California Legislature

SENATE COMMITTEE ON HEALTH

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Informational Hearing: The Affordable Care Act in California: What's at Stake
January 19, 2017 - 3:00pm

Background

Purpose. The federal Patient Protection and Affordable Care Act (ACA), approved on March 23, 2010, was the most transformative legislative action the U.S. health care system had seen in 40 years. The passage of the ACA meant sweeping changes to health care coverage in this country, including establishing more generous eligibility rules and federal funding for California's Medicaid (Medi-Cal) program, providing federally funded premium and cost-sharing subsidies offered through California's Health Benefit Exchange (known as Covered California), and imposing new requirements on health insurers that made it easier for individuals with pre-existing conditions to obtain coverage. The coverage expansions alone led to 20 million newly insured individuals in this country, including over 5 million Californians. President-elect Trump and the Republican leadership of the 115th Congress have announced their intentions to repeal and replace the ACA.

The purpose of this hearing is to inform policymakers and the public about the implementation of the ACA in California over the last six years, what is at stake if the ACA is repealed, and what changes could improve the ACA. While there are many provisions of the ACA that impact Medicare and other aspects of the U.S. health care system, the primary focus of this hearing is on the provisions which resulted in the major coverage expansions. These provisions were also proposed for repeal in the 2015-16 Congressional session in HR 3762, and are currently the subject of debate at the federal level.

Major provisions of the ACA. The ACA provided new funding and established new requirements with the goal of expanding health insurance coverage. Some of these requirements include:

Major Medicaid Provisions

Expanded eligibility	Requiring Medicaid coverage of adults without minor children under age 65 who were previously ineligible for Medi-Cal with incomes up to 138% of the federal poverty level (FPL) and extended income eligibility to previously ineligible parents with incomes up to 138 percent of the FPL (at or below $16,395 in 2016 for an individual and $22,108 for two individuals)
Former Foster Youth	Extending Medicaid coverage to former foster youth up to age 26
No Wrong Door	Allowing individuals to apply for Medicaid in person, via phone, by mail, and through the internet or facsimile
Administrative Simplification	• Eliminating the asset test for certain groups of applicants to Medicaid • Establishing a new methodology for counting income in Medicaid for most individuals, known as modified adjusted gross income (MAGI)

Major Health Insurance Coverage Reforms

Exchanges	• Requiring states to establish health care exchanges or participate in a new federal exchange where individuals and small businesses can comparison shop for comprehensive coverage • Providing advance premium tax credits (also referred to as subsidies) to reduce the cost of insurance coverage for individuals with incomes below 400% of the FPL (at or below $47,080 for an individual in 2016) who purchase individual insurance coverage through exchanges • Providing cost-sharing reductions for individuals with incomes below 250% of the FPL (at or below $29,425 in 2016) who purchase individual insurance coverage through exchanges • Creating temporary tax credits for small employers with no more than 25 full-time equivalent employees whose average annual wages are less than $50,000 • Requiring website information for individuals and small businesses to identify and compare available health insurance options

Individual Mandate	• Requiring all individuals with access to affordable coverage (cost less than 9% of household income) to purchase minimum essential coverage or pay a penalty of $695 or 2.5 percent of income (up to a cap) for 2016. • Exceptions are made for individuals not lawfully present in the U.S., religious objectors, incarcerated individuals, individuals with income below tax filing thresholds, members of Indian tribes, and people who are granted a hardship waiver or who have been without coverage for less than three months of the year
Employer Mandates	• Requiring employers with over 200 employees to enroll full-time employees into employer based health coverage with sufficient notice and options for employees to opt out • Requiring employers with at least 50-full-time employees to pay a penalty if the employer does not offer qualifying coverage and at least one full-time employee qualifies for premium tax credits to purchase insurance in an exchange. The penalty is $2,000 for each of all the full-time employees minus the first 30 employees. For employers with more 50 employees the penalty is higher

Major Insurance Market Reforms

Annual and lifetime limits	Prohibiting insurers from imposing lifetime or annual limits on the dollar value of benefits
Dependent coverage to age 26	Requiring coverage of dependents until the adult child turns age 26
Rating Factors	Limiting variations in premium rates that can be charged by health insurers for individuals and small groups by family structure (individual vs. family), geographic area, age (older people cannot be charged more than three times a younger person) and tobacco use (a tobacco user can only be charged 1.5 times a nontobacco user)
Guaranteed Issue and Renewability	Requiring health insurers to accept every employer and individual that applies during an open enrollment period or under special enrollment circumstances and requiring health insurers to renew policies
Preexisting Conditions	Prohibiting health insurers from imposing preexisting condition exclusions
Health Status Factors	Prohibiting insurers from establishing eligibility rules based on certain health status-related factors
Essential Health Benefits	Requiring health insurers to offer 10 essential health benefits including prescription drug coverage and mental health and substance use treatment with annual cost-sharing limitations and actuarial value requirements

Waiting Periods	Prohibiting health insurers from applying excessive waiting periods before coverage is effective
High Deductible Plans	Allowing high deductible catastrophic coverage for certain individuals under the age of 30
Preventive Services without Cost Sharing	Requiring coverage of preventive services without cost-sharing
Standard Benefits Comparison	Requiring standards for summary of benefits and coverage explanations
Provider Reimbursement Structures	Requiring provider reimbursement structures that improve health outcomes and prevent hospital readmissions
Medical Loss Ratio	Requiring annual rebates to enrollees if an insurer spends less than 80 to 85% of the premium on medical care
Grandfathered Plans	Allowing people to maintain coverage through grandfathered plans
Consumer Assistance	Funding for health insurance consumer assistance programs
Emergency Care Cost Sharing	Requiring in-network cost sharing for out-of-network emergency care without prior authorization from the insurer
Independent Consumer Appeals	Requiring processes for consumers to appeal claims and coverage denials and effective binding external review
Premium Rate Review	Requiring annual reviews of unreasonable rate increases in health insurance premiums
High Risk Pool	Requiring a temporary high-risk health insurance pool program

California has a history of strong consumer protections in its health insurance market; enacting some even before the ACA required them. However, prior to the ACA, the individual insurance market was not generally available to older individuals or individuals with preexisting conditions. If such individuals did have access to insurance, they paid much higher premiums than younger or healthier individuals or had coverage for preexisting conditions excluded from their insurance benefit. Additionally, health insurers could limit coverage by applying annual and lifetime limits on benefits, even to Californians with employer-based coverage.

California law makers passed at least 50 laws to harmonize California law with the ACA and establish Covered California, and implement the expansion in Medi-Cal. (For a complete list of the laws implementing the ACA please see the separate summary document). Given the many challenges to the ACA since its inception, California lawmakers suspended many of the pre ACA consumer insurance protections as a contingency should the ACA be altered. In the case of an ACA repeal, those provisions would become operative again.

Decline in uninsured from ACA. California has seen a remarkable decline in the number of people without health insurance coverage, as shown in Figure 1 and 2 below. Most notably, the percentage of Californians under age 65 without insurance declined from 22% in 2011 to 8.6% in 2015 (from 7.3 million in 2011 to 2.9 million in 2015). California experienced the largest percentage point decline in the uninsured rate of any state, according to the US Census Bureau.

Figure 1. Percentage of Non-Elderly Californians who are Uninsured

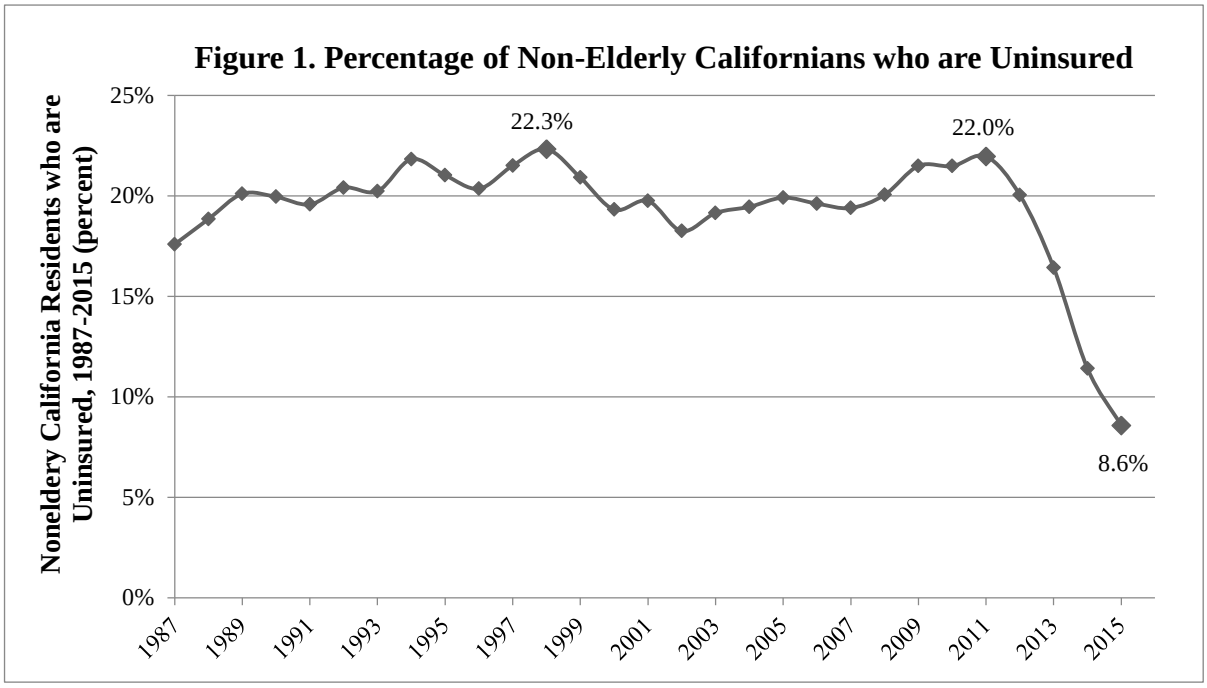
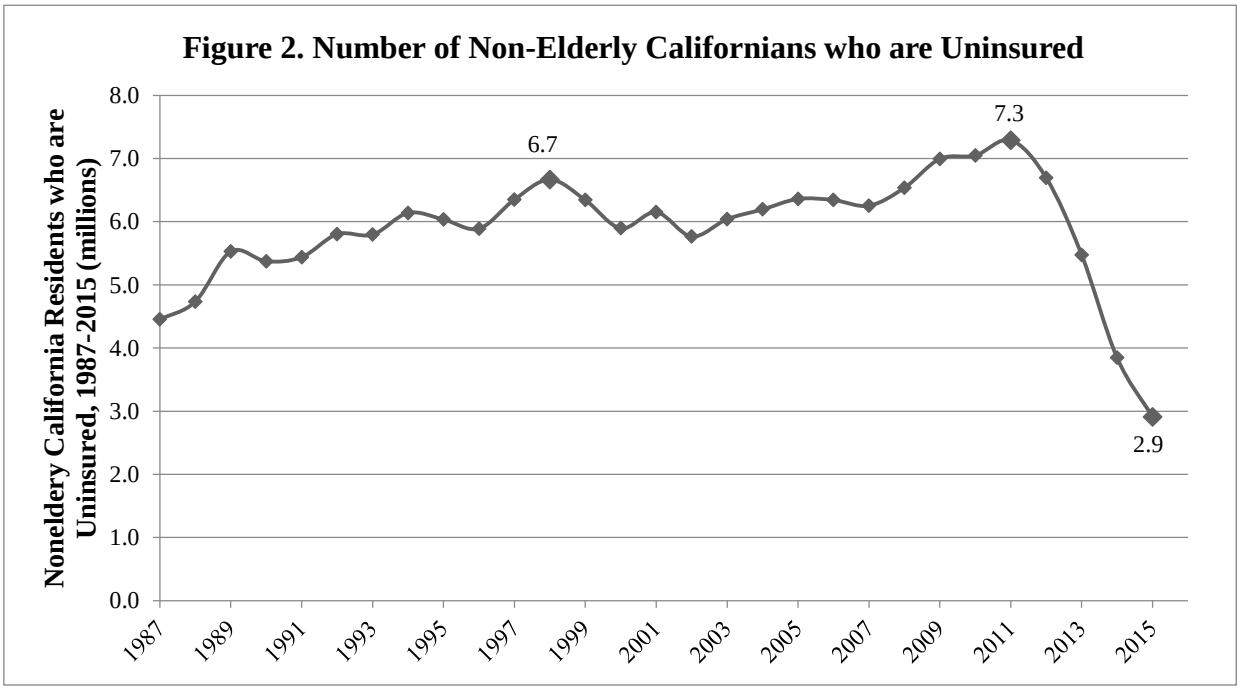


Figure 2. Number of Non-Elderly Californians who are Uninsured



The decline in uninsured as a result of the ACA crosses the major race/ethnic and income groups in California, as shown in the Figure 3 and 4 below:

Figure 3: Rate of Uninsured Californians, by Race/Ethnicity, 2013-2015

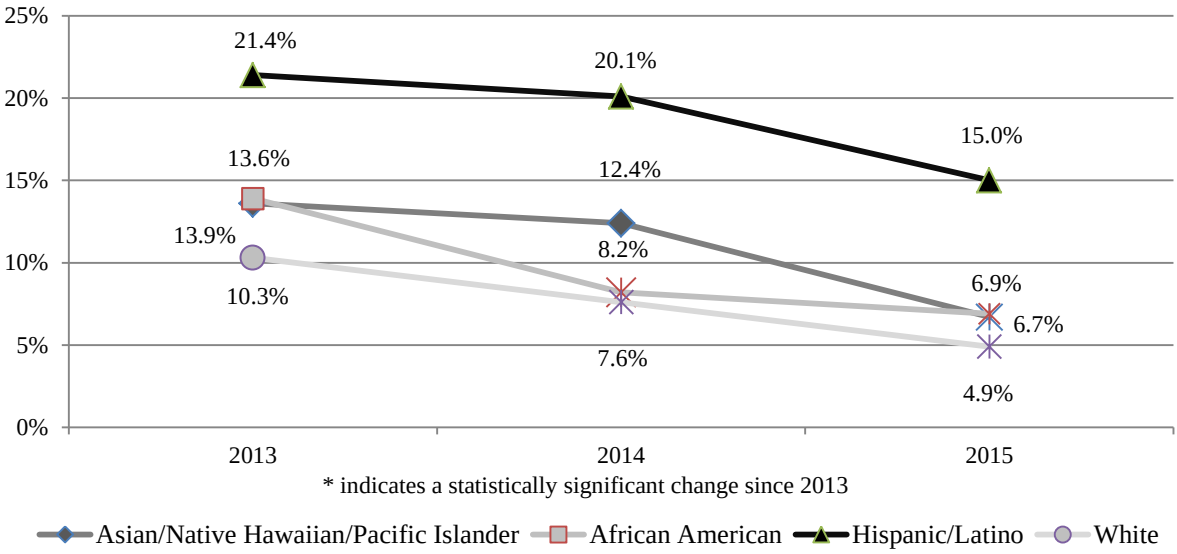
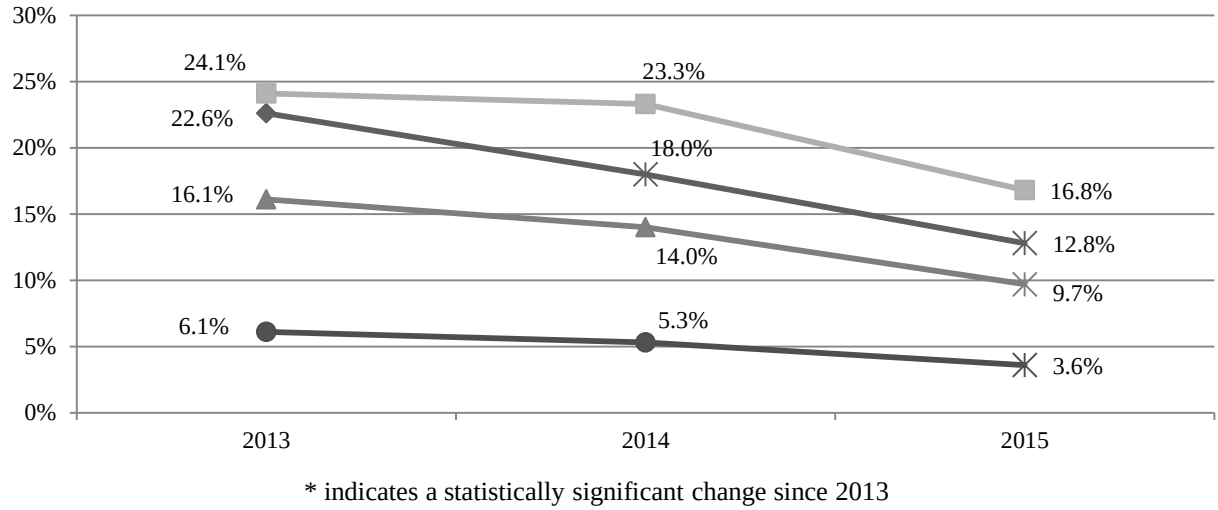


Figure 4: Rate of Uninsured Californians, by Income Level, 2013-2015



Medi-Cal and the "optional expansion" .Medi-Cal is administered by the Department of Health Care Services, with Medi-Cal eligibility determined primarily by county social service

departments. As a joint federal–state program, federal matching funds are available to the state for the provision of health care services for most low-income persons. In June 2016, there were 13.6 million individuals enrolled in Medi-Cal, comprising 34.5% of the state's population. Medi-Cal enrollment varies by county, with a low of 16.9% in Placer County to a high of 55.1% in Tulare County. Of the 10 counties with the highest shares of residents enrolled in Medi-Cal, six are in the San Joaquin Valley: Tulare (55.1%), Merced (51.5 %), Fresno (49.8 %), Madera (45%), Kern (45.9%), and Stanislaus (44.8%).

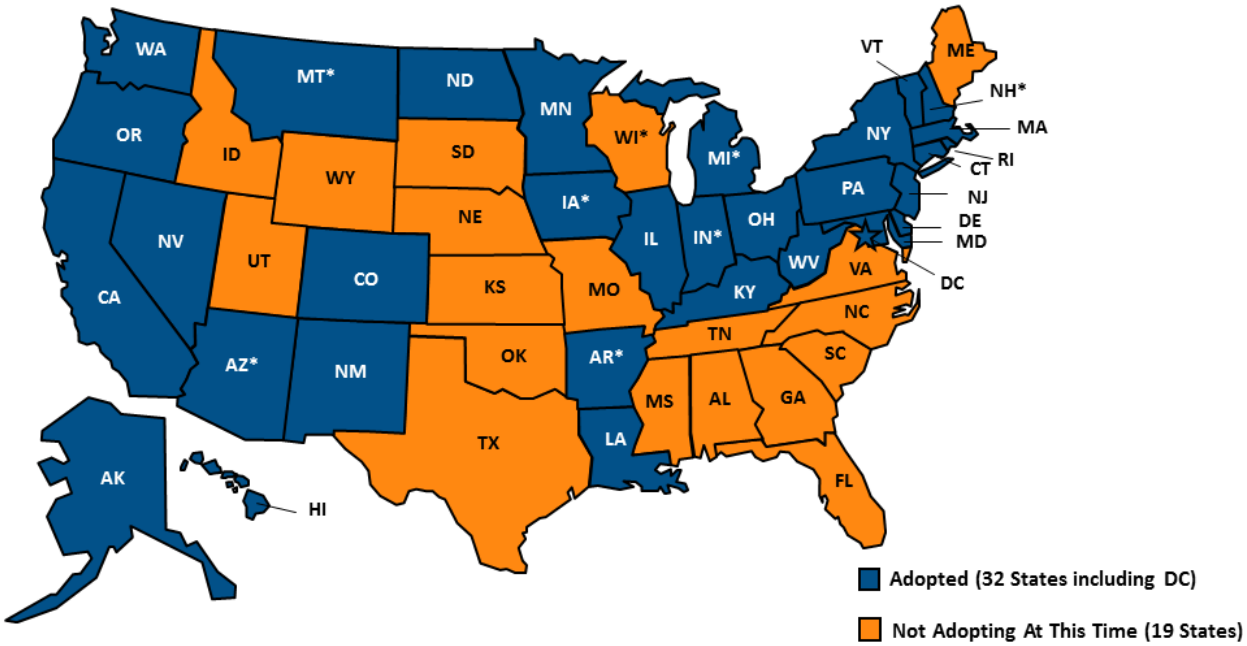
Prior to the ACA, Medi-Cal eligibility was mainly restricted to low-income families with children, seniors and persons with disabilities, and pregnant women. The coverage expansion began with state authorization of the Low-Income Health Program (LIHP) as an optional, locally funded, federally reimbursed health care coverage program under the terms of the state's 2010 Medicaid waiver for low-income individuals ineligible for Medi-Cal. The LIHP was a time-limited predecessor to the ACA expansion of Medicaid.

As part of the ACA, beginning January 1, 2014, the state expanded Medi-Cal eligibility to include additional low-income populations—primarily childless adults who did not previously qualify for the program. In California, the two principle groups included in the Medicaid eligibility expansion are non-disabled adults ages 18-64 without minor children and with incomes 0-138% of the FPL (up to $16,394 for an individual and $22,108 for a couple), and parents and caretaker relatives with incomes between 109-138 percent of the FPL (up to $27,821 for a family of 3). The expansion also covers legal immigrants subject to the five year bar from federal Medicaid funding (who are currently proposed to shift from Medi-Cal to Covered California coverage in 2018).

In June 2016, 3.69 million individuals received coverage through this Medi-Cal expansion. This enrollment is projected to increase in the state's 2016-17 budget year to 3.9 million individuals, and the Governor's January 2017-18 Budget projects a total of 4.1 million individuals for the budget year. This expansion is referred to by the Brown Administration as the "optional expansion" because the 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius* made the Medicaid expansion optional for states. Total projected enrollment in Medi-Cal for 2016-17 was 14.1 million, meaning the ACA mandatory expansion of 3.9 million individuals in 2016-17 represents 27.6 % of overall Medi-Cal enrollment.

As shown in the map below, California is one of 32 states that has implemented the Medicaid expansion.

Current Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated October 14, 2016.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

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Federal funds pay for nearly all of the cost of the Medi-Cal optional expansion. California's historical federal matching rate (referred to as the Federal Medicaid Assistance Percentage or "FMAP") for Medicaid services is generally 50%, meaning for every dollar the state spends, the federal government provides one dollar in federal matching funds.

By contrast, the benefit cost of the Medi-Cal expansion was funded entirely by federal funds for the first three years of the ACA implementation (2014-16). FMAP percentage declined to 95% as of January 1, 2017, and will decrease to 94% in 2018, 93% in 2019, and to 90% in 2020 and thereafter.

	2015-2016	2016-2017	2017-2018
Total Medi-Cal spending (all fund sources)	$ 91 billion	$ 100 billion	$ 102.6 billion
Medi-Cal Optional Expansion (federal funds)	$ 19.9 billion	$ 19.2 billion	$ 17.3 billion
Medi-Cal Optional Expansion Enrollment	3.4 million	3.9 million	4.1 million
General Fund for Overall Medi-Cal Budget	$ 17.7 billion	$ 19.6 billion	$ 19.1 billion
Total General Fund/Overall State Budget	$ 115.6 billion	$ 122.5 billion	$ 122.5 billion

"Mandatory expansion" and changes to make Medi-Cal enrollment and retention easier. In addition to the optional expansion, the ACA made a number of changes that made it easier to enroll and remain enrolled in Medicaid. The Brown Administration refers to these changes as the "mandatory expansion." These changes include:

Medicaid enrollment simplification.

- Pre-populated renewal forms for most individuals (Medi-Cal beneficiaries generally have to have their eligibility redetermined annually, and pre-populated forms have their information already entered);
- A longer time period to fix Medi-Cal redetermination forms that have been received late;
- A single-streamlined application for use to enroll in Covered California and Medi-Cal;
- The elimination of semi-annual status reports for adults in Medi-Cal; and,
- The ability of counties to electronically verify eligibility-related information (such as income) in lieu of paper-based documentation provided by applicants.

No asset test for individuals under age 65. The ACA eliminated the asset test for individuals under age 65. Prior to the ACA, most adults had an asset limit of $2,000 for single individuals and $3,000 for couples.

Hospital presumptive eligibility. The ACA required states to establish a hospital presumptive eligibility (PE) program whereby hospitals can determine temporary eligibility for Medicaid on-line at the hospital for individuals under age 65. The hospital PE program provides qualified individuals under age 65 immediate access to temporary, no-cost Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage.

As a result of the enrollment simplifications and eligibility expansions, enrollment in Medi-Cal has increased substantially since 2007, and "take-up" in Medi-Cal is much higher than historical trends from 2009. Enrollment in Medi-Cal in January 2013 was 7.9 million people, which increased to 13.6 million individuals in June 2016, an increase of 73%. For people without other coverage, the Medi-Cal take-up rate is 90% when previous estimates (using a different methodology) assumed a take-up rate of 68% for adults and 84% for children.

Covered California. Covered California is led by a five-member board appointed by the Governor and the leaders of the state Legislature. The Secretary of the Health and Human Services Agency serves as an ex officio voting member of the board. The board is responsible for making major policy decisions and for hiring senior staff. Covered California received more than $1 billion in federal grant funding for its launch; to build the information technology infrastructure; hire staff; undertake multicultural marketing, outreach and education efforts statewide; and work with community partners to educate target communities. Since 2014, Covered California has provided individual health insurance through private plans supported by federally funded tax subsidies and products for individuals and small businesses.

It is estimated that 1.4 million people will be enrolled in Covered California in 2017-18. Covered California is a self-sustaining entity funded through fees assessed on the participating health plans. The Covered California budget forecast assumes budgets of between $313 million and $320 million for FY 2017-18 through FY 2019-20. Between Covered California's headquarters in Sacramento and service centers in Rancho Cordova and Fresno, it employs more than 1,200 people.

Covered California enrollment activities. Covered California's first open enrollment period, October 1, 2013 until March 31, 2014, enrolled more than 3 million Californians: 1.4 million in private health insurance through Covered California and more than 1.9 million in Medi-Cal. As of December 2016, Covered California announced 1.2 million people renewed their coverage for 2017 and 139,000 individuals had newly enrolled in coverage through Covered California. The Covered California website is available in both English and Spanish. Landing pages exist in 11 languages: including Arabic, Armenian, Chinese, Farsi, Hmong, Khmer, Korean, Lao, Russian, Tagalog, and Vietnamese. In the first two enrollment periods Certified Insurance Agents signed up at least 40% of the total number of those enrolled. Covered California's partners opened more than 400 storefronts in retail locations, such as malls, to help serve consumers on a drop-in basis that met their scheduling needs. According to its 2015 report to the Legislature, Covered California had a comprehensive $46 million advertising campaign, for a total community outreach campaign investment of $94 million. More than 1,402 organizations statewide use new and existing resources to reach the state's various ethnic groups in both urban and rural areas, including schools, nonprofit community organizations, faith-based organizations, medical providers, unions, and elected officials. Covered California had 6,365 Certified Enrollment Counselors, nearly 15,000 Certified Insurance Agents and thousands of county eligibility workers engaged in outreach and enrollment to help reach targeted communities in California.

Advanced premium tax credits and cost sharing subsidies Almost 90% of Covered California enrollees benefit from receiving federal subsidies to lower their premium costs. In 2014, Covered California administered more than $3 billion in federal subsidies to make health care more affordable for Californians. Approximately 800,000 California households received federal subsidies to pay their monthly premiums, with the estimated average amount received being about $436 per month. For June of 2016, over 85,000 people were enrolled in Covered California from the greater San Joaquin Valley, of whom over 94% benefited from federal subsidies. For 2017, Covered California is estimating $4.6 billion in federal premium subsidies and another $800,000 in federal cost sharing subsidies.

Covered California plans and rates. Unlike other health benefit exchanges, Covered California is an "active purchaser," which means it selects plans and products to give uninsured Californians a mix of price and choice. In 2016, more than 90% of hospitals in California were available through at least one health insurance company, and about three-quarters (74%) were available through three or more companies. For 2017, Covered California is offering 11 health plans with new expanded options in Orange, San Francisco, and Santa Cruz counties. In addition, Covered California has required plans to lower copays for primary care visits and urgent care, saving consumers up to $55 per visit. Consumers in Silver, Gold and Platinum plans will pay a flat copay for emergency room visits without having to satisfy a deductible.

Until 2017, statewide weighted average rate increases were approximately four percent, a dramatic reduction from the trends that individuals faced in the years prior to the ACA. The modest rate increases negotiated for 2016 represented the second year of Covered California's success as an active purchaser. In the summer of 2016, Covered California unveiled its 2017 rates. The statewide weighted average change in rates is 13.2%, up from approximately 4% in each of the previous two years. Most consumers will see a much smaller increase or pay less if they are willing to switch to another plan.

Covered California indicates the rate increases for 2017 are a one-time adjustment due in large part to the end of federal programs such as the reinsurance program that helped keep rates low by supporting plans that had sicker enrollees and thus higher costs. With reinsurance expiring at the end of 2016, plans no longer receive reinsurance payments and have to adjust their rates to make up for those losses. It is estimated that the end of reinsurance added between 4% and 7% to rates in 2017. Additionally, the cost of health care continues to go up every year, with the cost of specialty drugs being a driver of those cost increases.

Repeal and replace. The Republican Congressional leadership and President-elect Donald Trump have called for a "repeal and replace" of the ACA. The U.S. Senate and House have passed a budget resolution calling key federal congressional committees to develop repeal legislation by the end of January. Previous attempts to dismantle key provisions of the ACA may indicate what is in store for replacement. In 2016, the 114th Congress passed HR 3762, which would have repealed the major coverage expansions of the ACA and the revenue increases used to fund the ACA, with different operative dates. These include the Medicaid expansions, the premium and cost-sharing subsidies for exchanges, the individual and large employer coverage requirements, and hospital presumptive eligibility. The Congressional Budget Office and Joint Committee on Taxation have estimated that enacting HR 3762 would increase the number of people without health insurance (relative to current law projections) by 18 million in the first

new plan year following enactment. After the elimination of the ACA's expansion of Medicaid eligibility and of subsidies for insurance purchased through the ACA marketplaces, that number would increase to 27 million, and to 32 million in 2026. Premiums in the individual market (for individual policies purchased through exchanges or directly from insurers) would increase by 20% to 25%—relative to projections under the ACA—in the first new plan year following enactment. The increase would reach about 50 percent in the year following the elimination of the Medicaid expansion and the exchange subsidies, and premiums would about double by 2026. President Obama vetoed HR 3762.

What's at stake. In addition to the millions of Californian lives affected, the repeal of the ACA could significantly impact the state's economic landscape. According to a recent University of California – Berkeley study, completely or partially overturning the ACA will impact vital components of California's economy, including the Medi-Cal expansion (and the $15.5 billion in federal funding provided to California for it), and $5 billion in federal funding subsidies to provide more affordable coverage for eligible enrollees under Covered California. The economic losses associated with these lost federal dollars would be partially offset by limited economic gains from other provisions that may be included as part of the repeal of the ACA, which could yield $6.3 billion in tax cuts to California insurers and high-income households and nearly $1.3 billion in eliminated penalties for uninsured individuals and employers not offering affordable coverage.

In addition to the financial implications, the repeal of the ACA will result in an approximate net loss of 209,000 jobs in California, with 135,000 coming from the health care industry. Most affected could be the State's Central Valley residents, who rely heavily on Medi-Cal and could be double hit with loss in health care services as well as cutbacks in employment opportunities. In Fresno County, the proportion of people with Medi-Cal coverage covered has jumped from 38% to 50%; in Tulare County, it has gone from 43% to 55%; and, in Kern County, it has grown from 34% to 45%. The region has also prospered from the jobs created by the ACA expansions: 6,000 jobs in Fresno; 3,000 jobs in Tulare; and, 5,000 jobs in Kern. The two hardest hit counties in terms of job losses from a repeal of the ACA are projected to be Los Angeles County (63,000 jobs) and San Bernardino County (12,000 job). Decline in employment will have additional effects on the local economy as well, indirectly impacting food and retail industries. These losses will directly affect the state's gross domestic product (GDP), with a projected net loss of $20.3 billion under partial ACA repeal. Similarly, state and local governments may experience a decline of $1.5 billion in tax revenue as a result of declines in income tax, sales tax, and other tax revenue.

Conclusion. Prior to the enactment of the major ACA coverage expansions, over 40 million Americans (including 7 million Californians) were uninsured. The consequences of a lack of insurance are dire. The federal Institute of Medicine put it succinctly: uninsured people are more likely to receive too little medical care and receive it too late; as a result, they are sicker and die sooner. The repeal of the Medicaid expansion and the advanced premium tax credits and cost-sharing subsidies would have a devastating impact on Californians who rely on the ACA for health insurance coverage. The state would likely be unable to backfill the loss of $20 billion in federal funds without massive tax increases or major program reductions. Twenty billion dollars is more than the amount California currently spending in its state budget on state courts, corrections and the University of California combined. The loss of this financing is a significant

blow to these major program expansions which are critical pieces that provide foundational support necessary to make the popular mandates on insurers work without destabilizing the entire health insurance market. An insurance market without stability will also have significant impacts on those Americans and Californians who are not dependent on Medi-Cal and Covered California for their health coverage. The loss of funding for the ACA will not only substantially affect California's GDP and employment rates, but its ramifications will be deeply felt on a local and individual level in terms of economic and health status for our residents.