CALIFORNIA STRATEGIES
Covering California's Remaining Uninsured and Improving Affordability

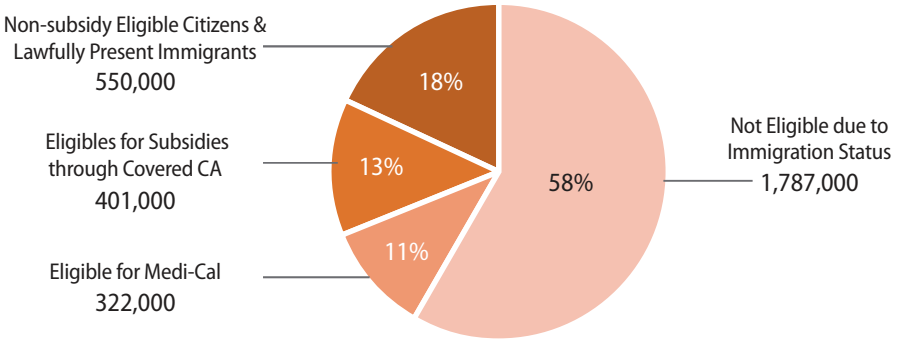
JUNE 2018 • ISSUE BRIEF

REVIEW OF 2018 POLICY PROPOSALS

California's successful implementation of the Affordable Care Act (ACA) dramatically reduced the number of uninsured to an historic low of 7 percent, approximately three million uninsured Californians. As outlined in this ITUP issue brief and the charts below, Californians have different reasons for being uninsured, including individuals who cannot access existing coverage programs because of immigration status and low- and moderate-income individuals who cannot afford the cost of premiums or cost sharing at the point of care. Each of the subgroups of the remaining uninsured, and the coverage and affordability challenges they face, can be addressed by targeted policy changes. This issue brief analyzes policy proposals advanced this year to move the state closer to universal coverage by focusing on the challenges many Californians face.

Profile of Uninsured Californians

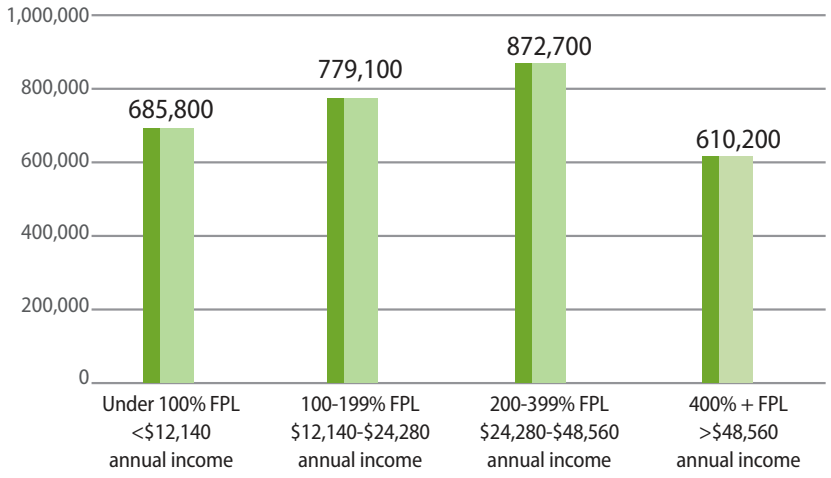
Nonelderly, 2017 Projections



Source: Miranda Dietz, Dave Graham-Squire, Tara Becker, Xiao Chen, Laurel Lucia, and Ken Jacobs, "Preliminary CalSIM v 2.0 Regional Remaining Uninsured Projections," August 2016; Chart prepared by Insure the Uninsured Project.

Uninsured Californians by Poverty Level

Nonelderly, 2016



Source: Kaiser Family Foundation estimates based on the Census Bureau's March Current Population Survey (CPS: Annual Social and Economic Supplements), 2014-2017; Chart prepared by Insure the Uninsured Project.

1 MEDI-CAL EXPANSION #1: Cover low-income undocumented adults in Medi-Cal

Problem Statement

The majority of the remaining three million uninsured Californians are undocumented adults, approximately 1.8 million, or 58 percent of the remaining uninsured. According to a recent report by the Legislative Analyst's Office (LAO), a Medi-Cal expansion for this population could cover up to 1.2 million low-income undocumented adults.

Coverage Challenges

Undocumented adults face significant barriers to coverage including:

- Undocumented adults have limited resources to pay for health coverage. An estimated 1.2 million are eligible under existing Medi-Cal rules, with incomes at or below 138 percent of the federal poverty level (FPL), representing approximately 40 percent of the remaining uninsured.[1]
- Although in California undocumented immigrant men age 18 to 64 have the highest labor market participation of any population, at 75 percent undocumented working age men also have the highest uninsured rate in the state.[2]
- Undocumented adults are primarily eligible for Medi-Cal coverage of emergency and pregnancy-related services, and long-term care services when needed. However, emergency care is limited to the services necessary for the treatment of an emergency medical condition.[3] Emergency care is episodic and does not promote prevention and treatment of chronic and emerging health conditions.
- Because of immigration status, undocumented adults are not eligible to buy individual coverage in the state ACA marketplace, Covered California, even if they pay the full premium, and are unable to receive federal subsidies for coverage.

Policy Goal

Provide comprehensive coverage for the largest group of remaining uninsured Californians – undocumented, low-income adults – and promote regular access to health care services that prevent and address ongoing health care needs.

Policy Approaches

Expand eligibility for comprehensive Medi-Cal benefits (full-scope) to adults age 19 and over with incomes at or below 138 percent of the FPL, ($16,754 per year) regardless of immigration status.

Alternative 1: Extend Medi-Cal coverage to income-eligible undocumented adults 19-25 years of age.

Alternative 2: Extend Medi-Cal coverage to income-eligible undocumented adults 65 and over.

Federal and State Context

Federal. Under federal rules, states choosing to provide comprehensive (full-scope) Medicaid coverage for undocumented adults must generally do so with state or local funds, except as described below.

Federal Medicaid funding is available for states to cover some undocumented immigrants for some services, primarily pregnancy-related and emergency services (restricted scope).

In addition, federal law also requires certain lawfully present immigrants to wait five years after achieving legal immigration status to be eligible for Medicaid, a requirement often referred to as the "five-year bar."[4]

State. California currently includes the following low-income immigrants in comprehensive (full-scope) Medi-Cal:

- Children under age 19 who meet specified income standards, regardless of immigration status.
- Lawfully present immigrants during the five-year waiting period for federal Medicaid.[5]
- Certain immigrant groups that are known to federal immigration authorities, including young adults with Deferred Action for Childhood Arrivals status.[6]

Undocumented adults are eligible for restricted-scope Medi-Cal. Restricted-scope Medi-Cal covers limited benefits including emergency and pregnancy related services, breast and cervical cancer-related treatment services, family planning services and long-term care services.[7] According to data from the California Department of Health Care Services, more than 80 percent of income eligible undocumented adults, approximately one million, are enrolled in restricted-scope Medi-Cal coverage.[8]

Some California counties provide limited health care services to undocumented individuals through their medically indigent adult programs. (See the ITUP publication, (See the ITUP publication, "County Medically Indigent Care Programs, Key Characteristics.")

For additional detail on federal rules and programs regarding coverage for immigrants see National Immigration Law Center, "Overview of Immigrant Eligibility for Federal Programs," December 2015.

Prior Proposals

As part of the 2015-16 state budget, California extended comprehensive Medi-Cal coverage to all low-income children under age 19, regardless of immigration status.[9]

Senate Bill (SB) 10 (Lara), Chapter 18, Statutes of 2016, directed Covered California to seek a federal waiver allowing undocumented individuals to purchase coverage on the state exchange. California withdrew its federal waiver application on January 18, 2017.

SB 1005 (Lara) of 2014 would have extended full-scope Medi-Cal eligibility coverage to low-income, undocumented adults but failed passage.

The 2017-18 Budget Conference Committee considered extending Medi-Cal coverage to undocumented adults up to age 26 but did not include the expansion in the final budget.

2018 Proposals

Legislation introduced in early 2018 proposed the expansion of Medi-Cal to all undocumented adults. The bills were recently amended as follows:

- SB 974 (Lara) extends eligibility for full-scope Medi-Cal benefits to low-income adults age 65 and over who are otherwise eligible but for their immigration status. *(As amended May 25, 2018)*
- Assembly Bill (AB) 2965 (Arambula) extends eligibility for full-scope Medi-Cal benefits to individuals ages 19-25 who are otherwise eligible but for their immigration status. *(As amended May 25, 2018)*

In addition, as part of the state budget process for 2018-19, the Legislature is considering a Medi-Cal expansion for undocumented adults as follows:

- The Assembly version of the budget added $125 million for state fiscal year (FY) 2018-19 and $250 million for FY 2019-20 full-year to expand Medi-Cal to income-eligible, undocumented adults 19-25.
- The Senate added $75 million for FY 2018-19 ($150 million full-year costs for FY 2019-20) to cover income-eligible adults age 65 and over, regardless of immigration status.

A budget conference committee composed of members from both houses will reconcile the differences between the Senate and Assembly versions of the budgets, for this and other proposals discussed below where there are differences in the budgets passed by the two houses.

Potential Costs

This expansion must be financed primarily with state funds, beyond the federal funds the state receives for restricted-scope Medi-Cal for undocumented adults.

According to the LAO, the total state cost of covering low-income, undocumented adults in full-scope Medi-Cal would be $3 billion ($4.7 billion total funds, including federal Medicaid and existing General Fund spending for restricted-scope Medi-Cal services).[10]

The LAO also estimated the state costs in FY 2018-19 to provide comprehensive Medi-Cal coverage for an estimated 111,000 undocumented adults age 19-25 at $140 million and for an estimated 36,000 undocumented adults age 65 and over at $330 million.[11]

Implementation Issues and Key Questions

As a state-only Medi-Cal expansion, the ongoing costs will be subject to the annual state budget process. Like other Medi-Cal programs that rely on state funds, this expansion could be vulnerable to elimination during future fiscal downturns.

Providing state coverage for undocumented adults could have implications for other state and federal funding that currently supports care for the remaining uninsured at the local level.

For example, the Assembly Appropriations Committee analysis of AB 2965 pointed out that a 2013 budget agreement between the state and counties to realign funding for county indigent health care might need to be reexamined if Medi-Cal is expanded to all undocumented adults. The 2013 agreement reallocated funds from the counties to the state because the ACA Medi-Cal expansion reduced county indigent care costs.[12] Covering undocumented adults in Medi-Cal could also reduce indigent care costs in some counties, depending on the scope of the expansion.

Uncertainty surrounding federal immigration policy appears to be having a chilling effect on immigrant access to health care and may also discourage undocumented adults from applying for Medi-Cal if newly eligible.

Contributing to the uncertainty are potential federal policy changes from the Trump Administration which surfaced in the form of a draft executive order and proposed regulations. The leaked federal changes could negatively impact the path to legalization for immigrants who receive certain federal benefits, including Medicaid.[13]

Other States

No state currently provides comprehensive, state-only Medicaid coverage to undocumented adults.

Six states (California, Illinois, Massachusetts, New York, Oregon, and Washington) and the District of Columbia use state-only funds to cover undocumented, income-eligible children through the state Medicaid program.[14]

Only California and New York provide state-funded medical assistance to otherwise eligible, lawfully residing immigrants, regardless of date of entry.[15] Thirty-two states, including California and the District of Columbia, administer the federal option to eliminate the five-year bar for lawfully present children. Thirty-four states, including California, use the federal option to provide prenatal care for lawfully present pregnant women.[16]

Hawaii and Massachusetts provide state subsidies for marketplace coverage of newly legalized, low-income, lawfully residing immigrants. Colorado provides medical assistance to lawfully residing immigrants with incomes under 250 percent FPL through the Colorado Indigent Care Program.[17]

Other states, such as Pennsylvania and Minnesota, provide medical assistance to some newly legalized, low-income, lawfully residing immigrants, such as seniors and individuals with specific health conditions.[18]

Fifteen states, including California, administer the federal Children's Health Insurance Program option to provide prenatal-care to income-eligible, undocumented women.[19]

2 MEDI-CAL EXPANSION #2: Eliminate monthly out-of-pocket costs for certain low-income seniors and disabled persons enrolled in Medi-Cal

Problem Statement

Approximately 27,000 seniors and persons with disabilities with incomes between 124 and 138 percent FPL are eligible for Medi-Cal, but for these individuals Medi-Cal coverage begins only after they pay a monthly out-of-pocket amount (share of cost) for medical care, similar to a health insurance deductible.[20]

Coverage Challenges

- Under the ACA, California expanded Medi-Cal to cover adults under 65 with incomes at or below 138 percent FPL using simplified eligibility rules that primarily consider income. However, seniors must still qualify under more complicated eligibility criteria and if their countable income (see below for more detail) is over 123 percent FPL, may have to pay a share of cost.
- Under the Share of Cost Medi-Cal program, individuals over 65 still qualify for full-scope Medi-Cal but must spend as much as $600 each month on medical care before Medi-Cal coverage begins.[21]
- Seniors and persons with disabilities age 65 and older with incomes over 123 percent FPL can purchase coverage through Covered California but are ineligible for ACA premium and cost sharing subsidies.
- Given the likelihood that seniors and persons with disabilities have ongoing health care needs, the monthly share of cost could serve as a significant barrier to care.

Policy Goals

- Apply a uniform income standard (up to 138 percent FPL) in Medi-Cal for eligible low-income adults, regardless of age.
- Replace the complex and dated formula that imposes the Medi-Cal share of cost for this population with simplified eligibility rules based on income.

- Improve access to care for affected seniors and persons with disabilities by eliminating financial barriers to accessing care.

Federal and State Context

Federal. Federal law establishes a Medicaid option for states to cover seniors and persons with disabilities with incomes above the federal Supplemental Security Income (SSI) eligibility level of 75 percent FPL up to a maximum of 100 percent FPL.[22]

Subject to some federal limitations, states have flexibility to establish the process for determining countable income for eligibility purposes, including specific exclusions of income and standard dollar deductions, known as income disregards.[23]

State. In 2000, California elected to implement the federal option and created the Medi-Cal Aged and Disabled Federal Poverty Level (A&D FPL) program.[24] The Medi-Cal A&D FPL program covers seniors and persons with disabilities with incomes up to 100 percent FPL, plus a standard income disregard of $230 for an individual and $310 for a couple. The resulting formula for countable income disregards (deducts) $230 from monthly income, along with any other applicable deductions or exclusions, and individuals are eligible if the remaining monthly income is at or below 100 percent FPL.

The formulas and income exclusions in the Medi-Cal A&D FPL program have not been updated over time and what started out as eligibility at 133 percent FPL is now effectively 123 percent FPL ($14,834 per year for an individual and $19,975 for a couple).

Prior Proposals

California policymakers have considered different strategies to improve affordability of the Medi-Cal program for seniors with incomes above 123 percent FPL including the following unsuccessful legislative efforts:

- AB 763 (Burke) of 2015 and AB 2025 (Dickinson) of 2014 increased the income eligibility for the Medi-Cal A&D FPL program to 138 percent FPL.
- As originally introduced, AB 55 (Dymally) of 2006 increased the Medi-Cal A&D income threshold to 133 percent FPL.
- AB 969 (Chan) of 2001 incorporated annual cost of living adjustments in the Medi-Cal A&D FPL program formula.

As part of the budget process for the last three years, the Legislature considered but did not include changes to the Medi-Cal A&D FPL program eligibility rules.

2018 Proposals

AB 2430 (Arambula) expands Medi-Cal eligibility in the Medi-Cal A&D FPL program by increasing income disregards so that individuals would be eligible up to 138 percent FPL.

The Legislature is also considering budget proposals that adjust the program eligibility to 138 percent FPL.

Potential Costs

If the state adjusts the income eligibility to cover this group of uninsured, the state will receive 50 percent federal matching funds.

In 2015, AB 763 (Burke) increased the income eligibility to 138 percent FPL. At the time, the Assembly Appropriations Committee estimated the cost at $60 million ($30 million state General Fund) and projected enrollment at approximately 20,000.[25] AB 763 failed passage in the Assembly Appropriations Committee.

The Assembly version of the 2018-19 Budget adds $30 million state General Fund to expand eligibility up to 138 percent FPL. The Senate adds $15 million in FY 2018-19 to implement the eligibility expansion effective January 1, 2019, and $30 million annually thereafter.

Implementation Issues and Key Questions

Since the program exists, changing the formulas to cover all eligible adults up to 138 percent is primarily an issue of policymaker priorities for state funding. Simplifying eligibility based primarily on income would make the program easier for individuals to apply for and understand.

Seniors and people with disabilities are a relatively high-cost population to cover compared to younger, healthier groups.

Other States

By 2015, 21 states implemented the state option to expand Medicaid to low-income seniors and persons with disabilities. Eighteen states, including California, set the income eligibility level at the federal maximum of 100 percent FPL.[26]

Of the 18 states at the federal maximum income eligibility level, California has the highest level of income disregards and is the only state with income disregards over $100.

Fifteen of the 18 states have $20 income disregards, one state has a $25 income disregard and another a $75 disregard. In contrast, California's income disregards are $230 for an individual and $310 for a couple.[27]

Because a higher amount of income is disregarded in California, seniors with incomes up to 123 percent, not just those at 100 percent FPL, qualify for the Medi-Cal

A&D Program. Because California has higher disregards, the income eligibility in other state Medicaid A&D Programs is lower than California.

3 INDIVIDUAL MARKET AFFORDABILITY #1: Provide financial assistance in the form of state subsidies to lower premiums for coverage through Covered California

Problem Statement

Of the remaining 3 million uninsured, an estimated 401,000 are currently eligible for subsidized coverage and another 550,000 are eligible to purchase unsubsidized coverage.[28] While federal ACA subsidies lower the cost of obtaining coverage, they may fall short of making coverage affordable for many Californians.

Affordability Challenges

- Cost is the primary reason Californians report for being uninsured. In 2016, among California Health Interview Survey respondents who reported they were uninsured and tried to purchase coverage through Covered California, the majority cited affordability as the main reason they remained uninsured.[29]
- The FPL standard for determining subsidies does not account for the higher cost of living in California and the discrepancy is greater in high-cost regions such as the San Francisco Bay Area.
- Federal ACA subsidies for coverage in Covered California may still leave individuals with significant costs in premiums, deductibles, and copayments.

Policy Goals

- Reduce the financial hardship of obtaining or retaining coverage by further lowering the share of monthly premium for low and moderate-income Californians who buy coverage in Covered California, thereby reducing the rate of uninsured Californians.
- Make premiums more affordable to encourage healthier people to seek and retain coverage.
- Attract younger and healthier individuals to improve the overall health of the risk pool (the group of individuals covered in a policy or market); a more favorable mix of healthy and higher-cost individuals can lower premiums for everyone in the individual market.

Federal and State Context

Federal. Under the ACA, federal tax credits that lower the monthly premium for coverage in Covered California are available to Californians with annual incomes up to 400 percent FPL ($48,420 for an individual, or $98,400 for a family of four) who meet all eligibility requirements and purchase coverage through Covered California. The amount of the tax credit is based on a federal formula using household income and family size; individuals generally pay some monthly premiums based on a sliding income scale.

Those over 400 percent FPL receive no financial assistance for coverage. While premiums vary by age and geographic region, a married couple in their early 60s with incomes above $66,000 face annual premiums of $14,000-$19,000.[30]

As of March 2018, 87 percent of Covered California enrollees qualified for subsidized coverage. In 2017, the federal government contributed $4.6 billion to subsidize premiums for 1 million eligible Covered California enrollees.[31]

Before Congress reduced the federal individual mandate penalty to $0 starting in 2019, taxpayers could avoid the penalty for being uninsured if the only coverage available to them was unaffordable, defined for this purpose as more than 8.16 percent of the taxpayer's income. The UC Berkeley Labor Center estimates that in 2017 hundreds of thousands of Californians *over* the 400 percent FPL threshold ineligible for federal subsidies spent more than 8.16 percent of their income on premiums for coverage in the individual market.[32]

State. In 2010, California passed state legislation to implement the ACA, including the establishment of the state exchange, Covered California, which administers eligibility for federal subsidies in accordance with federal law.[33] As an active purchaser, Covered California negotiates with health plans to lower premium costs.

A 2015 study conducted for Covered California showed that access to subsidized coverage increases the likelihood that Californians will purchase coverage.[34] Those who receive subsidies through Covered California rated their subsidies as "very or extremely important" in the decision to purchase coverage.

2018 Proposals

AB 2459 (Friedman) establishes a state premium tax credit for individuals with incomes between 400 and 600 percent FPL who purchase coverage through Covered California, contingent on annual appropriations to the state Franchise Tax Board (FTB). This bill sunsets in seven years and requires a report by the LAO after five years. *(As amended May 25, 2018)*

AB 2565 (Chiu) requires Covered California to offer enhanced premium assistance to consumers with incomes between 138 and 400 percent FPL eligible for federal tax credits, ranging from reductions to zero premium at 139 percent FPL up to a maximum premium of 8.16 percent of income for those between 299 and 400 percent FPL. *(As amended May 25, 2018)*

SB 1255 (Hernandez) requires Covered California to administer state financial assistance (defined as premium tax credits or reductions in cost-sharing) with priority for (1) consumers whose share of premium is more than 8 percent of income and (2) those with incomes 200 percent FPL or above who are subject to significant cost-sharing responsibilities. *(As amended May 25, 2018)*

The Legislature is considering a budget augmentation of $150 million General Fund in 2018-19 and $300 million ongoing for state premium assistance in Covered California.

Potential Costs

This policy change will need to be financed using 100 percent state funds.

Based on preliminary estimates from the UC Berkeley Labor Center, the Assembly Appropriations Committee estimates the revenue loss from providing a state tax credit for individuals over 400 percent FPL ($48,240 per year) at approximately $500 million.[35]

In addition, the FTB would incur costs of $2.2 million to administer the new tax credit. Covered California would incur additional undetermined costs to certify and manage the credits, and reprogram the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). CalHEERS is the technology platform that supports Covered California eligibility and enrollment and calculates credits for eligible individuals as part of the enrollment process.

Based on preliminary cost estimates from the UC Berkeley Labor Center, the Assembly Appropriations Committee estimates the cost for AB 2565 in the several hundred million up to $500 million. Changes to CalHEERS associated with AB 2565 are estimated to cost in the millions.[36]

The Senate Appropriations Committee estimates indeterminate costs, likely in the low-mid hundreds of millions, for the financial assistance required under SB 1255, and CalHEERS costs in the low-mid tens of millions.[37]

Prior Proposals

While there have been no legislative or budget proposals to offer additional state premium assistance prior to this year, one of the highest cost counties in the state provides additional financial assistance to certain workers. SF Covered Medical Reimbursement Account (SFCovered MRA) offers premium subsidies to certain San Francisco workers with incomes under 500 percent FPL who purchase coverage through Covered California. Enrollees in the program pay 40 percent of the Covered California premiums, with the remainder subsidized by the program.[38]

Implementation Issues and Key Questions

The costs of offering additional financial assistance will be ongoing and subject to the annual state budget process.

As the cost estimates indicate, both Covered California and FTB will incur costs to set up and administer a new state tax credit for the purchase of individual coverage through Covered California.

Covered California will incur costs to develop administrative processes for state-supported subsidies, train staff, and add new functionality to the technology platform in CalHEERS. To date, major changes to CalHEERS have been costly and time consuming, often resulting in implementation delays associated with policy changes and system improvements.

Other States

Massachusetts and Vermont offer state financial assistance in the form of additional exchange subsidies. In Massachusetts, individuals under 300 percent FPL are eligible for state-funded subsidies, and those under 150 percent FPL receive fully subsidized coverage (no premium cost to the consumer). In Vermont, those under 300 percent FPL are eligible for a state-funded subsidy to lower the maximum percentage of income paid on premiums by an additional 1.5 percent.[39]

In Hawaii, individuals ineligible for Medicaid with incomes under 100 percent FPL receive state premium assistance in addition to federal subsidies.[40]

4 INDIVIDUAL MARKET AFFORDABILITY #2: Provide financial assistance in the form of state subsidies to lower out-of-pocket costs for Covered California enrollees

Problem Statement

High out-of-pocket costs for health care services are a barrier to accessing health care. Even with coverage, Californians may experience hardship accessing care due to cost at the point of service, and as a result, delay or forego necessary health care services. High costs for health care services may discourage individuals from purchasing or retaining coverage.[41]

Affordability Challenges

- A 2014 study of Covered California enrollees found that roughly 4 out of 10 found it difficult to pay for out-of-pocket costs.[40] In 2016, 28 percent of adults in California reported cost problems that inhibited their access to care.[42]
- Low-income enrollees in Covered California are particularly likely to purchase a Bronze plan – one in four individuals with incomes at or below 400 percent FPL, and one in three with incomes between 200 and 400 percent FPL. Bronze plans offer lower premiums than other choices but require enrollees to pay a sizable portion of health care services out-of-pocket, including an annual deductible of $6,300.[43]
- Research by the Kaiser Family Foundation has shown that most U.S. households in the subsidy-eligible income range do not have sufficient savings to cover a $6,300 deductible.[44]
- Federal ACA subsidies for coverage in Covered California may still leave individuals with significant out-of-pocket costs in deductibles and copayments. The federal FPL standard does not account for the higher cost of living in California and the discrepancy is greater in high-cost regions such as the San Francisco Bay Area.[45]

Policy Goals

- Improve affordability of health care by reducing the amount consumers pay for health care in the form of deductibles and copayments at the point of service.
- Ensure that out-of-pocket costs at the point of service do not discourage individuals from seeking necessary care, including preventive services and ongoing treatment of chronic health conditions.
- Incentivize individuals to purchase coverage by increasing the value and impact of having coverage through lower out-of-pocket costs.

State and Federal Context

Federal. The ACA establishes specific levels of coverage aimed at helping consumers more easily compare coverage options. Sometimes referred to as "coverage tiers" or "metal tiers," the ACA levels of coverage reflect a plan's actuarial value – the percent of benefit costs covered by the policy across an average population. For example, a silver level plan covers 70 percent of the cost of benefits, on average, with the consumer paying the remainder through deductibles and copayments, while a bronze level plan covers 60 percent of the benefit costs.[46]

In addition, the ACA establishes cost-sharing reductions (CSRs) – payments to insurers to reduce the out-of-pocket costs for individuals between 138 and 250 percent FPL who purchase a "silver plan" in the exchange. The Trump Administration discontinued CSR payments to insurers in 2017 and litigation is pending to reinstate the payments. Insurers must, however, provide the cost reductions even if they do not receive the CSR payments.

State. As of March 2018, 68 percent of Covered California enrollees qualified for CSRs based on income, and 50 percent enrolled in a silver plan with CSRs.[47]

When the federal government discontinued CSR payments in October 2017, Covered California worked with participating health plans to add the cost of losing the payments to silver plan premiums, which are offset by increased premium subsidies for those eligible to receive assistance.

For individuals not eligible for subsidies, health plans developed silver level coverage plans in the individual market outside of Covered California, without the additional cost of the CSR workaround.

Prior Proposals

While there have been no statewide efforts to offer additional state financial assistance to lower out-of-pocket costs prior to this year, one of the highest cost regions in the state offers additional financial assistance to certain workers. SF Covered Medical Reimbursement Account (SFCovered MRA) provides cost-sharing subsidies to certain San Francisco workers that purchase coverage in Covered California and are under 500 percent FPL but not eligible for Medi-Cal or Medicare. Covered San Francisco MRA enrollees receive funding in their MRA sufficient to keep their deductibles below 5 percent of income.[48]

2018 Proposals

SB 1255 (Hernandez) requires Covered California to administer state financial assistance (defined in the bill as premium tax credits or reductions in cost-sharing) with priority for (1) consumers whose share of premium is 8 percent of income and (2) those with incomes 200 percent FPL or above who are subject to significant cost-sharing. *(As amended May 25, 2018)*

AB 3148 (Arambula) requires Covered California to offer additional cost sharing assistance to individuals with incomes between 200 and 400 percent FPL who are eligible for federal premium tax credits. AB 3148 failed passage on the Assembly Appropriations Suspense file.

Potential Costs

This policy change will need to be financed with 100 percent state funds.

The Senate Appropriations Committee estimates indeterminate costs, likely in the low-mid hundreds of millions, for the financial assistance required in SB 1255. Changes to CalHEERS associated with SB 1255 are estimated to cost in the low-mid tens of millions.[49]

Implementation Issues and Key Questions

Covered California will incur costs to develop administrative processes for state-supported subsidies, train staff, and adjust the technology platform in CalHEERS. To date, major changes to CalHEERS have been costly and time consuming, often resulting in implementation delays associated with policy changes and system improvements.

Other States

Massachusetts and Vermont offer state financial assistance to lower out-of-pocket costs for consumers under 300 percent FPL who purchase coverage on the exchange.[50]

5 INDIVIDUAL MARKET AFFORDABILITY #3: Provide state-funded assistance for dependent coverage through Covered California where the employee share for dependent coverage is a financial hardship

Problem Statement

The ACA definition of affordability that determines a family's eligibility for marketplace premium assistance excludes employee costs for dependent coverage. Federal rules only consider employee costs for their own coverage. This results in some families being unable to afford coverage for all family members and others enrolling in employer-sponsored insurance that they struggle to afford.

Affordability Challenges

- Federal law prohibits an employee (and dependents) from accessing ACA subsidies in the marketplace if the employee is offered "affordable" employer-sponsored insurance (ESI). Affordable is defined for this purpose as the cost of coverage for the employee only and excludes the employee's cost for dependent coverage.

- Many employees can afford ESI for themselves but may not be able to afford the additional costs to cover dependents or the full cost of coverage in the marketplace for their dependents. This affordability challenge has become known as the "family glitch."

Policy Goals

- Address the family glitch by improving the affordability of coverage in the exchange for dependents of employees with annual incomes under 400 percent FPL.
- Equitably apply a uniform income eligibility standard for marketplace premium and cost sharing subsidies. Currently, some families with incomes under 400 percent FPL are unable to access subsidies because of the family glitch as outlined above.
- Improve the risk mix in Covered California by encouraging families to cover all family members, including younger healthier members, through assistance to lower premiums and reduce cost sharing for dependent coverage.

Federal and State Context

Federal. Federal law requires large employers to offer affordable ESI to full-time employees and their dependent children up to age 26 or pay a penalty.

The U.S. Internal Revenue Service (IRS) defined affordable coverage for an employee and their dependents in a 2013 final rule. The rule defines an employee-only, job-based health plan that costs 9.56 percent or less (in 2018) of the employee's household income as affordable. The percentage is adjusted annually.

Under this definition, if an employee is offered ESI at the cost of 9.56 percent of the family's household income for employee-only coverage, coverage for the entire family is considered affordable and the family is ineligible for ACA subsidies in the marketplace.

According to research by the Urban Institute, the family glitch results in families facing total costs for coverage up to 15.8 percent of income, or 12 percent after the tax advantages of ESI are factored in.

State. California passed state legislation to implement the ACA, including the establishment of the state exchange, Covered California, which administers eligibility for federal subsidies in accordance with federal law.[51]

Prior Proposals

Congress has considered federal legislation to fix the family glitch, but the bills ultimately failed to pass. For example, former Senator Al Franken (D-MN) introduced the Family Coverage Act in 2014 (S.2434) to eliminate the family glitch.

There have been no prior state efforts to address the family glitch in California.

Implementation Issues and Key Questions

California lawmakers introduced legislation to address affordability concerns for individual market consumers already eligible for ACA premium subsidies and for those with incomes above 400 percent FPL, but no legislation currently seeks to address the family glitch for dependents in families under 400 percent FPL.

According to estimates from the UC Berkeley Labor Center and UCLA Center for Health Policy Research, addressing the family glitch will result in 30,000 uninsured Californians gaining coverage. However, the largest group that would benefit from this proposal (110,000) will be individuals enrolled in ESI transitioning to more affordable coverage in the marketplace.[52]

Cost Estimates

To fix the family glitch for 6 million people nationwide, Urban Institute estimated the additional costs to the federal government for premium tax credits and cost-sharing reductions to be between $3.7 billion and $6.5 billion in 2016.

Other States

No state has addressed the family glitch.

SF Covered Medical Reimbursement Account (SFCovered MRA) provides premium and cost sharing subsidies for specific employees and their adult dependents enrolled in Covered California. It is not known to what extent individuals affected by the family glitch have enrolled in this program.

CONCLUSION

Even before the ACA, California adopted coverage programs beyond federal mandatory programs, and populations, extending coverage to many of the state's lowest income residents. The California Legislature is currently considering multiple policy changes that would address the coverage and affordability challenges of the uninsured. This issue brief also makes clear that many of the proposals would rely on state funds with no federal financial participation available. California can continue moving toward universal coverage by adopting incremental policy changes to cover subgroups of the remaining uninsured.

OVERVIEW OF POLICY PROPOSALS

Covering California's Remaining Uninsured and Improving Affordability

	Medi-Cal Expansion #1	Medi-Cal Expansion #2	Individual Market Affordability #1	Individual Market Affordability #2	Individual Market Affordability #3
Policy	Cover low-income undocumented adults in Medi-Cal	Expand eligibility in the Medi-Cal Aged and Disabled Federal Poverty Level (FPL) Program to 138 percent FPL	Provide financial assistance in the form of state subsidies to lower premiums for coverage through Covered California	Provide financial assistance in the form of state subsidies to lower out-of-pocket costs for Covered California enrollees	Provide state-funded assistance for dependent coverage through Covered California for families who cannot afford the employee share of premiums for dependent coverage
Problem Statement	The majority of the remaining uninsured are undocumented adults and many are low-income; extending Medi-Cal to this population could cover up to 1.2 million undocumented adults.	Around 27,000 seniors and persons with disabilities with incomes under 138 percent FPL must pay a monthly amount for medical care, similar to a health insurance deductible, to be eligible for Medi-Cal.	While federal ACA subsidies lower the cost of obtaining coverage through Covered California, the subsidies may fall short of making coverage affordable for many Californians.	Californians may experience hardship accessing care due to costs at the point of service in the form of deductibles and copayments, and as a result, delay or forego necessary health care services.	For individuals with employer coverage, the ACA definition of affordability excludes employee premiums for dependents, affecting 30,000 uninsured Californians.
Proposals	SB 974 (Lara) extends eligibility for full-scope Medi-Cal benefits to low-income adults 65 and over regardless of immigration status. (As amended May 25, 2018) AB 2965 (Arambula) extends eligibility for full-scope Medi-Cal benefits to individuals ages 19-25, who are otherwise eligible but for their immigration status. (As amended May 25, 2018) The Legislature is considering budget proposals that expand Medi-Cal to undocumented adults.	AB 2430 (Arambula) expands Medi-Cal eligibility for seniors and persons with disabilities so that individuals would be eligible with incomes up to 138 percent FPL. The Legislature is also considering budget proposals that adjust the program eligibility to 138 percent FPL.	AB 2459 (Friedman) establishes a state premium tax credit for individuals with incomes between 400 and 600 percent FPL who purchase coverage through Covered California. (As amended May 25, 2018) AB 2565 (Chiu) requires Covered California to offer enhanced premium assistance to consumers with incomes between 138 and 400 percent FPL. (As amended May 25, 2018) SB 1255 (Hernandez) requires Covered California to administer state premium tax credits or cost-sharing reductions. (As amended May 25, 2018)	SB 1255 (Hernandez) requires Covered California to administer state financial assistance (defined in the bill as premium tax credits or reductions in cost-sharing). (As amended May 25, 2018) The Legislature is considering budget augmentations that include $150 million General Fund in 2018-19 and $300 million ongoing for state premium assistance in Covered California similar to this bill and legislation for this proposal and Affordability proposal #1.	None

NOTES

1. Legislative Analyst's Office (LAO), "Estimating the Costs of Expanding Full-Scope Medi-Cal Coverage to Undocumented Adults," May 10, 2018.
2. The 75 percent uninsured rate includes undocumented adults reporting public coverage because they are assumed to have restricted scope Medi-Cal and are considered uninsured. Steven P. Wallace, Jacqueline Torres, Tabashir Sadegh-Nobari, Nadereh Pourat, and E. Richard Brown, "Undocumented Immigrants and Health Reform," UCLA Center for Health Policy Research Final Report to The Commonwealth Fund, August 2012.
3. Only medical care that is strictly of an emergency nature, such as treatment in an emergency room, or treatment in a critical care unit or intensive care unit, meets this requirement. The California Department of Health Care Services Manual of Criteria defines emergency medical condition as a condition, if not treated urgently, would (1) place the patient's health in serious jeopardy; (2) result in serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.
4. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) imposed federal eligibility limits on some lawfully present immigrants for various federally sponsored health programs, including Medicaid. Lawfully present immigrants who gained legal status after August 22, 1996 must wait five years before becoming eligible for full-scope, federally-funded Medicaid coverage. Certain immigrant groups are exempt from the five-year bar, including refugees, asylees, Cuban/Haitian entrants, trafficking victims, and families of veterans.
5. See Welfare and Institutions Code §14007.5.
6. California Department of Health Care Services, "Medi-Cal Statistical Brief – Medi-Cal's Non-Citizen Population," Research and Analytic Studies Division, October 2015.
7. California Welfare and Institutions Code Sections 24003, 14007.65, 14007.7, 14148, 14148.5, and 15832. California Health and Safety Code Section 104162.
8. LAO, "Estimating the Costs of Expanding Full-Scope Medi-Cal Coverage."
9. SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2016. SB 4 (Lara), Chapter 709, Statutes of 2015, refined the program enacted in the budget.
10. LAO, "Estimating the Costs of Expanding Full-Scope Medi-Cal Coverage."
11. LAO, "Estimating the Costs of Expanding Full-Scope Medi-Cal Coverage."
12. Assembly Appropriations Committee analysis of AB 2965 (Arambula), as amended March 23, 2018, posted online May 24, 2018. See information about the 2013 Health Realignment provided by the California Association of Public Hospitals and Health Systems.
13. For more information, see Kaiser Family Foundation, "Proposed Changes to "Public Charge" Policies for Immigrants: Implications for Health Coverage," February 2018.
14. National Immigration Law Center (NILC), "Health Coverage for Immigrant Children and Health Coverage for Pregnant Women," January 2018. NILC, "Table – Medical Assistance Programs for Immigrants in Various States," January 2018.
15. NILC, "Table – Medical Assistance Programs."
16. NILC, "Table – Medical Assistance Programs."
17. NILC, "Table – Medical Assistance Programs."
18. NILC, "Table – Medical Assistance Programs."
19. NILC, "Table – Medical Assistance Programs."
20. Assembly Appropriations Committee analysis of AB 2430, as introduced February 14, 2018, posted online May 21, 2018.
21. Assembly Appropriations Committee analysis of AB 2430.
22. 42 U.S. Code §§ 1396a(a)(10)(A)(ii)(X); 1396a(m).
23. Assembly Health Committee analysis of AB 763, as introduced February 25, 2015, posted online April 3, 2015.
24. AB 2877 (Thomson, Chapter 93, Statutes of 2000.)
25. Assembly Appropriations Committee analysis of AB 763.
26. Molly O'Malley Watts, Elizabeth Cornachione, and Marybeth Masumeci, "Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015," Kaiser Family Foundation, March 2016.
27. Watts, "Medicaid Financial Eligibility."
28. Miranda Dietz, Dave Graham-Squire, Tara Becker, Xiao Chen, Laurel Lucia, and Ken Jacobs, "Preliminary CalSIM v 2.0 Regional Remaining Uninsured Projections," August 2016.
29. UCLA Center for Health Policy Research, AskCHIS 2016, "Difficulty of finding affordable plan through Covered California."
30. Covered California online, "Shop and Compare."
31. LAO, "What the Patient Protection and Affordable Care Act (ACA) Means for California," March 2017.
32. Laurel Lucia and Ken Jacobs, "Towards Universal Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment," University of California, Berkeley Center for Labor Research and Education, March 5, 2018.
33. AB 1602 (John A. Perez), Chapter 1655, Statutes of 2010.
34. NORC at the University of Chicago, "Covered California Overview of Findings from the Third California Affordable Care Act Consumer Tracking Survey," October 2015.
35. Assembly Appropriations Committee analysis of AB 2459, as introduced February 14, 2018, posted online May 21, 2018.
36. Assembly Appropriations Committee analysis of AB 2565, as introduced February 15, 2018, posted online May 21, 2018.
37. Senate Appropriations Committee analysis of SB 1255, as introduced February 15, 2018, posted online May 22, 2018.
38. Ken Jacobs, "Universal Access to Care: Lessons from San Francisco, Testimony to the California Assembly Select Committee on Health Care Delivery Systems and Universal Coverage," December 11, 2017.
39. Lucia, "Towards Universal Coverage."
40. State of Hawaii online, "Hawaii Health Care Premium Assistance Program."
41. Linda J. Blumberg and John Holahan, "After King v. Burwell: Next Steps for the Affordable Care Act," Urban Institute, August 2015.
42. Vicki Fung, Catherine Y. Liang, Karen Donelan, Cassandra G. K. Peitzman, William H. Dow, Alan M. Zaslavsky, Bruce Fireman, Stephen F. Derose, Michael E. Chernew, Joseph P. Newhouse, and John Hsu, "Nearly One-Third Of Enrollees In California's Individual Market Missed Opportunities To Receive Financial Assistance," Health Affairs 36, No. 1 (2017): 21-31.
43. Munira Z. Gunja, Sara R. Collins, Michelle M. Doty, and Sophie Beutel, "Insurance Coverage, Access to Care, and Medical Debt Since the ACA: A Look at California, Florida, New York, and Texas," The Commonwealth Fund, March 2017.
44. Lucia, "Towards Universal Coverage."

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45. Matthew Rae, Gary Claxton and Larry Levitt, "Do Health Plan Enrollees have Enough Money to Pay Cost Sharing?" Kaiser Family Foundation, November 13, 2017.
46. Lucia, "Towards Universal Coverage."
47. There are four levels of coverage in ACA plans. As the plan category increases in value, the proportion of costs covered by the health plan increases.
    Bronze: plan pays 60%, consumer pays 40%
    Silver: plan pays 70%, consumer pays 30%
    Gold: plan pays 80%, consumer pays 20%
    Platinum: plan pays 90%, consumer pays 10%
48. Covered California, "Active Member Profiles," March 2018.
49. Ken Jacobs, "Universal Access to Care."
50. Senate Appropriations Committee analysis of SB 1255, as introduced February 15, 2018, posted online May 22, 2018.
51. Lucia, "Towards Universal Coverage."
52. AB 1602 (John A. Perez), Chapter 1655, Statutes of 2010.
53. Lucia, "Towards Universal Coverage."

Acknowledgement

This research is supported by the California HealthCare Foundation (CHCF), which works to ensure that people have access to the care they need, when they need it, at a price they can afford. Visit www.chcf.org to learn more.

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Insure the Uninsured Project (ITUP) is a Sacramento-based nonprofit health policy institute that for more than two decades has provided expert analysis and facilitated convenings for California policymakers and decisionmakers focused on health reform.

The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad- based stakeholder engagement.

ITUP is generously supported by the following funders:

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