

The California Department of Health Care Services presented its projections of the cost impacts of the House and Senate bills today (January 12, 2010). Their bottom lines are that in the year 2018-19<sup>1</sup>, the House version would cost the state \$819 million, and the Senate version would cost the state \$959 million annually.<sup>2</sup>

- These costs include the enrollment of the new expansion populations<sup>3</sup> for which the state receives a 90/10 match in the House version and an 83/17 match in the Senate version.<sup>4</sup>
- It also assumes that 100% of the eligible but not enrolled uninsured indigent will enroll as a result of the individual mandate for whom the state will get a 50/50 match.<sup>5</sup>
- It assumes that the state achieves savings because some of those now eligible for state programs would enroll in the Exchange where the federal government pays 100% of the subsidies.<sup>6</sup>
- It assumes that the state does not collect back any realignment or other funding from counties that has supported the \$1.8 billion cost of their county indigent programs.<sup>7</sup>

If the state increases provider reimbursement rates to 80% of Medicare, as the state argues it should and will need to do in order to increase provider participation, the cost to the state increases by \$2.7 billion in the House version and \$3.2 billion in the Senate version.<sup>8</sup>

ITUP suggests that the best way to hold states harmless from any increase in costs due to reform is to increase the entire FMAP the requisite percentage to achieve financial "hold harmless" for states, thus there would be no differential between the match for new and existing program eligibles and no incentives to manage the program enrollment and reimbursement rates in a differential fashion for different populations; we would argue that the matching rates between CHIP (if it is continued, as the Senate proposes<sup>9</sup>) and Medicaid should be equalized as well.

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<sup>1</sup> The analysis assumes a 6% per annum growth rate in per capita costs, a base rate of \$111 pmpm (per member per month) for children, \$187 pmpm for parents, and \$254 pmpm for MIAs.

<sup>2</sup> California Department of Health Care Services, Health Care Reform Cost and Savings Estimate: Full implementation (December 4, 2009), HR 3962 Analysis as of 11/6/09 version and HR 3590 Analysis as of 11/23/09 version.

<sup>3</sup> These primarily adult populations are the MIAs (Medically Indigent Adults) and parents with incomes between 106% of FPL and 133% of FPL (Senate version) or 150% of FPL (House version). In the House version, the total cost in 2018-19 is \$8.2

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billion of which the state responsibility is \$740 million. In the Senate version, the total annual cost in 2018-19 is \$6.9 billion of which the state share is \$1.2 billion.

<sup>4</sup> For the first two years, both versions require the federal government to pay for these costs at 100% of costs.

<sup>5</sup> DHCS projects nearly \$2.8 billion in annual costs in 2018-19 of which half is federal match and half is state match. The Governor proposes that the California match be increased to 57/43, the national average, due to our state's high poverty and uninsured rates – a proposal that makes particularly good sense, given the state's dire budget deficit.

<sup>6</sup> The savings to the state General Fund under the House version is \$1.2 billion. This includes the shift of a portion of the Healthy Families children into the Exchange at 100% federal cost (the rest move into Medi-Cal), and savings of 80% of current state programs' spending for the uninsured populations, including Family PACT, ADAP, MRMIP, Breast, Cervical and Prostate Cancer Treatment, AIM, GHPP, etc. State savings may also include some CCS, Medically Needy Share of Cost, and Pregnant Women's program spending that are not otherwise counted in this analysis.

<sup>7</sup> Counties reported spending \$1.8 billion in 2005-6 on physical health and that figure has likely grown somewhat since; however counties are struggling to maintain services in light of the recession-induced decline in their realignment funds. Many county programs are congruent with the federal program expansions in that they do not cover the undocumented in their program; others cover them only for emergency care; whereas counties with county hospitals typically treat all patients in their facilities without regard to immigration status. County income eligibility is also highly variable -- with San Francisco County covering the uninsured indigent with incomes up to 500% of FPL, while Fresno limits coverage to 68% of FPL and Los Angeles to 133% of FPL. Most counties exclude children, while counties with public hospitals will treat uninsured children in their facilities. In addition county mental health programs treat the uninsured with severe mental illness, and expenditures on these services will qualify for a federal match at 100% for the first two years and either 90/10 (House) or 83/17 (Senate) thereafter.

<sup>8</sup> California has historically underpaid physicians and other providers of outpatient services other than community and county clinics with FQHC or look-alike status. The state argues with some strong justification that it should increase these rates to 80% of Medicare. The House requires that primary care must be reimbursed at 100% of Medicare and that cost is built into the earlier assumptions, this element of cost is to increase reimbursement rates for other outpatient services to 80% of Medicare payments (House version) and all outpatient services (Senate version). This increase is not mandated by either reform bill, but is a matter of correcting California's historical payment inequities.

<sup>9</sup> This would result in an anomaly of a relatively small CHIP program for children, co-existing with the far larger Exchange, Medicaid and private employment based systems of coverage for their parents, but it is strongly preferred by some advocates who maintain CHIP is uniquely suited to assure children's healthy development.