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Addressing California's Health Coverage Gaps: The Impact of National Health Care Reform

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INTRODUCTION

It is easy to lose sight of the human face of health care reform—the millions of individuals and families who lack affordable insurance coverage or who are at risk of losing coverage or access to health care services. These are the unlucky victims of rising health costs and declining insurance coverage, trends that have affected more and more Americans over the last decade and pushed health care reform to the top of the national political agenda. The financial costs are clear: The uninsured are sicker and die earlier than those who have insurance coverage, creating an estimated loss to the U.S. economy of $100 to $200 billion annually.[1] In California, some have estimated that insured Californians pay a "hidden tax" of a roughly 10 percent increase in private insurance premiums to pay for the health care costs of the uninsured.[2] But the focus of this brief is on the human face of this problem. The bills passed by the House and pending before the U.S. Senate must be carefully considered in terms of how well they will meet the needs of gap groups—those who lack private or public coverage and those who are underinsured and cannot access the services they need.

California's attempts at incremental or comprehensive reforms to cover the uninsured speak to the difficulties in achieving universal coverage on a state-by-state (or program-by-program) basis.[3,4] While states and counties have significant responsibility (and capacity) for addressing gaps in coverage, local solutions are piecemeal and fail to address the overwhelming demands that cross county and state lines. States do have strengths in the areas of designing and piloting innovative coverage initiatives, improving health care quality, regulating insurance markets, and protecting consumers. They find themselves stymied, however, by larger economic forces. As evidenced by California's severe fiscal situation, state budgets act as serious barriers to most large-scale reforms. California has responded to its budget crisis by restricting Medicaid eligibility and services. Unfortunately, California is not unique in this regard. By early 2009, half of the states and the District of Columbia had enacted or proposed Medicaid or Children's Health Insurance Program (CHIP) cuts.[5]

All attention is now on the federal proposals to address the growing number of uninsured, which is predicted to increase from 46 million in 2007 to 61 million nationally by 2020.[6] After the CHIP reauthorization earlier this year, the challenge now is to expand coverage to low- to moderate-income adults. This brief analyzes how well the House bill (the Affordable Health Care for America Act (H.R. 3962)) and the Senate proposal (the Patient Protection and Affordable Care Act) will succeed in filling existing coverage gaps.[7] To this end, this brief focuses on data describing California's notably heterogeneous gap groups and safety net system. The analysis of the effect of these bills on California's uninsured lets California policy makers understand where to focus ongoing coverage efforts after national health care reform.

Analyzing California's data also benefits federal policy makers in two distinct ways. First, the risk factors that confront Californians, particularly the decline in job-based coverage and stagnant wages, exist at the national level and require national solutions. Second, California has the largest number of uninsured residents in the nation and ranks eighth in the proportion of its population that is uninsured.[8] The sheer scope of the California crisis requires that federal health care reform proposals be assessed in terms of their potential for covering California's gap populations.

Because none of the Congressional proposals purport to cover 100 percent of the uninsured, and because newly-insured populations will continue to turn to safety net providers for care, this brief also describes the role of California's health care safety net system in caring for the uninsured and underserved.

Part I: Closing the Gap

A nuanced understanding of the populations left uncovered by the gaps in our health care system must inform the policy debate. From the perspective of the uninsured, policies will be measured in terms of affordability, eligibility for coverage independent of health status and age, and access to adequate benefits and providers.

In 2007, 6.6 million Californians (20.2 percent) lacked health insurance at any given time, outpacing the national average of 17.4 percent.[9] The consequences of being uninsured can be catastrophic. In 2008, an estimated 3,100 people died in California due to lack of health insurance (equaling eight working-age Californians per day).[10] A look into the profile of the uninsured reveals data that challenges some of our assumptions about where the needs lie. For example, not all individuals over the age of 64 qualify for or can afford Medicare (particularly immigrants). A smaller majority of California workers (56.7 percent) get health insurance through their jobs, compared to the national average of 62 percent.[11]

The employed and self-employed

An overwhelming majority of the uninsured in California (87 percent) work.[12] The demographics of the working uninsured point to the need to focus on low-wage and self-employed workers, who comprise a significant proportion of the uninsured. In California, 40.9 percent (985,200) of workers employed by companies with fewer than ten employees and 30.3 percent (615,000) of self-employed workers were likely to be uninsured in 2007.[13] Small employers are disadvantaged in the commercial insurance marketplace and often unable to secure affordable benefits for their employees. California provides guaranteed issue and renewability for firms with two to 50 workers. However, while rates for these small businesses may vary no more than 10 percent based on pre-existing conditions, they are still higher than what larger firms pay. Nationally, small businesses pay up to 18 percent more per worker for the same health insurance policy over large firms due to adverse selection, brokerage fees and higher administrative costs.[14] Self-employed individuals who do not have a spouse with job-based coverage for dependents are left to the individual market, where they may be denied coverage based on pre-existing conditions. The lack of affordable options creates a barrier to small business start-ups and self-employment.[15]

California Trends

Between 1987 and 2007, job-based insurance decreased from 64.6 percent to 56.7 percent in California, mirroring the national decline from 70.1 percent to 62.2 percent.[16] This decline was due in large part to rising health care costs and the lack of affordable health insurance products. An increase in service sector, agricultural and part-time employment also contributed to the decrease in job-based coverage.[17] While Medi-Cal and individually purchased coverage helped compensate for this decline in job-based coverage, it has not been enough to stop the rising number of uninsured.[18]

Congressional proposals have much to offer the self-employed and uninsured employees. Among the most promising approaches to cover this population are:

- **Private insurance market reforms** that would reduce the barriers that the self-employed and small groups face to securing coverage, particularly by prohibiting the exclusion of individuals with pre-existing medical conditions and enforcing guaranteed issue and renewability.

- An insurance **exchange** that would greatly expand affordable coverage options for the self-employed and small-businesses. The House bill creates a national exchange or lets states opt out and create their own exchange, whereas the under the Senate bill the exchanges would be state-based or regional. While this difference is significant in many parts of the country, given its size and highly-developed health insurance market, California would likely choose a state-based approach under either scenario. The House and Senate proposals also include in the insurance exchange a new **public insurance plan**, which if it can keep costs below private insurance would be particularly attractive for the self-employed and low-wage employees.

- **Premium and cost-sharing subsidies** for low- and middle-income individuals and families.[19] An estimated two million Californians between 151 and 400 percent of FPL, 1.5 million of whom are currently uninsured and 500,000 of whom currently purchase coverage in the private market, would gain subsidized coverage through the exchange as proposed in the two bills.[20]

    - Combined maximum contributions toward premiums and out-of-pocket costs for the lowest-income individuals (under 250 percent of FPL) are significantly higher in the Senate bill than in the House bill; they are comparable in the two bills for families between 250 and 350 percent of FPL; and lower in the Senate bill between 350 and 400 (Table 1). The average subsidy in the House bill is $6,800 compared to $5,500 in the Senate. Subsidy levels in the Senate bill are also based on plans with lower actuarial values than in the House bill, so individuals would bear a greater share of the overall costs under the Senate version. Under H.R. 3962, California families that receive subsidies through the health insurance exchange will have considerably lower premium costs compared to what they pay on the individual market, in the order of 5.5 percent rather than 14 percent of family income for a family between 151 and 400 percent of FPL.[21]

    - Under the House bill, if a state has higher benefit standards than those set by federal law, the state must reimburse the federal government for the increased subsidy cost created by complying with the mandate. Under the Senate the additional premium costs would be borne by individuals and families. Under both bills, the affordability protections would erode over time if premium costs continue to increase faster than income. The ratio of federal subsidization remains stable. The erosion would be minimal for those whose relative contributions to premiums are small; it would be significant for those who receive only a small premium subsidy. Given that health care costs have consistently outpaced income growth, this will result in significant additional burdens on many individuals.

Table 1
Subsidies, Limits on Out of Pocket (OOP) Expenditures, and Plan Actuarial Values[a]

	House Bill (H.R. 3962)	**Senate Bill**
Under 100% FPL	Medicaid	Medicaid
100–133% FPL *Max premium* *Max OOP (indiv./family)* *Actuarial value*[a]	Medicaid No premium contributions	Medicaid[b] – If in the exchange: 2% of income $2,120 / $4,241 (1/3 of HDHP in 2013[c]) 90%
134–150% FPL *Max premium* *Max OOP (indiv./family)* *Actuarial value*[a]	Medicaid[b] – If in the exchange: 1.5 – 3% of income $500 / $1,000 97%	 4 – 4.6% of income $2,120 / $4,241 (1/3 of HDHP in 2013[c]) 90%
151–200% FPL *Max premium* *Max OOP (indiv./family)* *Actuarial value*[a]	 3 – 5.5% of income $1,000 / $2,000 93%	 4.6 – 6.3% of income $2,120 / $4,241 (1/3 of HDHP in 2013[c]) 80%
201–250% FPL *Max premium* *Max OOP (indiv./family)* *Actuarial value*[a]	 5.5 – 8% of income $2,000 / $4,000 85%	 6.3 – 8.1% of income $3,213 / $6,426 (1/2 of HDHP in 2013[c]) 70%
251–300% FPL *Max premium* *Max OOP (indiv./family)* *Actuarial value*[a]	 8 – 10% of income $4,000 / $8,000 78%	 8.1 – 9.8% of income $3,213 / $6,426 (1/2 of HDHP in 2013[c]) 70%
301–350% FPL *Max premium* *Max OOP (indiv./family)* *Actuarial value*[a]	 10 – 11% of income $4,500 / $9,000 72%	 9.8% of income $4,286 / $8,573 (2/3 of HDHP in 2013[c]) 70%
351–400% FPL *Max premium* *Max OOP (indiv./family)* *Actuarial value*[a]	 11 – 12% of income $5000 / $10,000 70%	 9.8% of income $4,286 / $8,573 (2/3 of HDHP in 2013[c]) 70%
Over 400% FPL *Max OOP (indiv./family)* *Actuarial value*[a] *(min)*	No subsidies $5000 / $10,000 70%	No subsidies $6,426 / $12,853 (HDHP Limit in 2013[c]) 60%

Notes:

a. The actuarial value of the plan, or the percentage of medical expenses that the plan pays for a standard set of services over a covered population, provides an important gauge of the plan's value and of the adequacy of the coverage. The balance is paid by insured individuals and families. For plans with comparable benefits, the lower the actuarial value of the plan, the more individuals pay out of pocket for the same coverage. Both bills start with a plan with an actuarial value of 70 percent. The number indicated in the table is the actuarial value with cost-sharing subsidies.

b. Qualified (documented) immigrants at this income level who would otherwise qualify for Medicaid but for the five-year waiting period would be eligible for subsidies in the exchange.

c. Out of pocket (OOP) costs in the Senate bill are pegged to High Deductible Health Plan (HDHP) OOP limits: $5,800 for individual coverage and $11,600 for family coverage in 2009 (increasing to $5,950 and $11,900 in 2010). These limits increase annually. See Internal Revenue Code, 26 U.S.C. § 223(c), indexed for cost of living adjustments. The amounts in this table are brought forward from 2010 assuming an annual increase of 2.6 percent.

- Incentives in the form of **tax credits** that could help small employers expand coverage for their employees, though the amount of the credit and the number of employees required to be eligible vary. See Table 2. Under both bills, the 20 percent of employers in California that have 25 of fewer employees and average wages that are less than $40,000 would qualify for subsidies.[22] These firms employ approximately 4.1 percent of the workforce.

Table 2
Tax Credits

	House Bill (H.R. 3962)	**Senate Bill**
Covered employers	Max 25 employees Average wages up to $40,000 Contribute a minimum of 72% of the cost of an individual premium and 65% of the cost of a family premium.	Max 25 employees Average wages up to $40,000 Contribute a minimum of 50% of premium costs.
Covered employees	Incomes between $5,000 and $80,000	Unspecified
Tax credit	50% of premium costs for the smallest firms (10 or fewer employees) and average wages up to $20,000; phases out as firm size and wages increase.	*Phase I*: Up to 35% of premium costs for the smallest firms (10 or fewer employees) and average wages up to $20,000; up to 25% for tax-exempt small businesses; *Phase II*: Up to 50% of premium costs for the smallest firms (10 or fewer employees) and average wages up to $20,000; up to 35% for tax-exempt small businesses.

- An **individual mandate**. All of the proposals require individuals to have insurance that meets minimum coverage standards and impose penalties for non-compliance as well as exemptions for financial hardship. The tension between affordability and the overall price tag of the proposals has increased the potential financial burden on individuals and families. However, of the estimated 4.4 million non-elderly uninsured Californian adults affected by the mandate, the vast majority of whom either work or are in a family in which someone works, 3.2 million would be eligible for Medi-Cal or subsidized coverage through the exchange, 500,000 would be required to take up coverage through their employer, and 700,000 would be required to purchase coverage but would not be eligible for subsidies due to their family income.[23]

- **Shared responsibility for employers**. The degree to which Congressional proposals would affect small employers depends on firm size and payroll size. Both proposals exempt the smallest businesses.

    - The House bill has a "play-or-pay" requirement that would effectively shore up employer-sponsored coverage. Under the House proposal, employers must offer coverage to their employees and contribute at least 72.5 percent

of the premium cost for individual coverage (65 percent for family coverage) of the lowest cost plan, or pay up to eight percent of payroll into the insurance exchange (businesses with payrolls between $500,000 and $750,000 would pay between two and six percent of payroll if they did not provide coverage). While only one third of California firms have payrolls over $750,000, these firms employ 87.3 percent of the workforce. An estimated 55 percent of firms in California, which employ 8.5 percent of employees, have payrolls under $500,000 and would not be required to pay.[24]

- The Senate bill has a significantly weaker form of shared responsibility for employers. Large employers (50 or more employees) that fail to offer minimum essential coverage to their full-time (30 or more hours) employees would pay $750 per year, pro-rated by the number of months in which the penalty applies and multiplied by the entire number of their full-time employees, if at least one full-time employee receives subsidies through the exchange that month. Employers with extended waiting periods would pay a penalty for each worker to whom the waiting period applies: $400 for 30 to 60 day waiting periods and $600 for 60 to 90 day waiting periods. Waiting periods of more than 90 days are banned. Finally, employers who offer coverage to their employees, but at a cost of more than 9.8 percent of family income, whose employees opt to receive subsidized coverage through the exchange must pay the lesser of $3,000 per employee receiving subsidies or $750 multiplied by the total number of full-time employees. The penalty for long waiting periods will help to reduce transitional uninsurance. The assessment on employers who fail to offer coverage, however, is too small relative to the cost of providing coverage to have a significant effect on employers' coverage decisions. The exclusion of part-time workers from all Senate bill provisions can be expected to result in a reduction of workers' hours as employers seek to avoid the assessment.

- Both bills require employers that offer coverage to automatically enroll employees into the health benefit plan with the lowest employee premium. Employees could make an affirmative election to opt out of that coverage. The House bill applies to all employers electing to provide coverage. The Senate bill applies to only to large firms with 200 or more full-time employees.

Individuals and small businesses would clearly benefit from policies that facilitate early participation in an exchange which provides a range of affordable coverage options. For small businesses, the economist Jonathan Gruber analyzed the impact of shared responsibility reform proposals similar to those under consideration by the Congress and projected these proposals would save small businesses up to $855 billion over a ten year period relative to the cost they would incur without health care reform.[25] For individuals in California, two million uninsured adults under 400 percent of FPL would gain coverage under the House bill.[26] A shared responsibility model will expand coverage overall for the self-employed and small businesses; the challenge is to not shift too much responsibility on the shoulders of entrepreneurs, their employees, and their families.

Unemployed adults

While most uninsured Californians are in working families, the recent and dramatic increase in unemployed individuals—500,000 working aged adults since November 2007—will only swell the ranks of the uninsured.[27] Absent health care reform, the number of uninsured in California is predicted to increase by almost 600,000 by 2012.[28] Additionally, laid off workers who were previously insured may now remain uninsured for the duration of their unemployment as well as during the first six months of a new job. While the unemployed have theoretical access to continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), it is prohibitively expensive for many households. In California, COBRA coverage can cost nearly 82 percent of unemployment benefits.[29] For families, the monthly COBRA premium was $1,079 per month in 2008.[30] While many states have enacted COBRA-like laws to extend COBRA coverage, only 18 to 26 percent of eligible people have used the benefit in any given year.[31]

Because the exchange and other key provisions of reform will not go into effect before 2013 (or 2014 under the Senate version), the House bill provides some coverage options to bridge the gap, including the right for former employees to continue their COBRA coverage until the exchange is operating, or the individual secures other coverage. The bill does not, however, continue the COBRA subsidies provided in the American Recovery and Reinvestment Act (ARRA) of 2009. The Senate bill contains no equivalent COBRA provision.

For the unemployed, the importance of the proposals discussed in the previous section cannot be underestimated. Of particular significance, under all of the Congressional proposals unemployed Californians would have access to subsidies through the exchange. While subsidies are normally based on income in the most recent tax year, they allow for the subsidy amount to be recalculated in the case of major changes, including a loss of income. Ensuring a streamlined recalculation process will be essential for the recently unemployed.

Low-income adults

Many of California's uninsured adults are poor, childless adults—1.7 million people below 200 percent of FPL in 2007.[32] Limited public options currently exist. In the absence of a Medicaid waiver, federal law prohibits inclusion of childless adults in Medicaid regardless of their income level. California had extended eligibility for Medi-Cal, the state's Medicaid program, to childless adults as "medically indigent persons" (MIPs) until 1982 when it eliminated the MIP Medi-Cal program and transferred responsibility for medically indigent adults ages 21 to 64 to the counties.[33] California law mandates that counties provide a minimum level of health care to these individuals, but they remain uninsured.

In addition, in California, 1.4 million parents below 200 percent FPL were uninsured in 2007.[34] California has been more generous than most other states with its Medicaid program and provides Medi-Cal coverage to parents at or just over 100 percent of FPL, with higher income limits for pregnant women.[35] But those with incomes above that level are ineligible for public insurance. Adults who do qualify for California's relatively generous coverage may not remain enrolled due to the complexity of Medicaid rules. Retaining Medi-

Cal coverage can be problematic for eligible individuals, with many beneficiaries losing coverage due to onerous paperwork requirements, and agency eligibility worker errors.[36]

Expanding Medicaid eligibility for low-income adults and increasing federal support for state Medicaid programs are essential steps that must be taken together. The House bill expands Medicaid to 150 percent of FPL ($16,245 for an individual in 2009). The Senate bill expands Medicaid to 133 percent of FPL. Both Congressional proposals increase the Federal Medical Assistance Percentage (FMAP), which is the share of Medicaid funded with federal dollars, for newly-eligible Medicaid populations; but the FMAP remains at current levels for existing Medi-Cal populations and Medicaid expansions would still eventually require additional state spending. Under the House bill, Medicaid expansions would receive 100 percent federal financing through 2014 and 91 percent beginning in 2015. Under the Senate proposal, states would receive 100 percent federal financing through 2016; by 2019, the FMAP increase is 32.3 percentage points over the current FMAP, not to exceed 95 percent. The American Recovery and Reinvestment Act (ARRA) of 2009 increased California's FMAP from 50 percent to 61.59 percent through 2010 only, meaning that California's FMAP for expanded Medicaid categories would be 82.3 percent beginning in 2019. Some of the increased costs to California associated with the Medicaid expansion would be offset by reduced state expenditures on the uninsured. California spends at least $2.14 billion annually on care for the uninsured.[37]

High levels of state funding create a conflict of interest for cash-strapped states that may erect enrollment barriers, such as mid-year recertification requirements used in California, to limit state spending. An *ongoing* increased federal share in Medicaid financing, rather than the limited and temporary increases contained in the House and Senate bills, would not only relieve the fiscal burden on states but also strengthen the states' incentive to increase enrollment and retention efforts.

California's Section 1115 waiver will expire in September 2010 and the state is considering a range of waiver options, including a comprehensive waiver that could make fundamental changes to the Medi-Cal program, expand the number of county Health Care Coverage Initiatives to increase access to care for low-income uninsured adults, and expand organized delivery systems. Medicaid reforms moving forward in Congress will impact the waiver—most notably, expanding coverage to low-income, childless adults. Because the Medicaid expansions under either the House or Senate bills will ultimately result in cost increases to California, and because California must increase physician payment rates to ensure a sufficient provider network for the newly-insured, new funding opportunities in the waiver negotiation are crucial. Reforms under the waiver must be budget neutral to the federal government, making expansions intrinsically linked to cost-saving delivery system reforms.

Medicaid expansions would increase Medi-Cal eligibility by 2 million individuals under the House bill or 1.7 million individuals under the Senate bill.[38] Medicaid expansions must be accompanied by policy changes to strengthen eligibility, or eligible members of this population will remain uninsured. Both bills include provisions to base Medicaid eligibility on income, not assets as is currently the practice. This vital elimination of asset-based restrictions will allow individuals to maintain some financial security and increase the likelihood they will grow their incomes above the Medicaid threshold, while reducing

application barriers for eligible individuals and lowering the administrative costs of eligibility verification. All low-income individuals would be best served by strong due process protections, which exist in the Medicaid program but may not be equally robust in the exchange.

The Senate bill also creates the option of a basic health plan that states could adopt for individuals between 133 and 200 percent of FPL, modeled on the state of Washington's Basic Health, in which a state-sponsored program would provide low-cost health care coverage through private health plans. California could do this by drawing on its existing Local Initiatives and County Organized Health Systems.

The near-elderly (people age 55 to 64)

In California, one of out six individuals ages 55 to 64 was likely to be uninsured in 2007.[39] The near-elderly are highly diverse in income, health status and sources of health insurance, but 5.1 million individuals ages 55 to 64 are uninsured nationally.[40] Moreover, the uninsured near-elderly are quickly being joined by their younger counterparts. In California, adults ages 45 to 54 make up the fastest growing segment of the uninsured: approximately 20 percent of 45 to 54 year olds were uninsured in 2007, up from 15.9 percent in 2000.[41] Once older Americans are uninsured, they are likely to remain uninsured longer. Unstable insurance coverage, rising out-of-pocket health care costs, high rates of chronic health conditions, and more expensive health insurance premiums, particularly in the individual market, leave older Californians vulnerable to both financial risk and exacerbated health care needs.[42]

For the near-elderly who are working, nationally premiums for an average employer health insurance package for workers ages 55 to 64 are estimated to be almost $9,000 per year, compared to an overall average of $4,284 for all workers.[43] Federal **reinsurance** of employer-based coverage for retirees who are not yet Medicare eligible would help to stabilize retiree health plans. Both bills include a temporary reinsurance program for employers that provide insurance coverage to retirees ages 55 to 64. Employers would be reimbursed for 80 percent of retiree claims between $15,000 and $90,000.

Covering the near elderly makes good sense from the standpoint of Medicare spending as well. After they qualify for Medicare, annual spending on previously uninsured adults outpaces spending on previously insured adults by more than 20 percent.[44]

Because the near-elderly gap group is the most expensive population to cover, options that lower the price of coverage in the exchange or any remaining individual market, such as **guaranteed issue, guaranteed renewability and community rating**, would greatly reduce the barriers to coverage. Guaranteed issue and renewability appear in all proposals. Insurers may rate policies based on age but the ratio is restricted to 2 to 1 in the House bill and 3 to 1 in the Senate bill. Cost-sharing limits discussed above could potentially reduce the likelihood of medical bankruptcy among sicker and lower-income individuals in this age group. Given higher premium costs, the near-elderly are more likely to face affordability problems than their younger counterparts. However, under either bill, at current health care costs the number of near-elderly Californians whose premium costs

would be high enough that they would qualify for a hardship waiver from the individual mandate is relatively small: 60,000 in the House bill and 170,000 in the Senate bill; the difference is a result of the Senate's lower cost threshold for opting out of coverage.

Stop gap measures in both bills provide some measure of relief to this population as well. Under the House bill, $5 billion would be used to create a temporary high-risk pool for people who are uninsurable due to pre-existing conditions. Under the Senate proposal, a temporary insurance program will provides financial assistance to who have been uninsured for several months and have a pre-existing conditions until the exchanges are operational in 2014.

Low-income children

In 2007, 16 percent of the uninsured in California were children.[45] Data from 2007 show that many uninsured children were eligible for either Medi-Cal (30 percent of the 683,000 uninsured children) or Healthy Families (CHIP) (26.4 percent) but were not enrolled. A remaining 22.7 percent were eligible for a county-based "Healthy Kids" program that did not have enough resources to serve them.[46] California has aggressively pursued outreach and enrollment initiatives targeted to eligible children. Federal reauthorization of CHIP may greatly reduce the number of uninsured children in California by expanding eligibility to 300 percent of FPL and adding an estimated 440,000 children and 300 mothers to the monthly average enrollment by 2013.[47] Medicaid expansions will have little impact on children in California who are already eligible for Medi-Cal or Healthy Families, although some children ages 6 to 19 over 100 percent of FPL who currently qualify for Healthy Families would shift to Medi-Cal.

Covering all children is a relatively inexpensive, sound investment in the future.[48] Children who experience periods of uninsurance are more likely to delay care and have unmet medical needs, with consequences worsening the longer a child is uninsured.[49] The need for federal solutions to the problem cannot be over-emphasized. For non-entitlement programs like CHIP, state-level solutions are subject to the vagaries of the budget: in July 2009, for example, budget cuts, eventually reversed in September, would have put 330,000 children on a wait list for California's Healthy Families (CHIP) program and disenrolled 670,000 more. Moreover, as parents lose coverage during these economic hard times, their children are less likely to be insured.

Shoring up Medicaid and CHIP by investing in **enrollment and retention** promises to cover most uninsured children. Providing Medicaid to all uninsured newborns is a positive step. Eliminating waiting periods for children under age two is another constructive measure. Targeting the parents of low-income children is also expected to result in increased enrollment of their children.

Children who are not eligible for Medicaid or CHIP but who are under 400 percent of FPL would—like their parents—be eligible for subsidized coverage through a plan in the exchange if their parents are not offered affordable coverage by their employer. Policy makers should draw from what works best in Medicaid and CHIP in designing the exchange and benefit packages. Congressional proposals shift children from CHIP into Medicaid or

the exchange, depending on their income level. Under the House bill, CHIP expires in 2013. The Senate bill maintains the CHIP program through 2019 but as introduced provides no funding past the current 2013 reauthorization date. CHIP presents challenges, namely, that unlike the entitlement program Medicaid it has required periodic Congressional reauthorization (the Senate bill would not remedy this problem). But abandoning a public program like CHIP that has a track record of serving children well in favor of private insurance creates legitimate concerns, some of which would be alleviated if the exchange includes a public plan option with a clear public mission. Moreover, if low-income children are shifted out of Medicaid and into CHIP or private insurance, **maintaining access to key benefits** such as the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and **ensuring cost-sharing protections** are essential. Unfortunately, whereas H.R. 3200 included EPSDT services in the benefit design for all plans in the exchange, current House and Senate bills fail to maintain EPSDT benefits for children.

Under the House bill, 337,000 additional California children in families with incomes up to 150 percent FPL will become eligible for Medi-Cal.[50] More than 80 percent of the 7.8 million uninsured children nationwide would be eligible for a public program or a subsidy under the health care reform proposals under consideration.[51] Nine percent of uninsured children are over 400 percent of FPL and would face the same affordability barriers as adults; they may remain uninsured under existing Congressional proposals.[52,53,54] Some higher-income children—and young adults—may be covered through dependent coverage. The House and Senate proposals allow dependent coverage up to age 27 and 26, respectively. In 2007, one million young adults, 27.4 percent of 19 to 26 year olds, went without health insurance for all or some part of the year. This compares to 18.6 percent for all adults.[55] Over the next few years, affordability levels for children will require adjustment to achieve full coverage. Separately, another 9 percent of children nationwide would be ineligible for Medicaid, CHIP or subsidies due to their immigration status.[56,57] Neither of the proposals in Congress addresses what to do about undocumented children.

Undocumented immigrants

In 2007, 1.07 million undocumented adults lacked health insurance in California, which amounts to just over 20 percent of the state's uninsured population.[58] Fewer than five percent of uninsured Californians are estimated to be undocumented children.[59] Nationally, the estimated 6 to 8 million uninsured undocumented immigrants use health care services less than the rest of the population. Although they are generally young and healthy, when they do need care undocumented immigrants tend to delay access for fear of being reported to immigration authorities. Moreover, only a small fraction of the cost of the care provided to undocumented immigrants is paid for in public dollars, specifically for limited Medicaid programs.[60] In fiscal year 2009-2010, the expected cost to California is $703 million for 780,000 undocumented immigrants—$900 per person on average. More than half of this amount ($486 million) goes to emergency services. Other services, such as prenatal and post-partum care, breast and cervical cancer treatment, long-term care services, and abortion, are anticipated to be scaled back, resulting in likely cost-shifts to counties.[61]

Both Congressional proposals exempt undocumented immigrants from the individual coverage mandate and exclude them from insurance exchange subsidies. The

majority of undocumented immigrants—8 million individuals by 2019 according to Congressional Budget Office (CBO) estimates—are therefore likely to remain uninsured. The House bill allows undocumented immigrants to purchase coverage in the exchange without subsidies. The Senate bill would bar undocumented immigrants from purchasing coverage in the exchange even without a subsidy. The Senate bill also proposes citizenship verification measures in the exchange that duplicate the verification process that employers are already required to perform and that would, as happened with Medicaid, result in barring *citizens* from obtaining coverage for which they are eligible.[62]

In addition, under the House and Senate bills, *legally-present* non-citizen adults would continue to be prevented from enrolling in Medicaid during their first five years in the United States, although California extends Medi-Cal to all qualified immigrants using state funds. These individuals could also get subsidized coverage through the exchange (see Table 1).

Undocumented immigrants are excluded from health care reform for immigration policy reasons that are separate from either the health care needs of the population or the relative fiscal impact of covering them. Not only are these exclusionary policies objectionable for moral and humanitarian reasons; they also make for bad public policy. Restricting access to coverage and health care for undocumented immigrants has myriad negative consequences, among them: uninsured undocumented parents are less likely to enroll their citizen children in health insurance; to the extent that cost-shifting occurs from uninsured undocumented immigrants, these costs fall on the insured and on providers, including safety net providers such as community health centers and hospitals; and public health risks increase if undocumented immigrants lack access to treatment for contagious diseases.[63,64]

The underinsured

An estimated 5.4 million Californians with insurance lack adequate coverage and spend more than 10 percent of their pre-tax income on health care.[65] Being underinsured, defined as having medical expenses that exceed 10 percent of income or a deductible that exceeds five percent of income, is a growing problem, affecting upwards of 25 million Americans in 2007.[66] Underinsurance is exacerbated in states like California that have a large individual insurance market and permit insurance underwriting that limits coverage to people with pre-existing health conditions. The deterioration of benefits, such as plans that do not cover adult physicals, coupled with the rising costs of insurance premiums has the potential to put many Californians at risk for delaying preventive care. The underinsurance problem is not limited to medical care. Thirty-nine percent of Californians do not have dental insurance coverage.[67] The underinsured face high rates of medical debt.[68] Because women use more health care services than men, they are more likely to have problems with medical debt and are likely to forego care because of cost.[69]

Congressional proposals promise to ease the burden on the underinsured in these key ways. Both Congressional proposals:

- Include **insurance market reforms**, particularly guaranteed issue and renewability. All proposals also support creation of a basic but comprehensive benefits package

offered through the insurance exchanges. They eliminate lifetime and unreasonable annual caps on insurance coverage and also prohibit most insurance plans for charging cost-sharing for preventive care.

- Set **minimum standards** on **health insurance products** and for **creditable coverage**. The same rules would apply to all individual and small group plans, though for those currently enrolled, both bills grandfather in individual and employer-based plans that do not meet the standards.

    - The House bill eliminates the individual market outside of the exchange. Under the House bill, employer-based plans would have five years to meet the same standards as the exchange plans, which include a minimum set of covered services and out-of-pocket maximums (see Table 1).

    - In the Senate bill all employer plans are considered to provide minimum essential coverage, although employees and their families may turn down employer coverage and receive subsidized coverage through the exchange if the employee premium cost is more than 9.8 percent of family income or if the actuarial value is less than 60 percent. The Senate bill would set limits on deductibles for all small business plans of $2,000 for an individual and $4,000 for a family. Fully-insured plans must meet standards on lifetime and annual limits, out-of-pocket maximums, and first dollar coverage for preventive services; but these standards do not apply to self-insured plans. This is likely to drive large California employers to self insure in order to avoid the standards. Under the Senate bill, underinsurance is likely to continue in important sectors of the group market.

- Provide **subsidies** to low- and middle-income families, which reduce cost-sharing and out of pocket limits (see Table 1). Both bills base premium subsidies on a plan with a 70 percent actuarial value with additional cost-sharing subsidies for families with incomes under 350 percent of FPL in the House bill and 200 percent of FPL in the Senate bill. To put this in perspective, a typical high-deductible plan with a Health Savings Account has an actuarial value of 76 percent, a typical PPO 80 to 84 percent, and a typical HMO 93 percent.[70] For low-income families, the House bill has higher actuarial values and lower out-of-pocket costs than the Senate bill, and does a better job of addressing underinsurance.

Remaining challenges for the underinsured will involve ensuring that improvements in private insurance market regulation within the exchange also apply to plans outside the exchange, and closing the affordability gap through reasonably-priced products for this group.

Part II: Preserving the Safety Net

The safety net remains essential. While all Congressional proposals will result in significant declines in the total number of uninsured, none will eliminate the problem of uninsurance entirely. Estimates have predicted that by 2019 the number of uninsured would drop to 18 million under the House bill and 24 million people under the Senate bill.[71,72] This would leave 8 percent of the population uninsured in the Senate bill and 6 percent in the House bill, compared to 19 percent in the CBO's baseline scenario.

In California, of the 6.4 million uninsured during some part of the year in 2007, as measured by the California Health Interview Survey, four million would be eligible for Medi-Cal or subsidies in the exchange under both of the bills; an additional million would be eligible for coverage in the exchange but would not be eligible for subsidies due to their income level; and up to 1.4 million would not have access to coverage due to their immigration status.[73]

These remaining uninsured will still require a coordinated health care delivery system. Moreover, the newly insured will require access to health care services. Massachusetts' experience suggests that a sudden jump in the newly-insured population and the concomitant crisis in provider capacity will require that the safety net delivery system have sufficient resources to address the unmet needs of this population.

Many of the uninsured rely on a health care safety net comprised of public and private not-for-profit primary care clinics, public hospitals, and, to a lesser extent, private providers. While this safety net is the primary source of care for 2 million uninsured people, a sizable number of *insured* non-elderly Californians (5.3 million in 2005) also seek regular care from these providers.[74] In California, the state shares responsibility for providing health care services to the uninsured with the counties.[75] Under state law, California counties are responsible for caring for Medically Indigent Persons (MIPs), discussed above. To care for the uninsured in local safety net systems, it is estimated that counties spend $1.8 billion on 1.2 million users annually.[76] However, there are limits to what California's health care safety net can provide. A recent survey conducted by the California Association of Public Hospitals indicates that the state's public hospitals experienced a four percent increase in the number of patients (100,000 additional patients) from October 2007 to October 2008.[77] Visits to community health centers across the nation increased 14 percent between June 2008 and June 2009. *Uninsured* visits to community health centers rose by 21 percent over the same time period. Nationally, safety net providers have been experiencing increased price pressures from their private counterparts combined with growing demand for services by the uninsured.[78]

The House and Senate proposals both provide increased support for community health centers and the National Health Services Corps, which will increase the provider presence in underserved communities. The proposals also include provisions to support a primary care workforce necessary to meet the needs of the newly insured. These include bonuses or payment increases for primary care providers under Medicare and Medicaid, an increase in the number of Graduate Medical Education primary care training positions, and

establishing a Workforce Advisory Committee to develop a national workforce strategy. Under the House bill, primary care providers would receive higher Medicaid reimbursement rates starting at no less than 80 percent of Medicare rates in 2010, 90 percent in 2011 and 100 percent in 2012 and after. Under the Senate proposal primary care providers, and general surgeons practicing in Health Professional Shortage Areas, will receive a 10 percent Medicare payment bonus for five years, starting in 2011.

Even so, safety net funding remains essential, particularly Medicaid Disproportionate Share Hospital (DSH) payments to hospitals that serve a large number of low-income patients. These payments supplement the regular reimbursements hospitals receive for treating Medicaid beneficiaries on an inpatient basis. The House Bill would reduce DSH payments by a total of $10 billion through 2019, imposing the largest reductions in states with the lowest uninsured rates. The Senate bill would reduce state DSH payments by 50 percent once the state's uninsured rate decreases by at least 45 percent (25 percent for low DSH states). State DSH allotments would not fall below 35 percent of the total allotment in 2012 if the state's uninsured rate continues to decrease. These measures would dramatically cut California's DSH funding of $1.1 billion per year. Reducing DSH payments to this extent under the assumption that many of the uninsured would be covered under Medicaid and private insurance could put the safety net at risk and should be delayed until data on enrollment, service utilization, provider contracting, and reimbursement are available.

Congressional proposals demonstrate a consensus that the health care delivery system requires broad-based reform. Proposed reforms, such as an emphasis on prevention, strengthening the public health system, expansion of the primary care workforce, and implementation of a chronic care management models will have a direct impact on the safety net. Other programs include grants targeting school-based health clinics and grants to local governments and community-based organizations to address health disparities and reduce chronic disease rates.

Finally, programs that will give the uninsured access to care through the safety net system even before they have access to insurance are important. For example, under the House proposal, the new Community-Based Collaborative Care Network would support consortia of providers to coordinate and integrate health care services, manage chronic conditions, and reduce emergency department use for low-income uninsured and underinsured populations for five years starting in 2011.

CONCLUSION

Focusing on the human face of health care reform tells us that Californians of all ages and from all walks of life face increasing uncertainty in their health care, and this problem is likely to get worse. The enormity of California's problem and its struggle to achieve universal coverage provides a window into the national problem. To close the health insecurity gap in California and the nation, policy makers must grapple not only with the sheer number of uninsured but also with the erosion of existing insurance benefits and uneven access to essential health care services.

Closing California's uninsurance gap and preserving the safety net are twin missions whose scope requires a comprehensive and nuanced national response. In our analysis of the two bills, we conclude that the House and the Senate proposals are likely to address many of California's gaps, expanding the number of insured individuals and shoring up the state's safety net. The comparison of the two proposals also points to some areas where gaps are likely to persist, specifically undocumented immigrants, and individuals who opt out of mandated coverage for affordability reasons. How California and the nation provide access to care for these remaining gap populations is the next challenge. Moreover, while the House and Senate proposals include provisions that will support California's safety net system, the state needs adequate federal support for its local and state-level safety net infrastructure. Federal proposals will benefit from existing state and county capacity to enroll individuals in public and private insurance programs. Adequate payments to Medicaid and safety net providers are essential to achieve timely and even implementation of federal reform.

California needs comprehensive national health care reform now and must also be responsive to opportunities in the federal bill and at the state level that allow the state to close the gaps even further. Not only will coverage expansions provide many in California's gap groups with financial and health security but California will finally have the means to achieve its long-time policy goal of universal coverage. California is poised to partner with the federal government and is readying itself to ensure successful implementation of federal provisions, including aligning some of the components of its Medi-Cal Section 1115 waiver with key provision in the Congressional proposals. The waiver negotiations provide one venue to address gaps left by the federal bill.

In sum, national health care reform proposals go a long way in meeting the health care needs of many of California's gap groups, particularly the House bill which has much stronger insurance coverage provisions than the Senate proposal. Health care reform will make a real difference in the lives of millions of Californians and across the nation.

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- *Healthy Families Parents (2001):* would cover parents of Healthy Families (CHIP) children up to 200% FPL, approximately 400,000 people. Legal structure is in place but program has not been funded;
- *Child Health and Disability Prevention Program Gateway (2002):* pays for periodic well-child visits and treatment of conditions for all uninsured children up to 200% of FPL;
- *PacAdvantage (1992 – 2006):* created as the Health Insurance Plan of California (HIPC) by the state in 1992 and taken over in 1998 by Pacific Business Group on Health (PBGH). PacAdvantage was an independent, non-profit voluntary purchasing pool for small businesses with 2-50 employees. Coverage for 116,000 beneficiaries ended when the program was discontinued in 2006 because of the withdrawal of participating health plans; and
- *2004 Federal Medicaid Hospital Waiver (SB 1448 passed in 2007):* $540 million was awarded to ten California counties in 2007 to expand coverage for 180,000 low-income, uninsured adults, primarily through administration and delivery of health services. It is estimated that 100,000 low-income adults are enrolled in programs to expand their access to services. See California Association of Public Hospitals, "California Public Hospitals and the Health Care Coverage Initiatives: A Model for Health Care Reform" (2009).

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