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Children's Health Coverage Under the ACA
Part III: Issue Diagnosis – Evolutionary Challenges

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This brief is the third in a series of four on the future of children's health in California. This brief in particular identifies the current and potential future evolutionary challenges to health care and health insurance.

Evolutionary Challenges

Several challenges to insuring all children in California will remain in both the public and private sector after the implementation of the Affordable Care Act (ACA). Some families with employer-based coverage will continue to incur high costs, with limited contributions from employers to family plans compared to employee-only coverage. The opportunity to opt out of employer family plans and seek coverage through Covered California, the state's health insurance marketplace, with premium subsidies will be limited, as the affordability test to qualify for premium assistance is based on the cost of employee-only coverage, not family coverage. However, many families who previously purchased coverage in the non-group market will have access to more affordable and comprehensive plans through the Exchange. Additionally, in developing an integrated children's health system post-reform, the patchwork of funding streams of public coverage programs should be redesigned to clarify funding responsibilities of the State, counties, and federal government.

Private Programs

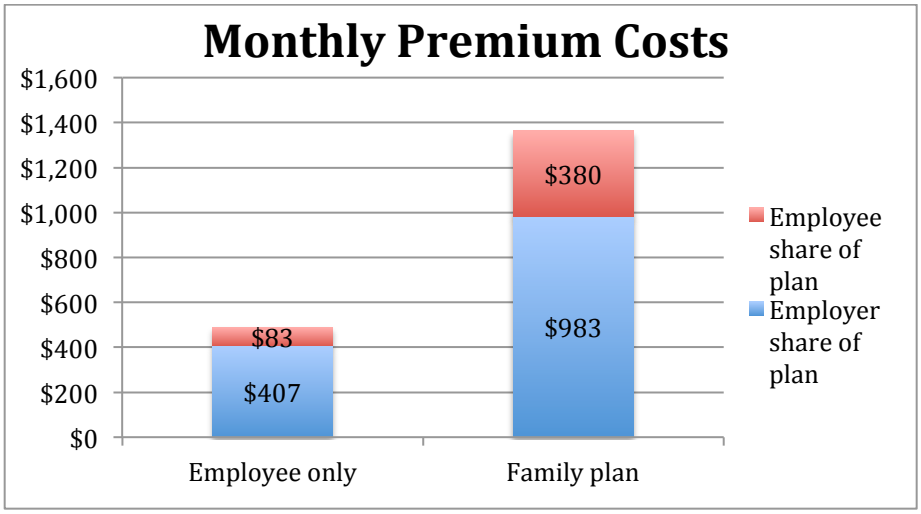
Employer-Based Coverage

A majority of children in California are covered by private insurance through their parent's employer. However, the proportion of California employers offering insurance coverage to employees has declined significantly in the last few years, from 73% in 2009 to 60% in 2012, with employee coverage rates among small businesses declining from 71% in 2004 to 63% in 2012.[1] Generally, larger firms that pay higher wages and employ fewer part-time workers are more likely to offer coverage than small, low-wage firms with many part-time employees. While many firms offer insurance to employees, some do not offer coverage to the dependents of employees. Often when family coverage is offered it is costly and the employee pays much of the added cost.

Coverage for dependents is often expensive. For family coverage, monthly premiums average $1,386 in California, slightly higher than the national average of $1,312, compared to a California average of $545 and national average of $468 for coverage of an individual.[2] Family plans offered though employers with fewer than 200 employees are on average $1,134 cheaper per year than coverage offered through large employers, likely because small employers often offer plans with higher deductibles.[3, 4] Premiums continue to rise significantly over time, totaling a 169.7% increase in the cost of family

[1] California HealthCare Foundation (2013). *California Employer Health Benefits Survey: Fewer Covered, More Cost*. California Health Care Almanac.
[2] Ibid.
[3] Ibid.
[4] Kaiser Family Foundation (2013). *2013 Employer Health Benefits Survey*.

coverage between 2002 and 2012.[5] It is unclear how premiums will be affected by the ACA and other factors, however the Congressional Budget Office estimates that premiums for a family plan will average at $1,267 in 2016.[6]



Source: Kaiser Family Foundation (2013). *2013 Employer Health Benefits Survey*.

Families are often responsible for significant portions of the cost of family coverage. Nationally, the average employee contribution to a family plan is $380 a month, 29% of the total cost.[7, 8] In California, 14% of employees pay more than half of the cost of coverage for family plans, yet only 3% of employees are responsible for half or more of the cost of employee-only coverage.[9] The share of cost employees are responsible for has increased over time; 21% of employers increased workers' share of premiums from 2011 to 2012, and 34% of employers anticipate increasing the employee share of premiums in the next year.

Additionally, 30% of family plans in California have a deductible of over $2,000, compared to only 13% of individual employee-only plans.[10] A third of covered employees with family plans have an annual out-of-pocket limit of $6,000 or more or no limit at all. These figures demonstrate the high cost of family plans and the burden of that cost to families.

The type of coverage offered also varies. Nationally, 82% of organizations that offer insurance only offer one type of health plan (i.e. PPO, HMO, etc.), but firms with over 200 employees are much more likely to offer options.[11] HMO coverage is on average $134 per month cheaper than PPO plans.

The ACA's employer mandate requires large employers (50 or more employees) to offer

[5] Op cit. California HealthCare Foundation.
[6] Congressional Budget Office (2012). *CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance*.
[7] Ibid.
[8] Op cit. Kaiser Family Foundation.
[9] Op cit. California HealthCare Foundation.
[10] Ibid.
[11] Ibid.

affordable coverage to employees and their dependents working at least 30 hours per week, beginning in 2015.[12] Firms that fail to offer coverage of minimum value (equivalent to 60% of bronze coverage, i.e. 36% of expected medical costs are paid by the employer) must pay penalties of $2,000 per employee, after the first 30 employees, if any employee utilizes subsidies in the Exchange.[13] Employers that offer unaffordable coverage (premiums greater than 9.5% of household income) must pay penalties of $3,000 per employee, again only if an employee utilizes subsidies. It is unclear if the penalties for inadequate or unaffordable insurance apply to coverage for dependents or just for coverage of employees. While 94% of large employers in California offer coverage to some or all employees, the percent of firms offering coverage to dependents is not known.[14] It is likely that more children will be covered through employer-sponsored insurance if large firms will be subject to "play or pay" penalties for dependents.

In California, 94% of employers are small businesses with fewer than 50 employees. These firms will not be subject to the ACA's employer mandate. While tax credits are currently available to low-wage small firms to offer coverage (and pay for at least 50% of the costs), it is unclear if additional children will receive coverage through their parent's small employer-sponsored insurance plans or through the Small Business Health Options Program (SHOP). Some small firms may opt to drop coverage for employees, allowing them to receive subsidies in the Exchange, while others might start to offer coverage for the first time, as Massachusetts employers did. The tipping points may be that higher wage small employers prefer purchasing benefits with pre-tax dollars (i.e. insurance essentially serves as untaxed income), while lower wage small employees see the Exchange offering better benefits for less real cost to the employers and their employees, due to the premium assistance available.

Privately Purchased Coverage

While those who purchase individual insurance plans make up a modest 6% of the non-elderly population (2 million individuals in California), this group benefits significantly from the creation of the Exchanges in 2014.[15, 16] Presently, 43% of privately purchased plans are family plans, which cost on average $592 a month.[17] While it may appear that privately purchased coverage is more affordable than a family plan obtained through an employer, private policyholders are responsible for the entire cost of premiums, while employers contribute to varying extents but can cover some or most of the cost. Additionally, many privately purchased plans have limited benefits and larger cost-sharing responsibilities. Many individuals, including children, who shift from privately purchased non-group insurance to Exchange coverage will receive more comprehensive coverage that may be more affordable given the significant premium assistance available.

Plans purchased in the non-group market are often expensive with high premiums and cost sharing. A survey of a major private health insurance exchange found that the

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[12] ACA §1513
[13] See Covered California's *Standard Benefits for Individuals* for a breakdown of the metal plan tiers.
[14] Op cit. California HealthCare Foundation.
[15] California HealthCare Foundation (2013). *Health Reform in Translation: Individual Coverage Before and After ACA*.
[16] Paul H. Keckley et al (2011). *The Impact of Health Reform on the Individual Insurance Market: A Strategic Assessment*. Deloitte Center for Health Solutions.
[17] Ibid.

average monthly premium for family coverage (averaging 2.9 family members) was $413 in 2012, although costs ranged from $269 to $965.[18] The average deductible for family plans was $4,079, with 53.8% of members facing deductibles of over $3,000.[19]

For many families who enroll in the Exchange, costs will decrease while benefits expand. Covered California premiums for a family of four range from less than $600 per month for Bronze coverage to more than $1,000 for Platinum coverage; however, premium subsidies can lower the monthly costs for families between 100-400% of the federal poverty level.[20] While subsidies are calculated based on the cost of the second lowest-cost Silver plan, families are free to choose more expensive plans, paying the extra cost themselves, or cheaper plans, reaping the savings. Gold and Platinum plans offer no deductible, while Silver plans are subject to a deductible up to $2,250 (includes medical and pharmacy deductible) with no deductible for families up to 200% FPL, and Bronze plans are subject to a $5,000 deductible. For some families, particularly those ineligible for premium assistance, potentially both premiums and out-of-pocket will increase compared to some plans previously offered in the individual market. Covered California estimates that half of all individual policyholders are grandfathered and thus can remain in plans that are not ACA compliant. Of the other half who are not grandfathered and faced plan cancellations in late 2013, approximately 50% of persons with individual insurance would get broader coverage and pay less in Covered California, 25% would be subject to higher premiums to receive broader coverage in the Exchange, while an additional 25% would pay more, but not receive any additional benefits.[21]

Some plans currently offered in the private market have limited benefits; many policies have an actuarial value of 55% or less, compared to bronze plans' 60% actuarial value.[22] Nationally only 17.3% of family plans offer maternity coverage, although all plans in California must cover maternity care as of July 2012,[23] and 87.4% offer pharmaceutical coverage.[24] Both of these benefits are essential health benefits available under all plans in Covered California and newly purchased plans in the individual and small group markets. Many of those moving from privately purchased coverage to the Exchange will see an expansion of benefits.

A large portion (86%) of adults who purchased individual insurance are unemployed, self-employed, or work for a business of fewer than 20 employees. Thus the ACA's employer mandate will not provide insurance coverage to most individuals who presently purchase private insurance.[25] It can be expected that many of the individuals and families currently purchasing coverage privately will over time opt to purchase Exchange plans.

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[18] eHealth , Inc. (2012). *The Cost and Benefits of Individual & Family Health Insurance Plans*.
[19] Ibid.
[20] Covered California website.
[21] Tori, L (2013). *Considerations for CCIIO Policy: California's Response to Presidential Announcement and to Meeting California's Consumers' Needs*. Covered California November 21, 2013 Board Meeting. Retrieved from http://www.healthexchange.ca.gov/BoardMeetings/Documents/November%2021,%202013/PPT%20-%20CCIIO%20Transition%20Policy.pdf
[22] Op cit. California HealthCare Foundation. *California Employer Health Benefits Survey: Fewer Covered, More Cost*.
[23] California Insurance Code 10123.866
[24] Op cit. ehealth.
[25] M. M. Doty et al (2009). *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*. The Commonwealth Fund.

Affordability Test for Dependents

While the employer mandate to provide coverage to employees and their dependents will result in fewer uninsured and under-insured children, there is a limitation in the way the ACA measures affordability of employment-based insurance, known as the "kid glitch" or "family glitch." Employees may opt out of coverage offered by their employers and utilize subsidies through the Exchange only if premiums are unaffordable, exceeding 9.5% of income. However, the affordability test only takes into account premiums for the employee, and does not include the cost to insure dependent children or spouses.[26] If the offer of coverage to the employee is affordable, but becomes unaffordable to cover additional family members, all parties are ineligible for premium subsidies in the Exchange. However, the individual mandate is based on the affordability of coverage for the entire family, meaning that if the cost of family coverage exceeds 8% of household income, then family members who remain uninsured will not be subject to the penalty.

The table below features the approximate cost to insure a family of three through an employer-sponsored plan and illustrates the situation many families face. Coverage for the employee only is affordable for moderate-income families, but coverage for the entire family exceeds 9.5% of income, as the employee is responsible for a significant share of premiums.

Costs of Coverage		
	Employee Only	**Family Plan**
Total Monthly Cost	$490	$1,363
Monthly Employee Contribution	$83	$540
% of $60,000 Household Income	1.66%	10.80%
% of $50,000 Household Income	1.99%	12.96%

While families will not fare worse than the status quo, the configuration of the affordability test could continue a significant strain on families with moderate incomes, due to the cost reasons specified previously. Families with incomes less than 250% FPL can acquire coverage for their children through Medi-Cal. Families between 250-400% FPL in this situation could incur a large portion of the cost of coverage through an employer, or purchase plans through Covered California at retail price without subsidies. However the scope of the impact may be limited. The Government Accountability Office projects that this rule will affect 460,000 children who were uninsured pre-ACA nationally – 6.5% of uninsured children.[27]

Some have proposed to modify the affordability test such that affordability of an employer offer would be assessed separately for the employee and for family coverage (i.e. if the cost of employee-only coverage is less than 9.5% of income, then the employee cannot receive premiums subsidies, but if the cost of family coverage exceeds 9.5% of income, the family members, excluding the employee, can receive subsidies). This alternative would result in access to subsidies for approximately 73,000 additional

[26] Internal Revenue Service 26 CFR Part 1

[27] Government Accountability Office (2012). *Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance, Report to Congressional Requesters.*

children in California.[28]

Financing of Public Programs

The various insurance programs described previously and in the second brief are funded through multiple avenues, including federal, state, and county funds. Many programs rely on "match" funding that is contingent upon other parties (i.e. in order to receive federal funds, the state has to match a designated amount). The mix of funding sources makes responsibility ambiguous and creates uncertainty about future funding sources and levels.

Medi-Cal is funded through a 50/50 match by the state and federal governments, while the Children's Health Insurance (CHIP, or Healthy Families, which is now a part of Medi-Cal) portion is 65% federally funded. Under the Affordable Care Act, coverage for individuals newly eligible for Medicaid is initially fully funded by federal dollars, tapering down to a 90/10 match in 2020. In California, medically indigent adults under 133% FPL and parents between 100-133% FPL will be newly eligible and thus will be funded by the federal government. Medically needy children, families, and pregnant women are funded through the standard 50/50 match Medicaid match. In 2015, the Medicaid match for the CHIP eligible children increases to 88/12.

Covered California premium subsidies are paid for by federal funds. The sources of funding for ACA provisions vary but include taxes on health insurance issuers, tanning salons, and medical device/pharmaceutical companies, penalties paid by uninsured individuals and employers that don't offer affordable coverage, and excise taxes on high end "Cadillac" plans.[29]

Payment for county mental health services is split between the federal government and the counties. Medi-Cal mental health services follow the 50/50 distribution for the current eligibility categories and 100% for the new eligibility categories, while the vast majority of non-Medi-Cal county-administered community and institutional services are paid for with county funds.[30] County indigent health programs are financed by the counties, with federal support in the form of Disproportionate Share Hospital funding, which goes to hospitals that serve large numbers of Medicaid and uninsured patients; the Safety Net Care Pool, which compensates county and community clinic providers for treating indigent patients; and Delivery System Reform Incentive Program funds, which incentivizes hospitals to improve their systems, ultimately lowering costs and improving care; in addition to state realignment funds, which shift money from the state to the counties for health purposes; and tobacco settlement funds, unrestricted money from California's litigation with tobacco companies.

Several of the ancillary limited benefit programs previously described are primarily

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[28] Ken Jacobs et al (2011). *Proposed Regulations Could Limit Access to Affordable Health Coverage for Workers' Children and Family Members*. Center for Labor Research and Education University of California, Berkeley; Center for Health Policy Research University of California, Los Angeles.

[29] Cadillac plans are expensive plans that offer extensive benefits to employees with little or no cost sharing. These plans are often regarded as excessive, encouraging overuse of care and distancing consumers from the true costs of medicine.

[30] Arnquist, S., & Harbage, P. (2013). *A Complex Case: Public Mental Health Delivery and Financing in California*. California HealthCare Foundation.

financed by state funds. The Child Health and Disability Program (CHDP) relies entirely upon General Funds for serving children ineligible for Medi-Cal but utilizes the standard 50/50 federal and state match for children enrolling in Medi-Cal, while Access for Infants and Mothers (AIM) utilizes a combination of General Funds, Proposition 99 tobacco tax revenues, and a 2:1 Federal CHIP match (for those eligible).[31] Services provided through Family PACT receive a 90/10 federal-state match for those eligible. Medi-Cal pays for all costs incurred by CCS Medi-Cal members.[32] CCS state-only is funded through a 50/50 match of State General Funds and county funds. Some counties administer their own CCS programs, while in other counties the State administers the program and covers the non-federal share.[33] Hospital care for the uninsured is funded though the federal streams mentioned previously as well as through limited scope Medi-Cal.

Simplification

Funding streams vary amongst programs and from year to year. Available funding changes based on annual budgets and distributions. In California, the State and counties periodically debate funding and responsibility allocations. Varying restrictions on funding make simplification and integration challenging.

Medi-Cal serves as an apt example of the complexities associated with multiple funding streams. Medi-Cal children are funded at different federal matching rates depending upon income and age. CHIP eligible children receive a larger federal match than lower-income Medicaid eligible children. This is somewhat complicated and confusing, but stems from the origins of Healthy Families and Medi-Cal operating as separate programs. While the programs have now merged in California, this is not the case in other states, and federal funding decisions for CHIP and Medicaid are made independently.

The differences in funding confound who is responsible for the programs and the children they serve. For example, the administration of CCS varies across the state, with some counties independently administering the program for their residents, while the State administers CCS for the remaining counties. The match requirements for the State and counties differ based on the proportions of members enrolled in Medi-Cal, Healthy Families/CHIP, or CCS state-only. This arrangement complicates what could be a relatively straightforward program and may even interfere with quality or access to care.

Simplifying the funding and distribution of responsibility is necessary to develop an integrated care system. While this is certainly a challenging task given California's history of conflict between the State and the counties over the responsibility for indigent care, the implementation of the ACA provides a unique opportunity to address inefficiencies and design a healthcare system that better serves California's children.

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[31] AIM is approximately 45% state funded, 55% federally funded. See Belshé, K., & McConville, S. (2013). *Rethinking the State-Local Relationship: Health Care*. Public Policy Institute of California.

[32] Ibid.

[33] Health Management Associates (2009). *Considerations for Redesign of the California Children's Services (CCS) Program*.

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