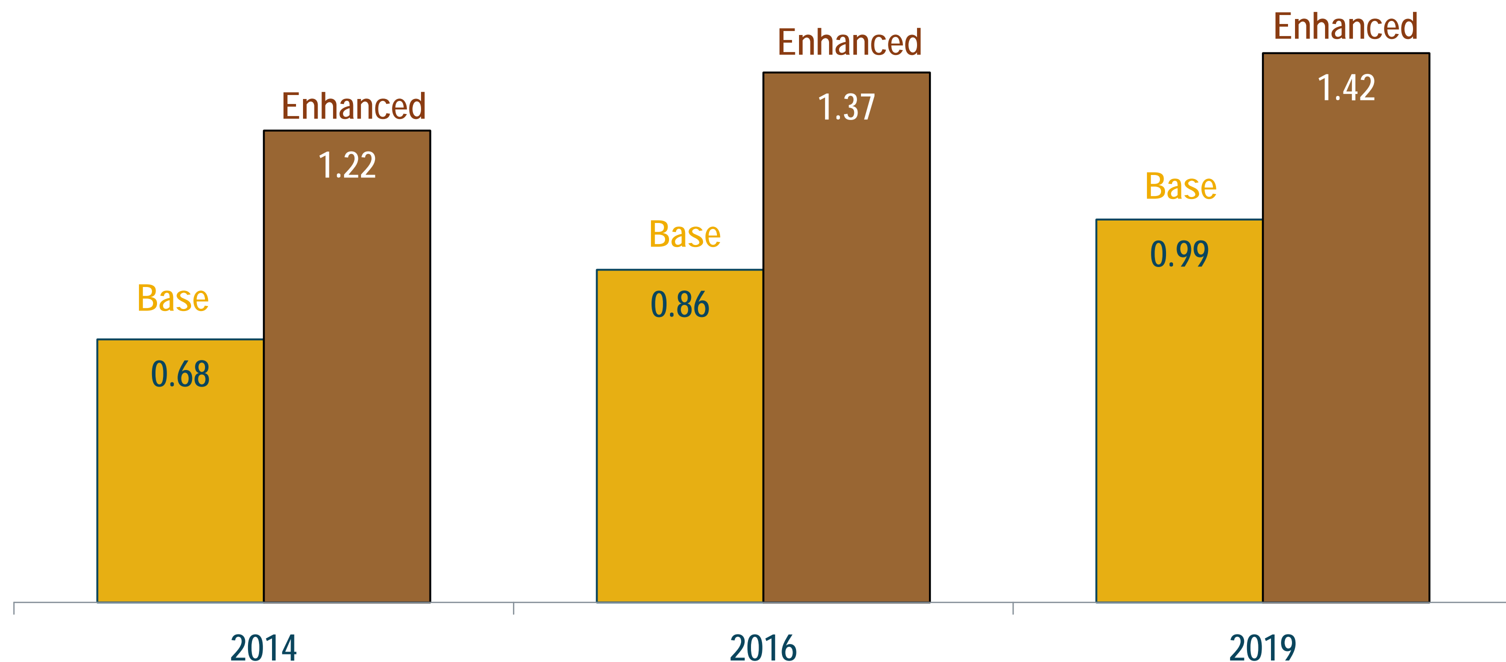
Source: UC Berkeley-UCLA CalSIM model, version 1.8

Medi-Cal Enrollment Increase Among Those Already Eligible

- 240,000-510,000 expected to enroll by 2019
- 71% of those eligible are children, remainder are parents
- Most of increase will happen regardless of the Expansion due to mandatory provisions of ACA:
  - minimum coverage requirement for individuals;
  - simplified eligibility, enrollment & renewal processes; and
  - improved awareness of coverage.

In total Medi-Cal predicted to grow by 1 million or more by 2019.

Californians under Age 65 Predicted to Take Up in the Subsidized Exchange and Medi-Cal, 2014-2019 (in millions)



Source: UC Berkeley-UCLA CalSIM model, version 1.8

Expanding Medi-Cal will Benefit Economy

- 100,000 new jobs per year in California due to ACA provisions including the Medi-Cal Expansion, according to Bay Area Council Economic Institute
- Research suggests that health insurance coverage can improve educational outcomes and worker productivity

Sources: Haveman and Weinberg 2012; Levine and Schanzenbach 2009; Pitard, Hulsey, Laditka and Laditka 2009; Dizioli and Pinheiro 2012; Nguyen and Zawacki 2009.

Expanding Medi-Cal Improves Health Outcomes

- Previous Medicaid expansions associated with reduced mortality
- Adults with Medicaid in Oregon were more likely to have regular place of care, usual doctor and use preventive care

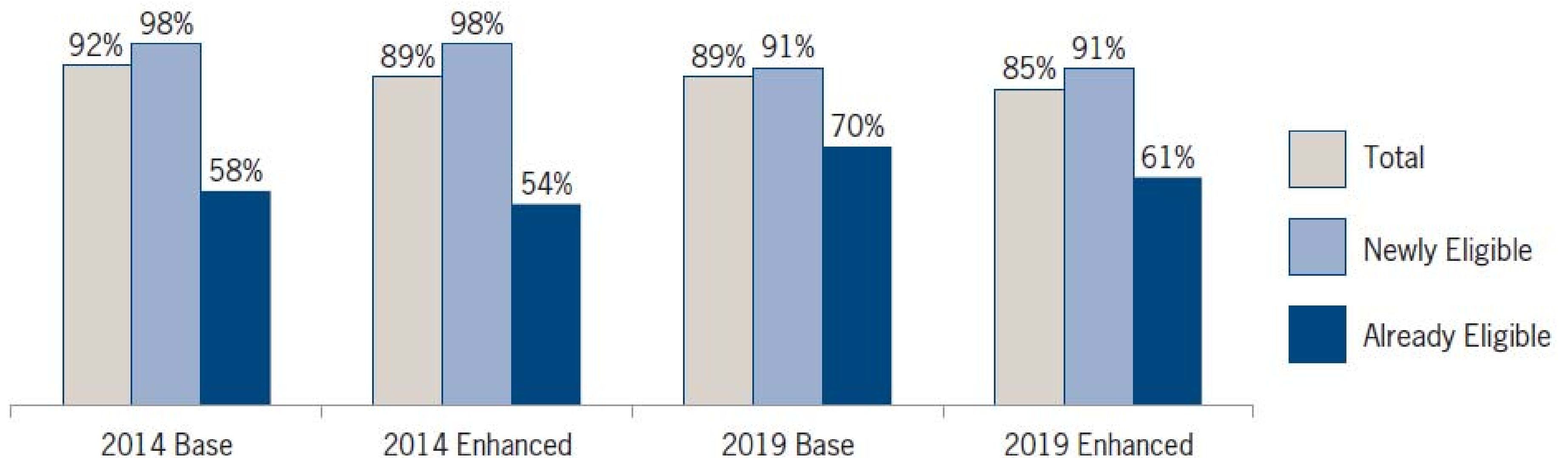
Sources: Sommers, Baicker and Epstein 2012; Baicker and Finkelstein 2011.

Federal Government will Pay:

- 100% of health care costs for newly eligible in 2014 through 2016, phasing down to 90%in 2020 and future years;
- 50% for parents and children who are already eligible for Medi-Cal;
- 88% for Healthy Families children in 2015 to 2019, and 65% in 2014; and
- 50% of administrative costs for all Medi-Cal enrollees and 65% for those eligible under Healthy Families.

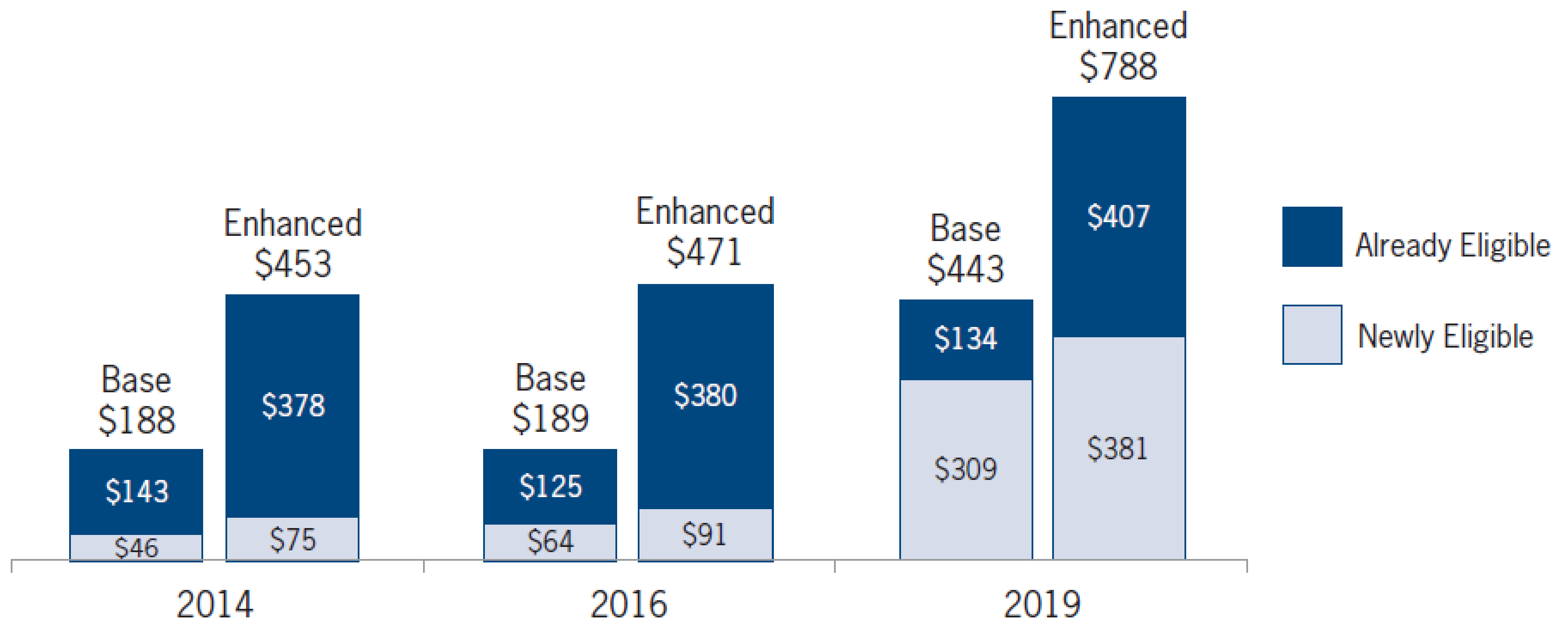
Federal Government Will Pay for At Least 85% of New Medi-Cal Spending

Share of New Medi-Cal Spending Federally-Paid with Expansion



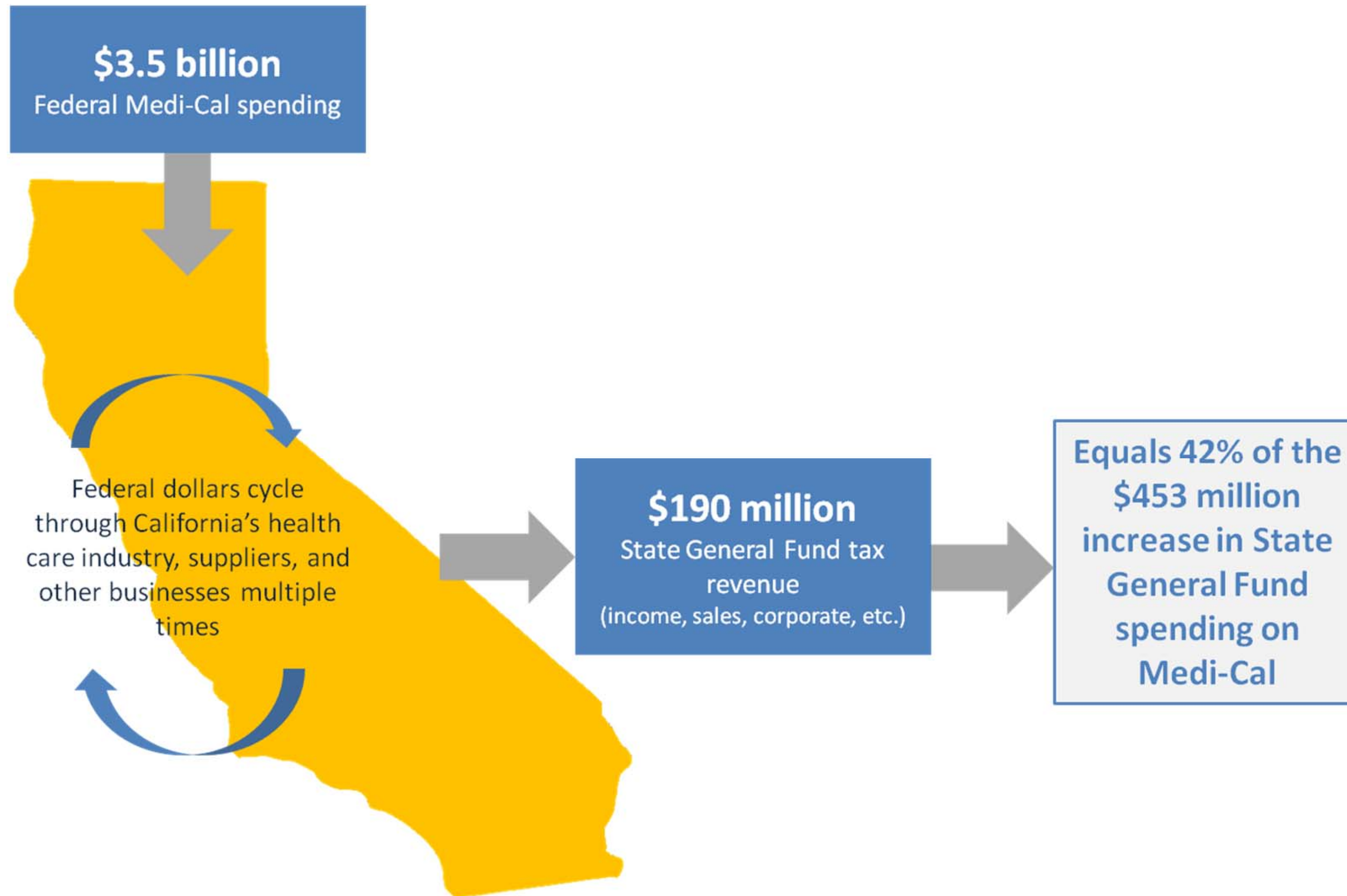
Source: Lucia L, Jacobs K, Watson G, Dietz M and Roby DH. Medi-Cal Expansion under the ACA: Significant Increase in Coverage with Minimal Cost to the State. January 2013.

Most New State Spending Not Due to Expansion in 2014-2016



Source: Lucia L, Jacobs K, Watson G, Dietz M and Roby DH. Medi-Cal Expansion under the ACA: Significant Increase in Coverage with Minimal Cost to the State. January 2013.

New Federal Medi-Cal Spending will Generate New State Tax Revenue

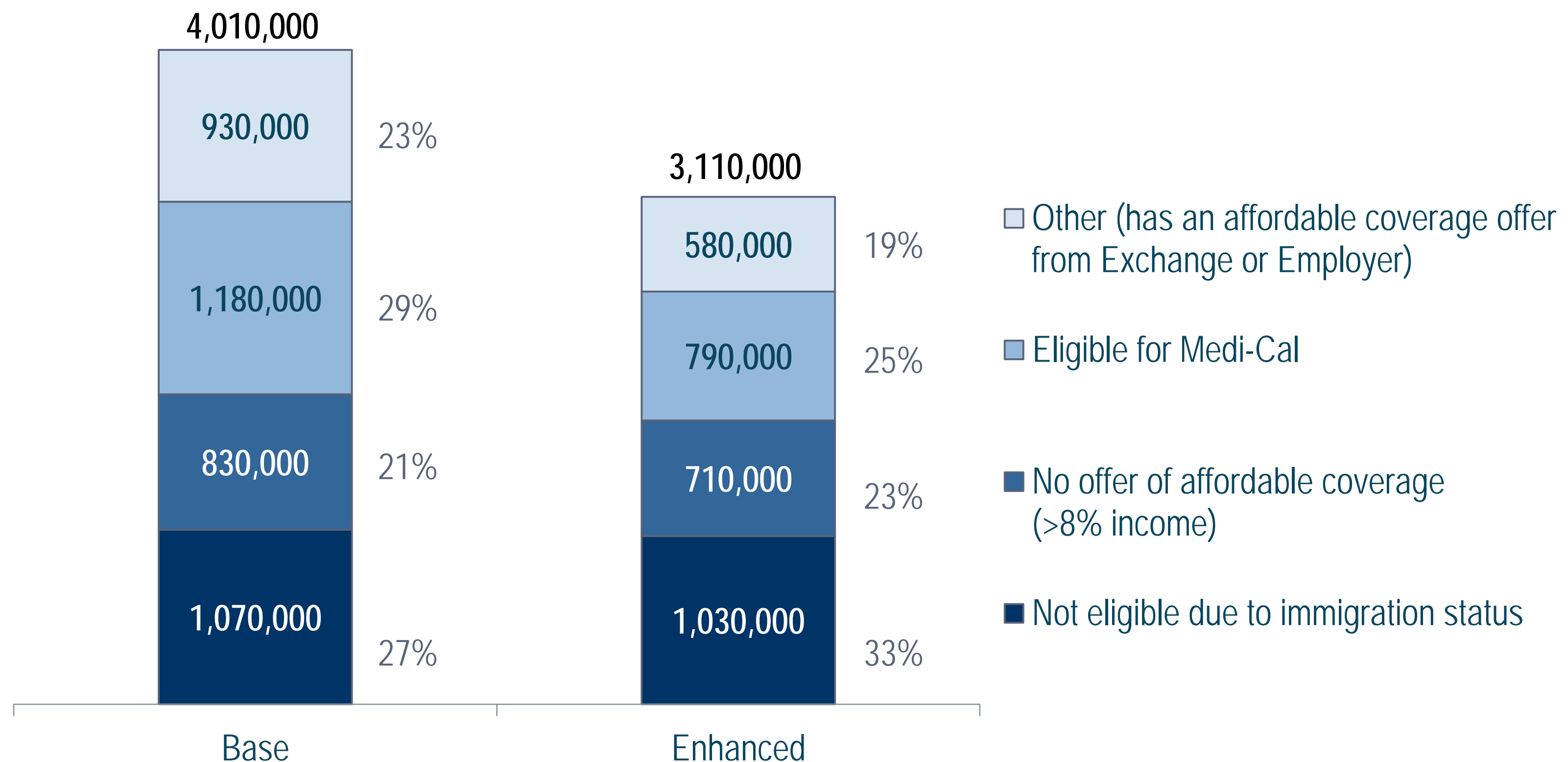


Source: Lucia L, Jacobs K, Watson G, Dietz M and Roby DH. Medi-Cal Expansion under the ACA: Significant Increase in Coverage with Minimal Cost to the State. January 2013.

Medi-Cal Expansion will Result in other State Savings

- Movement of some individuals from partial- to full-scope Medi-Cal with higher match rate
- State prison costs
  - Higher reimbursement for hospital services outside of the correctional system
  - Increased mental health and substance use coverage could reduce incarceration over time
- County savings harder to quantify

3-4 Million Californians are Predicted to Remain Uninsured in 2019



Source: UC Berkeley-UCLA CalSIM model, v1.8

For More Information

- UC Berkeley Center for Labor Research and Education:
  - http://laborcenter.berkeley.edu/healthcare/
  - Ken Jacobs (kjacobs9@berkeley.edu)
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Senate Budget Committee Hearing
Testimony from the California Pan-Ethnic Health Network
February 21, 2013

Thank you for the opportunity to provide testimony today regarding the remaining uninsured in California. My name is Sarah de Guia and I am the Director of Government Affairs with the California Pan-Ethnic Health Network (CPEHN). CPEHN is a multicultural health advocacy organization dedicated to improving the health of communities of color in California.

Background

With the passage of the Affordable Care Act (ACA), millions of Californians will gain access to health coverage in 2014, many of whom will have coverage for the first time. Currently, communities of color represent 60% of California's population but account for 75% of the uninsured.[i] Thus California's communities of color have a large stake in critical policy decisions regarding the implementation of the ACA. However, even with the expansion of Medi-Cal and tax credits to purchase health insurance through Covered California, communities of color are more likely to remain uninsured. Therefore, the State must also maintain a strong safety net and identify affordable health care options for these low-income Californians.

Research Efforts

To identify the impact of new coverage options on communities of color, CPEHN has been working with the UCLA Center for Health Policy Research and the UC Berkeley Labor Center. Researchers used the California Simulation of Insurance Markets (CalSIM) model, version 1.8, to estimate the size and characteristics of the populations under 65 who will enroll in the coverage they will be newly eligible for. The CalSIM model uses two scenarios to determine enrollment. The base scenario assumes that take up of Medi-Cal and the Exchange follows current trends and typical individual behavior patterns in the insurance market. The enhanced scenario assumes simplified eligibility determinations, increased outreach and enrollment efforts in a culturally sensitive and language appropriate manner, and a smooth transition into new coverage for those currently enrolled in other existing public programs.

In addition, CPEHN worked with researchers from the California Program on Access (CPAC) at UC Berkeley on a series of group interviews with low-income, racial and ethnic populations, including adults with Limited English Proficiency, to learn how information about health coverage is obtained, shared and acted upon.

Research Findings on the Newly Eligible

Recent estimates show that of the 1.42 million non-elderly adults who will be newly eligible to receive Medi-Cal, 67% or 950,000 will be from communities of color.[ii] Potentially 500,000 individuals who speak English less than very well will also be newly eligible for Medi-Cal.[iii] Communities of color have the potential to benefit from the federal tax credits to purchase health coverage in Covered California as well. Among the estimated 2.7 million individuals eligible for tax credits, 1.8 million, or 66%, will be people of color and 1.09 million, or 40%, will speak English less than very well.[iv]

The Remaining Uninsured

Estimates also show that up to 4 million Californians will remain uninsured by 2019.[v] These are individuals who will be unable to afford health care coverage, will be ineligible for new coverage options, or are unable to enroll into new coverage options.

Communities of color are more likely to be represented among the remaining uninsured. By 2020, communities of color are estimated to be 66% of California's total population and 82% of the remaining uninsured.[vi] The CalSIM models predicts that by 2019, two-thirds (66%) of Latinos will be uninsured and nearly three out of five uninsured adults will be Limited English Proficient (LEP).[vii] Additionally, families with incomes at or below 200 percent of the Federal Poverty Level are likely to remain uninsured (57%).[viii] Close to three quarters of the remaining uninsured will be U.S. citizens or lawful permanent residents.[ix] A small proportion will be uninsured due to immigration status. Under the base scenario, half of these remaining uninsured will be eligible for Medi-Cal or tax credits to purchase insurance through Covered California.[x] Further, an estimated 140,000 single childless adults who are legal immigrants will be newly eligible for health insurance through Covered California. However, only 40,000 to 80,000 are predicted to take up coverage in the Exchange leaving between 60,000 to 100,000 uninsured.

Potential Differences in Enrollment

The CalSIM model has shown that through enhanced outreach and enrollment, which includes culturally sensitive and language appropriate outreach and enrollment, more eligible adults will enroll in Medi-Cal and take up tax subsidies to purchase health care coverage. Yet even with enrollment assistance, millions are expected to remain without health care coverage.

For example, of the 1 million LEP adults eligible for Covered California, 46% are predicted to utilize the tax credits if language IS a barrier. Even with the enhanced enrollment measures, only 56% are predicted to enroll if language is NOT a barrier.[xi] Similarly, under the base scenario 34% or 480,000 are predicted to enroll into Medi-Cal whereas under the enhanced scenario 55% or 780,000 adults are likely to enroll.[xii] That is a difference of 300,000 low income Californians who could continue to lack health care coverage, 70% of whom will be from communities of color.[xiii]

Of the estimated 4 million remaining uninsured, 2 million are predicted to be eligible for Medi-Cal or the Exchange. However, that number decreases to 1.2 million or fewer under the enhanced scenario due to targeted outreach efforts, simplified enrollment processes, and pre-enrollment through other public programs.[xiv]

Group Interview Findings on Barriers to Enrollment

The focus groups that CPEHN helped to conduct provide insight into how communities of color understand the benefits of the ACA and the barriers they face enrolling in current programs. The findings outlined below are from the California Program on Access to Care's report, "Ensuring Access: Engaging Communities of Color in the ACA."[xv]

Knowledge of the ACA varies among communities of color. The group interviews conducted in conjunction with the California Program on Access to Care (CPAC) found that some racial and ethnic groups are more aware of the benefits under the ACA than others. For example, participants from Latino and African-American communities had heard of certain aspects of the ACA such as the mandates on individuals to purchase insurance and employers to offer coverage. Some also knew of the coverage expansion for low-income adults. However, Native American and Asian respondents were less informed and felt less comfortable about their knowledge of the ACA.

> *"We have heard that everyone has to buy health insurance or else you are breaking the law. If we aren't able to buy it, what will they do to us?"* - Cantonese focus group participant.[xvi]

Some respondents had sought information about the ACA but were dissatisfied with the lack of available bilingual community health workers to answer their questions. Participants from mixed status households had significant concerns about the immigration implications of enrolling in health care options.[xvii]

Focus group participants suggested that multiple mediums should be utilized to reach their communities with accurate, accessible, and linguistically appropriate messages. Participants suggested ethnic media and the internet, and had increased confidence if the website had a ".gov" address. However, other participants noted the lack of internet access in their communities as well as difficulties reaching communities such as field workers or day labors. Thus participants noted that community organizations, schools, and trusted community institutions such as churches, child care centers, libraries, and community health centers also need to play a role in educating and enrolling communities of color.

> *"…trust, cultural competency, and language by tying in to the institutional connection. What are those institutional connections in the community? Schools, churches, places of employment, boys and girls centers. Go to where they are."* – Health Access Interview Participant.[xviii]

Enrollment processes continue to pose challenges to participation by communities of color. Interview participants described enrolling in health coverage as "jumping through hoops." Many low-income families have competing pressures in their lives, such as working multiple jobs, serving as the primary caretaker for their relatives, and lower educational attainment. The group interview participants shared that with accessible, understandable information in their native language, their communities would have more success in enrolling into health care coverage. Additionally, universal and shorter applications would help simplify the enrollment process.

> *"They would [enroll] if the information was accessible and easily digestible. They read it and get it."* – African American focus group participant.[xix]

Lack of access to information in non-English languages impedes enrollment. Speaking a language other than English has been found to be a barrier to enrollment. Studies of Spanish-speaking Medicaid enrollees have shown that when bilingual materials are not available enrollees often do not complete the enrollment process.[xx] This was one of the key overarching themes from the focus group interviews. Communities need information available to them at every step in their own language. Translated forms, informational resources, and bilingual staff to help them through the enrollment process are all crucial aspects of ensuring that these communities do not face barriers to enrollment.

> *"It's best to have people in our native languages. We feel safer and more secure because they speak our language."* – Cantonese focus group participant.[xxi]

<u>Recommendations</u>

The policy decisions being made on how California implements health care reform will have significant effects on communities of color, who are the majority of the uninsured and those who will likely continue to lack health care coverage. While estimates predict positive impacts on enrollment through enhanced enrollment mechanisms, many questions remain about how individuals will respond to new options and how the State will implement the ACA. Therefore, we cannot afford to search for savings in an already underfunded safety net system. CPEHN poses the following recommendations to address the remaining uninsured and ensure that resources are positioned to enroll as many of the newly eligible as possible:

1. Maintain a strong safety net system.

Up to 4 million Californians will continue to lack health care coverage thus relying upon the safety net system for critical health care needs. The State must maintain and strengthen our system of public hospitals, community clinics, and other health care providers after the ACA is fully implemented.

2. Develop programs for Californians left without affordable coverage options.

California should develop programs for individuals that will not be able to afford to purchase subsidized health care coverage or enroll in public programs. Additionally, the State should continue to provide affordable health care coverage to all legal permanent residents. Over time, the State will save more by ensuring these individuals have access to coverage rather than shifting them to unaffordable health care options.

3. Target resources for assistance to those with the highest needs. Resources must be designated for in-person assistance to communities with the highest needs who may lack access to the internet and other traditional methods of enrollment, including low-income populations, immigrants, LEP, and persons with disabilities.

4. Invest in culturally and linguistically appropriate marketing and outreach. California has a long history of providing language appropriate outreach ad enrollment assistance through its public programs. Currently the Medi-Cal program provides language assistance in 13 languages and the Exchange will be translating materials into those same languages. The Exchange has approved $40 million for outreach and education grants. While these are great first steps, on-

going resources must be made available to community organizations, ethnic media, and others who have experience reaching out to communities of color.

5. Simplify enrollment processes.
Strong collaboration between state and local government agencies and providers should be encouraged so that programs such as the Low-Income Health Program, CalFresh, and others which already collect data on citizenship and income can share this data and accelerate enrollment. Additionally, individuals should be allowed to attest to this information when documentation in unavailable or obtaining the data will cause undue hardship. This will allow for quick verification of eligibility for public benefits and avoid unnecessary delays in application processing.

6. Involve communities of color in the decision-making process. Communities of color must be an integral partner to inform policy decisions on outreach, enrollment, simplification, and marketing to ensure success in implementing the ACA.

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[i] California HealthCare Foundation. *California's Uninsured: Treading Water.* December 2012. Available at: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CaliforniaUninsured2012.pdf.
[ii] UCLA Center for Health Policy Research and UC Berkeley Labor Center. *Medi-Cal Expansion under the Affordable Care Act: Significant Increase in Coverage with Minimal Cost to the State.* January 2013. Available at: http://healthpolicy.ucla.edu/publications/Documents/PDF/calsimreport-jan2013.pdf
[iii] California Pan-Ethnic Health Network. *Medi-Cal Expansion: What's at Stake for Communities of Color.* January 2013. Available at: http://www.cpehn.org/pdfs/Medi-CalExpansionFactSheet.pdf
[iv] California Pan-Ethnic Health Network. *Achieving Equity by Building a Bridge from Eligible to Enrolled.* January 2013. Available at: http://www.cpehn.org/pdfs/BuildingaBridgeFactSheet1-13.pdf
[v] UCLA Center for Health Policy Research and UC Berkeley Labor Center. *After Millions of Californians Gain Health Coverage under the Affordable Care Act, who will Remain Uninsured?* September 2012. Available at: http://laborcenter.berkeley.edu/healthcare/aca_uninsured.shtml
[vi] Id.
[vii] Id.
[viii] Id.
[ix] Id.
[x] Id.
[xi] CPEHN, *Achieving Equity*, Jan. 2013.
[xii] CPEHN, *Medi-Cal Expansion*, Jan. 2013.
[xiii] Id.
[xiv] UCLA Center for Health Policy Research and UC Berkeley Labor Center. *After Millions of Californians Gain Health Coverage*, Sept. 2012.
[xv] California Program on Access to Care. *Ensuring Access: Engaging Communities of Color in ACA*. August 2012. Available at: http://cpehn.org/pdfs/EnsuringAccess-EngagingCommunitiesofColorinACA.pdf
[xvi] Id.
[xvii] Id.
[xviii] Id.
[xix] Id.
[xx] The Kaiser Commission on Medicaid and the Uninsured. *Medicaid and Children: Overcoming Barriers on Enrollment. Findings from a National Survey.* Kaiser Family Foundation. January 2000.
[xxi] CPAC, *Ensuring Access*, Aug. 2012.