ITUP
INSURE THE UNINSURED PROJECT

Children's Health Coverage Under the ACA
Part IV: Policy Options & Recommendations

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Policy Options & Recommendations

The following brief is the final in a series of four on children's health coverage in California. It identifies policy options to address the issues discussed in the previous reports. First, the decision points on the federal and state level are identified, and various scenarios and options are presented. Then policy alternatives to address the issues of program overlap, remaining uninsured children, and the problems surrounding employer and Exchange coverage are compared. Finally, after consideration of the possible options, ITUP's recommendations are presented.

Decision Points

In the coming years, the federal government, the State, and local providers will be faced with multiple decisions regarding the maintenance and authorization of public programs, distributions of funding, and approaches to providing coverage.

End of State Maintenance of Effort Requirements for Adults in 2014

The Affordable Care Act (ACA) requires states to maintain the eligibility and enrollment standards for Medicaid and the Children's Insurance Program (CHIP) that were in place upon the ACA's enactment. These Maintenance of Effort (MOE) requirements ensure that those eligible for public programs in 2010 continue to have access to coverage without increasingly restrictive standards for eligibility or the application process. States that violate the MOE requirements risk losing federal funding.

As of January 1, 2014, the MOE requirements for adults in Medicaid expired. California is unlikely to experience any impact from the expiration of the MOE requirement for adults, as the Medicaid expansion solidifies coverage of low-income adults with incomes under 133% of FPL.

CHIP Reauthorization in 2015

The ACA increases the federal Children's Health Insurance Program (CHIP) matching rate by 23 percentage points (to 88%) in California through 2019. CHIP, which covers children above the Medicaid income threshold up to 250% FPL (in California CHIP is now fully a part of Medicaid[1]), is authorized and funded only through September 30, 2015. The program needs to be reauthorized prior to this date to fund it beyond 2015. California needs to decide what changes it wants as part of the reauthorization, although the State cannot further restrict eligibility. While there is extensive uncertainty surrounding the implications of the potential failure to reauthorize CHIP, some believe that the enhanced 88/12 match would be lost and some California children, likely those between 133% and 250% FPL, would be transitioned from Medi-Cal into Covered California.[2, 3] However, California would still be subject to the MOE

[1] In California, CHIP or Healthy Families was folded into Medi-Cal in 2013. Children previously in Healthy Families, now in Medi-Cal, must pay monthly premiums of $13 per child, up to $39 per family. Children enrolled in Medi-Cal with family incomes up to 150% of FPL pay no premium. Because California's CHIP program is a part of Medicaid, enrollment cannot be capped.
[2] Medicaid and CHIP Payment and Access Commission (2013). *Report to the Congress on Medicaid and CHIP.*

requiring coverage comparable to Medicaid of children up to 250% FPL until 2019.[4] Due to this, the State could be responsible for additional premium and cost sharing assistance as a wraparound to Covered California coverage. Others believe that if CHIP is not reauthorized, the enhanced 88/12 match simply becomes a Medicaid match, and that children under 250% FPL will remain in Medi-Cal. Additional guidance from the federal government is needed to adequately debate the reauthorization of CHIP.

Disproportionate Share Hospital Funding Cuts in 2014-2020

Federal disproportionate share hospital (DSH) funding reimburses hospitals for uncompensated care to the uninsured. These funds support hospitals that serve a significantly disproportionate number of low-income patients. California hospitals received nearly $1.1 billion in DSH funding in FY 2011, the second largest allotment for a single state.[5] DSH funding will be drastically reduced in the coming years, given that uncompensated care will decrease as coverage expands.

Based on a proposed methodology by the Centers for Medicare & Medicaid Services (CMS), DSH payments will be reduced considerably between 2014 and 2020. To determine the size of cuts on a per state basis, this methodology will consider multiple factors, including the size of the uninsured population and extent of uncompensated care. Aggregated cuts will start with $500 million in FY 2014, increasing to $1.8 billion in FY 2017, and escalating as high as $5.6 billion in FY 2019.[6]

Hospitals that currently rely on DSH funding will experience a cut in payments, but may also gain funding, in that previously uncompensated care to uninsured patients may now be reimbursed by Medi-Cal or Covered California plans. The remaining federal DSH funds could be redirected to better assist those facilities with the largest burdens to continue providing care to the remaining uninsured.

States Eligible to Submit Waivers in 2017

States may submit a §1332 Waiver for State Innovation, which will authorize states to opt out of certain ACA provisions in favor of alternative reforms beginning in 2017. The proposed alternatives would have to meet or exceed the ACA's outcomes, ensuring that just as many individuals have health insurance, that the coverage is as comprehensive, that the options are at least as affordable as plans available under the ACA, and that the cost to the federal government is equal to or less than the cost of the standard ACA provisions. States can opt to waive the individual mandate, the employer mandate, essential health benefits, and/or premium subsidies and the Exchanges themselves. Options like a single-payer model or alternative premium assistance could be considered by states.

Waivers may be submitted for a five-year time period and can be renewed. Before a state may submit a §1332 state innovation waiver, its legislature must pass legislation authorizing the state to apply for a waiver, and the state must receive public comments on its proposal.[7] Medicaid, CHIP, and Medicare waivers can be coupled with State Innovation Waivers to coordinate

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[3] Manatt Health Solutions (2010). *Implementing National Health Reform in California: Changes to Public and Private Insurance*. California HealthCare Foundation.
[4] Section 2101(b) of the Affordable Care Act.
[5] Kaiser Family Foundation. *Federal Medicaid Disproportionate Share Hospital (DSH) Allotments*.
[6] 42 CFR Part 447. Federal Register Vol. 78, No. 94.
[7] Cross-Call, Jesse (2011). *Understanding Health Reform's Waivers for State Innovation*. Center on Budget and Policy Priorities. Retrieved from http://www.cbpp.org/cms/?fa=view&id=3475

alternative methods. The Department of Health and Human Services and the Department of the Treasury will review waiver applications. If the alternative reforms pursued under the waiver fail to meet the cost, quality, affordability, or outcomes guidelines of the ACA once implemented, then the standard ACA provisions will be re-implemented.

The option to submit State Innovation Waivers will allow states to pursue alternative means of providing coverage. Through this process, more efficient and effective strategies could be identified, resulting in coverage for more people or additional cost savings. However many of these strategies will be experimental and come with risks. If the alternatives are unsuccessful, coverage rates could decline, which would exacerbate the health problems of children without coverage and access to care. States should carefully research and design alternative reforms to ensure their success and minimize gaps in coverage.

End of Maintenance of Effort Requirements and the 88/12 Match for Children in 2019

The MOE requirements for adults in Medicaid described previously also apply to children in Medicaid and CHIP; however, the requirements for children extend until 2019. As of October 1, 2019, states will have the option to modify the eligibility criteria for Medicaid and CHIP for children, and will no longer be assured an 88/12 federal funding match through CHIP.

For instance, California could shift children with household incomes over 133% FPL into Covered California. Doing so could result in state cost savings, as the federal government would pay 100% of the cost of premium subsidies in the Exchange, compared to 50% of the cost of Medi-Cal coverage. This option would lead to fewer children covered, as some parents could find Covered California premiums unaffordable, but this could be mitigated by the State providing premium assistance and wrap-around benefits to supplement Covered California's federal subsidies.

Program Overlap Options

The populations served by the Child Health and Disability Program (CHDP), California Children's Services (CCS), Family Planning, Access, Care, and Treatment (Family PACT), Healthy Kids, and Access for Infants and Mothers (AIM) are now eligible for Medi-Cal or subsidized Exchange coverage, based on income (see table). The only children who would remain uninsured in the absence of these programs are the undocumented and those children who fail to enroll in Medi-Cal or the Exchange despite eligibility. There are several policy options to address the extent of unnecessary overlap in services.

Children's Programs Overlap		
	Current Eligibility	**2014 Eligibility**
CCS	Up to 250% FPL	Medi-Cal
CHDP	Up to 200% FPL	Medi-Cal
Family PACT	Up to 200% FPL	Medi-Cal
AIM	200 - 300% FPL	Exchange
Healthy Kids	250% - 300% FPL	Exchange

Phase In and Integrate Programs

The State may wish to integrate some or all of these programs. It can be argued that all services currently available through these programs will be available to all through Medi-Cal or Covered California, except for children who remain uninsured, especially the undocumented. The state may wish to construct a system of care for remaining uninsured children and provide additional

premium assistance to enroll children in Covered California with the General Fund savings obtained through program integration.

AIM and pregnancy-only Medi-Cal serve as an apt example of the overlap of services and eligibility. California covers prenatal care and deliveries for all pregnant women, regardless of immigration status, up to 300% of FPL. Pregnant women with incomes under 200% FPL qualify for limited scope Medi-Cal and those with incomes between 200 and 300% FPL qualify for AIM. All women, except the undocumented, between 138 and 400% FPL qualify for subsidies from the Exchange. Some of the funding from AIM and the Medi-Cal pregnancy-only program could be used to pay for premium assistance and wrap-around benefits for those women eligible for Covered California during pregnancy - a time when the expenses of childbirth and childrearing put extra financial burdens on families. Additionally, the funding currently used to cover infants up to age two with family incomes between 250 and 300% of FPL in AIM could be used for premium assistance and upgraded benefits in the Exchange for infants.

If AIM and pregnancy-only Medi-Cal were to be consolidated with Covered California, the State should preserve a similar benefit for women who remain uninsured to ensure positive birth outcomes. Without this, undocumented and other uninsured pregnant women would not have a source of coverage. However, integrating AIM is unlikely to have a profound effect on the undocumented; the number of undocumented women who are currently eligible for AIM is likely small, given income ranges of undocumented families. The median household income of undocumented persons in California is $29,700, which indicates that most are within the income guidelines for pregnancy-only or restricted scope Medi-Cal.[8, 9]

Additionally, the State may wish to reform Family PACT in light of the ACA expansions that require coverage of family planning services for employer plans, qualified health plans under Covered California, and in Medi-Cal. There will be a substantial drop-off in the use of stand-alone family planning, as the ACA expansions take widespread effect. The Confidential Health Information Act, SB 138, will ensure that sensitive services will remain confidential to the patient, beginning in 2015.[10] Family PACT's services will be readily available through insurance coverage and services cannot be disclosed to parents, spouses, or other parties. As with the other programs, discontinuing Family PACT would leave undocumented or otherwise uninsured individuals without a source of coverage for reproductive health services. The residual program for these benefits would need to be coordinated with and integrated into a coordinated benefit program available to the remaining uninsured to assure access not only to family planning services, but also CCS, CHDP, and restricted scope Medi-Cal. Because teenagers make up a very small portion of Family PACT's beneficiaries, any changes to the program should be the same for both adults and children.[11, 12]

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[8] Households of two or more individuals with the this average income level qualify for emergency Medi-Cal. Considering that a pregnant woman counts as two persons when considering household size, the average undocumented pregnant woman would qualify for emergency Medi-Cal, and few will qualify for AIM coverage.

[9] Karina Fortuny et al (2007). *The Characteristics of Unauthorized Immigrants in California, Los Angeles County, and the United States*. Urban Institute.

[10] California Family Health Council. *Press Release: Confidential Health Information Act Clears California Legislature*. September 11, 2013. Retrieved from http://cfhc.org/about/press/confidential-health-information-act-clears-california-legislature

[11] Only 6% of clients served were under the age of 18. See Bixby Center for Global Reproductive Health, University of California San Francisco (2013). *Preliminary Program Report FY 2012-13, Family PACT*.

[12] E.g., if Family PACT were to be folded into Covered California, Medi-Cal, and a new state set of benefits for the uninsured, this would need to be done for both adults and children.

CCS currently provides treatment for chronic diseases for Medi-Cal children and for those who do not qualify for Medi-Cal due to income or immigration status through CCS state-only (funded via a state/county match). Children with family incomes over 250% FPL are covered for treatment for chronic diseases through Covered California or employer-sponsored plans. Although it may not be possible to revise the Medi-Cal CCS program pending outcomes of its pilot projects, benefits for CCS children under 250% FPL could be better provided if primary and specialty care were coordinated in all respects through Medi-Cal managed care plans.

Maintaining historically disconnected silos is not beneficial to children. Discontinuing all or some of these limited benefit programs would marginalize the remaining uninsured, leaving them to seek uncompensated care from safety net providers. Creating an alternative source of integrated care for remaining uninsured children that provides basic access to services would be necessary if this alternative is pursued.

Condense Programs Into A Single Program

Enrollment and efficiencies could be best maximized by consolidating the ancillary limited benefit programs into a common program to serve remaining uninsured children. This could be done by expanding the benefits of CHDP, which already has the infrastructure of providing preventive screenings to uninsured kids. This option would provide well child visits and preventive care, family planning, emergency services, and chronic disease management and treatment to those remaining uninsured children who do not qualify for full scope Medi-Cal or Covered California. It would connect the separate programs like CHDP, emergency Medi-Cal, Family PACT, and state-only CCS, and no loss of benefits would occur. This alternative would reduce administrative costs and improve coordination of care, ultimately providing better care to children.

These benefits would need to be integrated and coordinated with other state and local benefit programs available to the uninsured to assure access to important services for every Californian. There should be a wraparound option for counties and local nonprofits that cover/administer broader scope benefits-- whether in nonprofit programs like Healthy Kids or county health systems. The state funded and administered program could serve as a Part A, while the local supplement could serve as a Part B, providing the range of additional services. Depending on the funding available, an access model that provides access to care but not insurance, rather than a coverage model could also be considered.[13]

Maintain Existing Programs

The State may feel that the results of the ACA are too uncertain at this point to make drastic changes to its stand-alone programs. Many unknowns remain, such as the initial enrollment in Covered California and the Medicaid expansion, the results of the CCS pilot projects, and the opportunities to create Bridge Plans or a state Basic Health Plan. The State could delay decision making until ACA implementation is farther along and preliminary statistics on insurance uptake and remaining uninsured children are available. If this option is selected, then the State should monitor the outcomes of the ACA and determine if and when children's stand alone health programs should be altered. During the interim, the State should assure that the limited benefit programs for the remaining uninsured are better coordinated and integrated at the state and local levels. Additionally, the California Healthcare Eligibility, Enrollment, and Retention

[13] See Yoo, K., & Gupta, N. (2013). *The Affordable Care Act and Providing Health Care To the Residually Uninsured in a Post-Reform World*. Insure the Uninsured Project.

System (CalHEERS) used to apply and enroll in Medi-Cal and Covered California should be modified to assess eligibility for all such programs.

Remaining Uninsured Children

Post ACA implementation, there will be three categories of uninsured children: those who qualify for Medi-Cal but are not enrolled, those who qualify for Covered California but are not enrolled, and undocumented children who are ineligible for either program. The State should identify ways to reach out to families unaware of eligibility and those who cannot afford to pay Covered California premiums, as well as consider options for caring for those who are ineligible.

Expand Outreach Efforts

Many California children are currently eligible for Medi-Cal but are not enrolled. While multiple factors, such as stigma surrounding the program and enrollment barriers, could explain the limited uptake, the most likely explanations are that many families either do not know about Medi-Cal, do not know that their children are eligible, and some may have fears about issues related to immigration. These same issues are likely to affect Covered California eligible populations, despite the advertising and outreach efforts underway. The question remains as to how to identify and inform hard-to-reach groups. The State could utilize a number of outreach strategies to identify and inform the uninsured, facilitating enrollment, but doing so would not reduce the uninsured undocumented population.

Advertisements and other marketing materials could be customized for specific populations, using culturally appropriate messaging. Outreach to minority groups is essential, as a large proportion of uninsured children belong to minority populations.[14] Covered California has launched a $45 million advertising campaign to increase awareness of the Exchange and encourage individuals to enroll in coverage, featuring ads aimed at multiple ethnic groups and those who speak languages other than English.[15] While these advertisements will increase enrollment in both Medi-Cal and Covered California, they do not specifically mention the Medi-Cal program or its eligibility criteria. Separate ads for Medi-Cal may be necessary to inform the public that no-cost health insurance is available for low-income children.

Schools and childcare centers could be utilized to build towards universal coverage of children. Simple measures like sending handouts on Medi-Cal and Covered California eligibility to parents could increase awareness. Schools could request proof of insurance coverage or exemption upon registration, and immediately connect uninsured families to in-person assisters. The State could work directly with school districts to develop programs that would increase awareness and connect families to in-person assisters. Presently, applicants for free or reduced school lunch can apply for Medi-Cal at the same time; however only 74 applications were submitted in 2011-12, from a total of 14 schools in 3 counties.[16] Expanding this option to automatically determine Medi-Cal eligibility, with the option of waiving out, would likely capture many Medi-Cal-eligible children who are not presently enrolled.

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[14] Kaiser Family Foundation (2006). *Outreach Strategies for Medicaid and SCHIP: An Overview of Effective Strategies and Activities.* Kaiser Commission on Medicaid and the Uninsured.
[15] Daigle, Phil (2013). *Covered California Tests TV Ads*. California Health Benefit Exchange, Covered California News & Commentary. Retrieved from http://www.cahba.com/blog/2013/08/covered_california_advertising.html.
[16] AB 422

Create a Plan for Remaining Uninsured Children

As mentioned previously, some or all of the ancillary programs could be condensed into a single program that would provide access to children who remain uninsured. The creation of a single insurance plan that would exclusively serve the remaining uninsured would provide coverage for children who do not have access to Medi-Cal, Covered California, or employer-sponsored coverage. The eligible population could include undocumented children and those with household incomes above 250% FPL who miss open enrollment periods. The program could be designed such that the children who miss open enrollment periods are automatically provided enrollment assistance for Covered California upon the next annual open enrollment period.

This plan could be created by the State, as some counties, particularly those who do not serve the undocumented, might be reluctant to fund care for this population. Due to budget constraints, this plan would likely be limited scope with a focus on primary care and prevention plus emergencies, but would still provide essential access to care, potentially through a medical home model. As described earlier, CHDP could serve as the front-end building block and emergency Medi-Cal as the backstop for this limited benefit plan.

Provide Premium Assistance to Uninsured Exchange-Eligible Children

Some children are eligible for Covered California but remain uninsured because their parents cannot afford the premiums. The State, some employers or individual counties could choose to provide premium assistance to families facing financial hardships to ensure that children are covered. Some states presently offer premium assistance to subsidize the cost for employer-sponsored coverage, in lieu of Medicaid or CHIP; this model could be further developed. The State would need to establish criteria for financial hardship and affordability of premiums, and determine if premium assistance should go towards Covered California plans, employer-sponsored plans, or both types of coverage. Families subject to the kid glitch described below may particularly benefit from additional premium assistance.

Given the limitations of the State and county budgets, it is unclear to what degree this alternative would be politically or financially feasible.

The Affordability Kid Glitch

Some families between 250-400% FPL who are offered family coverage through an employer will not benefit from the premium assistance component of the Exchange. If the cost of *employee-only* coverage is less than 9.5% of household income (e.g. $83 per month for a family of three making $50,000 per year), but the cost of *family coverage* exceeds this threshold ($540 per month), the employment-based insurance is considered affordable, and thus the entire family is ineligible for subsidies in Covered California. This is known as the "kid glitch," in that families may be locked out of subsidies because the employee-only offer is affordable. This issue may impose a significant financial burden upon some middle-income families, although it should be noted that the ACA does nothing to increase the burden. There are three clear options to address this issue.

Modify the Affordability Test for the Entire Family Based on the Cost of Family Coverage

The US Treasury could choose to modify the affordability test such that all members of a family, including the employee, may receive subsidies in the Exchange if the cost of employer-sponsored *family coverage*, rather than employee-only coverage, exceeds 9.5% of household income. This option would provide more affordable coverage to families who were previously

limited to higher cost employer plans. However, the employee may have already had access to an affordable plan through work. Many families would benefit from having all family members in the same plan and network of providers.

This policy could encourage small employers not subject to the employer mandate/penalties to shift more of the cost of family coverage to the employees, as the ability to receive subsidized Exchange coverage would mean fewer employees and their families participating in employer-sponsored plans, and thus employers would be responsible for less in health care contributions. One study estimated that the number of Americans receiving subsidies under this scenario would nearly triple, while the number of individuals participating in employer-sponsored insurance would decline by 15%.[17] This alternative would substantially increase the federal government's spending on premium subsidies, by as much as $47.5 billion annually, although this estimate has been critiqued as overestimated.[18, 19]

Modify the Affordability Test for Dependents Based on the Cost of Dependent Coverage

Alternatively, the Treasury could alter the affordability test such that the eligibility of the employee and other family members for premium subsidies is assessed separately. If the cost of family coverage exceeds 9.5% of household income, but employee coverage does not, then the dependents are eligible for subsidies but the employee is not. This alternative would provide more affordable coverage to children, but generally the employees would continue to take up employer-sponsored coverage. This would however split family members amongst two, or three, in the case of two working parents, plans and networks of providers. Some of the incentives to employers to shift costs to employees may still be present, but would be reduced given that the affordability bar is higher. This alternative has been estimated to cost an additional $380 million in California.[20]

Maintain the Existing Affordability Test

The Treasury has the option to conduct the affordability test as currently specified in federal regulations. This would essentially make parents responsible for the cost of dependent coverage through an employer unless the employer does not sufficiently contribute to the employee-only plan. Parents would have to compare the cost of family coverage through employers with the retail price of Exchange plans without subsidies. Given the very high cost ($16,632 annually in California, although most families have some level of employer contribution) of family plans, some middle-income families may struggle to afford employer or full-price Covered California plans.[21]

Employer-Sponsored Dependent Coverage

The proportion of California employers offering insurance to employees has declined 13% in the past four years.[22] Employees offered coverage for dependents are often responsible for a

[17] Richard Burkhauser et al (2011). *An Offer You Can't Refuse: Estimating the Coverage Effects of the 2010 Affordable Care Act*. Employment Policies Institute.
[18] Ibid.
[19] 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.
[20] Ibid.
[21] California HealthCare Foundation (2013). *California Employer Health Benefits Survey: Fewer Covered, More Cost*. California Health Care Almanac.
[22] Ibid.

significant share of the cost. As the cost of insurance increases, many employers pass those costs along to the employees. While this issue could be addressed in many ways by fixing the kid glitch, other alternatives should be explored.

Under the ACA, employers with more than 50 full-time equivalent employees will be required to offer affordable coverage, equivalent to less than 9.5% of the employee's household income, and adequate coverage, equivalent to 60% of the cost of the least expensive bronze coverage, to employers and their dependents. Small employers will not be subject to the mandate to provide coverage. However, it is unclear if larger employers will be subject to the same penalties for failure to provide coverage to dependents as they are for coverage for employees. The State may wish to further regulate employers or alter the mandated employer responsibility for dependents to ensure that employees with children are not overburdened with rising healthcare costs.

Implement an Employer Mandate for Small Businesses

The State could choose to subject employers of 10 or more employees to the employer mandate. This would result in additional offers to employees, making them and their families ineligible for subsidies in the Exchange. It could also increase coverage opportunities among those ineligible for premium assistance. An additional mandate would, however, create a complex system for calculating and collecting penalties (i.e. what employers owe federal vs. state penalties, where to pay them, if the penalty amounts differ).

Require Contributions Towards Care Based on Hours

The San Francisco model could also be pursued as a statewide model. The City and County of San Francisco mandates that businesses with 20 or more employees (excluding nonprofits up to 50 employees) spend a minimum amount per hour per employee ($1.63 in 2014) on healthcare or health insurance.[23] Employers can choose to contribute towards insurance premiums, health savings accounts, reimbursements of employees for care, or utilize the City Option, which allows employers to contribute directly towards coverage in the city's insurance plan, Healthy San Francisco. Counties or the State could choose to implement a minimum amount for businesses to spend on healthcare for employees, based on hours worked. This has the advantage of reaching flex workers and seasonal workers, who are not reached by the federal employer mandate.

Either of these alternatives would receive significant opposition from representatives of small businesses. The political climate of San Francisco differs substantially from other parts of California; what works there may not be feasible elsewhere.

Limit the Employer Responsibility for Dependents

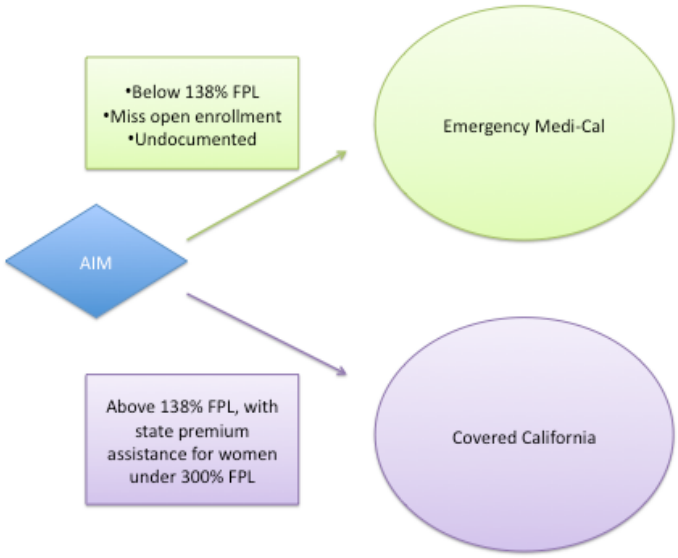
Some have suggested that the cost or even the offer of dependent coverage should not be the responsibility of employers, but rather the parents or society as a whole. This ideology would limit the responsibility of employers for dependents, instead shifting coverage for children to the Exchanges. While this is a novel concept, it is a radical departure from the system that successfully covers about half of children. Employers also commonly use a generous benefits package as a tool to recruit quality employees. As mentioned with the affordability test, there are disadvantages to family members being split amongst multiple health plans and provider

[23] City & County of San Francisco. *Health Care Security Ordinance*. Retrieved from http://sfgsa.org/index.aspx?page=418

networks, although there may be overlap in the provider networks of plans offered through and outside of the Exchange.

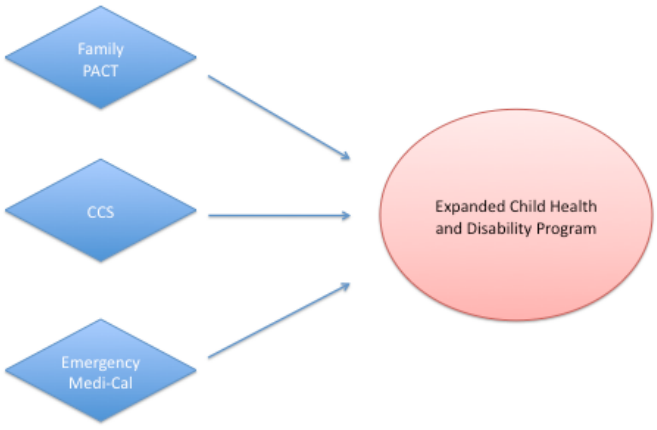
Recommendations

ITUP recommends that several of the limited benefit programs offered by the State be consolidated to shift towards basic coverage options. Part of this consolidation should include the expansion of benefits through CHDP to serve children who remain uninsured. We also recommend that the State conduct additional outreach to enroll children in Medi-Cal and Covered California, with a focus on raising awareness through schools. Finally, we recommend that the Affordability Test be altered such that the eligibility of the employee and other family members for premium subsidies is assessed separately, but the cost of dependent coverage would be subject to a higher threshold than employee-only coverage. We believe that these changes would ensure that more children are provided with comprehensive coverage options.



Consolidate Ancillary Programs

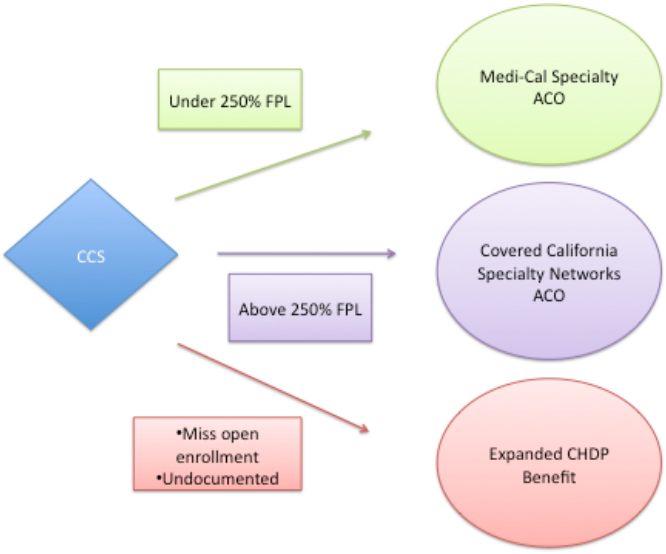
We recommend that AIM subscribers wherever possible be folded into full-scope insurance programs. All women should be enrolled in Medi-Cal, Covered California, employer-sponsored coverage, or another plan, and thus should have access to maternity and newborn care. The remaining uninsured pregnant women will still need coverage, regardless of immigration status. The State should actively work to enroll any women who are pregnant during the open enrollment period in Covered California plans, and provide them with additional premium assistance through the pregnancy to ensure that they maintain coverage. For women who miss open enrollment periods, restricted scope Medi-Cal eligibility for pregnancy should be expanded up to 300% FPL, regardless of immigration status. The pregnant women enrolled in pregnancy-only Medi-Cal should be given enrollment assistance during the following open enrollment period to enroll in Covered California, if eligible. Premium assistance, supplemental benefits, and cost-sharing assistance should be offered to women enrolled in Covered California plans who become pregnant and face difficulties paying premiums and coinsurance.



We recommend that CHDP, CCS state-only, emergency Medi-Cal, and family planning be folded into and fund a coherent integrated program for the remaining uninsured children. An additional option that should be considered when integrating Family PACT services is upgrading family planning clinics to become family health centers,

given the growing need for primary care.

Pending results of the CCS Medi-Cal pilot projects, we recommend that CCS Medi-Cal be embedded into Medi-Cal Managed Care to care for the whole child. As the plans will be responsible for providing care related to CCS conditions, they will incur additional financial risk. As such, the funding used for the CCS Medi-Cal program should be shifted to compensate the plans for the increased risk. This could be done by providing an enhanced capitation rate for members with CCS conditions. Both Medi-Cal Managed Care plans and Covered California plans should use an Accountable Care Organization (ACO) approach to provide care to this population. The plans should promote collaboration among specialty providers that serve the CCS population with performance incentives for producing better outcomes. Coordinating and integrating primary and specialty care can and should improve outcomes. The State should bring together a group of leading specialty providers and disease experts to create metrics for outcomes for this population. Managed Care plans should identify primary care providers that will work directly with specialists and take responsibility for complex patients. This is the way to get the best outcomes for children with chronic conditions, while the current approach fragments care.



Healthy Kids could also be altered, as families with incomes over Medi-Cal income thresholds will have access to Covered California plans. In those counties where funding is available, premium assistance for Covered California enrollment for children could be provided. Rather than incur the overlapping costs associated with operating two independent programs for low-income undocumented kids, it would be far easier and more affordable to give local programs the option to wrap Healthy Kids around emergency Medi-Cal, CCS state-only, and CHDP.

Program savings will need to be retargeted or they will revert to the federal, state, or county governments. Most savings should go towards providing at least the same level of benefits through a more comprehensive program from the remaining uninsured (described below).

Utilize CHDP as the Building Block to Serve Remaining Uninsured Children

We recommend that emergency Medi-Cal, Family PACT, CHDP, and CCS state-only be combined into a single program to serve the remaining uninsured children. Doing so would coordinate an integrated set of benefits in lieu of silos that have limited reach and confuse consumers. As CHDP currently reaches many uninsured children, its infrastructure should be used to create a base set of benefits offered through one program to remaining uninsured children. CHDP is currently a preventive care program as well as a feeder program that brings children into the Medi-Cal system, but has the potential to shift to a set of expanded primary care, prevention-focused services for uninsured kids. Prenatal and postnatal care, well child visits, preventive care, immunizations, school readiness, emergency services, family planning, and severe and chronic disease management and treatment services for CCS conditions should be the primary benefits.

Funding from the Proposition 99 tobacco tax could be reallocated, along with the funding dedicated to the consolidated programs, to serve this population through CHDP. Additionally, county Child Health Initiatives could merge local Healthy Kids programs into the expanded CHDP program to reduce administrative costs, build around emergency Medicaid funding, and offer a single consistent source of care for the remaining uninsured. Because Healthy Kids funding is local in nature, it would be feasible in some communities to offer a Part B set of supplemental benefits to wrap around the Part A state-wide program.

It is in the best interest of the state to ensure that all children, regardless of documentation or immigration status, receive necessary healthcare to achieve positive health outcomes. While providing any services to the undocumented can be politically controversial, the health and wellbeing of children should be prioritized. These children will represent an important part of tomorrow's workforce. Additionally, providing primary and preventive care through CHDP is less costly than routing all services through the emergency-based care in hospital systems.

Expand Outreach Efforts Through Schools and Childcare Centers

It is necessary to expand outreach for Medi-Cal and Covered California to ensure that all eligible children get coverage. There is an important opportunity to enroll children through school-based outreach. We recommend that extensive outreach efforts be conducted through schools and childcare centers, including sending in-person assisters to school events, distributing information on Covered California and Medi-Cal eligibility to all parents, and eventually requesting proof of health insurance or exemption upon school registration.[24] These methods would provide parents with information on coverage options and eligibility, and facilitate enrollment. Applications for free or reduced price school lunches should be screened for health coverage and enrolled in Medi-Cal if uninsured.

Modify the Affordability Test for Dependents Based on the Cost of Dependent Coverage

Before alternative strategies regarding the affordability test are implemented, the IRS needs to offer additional guidance about whether employers will be subject to penalties if dependent coverage is not adequate and affordable. We recommend that coverage for dependents be subject to the same standards as employee coverage, but the penalty for failure to provide coverage should be lower, approximately half of the penalty for failure to provide employee coverage. We also recommend that the federal government modify the affordability test for dependents based on the cost of dependent coverage, independent of the cost of employee-only coverage. Doing so will in many ways address the issue of employers shifting the cost of dependent coverage to the employees. However, it may be more financially feasible for the affordability test to be increased to a percentage of household income higher than 9.5%. This prevents families who have some level of employer sponsorship for family coverage from qualifying for subsidies, but ensures that there is ample funding to provide subsidies to those who truly have no help from employers. We believe that approximately 12.5% percent of household income may be a more reasonable threshold for families. With this guideline, the maximum premium for a family of three making $50,000 annually, equivalent to 256% FPL, would be $521 per month.

The ACA presents new opportunities and mandates for employers and it is unclear how the law will change employer offerings. We believe that outcomes of how employers respond to the

[24] School enrollment should not be contingent upon health coverage, however schools should request information on insurance coverage of students. This information is valuable for schools to have in case of illness or emergency, and can link uninsured families to sources of coverage.

federal mandate, what smaller employers do, etc. must be carefully assessed before further regulating employers. While regulating employers to ensure that costs are not unduly shifted to employees would ensure affordability, this is very difficult to do both logistically and politically. Ultimately, families may benefit from a shift from employer responsibility for dependent coverage to the Exchanges to cover kids, but this option would require extensive changes in the tax code and would fundamentally alter the status quo that has successfully insured about half of children. Therefore, we do not recommend further regulation of employers who offer dependent coverage at this time.

Conclusion

While there are still many questions surrounding the future of health insurance and care for California's children, we feel that now is the time to make additional improvements to the coverage systems. Combining smaller programs into more comprehensive coverage products would provide care for the whole child. Creating a state-based plan for remaining uninsured children would increase the number of insured kids. Altering the affordability test to alleviate the high costs of family plans would help parents with the affordability challenges. These are essential steps to improving the health of children and the outlook for California.

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Appendix 1: Summary of Policy Alternatives

Program Overlap Options	
Phase Out Programs	
Pro: General fund savings	Con: May marginalize undocumented members
Integrate Programs Into A Single Program	
Pro: Maximizes enrollment, reduces administrative costs	Con: Financial and political feasibility unclear
Maintain Existing Programs	
Pro: Allows decisions to be based on ACA's outcomes	Con: Excess administrative and program costs
Residually Uninsured Children	
Expand Outreach Efforts	
Pro: Captures hard-to-reach groups	Con: Additional funding required
Create a Plan for Residually Uninsured Children	
Pro: Provides coverage for kids without access	Con: Financial and political feasibility unclear
Provide Premium Assistance to Uninsured Exchange-Eligible Children	
Pro: Makes coverage more affordable	Con: Does not cover undocumented children
The Affordability Kid Glitch	
Modify the Affordability Test for the Entire Family Based on the Cost of Family Coverage	
Pro: Gives families access to subsidies	Con: High cost to the federal government
Modify the Affordability Test for Dependents Based on the Cost of Dependent Coverage	
Pro: Only gives families with very expensive employer coverage access to subsidies	Con: Some cost to the federal government
Maintain the Existing Affordability Test	
Pro: Parents compare cost of Exchange plans to employer plans	Con: Unaffordable to some families
Employer-Sponsored Dependent Coverage	
Implement an Employer Mandate for Small Businesses	
Pro: Expanded employer coverage, decrease in cost to federal government	Con: Cost to small businesses
Require Contributions Towards Care Based on Hours	
Pro: Holds most employers responsible for employees	Con: Limited feasibility
Limit the Employer Responsibility for Dependents	
Pro: Limits employer responsibility	Con: Abandons system that works for many

Appendix 2: Acronym Glossary

ABA	Applied Behavioral Analysis
ACA	Affordable Care Act
ACO	Accountable Care Organization
AIM	Access for Infants and Mothers
CalHEERS	California Healthcare Eligibility, Enrollment, and Retention System
CCS	California Children's Services
CHDP	Child Health and Disability Program
CHIP	Children's Health Insurance Program
CMSP	County Medical Services Program
DHCS	Department of Health Care Services
DSH	Disproportionate Share Hospital
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
Family PACT	Family Planning, Access, Care, and Treatment
FPL	Federal Poverty Level
HMO	Health Maintenance Organization
ITUP	Insure the Uninsured Project
LIHP	Low Income Health Program
MISP	Medically Indigent Services Program
MOE	Maintenance of Effort
PPO	Preferred Provider Organization
REM	Rare and Expensive Case Management Program (Maryland)
RPI	Registered Provisional Immigrant
SED	Serious Emotional Disturbances
TANF	Temporary Assistance to Needy Families