California Legislature

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Informational Hearing:
The Affordable Care Act in Jeopardy: What does it mean for California?
October 21, 2020

Overview

The federal Patient Protection and Affordable Care Act (ACA), approved on March 23, 2010, is the most significant legislative reform of the U.S. health care system within the last 40 years. The passage of the ACA brought sweeping changes to health care coverage, 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 the California's Health Benefit Exchange (known as Covered California, which was established because of the ACA), and imposing new requirements on health insurers that make it easier for individuals with pre-existing conditions to obtain coverage. The coverage expansions alone have led to 20 million newly insured individuals in this country, including over five million Californians. ACA coverage has been crucial to the U.S. response to the COVID-19 pandemic that has resulted in over 850,000 cases and over 16,500 deaths in California.

Since its passage, the ACA has been challenged multiple times in the courts and Congress. More recently, in *Texas v. Azar*, 18 state attorneys general, led by the state of Texas, and two individuals filed a lawsuit challenging the constitutionality of the individual mandate. The plaintiffs argue that the entire ACA should fall as a result of Congressional action in 2017 that made the ACA coverage penalty amount zero. This position is also supported by the U.S. Department of Justice. Associated with an earlier U.S. Supreme Court ruling, plaintiffs in *Texas* argued that with no penalty there is no longer an exercise of federal taxing power, and the entire ACA should be struck down. A federal district court agreed. A federal appeals court ruled the coverage mandate requirement unconstitutional and remanded the question of severability to the lower court. California, 20 other state attorneys general and the governor of Kentucky, and the U.S. House of Representatives have appealed the decision to the Supreme Court, which is scheduled to begin hearing *California v. Texas*, on November 10, 2020.

The purpose of this hearing is to inform California policymakers and the public about the implementation of the ACA in California over the last ten years, and what is at stake if the ACA is ruled unconstitutional. There are ten titles of the ACA:

- Title I expands access to high quality health insurance and care.
- Title II expands Medicaid.
- Title III deals with Medicare.
- Title IV focuses on public health.
- Title V addresses healthcare workforce issues.
- Title VI responds to health care fraud and transparency.
- Title VII promotes competition in U.S. pharmaceuticals related to biosimilar drugs.
- Title VIII, which was repealed because of financing, would have created a voluntary, national, long term care living assistance and support insurance program.
- Title IX creates new taxes and mandatory payments to finance the ACA.
- Title X contains amendments to incorporate revisions necessary for final passage.

The primary focus of this hearing is on the provisions which resulted in the major health coverage expansions.

Coverage expansions.
Under the ACA, Medi-Cal eligibility was expanded to include coverage of adults under age 65 without minor children with incomes up to 138% of the federal poverty level (FPL) which in 2020 is $17,609 for an individual and $23,791 for a couple, parents with income up to 138% FPL who were not previously eligible, and former foster youth up to age 26. The ACA allows "No Wrong Door" enrollment via phone, mail, internet and fax, as well as eliminated the asset test for certain groups and established a new method for counting income known as modified gross income or MAGI. The ACA requires states to establish hospital presumptive eligibility (PE) whereby hospitals can determine temporary eligibility and immediate access to temporary, no-cost coverage while applying for longer term coverage.

With respect to private health insurance, the ACA requires states to establish health benefit exchanges or participate in a new federal exchange where individuals and small businesses (with up to 100 employees) can comparison shop for comprehensive health coverage. Additionally, federal subsidies or tax credits reduced the cost of insurance coverage for individuals with incomes below 400% FPL ($51,040 for an individual and over $104,800 for a family of four in 2020) who purchase individual/family insurance coverage through an exchange. Cost sharing reductions are required in exchanges for individuals with income below 250% FPL ($31,900 for an individual in 2020). Tax credits for small employers were also made available.

The ACA coverage mandate requires most individuals to purchase minimum essential coverage or pay a penalty of up to $695 or 2.5% of income up to a cap. This penalty was reduced to zero by Congress in 2017 as previously mentioned. Exceptions to the mandate were made for individuals' without access to an affordable plan, individuals' not lawfully present, religious objectors, incarcerated individuals, individuals with income below tax

filing thresholds, members of Indian tribes, and people granted a hardship waiver or those without coverage for less than three months.

Employers with over 200 employees are required to offer full-time employees coverage, and those with over 50-full-time employees are required to pay a penalty if qualifying coverage was not offered and an employee qualifies for federal tax credits in an exchange.

Health insurance reforms.
Insurance companies are required to comply with a number of market reforms depending upon the markets their products are sold in, with most applicable to the individual and small group markets. Some of those reforms are listed below:

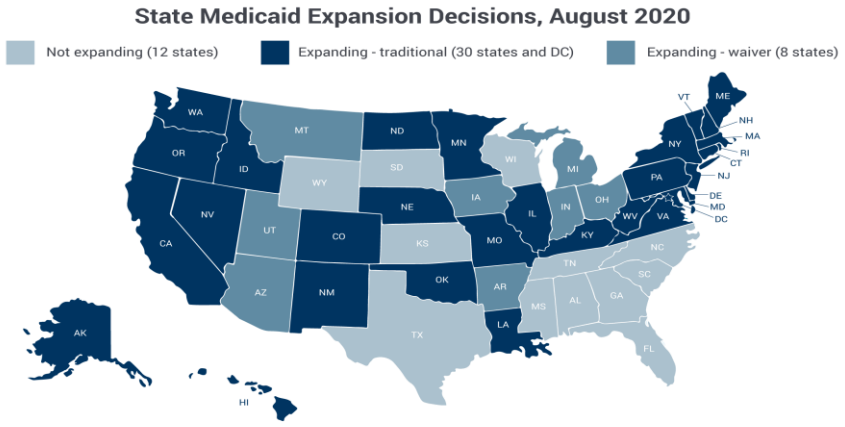
- Annual and lifetime limits – prohibit insurers from imposing lifetime or annual limits on the dollar value of essential health benefits.
- Essential health benefits – require coverage for 10 essential benefits including prescription drugs, mental health, substance use disorder treatment and behavioral health, rehabilitation and habilitative services and devices.
- Guaranteed issue and renewability – require acceptance of every employer and individual that applies/renews and pays premiums. Individual purchasers are subject to open enrollment and special enrollment periods.
- Preexisting conditions – prohibit health insurance companies from imposing preexisting condition exclusions.
- Health status factors – prohibit insurers from establishing rules based on certain health status-related factors.
- Premium rates – limit variations in premiums to only individual vs family structure, geographic area, age (older people cannot be charged more than three times a younger person), and tobacco use. In other words, premiums cannot be based on health status anymore. Require rate review to monitor for unreasonable rate increases.
- Dependent coverage to age 26 – children can remain on parents' coverage until age 26.
- Waiting periods – prohibit excessing waiting periods before coverage is effective.
- High deductible plans – allow high deductible catastrophic coverage for certain individuals under the age of 30.
- Preventive services without cost-sharing – require coverage of specified categories of preventive services as recommend by the U.S. Preventive Services Task Force.
- Medical loss ratios – require annual rebates to businesses and individuals that purchase health insurance when less than 85% or 80% of premiums are spent on medical care.
- Grandfathered plans – allow people to maintain coverage that does not meet ACA standards.

California has a history of strong consumer protections in its health insurance markets; 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 more than 50 laws to harmonize California law with the ACA, 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 legal and statutory challenges to the ACA since its inception, California lawmakers suspended 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.

Medi-Cal and the "optional expansion." Medi-Cal, which is administered by the Department of Health Care Services, provides comprehensive health care services at no or low cost for low-income individuals. Prior to the ACA, Medi-Cal eligibility was mainly restricted to low-income families with children, seniors and persons with disabilities, and pregnant women. California began coverage expansion 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 up to 138% of the FPL, and parents and caretaker relatives with incomes between 109-138% of the FPL. The expansion also covers legal immigrants subject to the five-year bar from federal Medicaid funding. According to the Medicaid and CHIP Payment and Access Commission in the map below, California is one of 38 states that has implemented or plans to implement the Medicaid expansion.



In June 2020, there were 12.8 million individuals enrolled in Medi-Cal, comprising 32.2% of the state's population. Medi-Cal enrollment varies by county, with a low of 15.2% in Placer County to a high of 52.3% in Tulare County. The ten counties with the highest shares of residents enrolled in Medi-Cal are, with the exception of Imperial County, primarily located in the San

Joaquin Valley and rural northern parts of California: Tulare (52.3%), Lake (49.7%), Imperial (49.2%), Merced (47.2 %), Fresno (46.2 %), Madera (45.9%), and Kern (45.5%), Colusa (45.3%), Mendocino (44%), and Del Norte (42.8%).

Federal funds pay for nearly all of the cost of the Medi-Cal optional expansion. 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. 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 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% in 2017, 94% in 2018, 93% in 2019, and to 90% in 2020, which it will stay at thereafter.

The Medi-Cal budget was $99.5 billion ($22.7 billion General Fund) in 2019-20 and $115.4 billion ($23.6 billion General Fund) in 2020-21. The Budget assumes caseload will peak at 14.5 million in July 2020, or about 2 million above what caseload would have been absent the COVID-19 pandemic. The Budget includes $898.6 million ($319.0 million General Fund) in 2019-20 and $6.9 billion ($2.4 billion General Fund) in 2020-21 for increased caseload.

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 Medi-Cal. These changes include:

- 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.
- The elimination of 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.

Finally, the ACA required states to establish a hospital PE program whereby hospitals can determine temporary eligibility for Medicaid online 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.

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.

More than four million people have been insured for at least one month directly through Covered California and more than 3.8 million people are currently enrolled in Medi-Cal due to the ACA. Millions more have purchased the same coverage directly from Covered California's 11 carriers on the "off-exchange" individual market. The Congressional action regarding the individual mandate penalty likely contributed to a 23.8% drop in the number of new consumers signing up with Covered California in the 2019 coverage year. This situation potentially hurt the risk mix, and caused California consumers paying an estimated $400 million more on their health care coverage in 2019. In response, Governor Newsom and the state Legislature appropriated General Funds for three years to support new state subsidies to eligible Californians, particularly those in the middle class who are currently just above the federal cutoff for financial help, and instituted a state-level mandate to encourage people to get covered for the 2020 coverage year.

In February of 2020, Covered California announced that 419,052 people had newly selected a health plan during the initial 2020 open-enrollment period (more than 122,000 or 41% higher than the previous year). By the end of a COVID-19 special enrollment period, Covered California announced that it reached peak enrollment over 1.53 million. This compares to its highest enrollment in October of 2018 of 1.3 million.

As of July of 2020, Covered California reported roughly 576,000 consumers, who earned between 200 and 400% FPL, were receiving an average of $608 per month, per household in federal tax credits and new state subsidies (which averages $23 per household), lowering the average household monthly premium from $881 per month to $272, a decrease of 70%. In addition, nearly 32,000 consumers with income between 400 and 600% FPL ($51,040 - $76,560) qualified for new state subsidies, averaging $504 per month, lowering their monthly premium by nearly half. Another 280,000 consumers with "off-exchange" coverage were also eligible had they enrolled through Covered California. In October, Covered California indicates that California's state-specific enhanced subsidies newly introduced in 2020 are benefiting about 590,000 enrollees in Covered California and are available again for both new and renewing members in 2021.

Californians will have an opportunity to enroll in individual market coverage for the 2021 plan year between November 1, 2020 and January 31, 2021. Covered California is launching a $157 million marketing and sales campaign and has announced a statewide weighted average premium rate change of a new record low of .5%. With the reduction in the statewide average rate change, the average rate change for unsubsidized consumers who shop and switch to the lowest cost plan in the same metal tier (metal tier refers to the cost-sharing structure of the plan with gold being low-cost sharing and bronze being high-cost sharing) is now -7.4%, which means because of competition in the market many Californians can get a lower gross premium if they shop and switch. In 2021, all 11 carriers will continue offering products across the state, and two companies will expand their coverage areas, providing increased competition and consumer

choice. Nearly all Californians (99.8%) will have two or more choices and 77% will have four or more plan choices.

Impact of the ACA in California. According to a September 2020 California HealthCare Foundation Issue Brief, California's uninsured rate has fallen from 17% to 7.1% because of the ACA. Over 1.5 million Californians have coverage through Covered California and 85% of them receive federal subsidies to help afford coverage. Medi-Cal provides coverage for 12.8 million Californians, including 3.8 million adults through the expansion. The 16.8 million nonelderly Californians with preexisting conditions cannot be rejected by a health insurer. Medi-Cal is covering close to a million of California's essential workers who worked during the COVID-19 pandemic as home health aides, grocery store workers, farmworkers, and others.

A fact sheet from the UC Berkeley Labor Center indicates that California is projected to receive over $20 billion in federal support for the ACA Medi-Cal expansion in 2020-21 and Californians received nearly $7 billion in federally-funded premium subsidies to help purchase insurance through Covered California. This $27 billion infusion of federal funding would be difficult, if not impossible to replace, as it is just $2 billion less that the projected state spending in 2020-21 for California's Corrections and Rehabilitation and Higher Education (University of California, California State University and Community College) systems combined. This federal spending has an economic ripple effect throughout the state economy and supports hundreds of thousands of jobs, not only in health care but other industries as well. According to the UC Berkeley Labor Center, uninsured rates fell for all California racial and ethnic groups under the ACA, with Latinos experiencing the largest reduction in uninsured rate from 26.3% in 2013 to 11.6% in 2017. While inequities were narrowed between racial and ethnic groups there is still much more to do. Uninsured rates among the self-employed and small business employees fell significantly under the ACA, and California's San Joaquin Valley experienced the largest decline in the uninsured rate of any California region, from 18.1% in 2013 to 7.6% in 2017.

Conclusion. Prior to the enactment of the major ACA coverage expansions, over 40 million Americans (including seven 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. People with health coverage are more likely to seek the testing and care they need, especially during this COVID-19 pandemic. The repeal of the Medicaid expansion and the loss of 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 $27 billion in federal funds without massive tax increases or major program reductions. The loss of this financing would be 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.