ITUP
INSURE THE UNINSURED PROJECT

Population-Specific Timeline
Implementation Dates and Guidelines
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Low-Income (< 133% FPL)

April 1, 2010

- **Medicaid Expansion.** Provides a state option that covers childless adults through a Medicaid state plan amendment (SPA).
- **FMAP.** Extends Medicaid federal match (FMAP) to cover MIAs up to 133% FPL.
- **Medi-Cal Expansion.** Makes necessary changes to state law for expanding coverage to newly eligibles, amending the Medi-Cal State Plan, and modifying the application and enrollment systems. The state is also required to define "benchmark benefits," including "wraparound" benefits for children.
- **Federal Medical Assistance Percentage.** FMAP available to states for all individuals below 133% FPL ($14,404 for an individual).

January 1, 2014

- **Medicaid Expansion.** Increases the eligibility for Medicaid to 133% the FPL for non-elderly individuals while also providing full federal funding to states to cover the expanded population.
- **Medically Indigent Adults.** Federal government will pay 100% of the cost of covering Medically Indigent Adults (MIAs) for three years; phase down starts with 95% in 2017, 94% in 2018, 93% in 2019, and 90% thereafter *(effective through 2016)*.
- **End of MOEs for Adults.** Maintenance of Effort (MOE) requirements for adults covered by Medi-Cal expires. States may begin modifying Medi-Cal eligibility levels, standards, and income requirements.

Mid-Low Income (133%-400% FPL)

September 2010

- **MIA Matching Funds.** All California counties express their intentions with respect to receipt of federal matching funds to cover MIAs up to 200% under a renewed §1115 waiver *(September 2010)*. Individuals between 133%-200% will be moved into the Exchange.

January 1, 2014

- **Health Insurance Exchanges Launch.** Health Insurance Exchanges in every State to be opened to individuals and small businesses, allowing individuals to comparison shop when seeking affordable health coverage. Subsidies available in the form of refundable tax credits only through the Exchange Purchase of insurance through the exchanges will be available for U.S. citizens and legal permanent residents.
- **Health Care Tax Credits.** In the exchanges, individuals with incomes between 133-400% of poverty will receive refundable tax credits in order to purchase private health

insurance and will pay affordable sliding-scale premiums capped at 2% - 9.5% of income.

Coverage Expansion for Medically Indigent Adults under the §1115 Waiver

- The state will build upon the existing 10 Coverage Initiatives (CIs) established via the existing waiver, and expand coverage to all 58 counties, creating Coverage Expansion and Enrollment Demonstration Projects (CEEDs).
- The CEEDs will provide health care benefits for the population of medically indigent adults (MIAs), uninsured adults 19 to 64 with incomes up to 200% FPL not eligible for Medicare or Medi-Cal.
- CEEDs will engage in county outreach and enrollment activities to target populations, including, but not limited to, the homeless, individuals frequently using hospital inpatient or emergency services (for avoidable reasons), and individuals with mental health or substance abuse treatment needs.
- Counties, not the state, would provide the match and may limit enrollment to meet funding limits.
- CEEDs will be designed to help facilitate the transition of eligible individuals to Medi-Cal coverage or to coverage through the state's Health Benefits Exchange by January 1, 2014.
- Beginning January 1, 2014 California must implement comprehensive health care reform for the populations target by CEED while including a prospective payment system reimbursement for qualified health centers and rural health clinics.
- DHCS will be required to evaluate all CEED projects.

Children and Young Adults

May 2010

- **Extending Dependent Coverage.** Selected health plans in California extend dependent coverage early to graduating college students.

September 23, 2010

- **Dependent Coverage Insurance Reform.** Extends dependent coverage up until age 26 for all individual and group polices.
- **Pre-existing Conditions.** Bars employer and new individual health plans from imposing pre-existing condition exclusion on children's coverage (*applies to adults as of January 1, 2014*).

January 1, 2014

- **Transition into Medi-Cal.** State is responsible for transitioning children ages 6-18 with family incomes between 100-133% FPL from the Healthy Families Program to Medi-Cal coverage.

April 1, 2015

- **Transitioning Children.** Permits States to transition children who are eligible for Healthy Families to Medi-Cal or other coverage comparable to Medi-Cal in the Exchange. However, HHS must first certify that Exchange coverage is adequate.

September 30, 2015

- **CHIP Funding Ends.** The block grant that funds the Children's Health Insurance Program (CHIP) expires.

October 1, 2015

- **Children in the Exchange.** Permits States to start enrolling children who are eligible for Healthy Families into the Exchange.

January 2019

- **Maintenance of Effort.** MOE requirements for children in Medicaid end. State may begin modifying Medi-Cal eligibility levels, standards, and income levels for children.

Organized Delivery Care Models for California Children's Services Under the §1115 Waiver

- DHCS will be required to establish organized health care delivery models for children eligible for the California Children's Services program (CCS) using the following four options: (1) An enhanced primary care case management program; (2) A provider-based accountable care organization; (3) A specialty health care plan; or (4) A Medi-Cal managed care plan that includes payment and coverage for CCS-eligible conditions.
- Regardless of which is used, the models must:
    - Establish clear standards for participation, exemption, enrollment, and disenrollment;
    - Provide care coordination linking children with special health care needs to appropriate services and resources;
    - Establish networks of providers to ensure timely access for CCS children;
    - Coordinate out-of-network access if appropriate;
    - Use CCS-approved providers;
    - Participate in a statewide quality improvement collaborative; and
    - Support medical homes that meet specified principles.
    - Children enrolled in Healthy Families will be authorized to enroll in the organized delivery models.
    - DHCS will conduct an evaluation as specified in the bill.

Seniors and Persons with Disabilities

March 23, 2010

- **Medicare Rebate.** Provides a $250 rebate for individuals in Medicare that have reached the Part D coverage gap.

Jan 1, 2011

- **Medicare Prevention.** Eliminates all cost sharing for preventive services, as recommended by the U.S. Preventive Task Force, covered by Medicare and waives the deductible for colorectal cancer screening test.
- **Pharmaceutical Discount.** Pharmaceutical manufacturers must provide a 50% discount on brand name drugs filled in the Medicare part D coverage gap while phasing in federal subsidies for generic filled prescriptions.

July 1, 2011

- **Medicare Income Freeze.** Freeze threshold for income-related Medicare part B premiums at 2010 levels through 2019, and reduce subsidy for specified individuals (those with incomes above $85,000/individual and $170,000/couple).

December 31, 2012

- **Federal Subsidies for Prescriptions in Part D Donut Hole.** Requires the phasing-in of federal subsidies for brand-name prescription drugs within the Medicare Part D coverage gap *(Tax years beginning 2013 or later)*.

Coordination Pilot for Dual Eligibles Under §1115 Waiver Legislation

- DHCS will establish pilot projects to give those eligible for Medicare and Medicaid (a.k.a. Dual Eligibles, a.k.a. Medis-Medis) a continuum of services and maximize coordination benefits between Medi-Cal, Medicare, or both .
- Pilot projects will be established in up to four counties, with specific requirements, including dual eligibles assigned as mandatory enrollees into managed care contracts.
- Any dual eligible has choice not to participate in a pilot project without receiving a reduction of the benefits available in the Medi-Cal or Medicare program.
- The pilot projects will attempt to: (1) improve continuity of acute care, long-term care, and home- and community-based services, (2) coordinate access to acute and long-term care services, (3) maximize the ability of dual eligibles to remain in their homes in lieu of institutions, and (4) increase the availability of and access to home- and community-based alternatives.
- DHCS will be required to identify health care models to be included in pilot projects while also developing a complete planning process and timeline by April 1, 2011. DHCS may implement the projects in phases then must report to the Legislature after the first full year on the operations of these pilots.

Managed Care for the SPD Population Under §1115 Waiver Legislation

- DHCS will be granted permission to enroll Seniors and Persons with Disabilities (SPDs) who do not have other health coverage into new or existing managed care health plans or county alternative models of care.
- DHCS will be required to ensure plan readiness before mandatory enrollment of the SPD population in managed care plans. Managed care health plans or county alternative models of care must comport with these requirements prior to enrollment of SPDs, including the development of medical homes into which SPD enrollees will be assigned.
- Enrollment of SPDs will be phased-in and will not begin until plans are deemed ready and the necessary federal approval has been acquired.
- Beneficiaries will have the choice to continue an established patient-provider relationship and fee-for-service will remain until enrollee is assigned to a provider through the enrollment process. Assignments are based on an enrollee's utilization of a provider, plan quality, and the inclusion of safety net providers within the health plan's network.
- DHCS must also establish a process for assigning enrollees, who have not made a care selection, into an organized delivery system.
- DHCS will provide the fiscal and policy committees of the Legislature with semiannual updates. In addition, DHCS, in collaboration with the Department of Social Services and county welfare departments, will monitor the In-home Supportive Services program and the adequacy of provider networks on a quarterly basis.

Persons with Pre-Existing Conditions

June 23, 2010

- **Funding for Pre-Existing Conditions.** $5 billion is available for uninsured individuals with pre-existing conditions to obtain insurance coverage in high-risk pools through 2014.

June 30, 2010

- **California High-Risk Pool.** Governor Schwarzenegger signs high-risk pool legislation into law, SB 227 (Alquist) and AB 1887 (Villines), establishing the new federally funded, state-administered high-risk pool.

August 31, 2010

- **High-Risk Pool Applications.** MRMIB begins accepting names and information for those who think they might apply for high-risk pool in California, officially called the Pre-Existing Conditions Insurance Plan (PCIP). MRMIB also announced the PCIP's expected premium rates will vary based on county and age. The pool is intended to provide coverage to approx. 25,000 uninsured California residents who have been denied health insurance because of pre-existing conditions or been offered only

unaffordable options. There will also be no annual eligibility review for PCIP and no open enrollment**,** meaning there is no need to reapply or renew coverage.

September 23, 2010

- **Insurance Limitations.** Prohibits individual and group health plans from rescinding coverage and from imposing a lifetime limit on the dollar value of coverage. This excludes cases of fraud and certain annual limits as determined by the Secretary.

December 31, 2013

- **Temporary High-Risk Pool.** The temporary high-risk pool ends.

January 1, 2014

- **Health Insurance Regulation.** Prohibits the discriminatory practices of insurance companies involving the sale and renewal of health plans based on health status, the exclusion of coverage for treatments based on pre-existing conditions, and increased rates due to health status, gender, etc. Premiums will only vary based on age (at no more than a 3.1 ratio), geography, family size, and tobacco use.

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