WESTERN CENTER ON LAW & POVERTY

Sacramento Office
1107 9th Street, Suite 801
Sacramento, CA 95814
916.442.0753
www.wclp.org

Recommendations on Implementing Health Reform

California Working Families Policy Summit
January 12, 2011

INTRODUCTION

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (ACA) which makes sweeping changes to our nation's health care system – greatly expanding access to health coverage. The ACA requires, by 2014, health plans to sell health coverage on a guarantee-issue basis (they cannot refuse to coverage people with a health condition) and requires citizens and qualified legal immigrants to have health coverage. All low-income citizens and lawfully present immigrants with incomes up to 138% of the Federal Poverty Level (FPL) will be eligible for Medi-Cal.[1]

Once the ACA is implemented in California, an estimated 1,863,000 uninsured "childless adults" in California who are not currently eligible for Medi-Cal but are served by county indigent health programs today will be newly eligible for Medi-Cal.[2] The federal government will pay for 100% of the costs for the newly eligible population – scaling down to 90% by 2020.

Under the ACA, those with incomes between 138% and 400% FPL who do not have access to job-based coverage will be eligible for premium and cost-sharing credits on a sliding scale through Exchanges – new consumer-friendly "one-stop shops" where consumers can purchase plans that cover all federally required benefits. The ACA changes the eligibility rules for Medicaid, moving to a tax-based gross income standard for counting income and eliminating the assets test for most people.

California enacted legislation in 2010 to establish the California Health Benefits Exchange – SB 900 (Alquist) and AB 1602 (Pérez). The Exchange, run by a five-member board, is charged with certifying qualified health plans; operating a telephone hotline to assist consumers; maintaining a website with information about applying and health plan choices; screening and enrolling into the Exchange, Medi-Cal, Healthy Families and county programs; granting hardship exemptions from the individual mandate; and establishing a navigator program do outreach, education, application assistance, and problem resolution for consumers with culturally and linguistically appropriate services.

On November 1, 2010, after more than a year of development, stakeholder input, and negotiations with federal officials, California entered into a new 1115 Medicaid waiver entitled the

---

[1] Medi-Cal is California's Medicaid program. Medicaid is a federal/state program, providing health coverage to some poor people with a combination of state and federal funds. Only certain categories of people have traditionally been eligible for Medi-Cal: children, parents, pregnant women, seniors and persons with disabilities. Other adults, traditionally called "childless adults" have not been eligible for Medi-Cal regardless of how low-income they are.

[2] 2007 California Health Interview Survey, www.askchis.com.

"California Bridge to Reform." This waiver will bring $10 billion in federal investment to California's health care system over the next five years, including funding for public hospitals and an investment pool for hospitals to improve their infrastructure and prepare California for elements of the ACA that will go into effect in 2014. Under the waiver, counties can receive federal funds (1:1 match) for providing health coverage to low-income "childless adults." Also, under the terms of the waiver agreement, seniors and persons with disabilities who have Medi-Cal-only coverage and live in counties with Medi-Cal managed care must enroll in one of the managed care plans. Medi-Cal managed care plans are health plans with a set network of doctors that the patients have to go to in contrast to "regular" or fee-for-service Medi-Cal where patients can go to any Medi-Cal doctor.

Health Care Alphabet Soup

- **ACA** = The Patient Protection and Affordable Care Act, AKA the health reform law.
- **DHCS** = Department of Health Care Services which runs Medi-Cal.
- **Exchange** = new consumer-friendly "one-stop shops" where consumers can purchase plans that cover all federally required benefits and can get tax credits for their premiums and cost sharing if their incomes are between 138% and 400% FPL.
- **FPL** = Federal Poverty Level. 100% FPL is $18,310 per year for a family of three.
- **Healthy Families** = California health coverage program for children with family incomes up to 250% FPL ($36,620 for a family of three).
- **Medicaid** = a federal/state program providing health coverage to poor people with a combination of state and federal funds.
- **Medi-Cal** = California's Medicaid program which provides health coverage to more than 7 million Californians.
- **Medi-Cal Waiver** brings in $10 billion to California's hospitals and health care systems over the next five years and allows for additional federal funds for counties to expand coverage to "childless adults" through:
- The **Low-Income Health Program** (**LIHP**): **Medicaid Coverage Expansion** (**MCE**) for those with incomes up to 133% FPL and a **Health Care Coverage Initiative** (**HCCI**) for those with incomes between 134% and 200%.
- **MRMIB** = Managed Risk Medical Insurance Board which runs Healthy Families, **AIM** (Access for Infants and Mothers) and the two high-risk pools for those who cannot get individual health insurance because of a pre-existing health condition: **MRMIP** (Major Risk Medical Insurance Program) and **PCIP** (Pre-existing Condition Insurance Plan).

POLICY OBJECTIVE #1
Design a new seamless Eligibility, Enrollment and Retention System for all public health programs.

Background
The Affordable Care Act (ACA) requires a new approach to determining eligibility for and enrolling consumers into health coverage including Medi-Cal, Healthy Families, the Exchange and county health programs. States must develop a single application which can be used to apply for all four programs; and consumers must be able to apply by phone, in person, by mail or online. The ACA requires a

seamless “no wrong door” application system so that wherever a consumer applies she is enrolled into the program for which she is eligible.

Today, eligibility for Medi-Cal is determined by counties using three different consortia systems: eligibility for Healthy Families is contracted out to a private vendor, eligibility for county indigent health programs are done by each county, and there is an aging statewide MEDS database (Medi-Cal Eligibility Data Systems). Enrollment processes for these programs and California's Health Benefit Exchange will have to be integrated and linked to state and federal verification systems (to verify income and immigration-status information). There are significant questions about how the architecture of this new system should be structured and because the development of IT systems is so time-consuming, the design and implementation should begin as soon as possible.

Recommended Actions

A. The Health and Human Services Agency, the Department of Health Care Services (DHCS), and the new Exchange Board should convene a workgroup to design the new system and should include counties and consumer advocates.
B. The Legislature should establish the parameters for the architecture for the new Eligibility, Enrollment, and Retention System including a single paper and electronic application for all public health programs, streamlined eligibility rules across programs, coordinated verification systems, procedures to ensure continuity of coverage at life transitions, and accounts that allow consumers and application assistors to access, update and correct their information.
C. DHCS and the Exchange should apply for and access the time-limited 100% federal funds for Exchange systems and 90% funds for Medi-Cal systems.
D. The Legislature should require that groups of persons likely eligible for Medi-Cal or the Exchange with in 2014 are sent enrollment information, e.g. adults enrolled in FamilyPACT – a public program providing family planning services to people with incomes up to 200% FPL, and that, where possible information regarding one program be used to enroll people into health coverage, e.g. CalFresh (formerly called Food Stamps).
E. The Centers for Medicare and Medicaid Services (CMS) and the Office of Consumer Information and Insurance Oversight (OCIIO) should issue guidance extending the time-period for which states can get the higher-match funds and simplifying the requirements for eligibility systems (for example, allowing a sampling system to determine the number of new v. old eligibles for funding).

POLICY OBJECTIVE #2
Expand health coverage for as many low-income Californians as possible.

Background

Under the ACA, as many as two million more Californians will be eligible for Medi-Cal and three to four million Californians will receive coverage through the Exchange. While the state is not required to expand Medi-Cal until 2014, the ACA allows states to receive 50/50 federal match to expand Medi-Cal now. California's budget climate makes early Medi-Cal expansion infeasible, but under the Medi-Cal waiver counties can receive the same match as the state to expand coverage.

The Low-Income Health Program (LIHP) portion of the waiver allows counties to draw down federal funds to provide coverage to those with incomes up to 133% through a Medicaid Coverage Expansion (MCE) and for those with incomes between 134% and 200% through a Health Care Coverage Initiative (HCCI) if they meet the standards in the waiver for benefits, due process, eligibility

processing, etc. Counties can receive unlimited federal matching funds for services provided to MCE enrollees, and federal matching funds for the HCCI Programs are capped. Individuals enrolled in the LIHPs will be transitioned to Medi-Cal or the Exchange for coverage before January 1, 2014.

Recommended Actions

A. Department of Health Care Services (DHCS) should provide support, specific information, and oversight to counties interested in participating in the LIHP.
B. Counties should participate in the LIHP to the fullest extent feasible to provide coverage for low-income residents.
C. The Legislature should change state Medi-Cal law to conform to the ACA, including expanding eligibility for childless adults and former foster youth, changing the Medi-Cal income-counting rules, and eliminating the assets test for those under 65 years of age.
D. DHCS should work with counties to ensure that LIHP enrollees are transitioned to Medi-Cal and the Exchange smoothly for seamless coverage between now and 2014.

POLICY OBJECTIVE #3
Develop a Consumer Assistance Program to assist all health care consumers.

Background

Today there is a confusing number of entities California health consumers can go to for help in resolving questions about or problems with their health coverage depending on their type of coverage, e.g. employer-based, Medicare, Medi-Cal, Healthy Families and HMO v. PPO. The ACA recognizes the need to educate health care consumers and help them with health coverage issues. Consumer education will be increasingly important as people will be required by law to have health coverage starting in 2014 and there will be new coverage options, including the Exchanges and the expansion of Medi-Cal. Consumers need help navigating their coverage options, applying for coverage, and resolving problems getting coverage and accessing services. Consumers need both a strong regulator to help when there are problems and independent community-based nonprofits to educate and assist consumers – particularly those who have limited English proficiency, low health literacy, and disabilities.

Recommended Actions

A. The Legislature should expand the charge of the Department of Managed Health Care's Help Center to assist all Californians, regardless of how they get their health coverage and should provide funding to community-based nonprofits with trained staff and experience assisting health consumers.
B. The Legislature should establish a system for complaint tracking across state and federal agencies and require regular reports about problems facing health care consumers.
C. Congress should include ongoing funding for the Consumer Assistance Program grants and should place a stronger emphasis on assistance by independent, experienced nonprofits and application assistors.

POLICY OBJECTIVE #4
Create a Transparent and Consumer-Friendly California Exchange.

See the Summit paper presented by Health Access.