ITUP
Insure the Uninsured Project

2018 Year-in-Review

	January	February	March	April	May	June
FEDERAL	President Trump signs legislation extending funding for the State Children's Health Insurance Program (SCHIP) until 2023. SCHIP provides no-cost or low-cost coverage for children and is integrated into the Medi-Cal program. Medi-Cal is California's state Medicaid program and provides health coverage to approximately 13 million low-income Californians.	Twenty Republican state attorneys general (AGs) and governors file a lawsuit, *Texas v. U.S.*, arguing that the elimination of the individual mandate tax penalty in 2019 by Congress invalidates the entire Affordable Care Act (ACA).[1] The Trump Administration releases its proposed Fiscal Year 2019 Budget. The budget proposes investments in combating the opioid epidemic, lowering drug costs, and repealing and replacing the ACA.	Senators Lamar Alexander (R-TN) and Susan Collins (R-ME) introduce S. 1771, a bipartisan bill to address individual market stabilization. The bill reinstates cost-sharing reduction subsidies in state and federal marketplaces through 2021, allocates reinsurance funding, and allows more state flexibility under Section 1332 Waivers.[2] The bill did not move in 2018.	Centers for Medicare and Medicaid Services (CMS) publish the Final Payment Notice for 2019, outlining changes to state and federal marketplaces. A Payment Notice is an annual release. Center for Consumer Information and Insurance Oversight releases guidance expanding the reasons individuals can claim a hardship exemption from the individual mandate.[3]		Final federal rule eases restrictions on Association Health Plans (AHPs), making it easier for small employers to sidestep ACA requirements and buy coverage as large employers; coverage not subject to ACA small employer rules. U.S. Attorney General announces he will not defend elements of the ACA in *Texas v. U.S*. Sixteen state AGs, including California, and the District of Columbia, intervene to defend the ACA.
STATE	Governor Brown releases his proposed Fiscal Year (FY) 2018-19 State Budget, budgeting $104.5 billion for the Department of Health Care Services (DHCS), including $101.5 billion for Medi-Cal. DHCS implements palliative care program standards for all Medi-Cal managed care (MCMC) plans and the Legislature restores optional adult dental benefits for Medi-Cal beneficiaries ages 21 and older. Senate Health Committee holds an Informational Hearing on Substance Use Disorder Treatment in California, covering oversight and effective approaches to treatment.	Covered California ends the fifth open enrollment period with 423,484 new consumers, up 3 percent over 2017. Total enrollment hovers around 1.2 million.[4] 2018 bills include strategies to defend against federal ACA rollbacks, expand coverage, improve affordability, and control costs. See ITUP blog on the 2017-18 legislation. DHCS issues guidance on new Annual Network Certification standards for MCMC plans.[5]	The UC Berkeley Labor Center releases a report entitled, "Toward Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment." ITUP testifies at the Joint Informational Hearing of the Senate Committee on Health and the Senate Committee on Education entitled, "Health Insurance Coverage and Access to Care for College Students." See ITUP testimony.		The Governor issues the May Revision to his proposed FY 2018-19 State Budget. Assembly Budget Subcommittee includes $1 billion in state budget surplus to expand health coverage and make coverage more affordable. This funding was not allocated in the final State Budget.	The FY 2018-19 state budget passes without any significant investments to expand or improve affordability of coverage. Budget includes funding to explore policy options on coverage and affordability. See ITUP publication on policy options and blog on the state budget. Covered California adopts a $350 million 2018-19 budget, including significant investments, $107 million, in marketing and outreach to promote enrollment.

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	July	August	September	October	November	December
FEDERAL	Based on a New Mexico federal court decision, CMS temporarily halts risk adjustment payments in state and federal exchanges and then releases a proposed rule to address issues raised by the federal court. Risk adjustment payments transfer funds from exchange health plans with lower risk enrollees to those with higher risk enrollees. Individuals with lower risk typically require less services when compared to those with higher risk.	State Medicaid Director Letter (SMDL) affirms limitations on budget neutrality policies for Section 1115 Medicaid Demonstration Waivers originally released in 2016.[6] Final rule expands the definition of short-term, limited duration insurance (STLDI) from 3 to 12 months and permits renewals. STLDI is typically used to fill temporary gaps in coverage.	Federal district judge hears oral arguments in Texas v. U.S.	The Federal Administration releases guidance easing requirements for Section 1332 Waivers. Section 1332 of the ACA allows states to waive some individual and small group market requirements so long as certain protections or "guardrails" are met.[7] Department of Homeland Security releases proposed rule on public charge. For more information, see ITUP fact sheet and comments on the proposed rule.	In the election, Democrats gain 40 seats in the House of Representatives and majority control in 2019. The Senate remains under Republican majority control with 2 seats gained. CMS publishes a proposed rule to roll-back provisions in the 2016 comprehensive Medicaid managed care final rule.[8] CMS issues final rule on moral and religious exemptions for coverage of contraceptives services.	New final rule issued on the risk adjustment payments for the 2018 plan year. The Texas federal district court issues a decision on Texas v U.S., determining that the elimination of the individual mandate penalty invalidates the entire ACA. Soon after, 17 state AGs, led by California AG Xavier Becerra, secure a ruling challenging the lower court decision and preventing any immediate actions to unravel the ACA.
STATE	Covered California announces preliminary rates for 2019, reflecting a weighted average increase of 8.7%. Covered California attributes 2.5-6% to the elimination of the individual mandate penalty.[1] The Health Home Program (HHP) begins in San Francisco County. The HHP offers extra services to certain Medi-Cal members with complex medical needs. Three MCMC plans implement the Whole Child Model (WCM) in 6 counties. The WCM allows plans to coordinate most Medi-Cal benefits for children with specific complex conditions.[9]		Governor Brown signs health legislation, including bills preserving the progress made under the ACA, such as legislation prohibiting STLDI. See ITUP fact sheet on the Final Results of the 2017-18 Legislative Session. The Legislature passes Assembly Bill 2472 (Wood, Chapter 677, Statutes of 2018) requiring an analysis of the feasibility of a public option to increase competition and choice for health care consumers. See ITUP issue brief on the public option.	Covered California opens enrollment for 2019 coverage.[4] United Healthcare (UHC) withdraws as a MCMC plan in Sacramento County. Federal CMS approves two State Plan Amendments (SPAs) on the HHP. SPA 18-0019 expands the health home program into Riverside and San Bernardino counties. SPA 18-0020 adds beneficiaries with serious mental illness (SMI) or serious emotional (SED) in San Francisco.	California voters elect Governor Gavin Newsom and Democratic super-majorities in both houses of the Legislature. CMS requires DHCS to audit Medical Loss Ratio (MLR) for the ACA adult Medi-Cal expansion population, requiring health plans to spend less than 85% on medical services or return funds to DHCS for payback to CMS. California returns approximately $2.5 billion to CMS in 2018.	As of December 1, 2018, 22 counties, serving 75% of the Medi-Cal population, are approved to deliver Drug Medi-Cal Organized Delivery System (DMC-ODS) services. DMC-ODS is a demonstration project in the state's Medi-Cal 2020 federal waiver to expand substance use disorder treatment services under a managed care structure. In anticipation of confusion resulting from the Texas federal ACA ruling, Covered California extends the 2019 enrollment deadline for January 1 coverage.

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ENDNOTES

[1] Under the ACA, individuals must demonstrate they have minimum coverage, or pay a tax penalty ($695 or 2.5 percent of the individual's income, whichever is higher, unless the individual is eligible for an exemption from the individual mandate.) At the end of 2017, Congress passed federal tax reform eliminating the individual mandate tax penalty starting in 2019.
[2] ACA cost sharing reduction subsidies are designed to improve affordability in state and federal marketplaces by minimizing enrollee out-of-pocket costs when they use services. Reinsurance limits the costs a health plan can incur per enrollee. Section 1332 of the ACA permits a state to apply for a federal waiver of certain individual and small group market rules, with certain limitations.
[3] The individual mandate requires that almost everyone have coverage or pay a penalty. An individual can seek a hardship exemption for reasons specified in the ACA, including being homeless, being recently evicted or facing eviction, or recently filing for bankruptcy.
[4] Covered California is California's ACA state marketplace. An open enrollment period is the annual period when people can enroll in or make changes to health insurance coverage.
[5] Network Certification standards set the standards Medi-Cal health plans must meet to demonstrate that their provider network will allow them to provide all medically necessary services needed for the anticipated enrollment and utilization. Standards include the number and types of network providers, as well as the time and distance a beneficiary must travel to access a network provider.
[6] Section 1115 of the Social Security Act gives the U.S. Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program. Federal rules require that Section 1115 state waivers do not cost the federal government more money than otherwise would have been spent on the Medicaid program – a concept referred to as "budget neutrality."
[7] Section 1332 guardrails require states securing a waiver to: 1) provide coverage that is as comprehensive and affordable as ACA plans, 2) provide coverage that protects against excessive out-of-pocket costs at the same level as the ACA, 3) cover a comparable number of state residents as the number covered under the ACA, and 4) prohibits an adverse impact on the federal deficit.
[8] In 2016, CMS released a comprehensive final rule on Medicaid managed care, the first comprehensive Medicaid managed care rule in over a decade.
[9] The Whole Child Model serves children in the California Children's Services (CCS) program, a program serving children with specific complex conditions including cystic fibrosis, hemophilia and cerebral palsy. Under CCS, children enrolled in health plans receive services related to their CCS condition through the Medi-Cal fee-for-service program and services not related to their CCS-condition from the health plan.

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