ITUP
INSURE THE UNINSURED PROJECT

Children's Health Coverage Under the ACA
Executive Summary

Prepared by Carolina Coleman

Funded by the Lucile Packard Foundation for Children's Health
January 2014

Approximately 95% of children residing in California have health insurance coverage, most through their parents' employers or through Medi-Cal, California's Medicaid program. As the Affordable Care Act (ACA) is implemented in 2014, some children and families will see changes to their plans and new opportunities to get covered. Meanwhile, the State is at a crossroads, and must determine if and how to alter existing programs and systems to better serve children. Several questions arise in the wake of ACA implementation: what will be the role of the numerous children's health programs post ACA, what can be done to ensure adequate coverage of vulnerable populations, including the remaining uninsured, and how can insurance programs be better coordinated for optimum efficiency and accessibility?

Health Insurance Programs for Children

California currently operates numerous public programs for children's health including Medi-Cal; Covered California (California's state-based Exchange or Marketplace); county mental health; county indigent health; Child Health and Disability Prevention (CHDP); California Children's Services (CCS); Family Planning, Access, Care, and Treatment (Family PACT); and Access for Infants and Mothers (AIM). Additional nonprofit insurance programs such as Healthy Kids, CaliforniaKids, and Kaiser Child Health Plan also serve children without access to public or private insurance. Each program offers different levels of coverage, eligibility requirements, provider networks, and consumer out-of-pocket responsibilities. This patchwork system creates numerous problems for children and their families, especially those of low and moderate incomes and/or limited English proficiency. Families must navigate a complex maze to identify the programs for which they qualify. Because eligibility changes with income, age, and their parents' job changes, many problems arise with children's continuity of care.

Children's Health Programs in California	
Medi-Cal	State-administered insurance for low-income children
Covered California	Private insurance with financial assistance for middle income families
County Mental Health	Treatment for severe and/or chronic disorders for low-income children
County Indigent Health	Few services available for children not eligible for Medi-Cal
Healthy Kids	Nonprofit coverage available in some counties in children ineligible for Medi-Cal
CHDP	Free preventative screenings for low-income children
CCS	Coverage for chronic medical conditions for low-income children
Family PACT	Coverage for family planning and reproductive health services for the low-income
AIM	Coverage for prenatal and infant care for middle income families
Kaiser Child Health Plan	Nonprofit coverage available for low-income children ineligible for Medi-Cal
California Kids	Nonprofit coverage available for low-income children ineligible for Medi-Cal

Program Overlap and Evolution

The services offered through limited benefit state-run programs like CCS, Family PACT, CHDP, and AIM are now available through Medi-Cal and Covered California. All Californians have access to these programs based on income, except the undocumented, who are ineligible for Covered California, even at full cost, and are only eligible for restricted-scope Medi-Cal. The

need for these programs will be reduced given that more children have access to full-scope programs. In the interest of budget savings, care coordination, and maximizing the number of insured children, the State will likely consider condensing, merging, and/or reducing funding for some coverage programs.

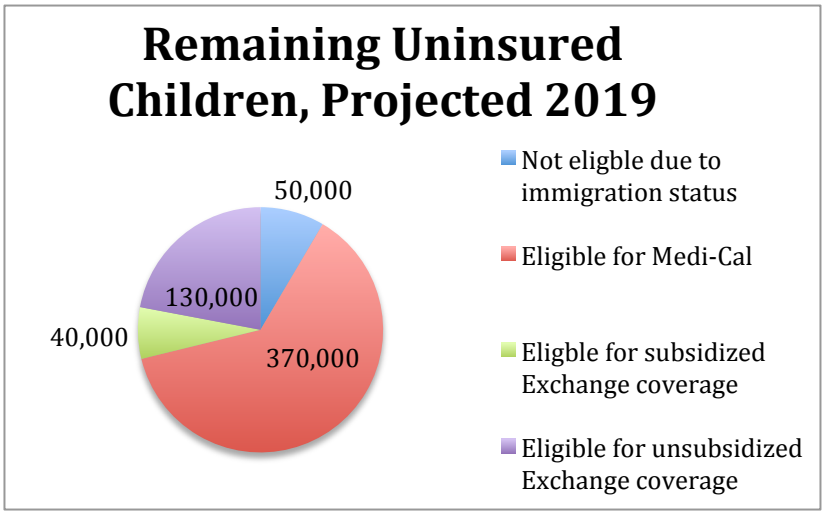
Private Coverage

A majority of children in California are covered by private insurance through their parents' employer. However, there are many issues with employment-based coverage for children. In recent years the number of employers offering coverage has declined, while increasing costs have been shifted to employees. Coverage for dependents is highly expensive, at an average of $16,632 per year for family plans. Lower-wage workers are less likely to receive coverage and more likely to pay a significant portion of the cost when offered coverage, particularly for coverage of dependents.

Approximately 453,000 California children are covered through private plans purchased in the individual market. Plans purchased in the non-group market are often expensive with high premiums and cost sharing or slim benefits. Many families who shift from privately purchased non-group insurance to Exchange coverage will receive more comprehensive benefits that may be more affordable given the significant premium assistance available. For some families, particularly those ineligible for premium assistance, costs, potentially both premiums and out-of-pocket costs, will increase compared to some plans previously offered in the individual market. Covered California estimated that approximately 25% of the individuals whose plans were cancelled in late 2013 face higher premiums but better benefits in the Exchange, an additional 25% have access to the same level of benefits and pay about the same in premiums, and half of subscribers now have better benefits and pay lower premiums.

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. 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. 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. Unaffordable employer plans or full price Covered California plans could significantly strain families with moderate incomes.



Remaining Uninsured Children

Although estimates vary, as low as 500,000 (point in time) or as many as 11% of children in California, totaling 1.04 million (over the course of the year), are uninsured. It is unclear how many of these children will remain uninsured post ACA implementation; many qualify for Medi-Cal or Covered California but the challenge is outreach and enrollment. Most undocumented

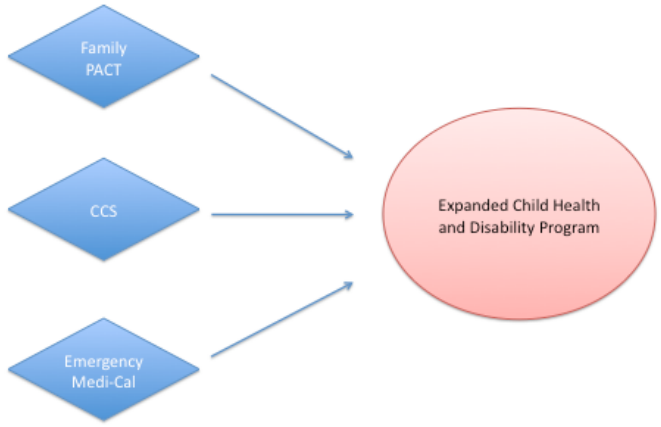
children will remain uninsured due to ineligibility for Medi-Cal and Covered California and limited access to employer-sponsored insurance. Remaining uninsured children will continue to rely upon community clinics and the county safety net for care; thus, it will be important to maintain funding for these institutions. However, the services available to the remaining uninsured vary widely by county and a significant portion of funding for county programs is being reallocated due to decreased need.

Recommendations

We recommend the following:

Phase in and integrate programs. Siloed programs should be integrated into full-scope insurance programs. AIM should be folded into Covered California with premium assistance for eligible women and infants, and pregnancy-only Medi-Cal for the remaining uninsured women ineligible for or not timely enrolled in Covered California. CCS for children enrolled in Medi-Cal should be carved into managed care. CHDP, CCS state-only, emergency Medi-Cal, and family planning should be folded into a coherent integrated program for remaining uninsured children.

Utilize CHDP as the Building Block to Serve Remaining Uninsured Children. Merging emergency Medi-Cal, part of Family PACT, CHDP, and CCS state-only into a single program for uninsured children 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. Additionally, county Child Health Initiatives could merge or coordinate local Healthy Kids programs (Part B) with the simplified state program (Part A) to reduce administrative costs and offer a single consistent source of care for the remaining uninsured.



Expand Outreach Efforts Through Schools and Childcare Centers. It is necessary to expand and improve outreach for Medi-Cal and Covered California to ensure that all eligible children get coverage. Extensive outreach efforts should be conducted through schools and childcare centers, including sending in-person assisters to school events and distributing information on Covered California and Medi-Cal eligibility to all parents.

Modify the Affordability Test for Dependents Based on the Cost of Dependent Coverage. Coverage for dependents should be part of the employer mandate, but the penalty for failure to provide coverage should be lower, approximately half of the penalty for failure to provide employee coverage. The federal government should 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. Approximately 12.5% percent of household income may be a more reasonable threshold for family coverage.

Thank you to the Lucile Packard Foundation for Children's Health for funding this project.

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Children's Health Coverage Under the ACA
Part I: Inventory of Children's Health Programs

Prepared by Carolina Coleman

Funded by the Lucile Packard Foundation for Children's Health
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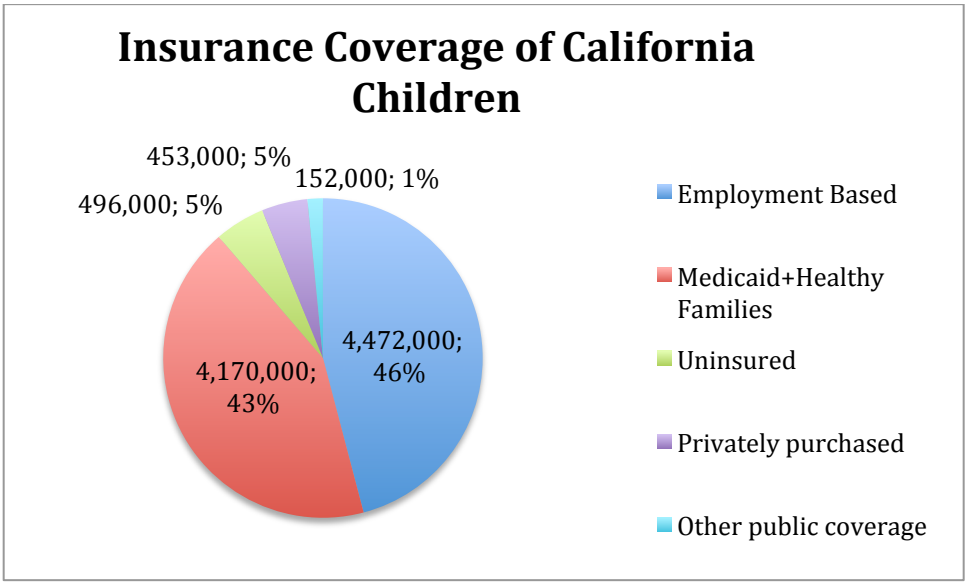
Introduction

This brief is the first in a series of four on the future of children's health in California. This series of papers aims to identify the current state of children's health insurance programs, envision how these programs may change with the implementation of the Affordable Care Act, identify issues and potentially vulnerable populations, and recommend solutions to these issues, with the goal of minimizing the number of uninsured children.

Although estimates vary, most of the 10 million children residing in California have health insurance coverage. Approximately 46% are covered through their parent's employment-based plan, 43% have Medi-Cal or Healthy Families, 5% purchased non-group insurance privately, and 1% have other public coverage, leaving 5% of kids uninsured.[1, 2] The implementation of the Affordable Care Act (ACA) will lead to more kids covered by health insurance, but the size of the remaining uninsured child population remains unclear. Several questions arise or remain in the wake of ACA implementation: what will be the role of the various children's health programs post ACA, what can be done to ensure adequate coverage of vulnerable populations, including the remaining uninsured, and how can insurance programs be better coordinated for optimum efficiency and accessibility?



Source: 2011-2012 California Health Interview Survey. UCLA Center for Health Policy Research. Estimates are point in time.

[1] California Health Interview Survey 2011-2012. UCLA Center for Health Policy Research.
[2] According to Medi-Cal and Healthy Families data, the point of time estimate for children enrolled in Medicaid and Healthy Families is 4.88 million, indicating approximately 50% of children receive Medi-Cal coverage. The course of the year population is likely significantly greater, as many children move in and out of Medi-Cal/Healthy Families eligibility.

Health Insurance Programs for Children

California currently operates numerous public programs for children's health including Medi-Cal; Covered California (the Exchange); county mental health; county indigent health; Child Health and Disability Prevention (CHDP); California Children's Services (CCS); Family Planning, Access, Care, and Treatment (Family PACT); and Access for Infants and Mothers (AIM). Additional nonprofit insurance programs such as Healthy Kids, CaliforniaKids, and Kaiser Child Health Plan also serve children without access to public or private insurance. Each program offers different levels of coverage, eligibility requirements, provider networks, and consumer out-of-pocket responsibilities. This patchwork system creates numerous problems for children and their families, especially those of low and moderate incomes and/or limited English proficiency. Families must navigate a complex maze to identify the programs for which they qualify. Because eligibility changes with income, age, and their parents' job changes, many problems arise with children's continuity of care.

Medi-Cal

California's Medicaid program, Medi-Cal, will provide medical insurance to over 10 million low income-individuals in 2014, close to half of whom are children.[3,4] Medicaid income eligibility varies with age, ranging from up to 100% of the federal poverty level (FPL) for older children to as much as 200% FPL for infants.[5] California's Children's Health Insurance Program (CHIP), Healthy Families, which provides coverage up to 250% FPL, was absorbed by Medi-Cal in 2013, and its 863,000 members transitioned into Medi-Cal managed care plans. Beginning in 2013, children are eligible for Medi-Cal up to 250% FPL, regardless of age.

Children must be legal residents or US citizens to qualify for full scope Medi-Cal. Restricted scope, or emergency Medi-Cal is available to low-income children regardless of immigration status when genuine emergency medical services are needed.[6]

Medi-Cal has seen a transformation in recent years, as most of the state has shifted from a fee-for-service system into managed care. Currently, 69% of Medi-Cal members are enrolled in managed care plans, with the remaining 31% being treated on a fee-for-service basis. Medi-Cal has also seen vast growth in enrollment. Average monthly enrollment increased 13.2% between 2007 and 2012.[7] As of 2011, 54% of Medi-Cal members are children, yet they only account for 27% of expenditures.[8]

Covered California

Covered California is California's Health Insurance Exchange, a virtual marketplace in which individuals, families, and small businesses can purchase private insurance that will be effective starting January 1, 2014. The Exchange is open to all children, regardless of current insurance

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[3] Nearly 9.3 million people were enrolled for a least one month in FY 2011-12; 7.5 million people were enrolled on January 1, 2012. California Department of Health Care Services (2012). *Medi-Cal Program Enrollment Totals for Fiscal Year 2011-12*.

[4] About 4 million Medi-Cal members enrolled in July 2012 were age 20 or younger. California Department of Health Care Services (2012). *Medi-Cal Program Population Distribution by Age/Gender, January 2012*.

[5] California Department of Health Care Services (2011). *New Federal Poverty Levels*. Letter 11-16.

[6] 12% of Medi-Cal members are restricted scope. California HealthCare Foundation (2013). *Medi-Cal Facts and Figures: A Program Transforms*. California Health Care Almanac.

[7] Ibid.

[8] Ibid.

status. Those in families with incomes between 250 and 400% of FPL ($94,200 for a family of four) will be eligible for subsidies to make coverage more affordable by covering a portion of health plan premiums. Those eligible for full scope Medi-Cal cannot receive premium subsidies. Cost-sharing subsidies that reduce copayments and coinsurance are also available to adults up to 250% FPL.[9] Exchange eligibility is open to US citizens and lawfully residing immigrants, but not to the undocumented. Those who are offered insurance through their employer (including their dependents) are not eligible for subsidies unless that coverage is deemed unaffordable (premiums for employee only coverage are in excess of 9.5% of household income). A projected 144,000 children (74% of those eligible) will enroll in subsidized coverage in Covered California, while 368,000 children will enroll in unsubsidized coverage, partially due to the "kid glitch" discussed in Part III.[10]

The Exchange offers a standardized package of essential health benefits that include inpatient, outpatient, and emergency care, maternity care, prescription drugs, laboratory services, mental health services, preventative care, and rehabilitative services. Also included are pediatric dental and vision services, up to age 19. Vision is offered in each medical plan; however, for 2014, families are offered a stand-alone dental plan for children. While premium assistance cannot go towards the cost of these plans, they are priced at as little as $8 per month per child.[11] There is some concern that this additional cost, along with no requirement for parents to purchase dental coverage for their children, will lead to a decline in dental coverage and thus care for children, despite dental health issues being one of the most common health problems among California children.[12]

Bridge Plans, Medi-Cal managed care plans available to select individuals through the Exchange, will be a late addition to Covered California offerings. Under the proposal pending federal approval, household members of children enrolled in Medi-Cal and individuals who lose Medi-Cal eligibility because of an increase in income (up to 250% FPL) will be allowed to keep coverage under Medi-Cal managed care plans. Bridge plans are part of an effort to provide continuity of care and keep all family members in the same plan and health care provider network. Bridge plans will not be subject to the requirement to offer all five tiers of coverage or to market their plans inside and outside Covered California.[13]

County Mental Health

Mental health care for both children and adults with lower incomes is fragmented between managed care plans and county mental health departments, creating challenges to integrated holistic health treatments. Psychological services for less severe disorders (i.e. mild to moderate depression, anxiety, etc.) are provided through Medi-Cal managed plans and their provider networks. Mental health services for Medi-Cal members with severe and chronic mental illness, including services available to children with serious emotional disturbances (SEDs), are delivered outside, or "carved out," of managed care. Those with severe mental health issues receive care from the county mental health plans, the services of which vary across the state.

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[9] Children under 250% FPL are eligible for Medi-Cal, while adults are only eligible up to 138% FPL.
[10] Gerald F. Kominski et al (2012). *Health Insurance Coverage in California under the Affordable Care Act, Revision of the March 22, 2012 Presentation to the California Health Benefit Exchange Board*. UC Berkeley Center for Labor Research and Education, UCLA Center for Health Policy Research..
[11] Covered California (2013). *Children's Dental Plan Rates 2014*.
[12] Foster, C. C. (2007). *Children's Dental Health in Santa Clara and San Mateo Counties: The 2007 Check-Up*. Lucile Packard Foundation for Children's Health.
[13] Proposed amendments to Government Code §100503 from SB X1 3 (Hernandez)

Beginning in 2011, the counties received additional funding to care for larger patient populations.[14] As mental health and substance use disorder services are essential health benefits under the ACA, coverage of these services is required, and access is expected to expand in the coming years.[15]

In FY 2012-13, nearly $1.4 billion was spent on county-administered mental health services to Medi-Cal children in California, with the share of that cost equally divided between the federal government and the counties.[16] While there are approximately 367,257 children with SEDs in households below 200% FPL, only 205,412 children received mental health services through the county programs in 2010.[17, 18] The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program within Medi-Cal pays for mental health services, including individual, group, and family therapy, provided through the county mental health departments for program-eligible children up to age 21. Some substance use disorder services such as Intensive Outpatient Treatment are currently only available to children and pregnant women, but the availability of these services will expand to all Medi-Cal members in 2014. County mental health departments will continue to treat uninsured kids with SEDs.

Some have expressed concern about the availability of applied behavioral analysis (ABA) for autistic children enrolled in Medi-Cal. This therapy was previously available to as many as 10,000 children with autism spectrum disorder in Healthy Families, but many children lost this benefit when transitioning from Healthy Families to Medi-Cal, as autism treatment is a carved-out benefit from managed care, but does not qualify as a SED or a service provided through county departments.[19] Autistic Medi-Cal members are instead being directed to California's 21 Regional Centers, nonprofit organizations that provide support and services to people with developmental disabilities, but the eligibility criteria for services through regional centers are significantly more stringent, leaving many (75% according to autism advocacy groups) children ineligible for the service.[20] An amendment to the 2013-14 state budget to fund $50 million for ABA therapy for Medi-Cal members was proposed but not adopted.[21]

County Indigent Health

Medically Indigent Service Programs (MISP) and County Medical Services Programs (CMSP) are operated at the county level and serve uninsured individuals with low incomes but who do not qualify for Medi-Cal. MISP counties operate their own programs with varying eligibility criteria, while CMSP counties have standard eligibility up to 200% FPL.[22] Patients are seen at public and community health clinics or contracted private providers and generally pay fees on a sliding scale. Only nine of the 35 MISP programs presently serve undocumented individuals and

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[14] California HealthCare Foundation (2013). *Mental Health Care in California: Painting a Picture*. California Health Care Almanac.
[15] Lee, H., & McConville, S. (2011). *Expanding Medi-Cal: Profiles of New Users*. Public Policy Institute of California.
[16] Arnquist, S., & Harbage, P. (2013). *A Complex Case: Public Mental Health Delivery and Financing in California*. California HealthCare Foundation.
[17] Op cit. California HealthCare Foundation (2013). *Mental Health Care in California: Painting a Picture*.
[18] Op cit. Arnquist.
[19] Gorn, D. (2013). *Autism, Dental, Mental Health Focus of Transition Concerns*. CaliforniaHealthline.
[20] Ibid.
[21] Megerian, C. (2013). *An Autism Treatment Lost in California's Shift From Healthy Families*. Los Angeles Times.
[22] County Medical Services Program website (2005). Summary CMSP Eligibility.

CMSP programs only provide emergency services to undocumented adults.[23, 24] Only six of the 35 counties with medically indigent services programs serve children,[25] and eligibility in CMSP counties is limited to those over age 21.[26] Healthcare, particularly for children, obtained through the indigent health programs is often intermittent, episodic, and discontinuous.[27] The Healthy Kids program, as described below, was created in part to promote continuous, coordinated care amongst the children served through indigent health systems. Post ACA implementation, the only low-income population that cannot be served by Medi-Cal or Covered California is the undocumented. Thus some counties essentially will have no population to care for and may need to either discontinue services or expand eligibility criteria.

Healthy Kids

Since 2001, Healthy Kids provides low-cost health insurance to uninsured, Medi-Cal ineligible children up to 300% of FPL regardless of immigration status, through local public/private partnerships.[28, 29] These programs provide comprehensive care, including dental, vision, prescriptions, and mental health benefits, with modest premiums and co-pays. Healthy Kids does not receive any state or federal funding for services rendered, instead relying on philanthropic contributions. In 2006, the Institute for Health Policy Solutions estimated a total enrollment of over 86,000 in 22 counties, but enrollment as of 2011 had declined to less than 39,000.[30, 31]

Despite success in the early and mid 2000s, Healthy Kids programs have faded. Due to limited funding and a lack of a continuous revenue stream, enrollment has been limited in several counties to younger children (0-5) or the programs have shut down completely. As of summer 2013, only 11 counties have active Healthy Kids Programs. In Los Angeles, the Low Income Health Program Healthy Way LA took on responsibility for former Healthy Kids patients when the 6-18 program was discontinued.

Child Health and Disability Prevention (CHDP)

CHDP is a no-cost preventive program that delivers periodic health assessments and preventive services, such as immunizations, to low-income (0-200% of FPL) children and youth (up to age 21 for Medi-Cal members and up to age 19 for the uninsured), regardless of immigration status, through private physicians, local health departments, community clinics, managed health care plans, and some school districts. CHDP provides services to children enrolled in Medi-Cal and those who are uninsured. CHDP for children ineligible for full-scope Medi-Cal is funded by state

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[23] Taylor, M. (2013). *The 2013-14 Budget: Examining the State and County Roles in the Medi-Cal Expansion*. Legislative Analyst's Office.
[24] Belshé, K., & McConville, S. (2013). *Rethinking the State-Local Relationship: Health Care*. Public Policy Institute of California.
[25] Ibid.
[26] Op cit. Belshé.
[27] Cousineau, M., & Farias, A. (2008). *The Impact of the Los Angeles Healthy Kids Program on County Indigent Care Programs*. Urban Institute.
[28] Children with family incomes up to 400% of FPL are covered in San Mateo County.
[29] Institute for Health Policy Solutions California (2007). *Overview of Local Children's Coverage Expansions*.
[30] Institute for Health Policy Solutions California (2006). *Healthy Kids Enrollment and Waiting Lists – October 2006*.
[31] Op cit. Cousineau 2008.

General Funds; $1.77 million proposed in FY 2013-14.[32] It serves approximately 45,000 children annually, although utilization is expected to decline to 27,000 in FY 2013-14.[33, 34]

In 2003, CHDP Gateway was created as an interim step to enroll more children in Medi-Cal and Healthy Families. When uninsured children receive services through CHDP Gateway, they are enrolled into Medi-Cal for the period of time during which their eligibility is being assessed, a process known as presumptive eligibility or pre-enrollment.[35] The introduction of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), the application system used to make real-time eligibility determinations for Medi-Cal and Covered California, will likely limit the use of the CHDP Gateway, as the time frame for eligibility determinations gets shorter and presumptive eligibility shrinks.

California Children's Services (CCS)

California Children's Services provides coverage of diagnostic and treatment services, medical case management, and physical/occupational therapy to approximately 165,000 individuals under 21 years old who have specific chronic medical conditions, including cardiovascular diseases, blood disorders, and various genetic conditions.[36] Much like the Genetically Handicapped Persons Program, CCS' counterpart program for adults, CCS provides services for the designated condition, not holistic health, on a fee-for-service basis. Primary care or treatments related to non-CCS conditions are not covered. Although open to all California residents, eligibility is limited by income and insurance status; families must have a maximum income of $40,000, qualify for Medi-Cal or Healthy Families, or have high out-of-pocket medical expenses.[37]

CCS members can have Medi-Cal coverage, private insurance coverage, or be uninsured; 90% of CCS members have Medi-Cal or Healthy Families coverage, accounting for 97% of expenditures.[38] Annual per patient spending is considerably higher for Medi-Cal/CCS ($11,000) and Healthy Families/CCS ($5,700) members than for CCS-only members ($3,000).[39] Medi-Cal is responsible for the cost of care through CCS for Medi-Cal members on a 50/50 match with the federal government, while the state and counties equally split the cost of coverage for the approximately 20,000 CCS-only children.[40]

CCS is carved out of the managed care plans for Healthy Families and Medi-Cal, which has posed some difficulties in integrating care and services to these children. CCS is conducting five pilot programs to improve care coordination, patient satisfaction, and program effectiveness.

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[32] A small amount of funding for CHDP comes from the Childhood Lead Poisoning Prevention Fund. See State of California, Department of Health Care Services, Fiscal Forecasting and Data Management Branch. *Family Health May 20103, Local Assistance Estimate for FY 2012-13 and 2013-14 – Child Health and Disability Prevention Program*, Report Date: May 2013.
[33] Ibid.
[34] Op cit. Belshé.
[35] State of California Department of Health Care Services. *CHDP Program Overview*. Updated July 2008.
[36] Michael Cousineau et al (2012). *Covering Kids: Children's Health Insurance in California*. California HealthCare Foundation.
[37] California Children's Services website. Retrieved from: www.dhcs.ca.gov/services/ccs
[38] Health Management Associates (2009). *Considerations for Redesign of the California Children's Services (CCS) Program*.
[39] Ibid.
[40] Governor's Budget Summary 2014-15.

The results of the pilots are expected in 2017, and could potentially be used to alter the CCS delivery system.[41]

Covered California plans will provide treatment and services for children with these severe medical conditions, but they may not be as comprehensive as CCS benefits, which include case management, durable medical equipment and their upkeep, and transportation to services.[42]

Family Planning, Access, Care, and Treatment (Family PACT)

Since 1997, the Family Planning, Access, Care and Treatment program has provided no-cost comprehensive family planning services to men, women, and teenagers without coverage for such services. Eligible individuals must be California residents, ineligible for no-cost Medi-Cal, but with family incomes below 200% of FPL. They must also have no other source of health care coverage unless that use of coverage would create a barrier to access because of confidentiality.[43] While initially funded by the state, Family PACT has been federally financed through a §1115 Medicaid Waiver (90/10 match). In FY 2010-11, over 1.83 million people received services through Family PACT, an 11% increase between 2006-07 and 2010-11.[44] Only 7% of clients are under age 18. Family planning services are currently covered by Medi-Cal, private insurance, and Covered California plans. With the Medi-Cal and Covered California expansions, most Family PACT services will move into those two programs.

Access for Infants and Mothers (AIM)

The Access for Infants and Mothers program provides low-cost health insurance coverage to uninsured pregnant women and infants up to age two, with incomes between 200-300% FPL. Those who do not qualify for pregnancy-only Medi-Cal are eligible, and the program is open to the undocumented if they are residents of California.[45, 46] The program provides comprehensive health care from the effective date of coverage until the last day of the month after 60 days after the pregnancy has ended. Babies born to women enrolled in AIM are eligible for Healthy Families. In 2012 through April 2013, 7,900 women were enrolled in AIM.[47]

The program is funded by General Funds, Proposition 99 tobacco tax revenues, and a 2:1 federal CHIP match for eligible infants and pregnant women, totaling $128.6 million in FY 2011-12.[48] Women must pay premiums that are 1.5% of adjusted annual household income, including an initial subscriber fee of $50. In April 2013, there were 6,080 women enrolled; Latinas comprised the largest proportion (37.3%), followed by Caucasians (27.2%) and Asian/Pacific Islanders (25.7%).[49]

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[41] Welfare and Institutions Code Section 14094.3
[42] Health and Safety Code § 123840.
[43] Welfare and Institutions Code Section 24003
[44] State of California, Department of Public Health – Office of Family Planning Bixby Center for Global Reproductive Health. *Family PACT Program Report, Fiscal Year 2010-2011*. University of California San Francisco.
[45] 10 CCR § 2699.200.
[46] Insurance Code § 12698.
[47] State of California, Managed Risk Medical Insurance Board. *AIM Subscriber and Health Plan Data: April 2013 Summary*.
[48] Op cit. Belshé.
[49] State of California, Managed Risk Medical Insurance Board, AIM Subscriber and Health Plan Data: April 2013 Summary, May 29, 2014.

In 2014, maternity and newborn care must be covered by all Covered California plans, including catastrophic plans. All women currently eligible for AIM are now eligible for premium subsidies, except the undocumented. It is unclear how many women who would have been covered by AIM will move into the Exchange. There are no statistics available about the portion of AIM members who are undocumented and thus cannot purchase coverage in the Exchange. It is also unclear how many women will fail to purchase Covered California plans despite eligibility, continuing to rely on AIM as a back up for treatment. Over time, most AIM enrollees will move into Covered California, leaving it as a back up for the remaining uninsured within its narrow frame of eligibility. The Governor's proposed 2014-15 budget would move AIM into the Department of Health Care Services and move Medi-Cal pregnancy-only coverage into Covered California with premium assistance and supplemental benefits at the woman's option. This could provide greater continuity of care and treatment for women eligible for this option.

Kaiser Permanente Child Health Plan

Since 1998, Kaiser Permanente has offered health care coverage to low-income children for $8-15 per month per child through the nonprofit Kaiser Permanente Child Health Plan.[50, 51] Children up to age 19 in households with incomes up to 300% FPL may enroll in the Kaiser Permanente Child Health Plan only if they have no access to other coverage.[52] There are no immigration requirements, but children must reside in a Kaiser Permanente Service Area. The plan covers primary and specialty care, prescription drugs, hospitalizations, as well as dental and vision care. Children are enrolled for a two-year period and have the option to be recertified for renewed coverage. Kaiser Permanente sets a membership capacity limit and can implement a waiting list when the cap is met. The program had over 80,000 children enrolled as of November 2013.[53]

In 2014, Kaiser Permanente will be restructuring this program to meet the requirements of the ACA. Low-income children who meet the eligibility requirements for the new Kaiser Permanente Child Health Program will be provided with a Kaiser Permanente premium subsidy for enrollment in Kaiser Permanente's standard off exchange platinum-level plan and enrollment in a pediatric dental plan. In addition, these members will be provided with a Medical Financial Assistance award to reduce cost sharing for services at KP facilities. The eligibility criteria for financial assistance will remain the same as under the original program.

CaliforniaKids

The CaliforniaKids Healthcare Foundation offers insurance to children ages 2 to 8 who are ineligible for Medi-Cal, at a cost of $82 per child, per month through partnerships with schools, healthcare providers, and community organizations in areas without Healthy Kids programs.[54] Benefits are limited to outpatient services, but include behavioral health, dental, prescription drug coverage. The program had less than 2,000 children enrolled in January 2011, but it has

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[50] Kaiser Permanente website. *Child Health Plan Overview*.
[51] Dana Hughes et al (2002). *Analyses of the Child Health Plan and Other Kaiser Permanente Services for Publicly and Privately Insured Children*. Center for Children's Access to Health Care, Institute for Health Policy Studies, University of California, San Francisco.
[52] Kaiser Foundation Health Plan, Inc. *Kaiser Permanente Child Health Plan: Individual Plan Membership Agreement and Disclosure Form and Evidence of Coverage, April 1, 2013 through March 31, 2014*.
[53] Kaiser Foundation Health Plan, Inc. Charitable Care and Coverage.
[54] CaliforniaKids website.

insured over 70,000 children since 1992.[55, 56] A 2006 brief reported that nearly all members of CaliforniaKids are undocumented.[57] The program is funded through charitable contributions and premiums paid by members.

Thank you to the Lucile Packard Foundation for Children's Health for funding this project.

[55] Op cit. Cousineau, *Covering Kids: Children's Health Insurance in California*.
[56] Op cit. CaliforniaKids website.
[57] CaliforniaKids Healthcare Foundation. *Our History, Our Experience, and Our Future July 1992 – March 2006*.

Appendix 1: Summary of Children's Health Programs in California

Children's Health Programs in California						
Program	**Run By**	**Benefits**	**Income Eligibility Criteria**	**Residency Criteria**	**Child Population**	**Premiums**
Medi-Cal	State	Comprehensive care including dental and vision	Under 250% FPL	Restricted coverage for the undocumented	4,870,000	$13/child for higher income families, none for lower income families
Covered California	State	Comprehensive care including dental and vision	100-400% FPL receive premium subsidies	Limited to legal residents	512,000 (estimated for 2019)	Unsubsidized plans start around $100/child
County Mental Health	Counties	Services for severe and/or chronic mental illness	Varies by county	Undocumented limited to emergency services in some counties	205,412	None
County Indigent Health	Counties	Varies by county, some only emergency services	Varies by county	Undocumented limited to emergency services in some counties, no services in others	Not Available	None
Healthy Kids	Counties	Comprehensive care including dental and vision	Ineligible for Medi-Cal, up to 300% FPL	Open to all statuses	39,000	$0-$15/child
CHDP	Counties	Preventative care, routine screenings	Up to 200% FPL	Open to all statuses	45,000	None
CCS	State / County Partnership	Treatment for specific chronic conditions	Have	Open to all statuses	165,000	None
Family PACT	State	Reproductive health services	No source of coverage, up to 200% FPL	Open to all statuses	128,100	None
AIM	State	Prenatal and infant care	200-300% FPL	Open to all statuses	7,900 (includes pregnant women)	1.5% of household income
Kaiser Permanente Child Health Plan	Nonprofit	Comprehensive care including dental and vision	No access to other coverage, up to 300% FPL	Open to all statuses	80,000	$8-$15/child
California Kids	Nonprofit	Outpatient care, limited emergency	Ineligible for Medi-Cal	Open to all statuses	2,000	$82/child

Appendix 2: Data on Children's Health Insurance Coverage in California

	California Health Interview Survey	Current Population Survey	Medi-Cal & Healthy Families Statistics
Type of measurement	Point in time	At some time during the year	Point in time
Year	2011-2012	2011	2012
Employer	45.90%	49%	-
Medi-Cal & Healthy Families	42.80%	38%	50%
Privately Purchased	4.70%	7%	
Uninsured	5.10%	11%	-
Other Public Insurance	1.60%	3%	-

Sources: California Health Interview Survey 2011-2012.
Michael Cousineau et al (2012). *Covering Kids: Children's Health Insurance in California*. California HealthCare Foundation.
California Department of Health Care Services (2012). *Medi-Cal Program Population Distribution by Age/Gender, January 2012*.
California Department of Health Care Services (2012). *Healthy Families Transition to Medi-Cal Strategic Plan/Phase 1 Implementation Plan*.

Appendix 3: Healthy Kids Programs, 2013

County	Ages 0 - 5	Ages 6 - 18
Los Angeles	Open	Closed
Marin	Open	Closed
Riverside/San Bernardino	Open	Open
San Francisco	Open	Open
San Mateo	Open	Open
Santa Barbara	Open	Open
Santa Clara	Open	Open
Santa Cruz	Open	Open
Solano	Open	Open
Sonoma	Open	Closed
Yolo	Closed for new enrollment	Closed for new enrollment

Source: California Coverage & Health Initiatives.

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Children's Health Coverage Under the ACA
Part II: Issue Diagnosis – Patient Care Challenges

Prepared by Carolina Coleman

Funded by the Lucile Packard Foundation for Children's Health
January 2014

This brief is the second in a series of four on the future of children's health in California. This report in particular identifies the current and potential future challenges to pediatric patient care, as well as special populations that should be considered when analyzing child health policy.

Patient Care Challenges

Several challenges to pediatric patient care will remain after the implementation of the Affordable Care Act (ACA). A sizeable population of children will continue to be uninsured, some who are ineligible for full scope Medi-Cal (California's Medicaid program) and Covered California (California's health insurance marketplace) due to immigration status, and some who are eligible, but are not enrolled. Some counties will continue to be responsible for services to remaining uninsured kids, but many others will not. California lawmakers will need to consider the extent of the need for smaller state-run programs when coverage is available through Medi-Cal and Covered California and if those funds can be better utilized elsewhere in the budget. Finally, when imagining an integrated health care system for children post-ACA, the special circumstances of specific populations of children and families, such as immigrants and children with special health care needs, should be given special consideration, as to prevent marginalization or decreased access.

Remaining Uninsured Children

In California, an estimated 11% of children, totaling 1.04 million, are uninsured for part or all of the year.[1] Estimates of how many children will remain uninsured post ACA implementation vary, due to different assumptions about the success of the implementation of the ACA, the extent of outreach, and limited data on the undocumented immigrant population. There are 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.

Of California's currently uninsured children, approximately 76% are eligible for Medi-Cal (including Healthy Families), based on household incomes below 250% FPL.[2] Of the 267,655 uninsured children who are ineligible for Medi-Cal, 144,000 (13% of uninsured kids) will be eligible for subsidies under the Covered California health insurance exchange in 2014, while 95,000 (9% of uninsured kids) will not be eligible for subsidies due to household incomes greater than 400% FPL. While these figures seem promising for extending coverage to all children in California, they do not consider factors like immigration status and actual likelihood to enroll.

The California Simulation of Insurance Markets model estimates that by 2019, 72,000-140,000 previously eligible but unenrolled children will enroll in Medi-Cal, while 447,000-515,000 eligible kids will fail to take up coverage.[3] However this is based on the assumption that only

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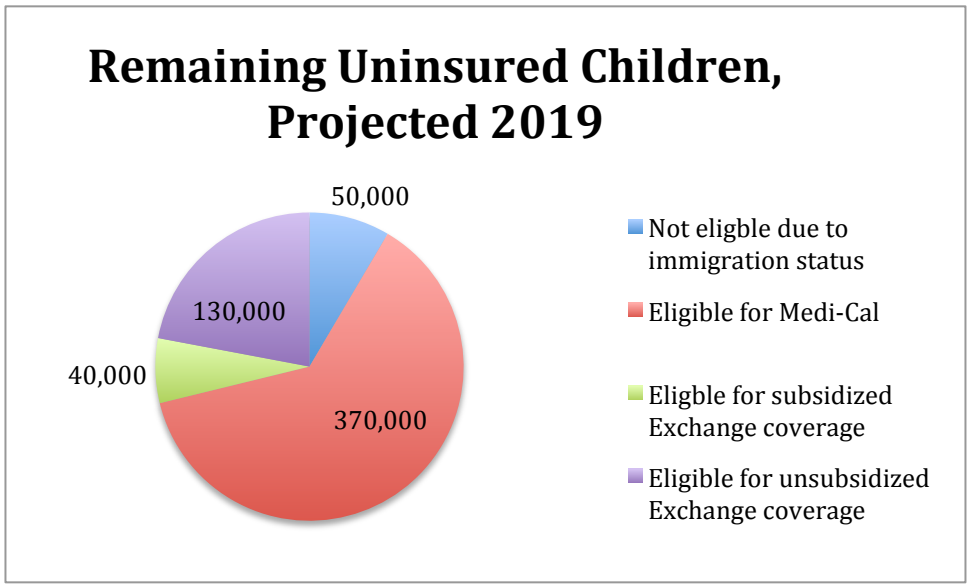
[1] California Health Interview Survey (2009). Any time during past year without insurance (under 65
[2] Michael Cousineau et al (2012). *Covering Kids: Children's Health Insurance in California*. California HealthCare Foundation.
[3] The failure to take up coverage figure includes children who have employer sponsored or privately purchased coverage, thus it is an overestimate of the uninsured. It does not include children who are

10% (base scenario) to 40% (enhanced scenario) of those eligible will enroll.[4] An additional 50,000 will remain uninsured despite being eligible for subsidies in Covered California, along with 130,000 children eligible for unsubsidized Exchange coverage. Based on these estimates, there will be 490,000–600,000 children,[5] contingent upon the extent of outreach, who remain uninsured despite eligibility. The Medi-Cal eligible but unenrolled children can enroll in the program at any time, however Covered California eligible children must wait until open enrollment periods to purchase coverage.



Source: Laurel Lucia et al, After Millions of Californians Gain Health Coverage under the Affordable Care Act, who will Remain Uninsured? UC Berkeley Center for Labor Research and Education, UCLA Center for Health Policy Research (September 2012).

Special Challenges in Payer and Provider Counties

Remaining uninsured children will continue to rely upon community clinics and the county safety net for care; thus, it will be important to maintain funding for these institutions. However, the services available to the remaining uninsured vary widely by county and each county's extent of commitment to serving the uninsured. Currently, 24 counties have Medically Indigent Services Programs (MISP), with half of those counties operating as "providers," which operate public hospitals and clinics, and the remaining half of counties are divided between "payer" counties that contract with private providers and "hybrid" counties that both operate their own public clinics and contract privately. The remaining counties have County Medical Services Programs (CMSP), which do not cover children. Eligibility for MISPs based on age, income, and immigration status, as well as the services offered, vary significantly, although generally provider counties offer coverage to broader groups of people. Most counties do not

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eligible for CHIP. Gerald F. Kominski et al (2012). *Health Insurance Coverage in California under the Affordable Care Act, Revision of the March 22, 2012 Presentation to the California Health Benefit Exchange Board*. UC Berkeley Center for Labor Research and Education, UCLA Center for Health Policy Research.

[4] Laurel Lucia et al (2012). *After Millions of Californians Gain Health Coverage under the Affordable Care Act, who will Remain Uninsured?* UC Berkeley Center for Labor Research and Education, UCLA Center for Health Policy Research.

[5] Ibid.

cover children, and if they do, services may be limited to public clinics.

Partial funding for these programs is available through an agreement with the State government; however, considering that the ACA will extend eligibility to a portion of the medically indigent, the State plans to reallocate some of this funding towards increasing Temporary Assistance to Needy Families (TANF) grants for low-income children. How this funding is allocated will determine the future of county medically indigent programs; some counties may opt to maintain eligibility for the remaining uninsured, while other programs may be discontinued or condensed when their patient population becomes Medi-Cal eligible.

As a result of the Medicaid Expansion and the creation of Covered California, some counties now have a significantly reduced responsibility or even no responsibility to care for those they define as medically indigent. A payer county that does not cover indigent care for individuals above 133% of the federal poverty level or for undocumented residents could have no remaining indigent care costs, as those previously served will all be eligible for Medi-Cal. The future of county indigent programs is unclear, but will depend upon state funding decisions and county preferences.

Coordination of Overlapping Programs and Services

The Affordable Care Act expands Medicaid eligibility and the extent of coverage, providing some services currently offered through other programs. The state has already addressed the potential overlap in coverage for low-income children by absorbing Healthy Families, California's Children's Health Insurance Program, into Medi-Cal.

The relevance and need of some of the smaller programs discussed is questionable post-ACA implementation. For example, the Child Health and Disability Program (CHDP) covers preventative services and health assessments for children up to 200% of the federal poverty level (FPL), however all children (with the exception of the undocumented) will be eligible for no-cost or low-cost ($13 per month per child) Medi-Cal up to 250% FPL.

Many pregnant women and infants between 200-300% FPL will qualify for subsidized Exchange plans and may not need Access for Infants and Mothers (AIM) coverage for prenatal and postpartum care, given that all health plans must cover maternity and newborn care.

Healthy Families is California's Children's Health Insurance Program (CHIP) has been absorbed by Medi-Cal. Its 863,000 members, who were above the previous Medi-Cal income threshold, transitioned into Medi-Cal managed care plans in phases in 2013.

Additionally, while eligibility for Medi-Cal and Covered California will be assessed through the California Healthcare Eligibility, Enrollment, and Retention system (CalHEERS), the application process for some of the other limited coverage programs will remain separate (although CalHEERS will send application data to the appropriate systems).[6]

In the interest of budget savings, care coordination, and maximizing the number of insured children, the State will likely consider modifying, condensing, or merging some coverage programs. Folding programs into Medi-Cal, Covered California, or a new comprehensive benefit

[6] Covered California. *California Healthcare Eligibility Enrollment, and Retention System (CalHEERS) Requirements Process*. Retrieved from http://www.healthexchange.ca.gov/StakeHolders/Documents/CalHEERS%20Requirement%20Process%20and%20Requirements%20Document.pdf

program would likely capture more individuals due to more effective outreach; awareness of Medi-Cal and the Exchange will be much higher than the various smaller, limited scope programs. Care continuity would also be superior, as individuals could stay with providers like the county and community safety net clinics or private physicians, versus being switched into plans with varying networks.

There are, however, disadvantages to consolidating programs, most notably eliminating the few available sources of coverage to undocumented immigrants. Additionally, condensing a program like California Children's Services (CCS), which provides specialty care to children with complex conditions, could leave particularly vulnerable populations in the care of less qualified provider networks and less comprehensive benefit packages, while the elimination of Family Planning, Access, Care, and Treatment (Family PACT), which covers reproductive and sexual health services, could discourage teenagers from seeking family planning services covered by their insurance due to confidentiality issues.

Special Populations

Children and families will be affected by the ACA in different ways. Some groups, like foster children, will benefit from extended Medi-Cal eligibility. Other families will have to navigate multiple unfamiliar insurance and health care systems. Some populations, such as children with special health care needs, are especially vulnerable and may not be appropriately served under the current system. These groups should be given special consideration when proposing changes to Medi-Cal, Covered California, and the health care system as a whole in an effort to insure 100% of children in California and to meet their most important health needs. These are vital investments in our state's future.

Mixed Eligibility Families

The creation of Bridge Plans, which allow household members of children in Medi-Cal to enroll in Medi-Cal managed plans despite incomes over the Medi-Cal income threshold for adults, will limit the number of families with different plans and provider networks due to children enrolled in Medi-Cal and parents in the Exchange.[7] Yet there will still be some families with mixed eligibility and uptake, such as families with non-custodial grandparents living in the home,[8] resulting in parents/other family members and children in different plans. Household members enrolling in multiple plans is not ideal, as this creates two or more sets of provider networks to coordinate, rules and guidelines to comprehend, and cost-sharing provisions to budget for. For example, if one parent receives employer-sponsored insurance while the children are enrolled in Exchange plans, the family has two different deductibles, out-of-pocket maximums, even local in-network hospitals. Differences in enrollment periods and processes could easily confuse families and even prevent coverage and/or care. These differences create challenges for families in planning and budgeting for care.

[7] Bridge plans were not offered during open enrollment in 2013-14 and are still pending contract negotiations.

[8] Under Medicaid rules, the eligibility of children is assessed based on the income of those legally responsible for the child (i.e. parents and legal guardians). Under these rules, the income of non-custodial caregivers such as grandparents, is not counted for the child, thus creating scenarios in which the children qualify for Medi-Cal because their counted household income is under 250% FPL, but the other household members are above 250% FPL and thus ineligible for Bridge Plans.

Immigrant Children

Children who are legal residents generally have full access to coverage programs in California. There is no waiting period for Medi-Cal, Exchange coverage, or access to subsidies. Those in the US on temporary visas can access Covered California and subsidies, but Medi-Cal eligibility is dependent on intent to remain in California.[9]

Undocumented immigrant children, however, have limited coverage options. The undocumented are ineligible for full-scope Medi-Cal, but can receive restricted scope in cases of necessary emergency care. Exchange coverage, with or without subsidies, is unavailable to undocumented immigrants. Some undocumented children may be covered through their parents' employer-sponsored plans or may receive services through community clinics or one of the ancillary programs described previously. CCS, CHDP, Family PACT, and AIM only require members to be residents of California, which can be proven without a green card or social security number. It is unclear how many undocumented children these programs currently serve. Some undocumented children have access to locally administered nonprofit programs such as Healthy Kids, CaliforniaKids, and Kaiser Child Health Plan.

Estimates of the size of the undocumented population vary considerably. One study of the impact of the ACA finds that in California, there are 140,000 undocumented immigrant children with household incomes less than 133% of FPL and 30,000 undocumented children between 134-400% of FPL.[10] These children would otherwise be eligible for Medi-Cal or subsidized Exchange coverage based on income; however, the exclusion of undocumented immigrants from the ACA disqualifies them from enrollment. Additionally, the authors project that 40,000 uninsured children who are legal residents or US citizens will not take up coverage in Medi-Cal or Covered California because their undocumented parents are unaware of their child's eligibility.

Undocumented children are a vulnerable population that is likely to remain uninsured. It is estimated that 48.6% of undocumented kids are currently uninsured,[11] and considering that the undocumented do not benefit from any of the ACA's coverage expansions, this figure is unlikely to change. UC Berkeley/UCLA estimates that approximately one million people in California will remain uninsured due to citizenship status.[12] Although it is unclear what portion of this population will be children, only approximately 10% of undocumented immigrants in the US are under age 18.[13] Illegal immigration has declined significantly in the past few years, potentially due to the recession, enhanced border enforcement, and improving economic opportunities in Mexico. Between 2008 and 2010, California's population of unlawfully present immigrants declined by 280,000.[14] If this trend continues, the population of uninsured undocumented children in California could further shrink as currently present undocumented children grow into adults.

The currently proposed immigration reform (S. 744, the Border Security, Economic

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[9] California Department of Health Care Services (2013). *Medi-Cal Handbook, Section 42: California Residency*.
[10] These estimates of the undocumented population vary considerably from Laurel Lucia et al's figures. Ninez Ponce et al (2011). *The Impact of Health Care Reform on California's Children in Immigrant Families*. UCLA Center for Health Policy Research.
[11] Ibid.
[12] Op cit. Kominski.
[13] Pew Research Hispanic Center (2013). *A Nation of Immigrants: A Portrait of the 40 Million, Including 11 Million Unauthorized*.
[14] Johnson, H., & Hill, L. (2011). *At Issue: Illegal Immigration*. Public Policy Institute of California.

Opportunity, and Immigration Modernization Act of 2013) offers a long-term path to citizenship and eligibility for public programs. However, the bill's potential impact on the short-term health coverage of immigrants seeking legal residency is limited. Those who would apply for registered provisional immigrant (RPI) status would have to wait at least 10 years for Medi-Cal eligibility.[15] Individuals would be eligible to purchase insurance coverage through the Exchanges once they obtain RPI status, however they would not be eligible for subsidies until they become legal permanent residents after 10 years of RPI status.[16] Given the average low income of undocumented households,[17] few could afford unsubsidized coverage through the Exchange. New RPIs would continue to rely upon state and local programs, such as unmatched Low Income Health Programs, CCS, CHDP, AIM, and Family PACT for coverage of specific services in the absence of Medi-Cal benefits.

Children in Foster Care

The 63,000 children in foster care in California are automatically eligible for Medi-Cal.[18] Former foster youth remain eligible for Medi-Cal until age 21, with the Medicaid Expansion extending eligibility until age 26, regardless of income.[19] Eligibility decisions for foster youth are often expedited to provide quick access to services.[20] Foster children are less likely to receive services through the Medi-Cal managed care system than other Medi-Cal populations, as their enrollment in a managed care plan is voluntary.[21, 22] The Health Care Program for Children in Foster Care provides care coordination, in additional to normal social work services through foster care, for these children. As of 2013, county departments of mental health must offer additional benefits, including extensive care coordination and home-based services, to foster children.[23]

Children in the Juvenile Justice System

Children in the juvenile justice system, 225,000 annually, have extensive health needs, particularly mental health needs, that can go unmet while incarcerated and upon their release.[24, 25] While many children in the juvenile justice system qualify for Medi-Cal, federal funds cannot be used to cover prison or jail health services for convicted individuals. The counties assume financial responsibility for healthcare for county jail inmates and the State for state prison inmates. When Medi-Cal members are booked into a correctional facility, they are disenrolled

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[15] S 744 Sec. 2101.
[16] Ibid.
[17] Passel, J. & D'Vera, C. (2009). *A Portrait of Unauthorized Immigrants in the United States,* Pew Research Hispanic Center.
[18] Arnquist, S., & Harbage, P. (2013). *A Complex Case: Public Mental Health Delivery and Financing in California*. California HealthCare Foundation.
[19] Individuals in foster care in California on their 18th birthday are automatically enrolled in Medi-Cal for continuation benefits until age 26. Welfare and Institutions Code §14005.28
[20] The Health Consumer Alliance (2006). *The Health Care Rights of Children in Foster Care.*
[21] Sphere Institute (2003). *Utilization of Medi-Cal Services by Current and Former Foster Care Children*.
[22] Medi-Cal Managed Care. Health Care Options Frequently Asked Questions. Retrieved from: http://www.healthcareoptions.dhcs.ca.gov/HCOCSP/HCO_Program/Frequently_Asked_Questions.aspx
[23] Op cit. Arnquist.
[24] Bussiere, A., & Burrell, S. (2006). I*mproving Access to Medi-Cal for Youth in the Juvenile Justice System*. *Youth Law Center*.
[25] Op cit. Arnquist.

from Medi-Cal, and must reapply upon release to be covered.[26] This creates challenges to continuous coverage, continuity of care, and timely treatment.

County staff who work with this population have argued that the paperwork associated with disenrollment and reenrollment is particularly burdensome and the overall process results in no coverage post release. While in some counties staff will help children reapply for Medi-Cal upon release, the youth still must go through the entire application and eligibility determination process again and wait up to 45 days for a decision from the County Social Services offices. The Youth Law Center recommends that the State suspend instead of terminate Medi-Cal coverage for children while they are incarcerated, so that services can be obtained immediately upon release.

Children with Disabilities and Chronic Health Conditions

Children with disabilities and/or chronic health conditions are a particularly vulnerable population in need of comprehensive, specialized care. Medi-Cal currently carves out benefits for many children with complex conditions, making treatment for the chronic conditions the responsibility of California Children's Services, while primary care still falls under managed care. Medi-Cal managed care plans may not have the highly specialized providers necessary to treat complicated and rare conditions.[27] During the 2011-12 transition of seniors and persons with disabilities to managed care, various managed care plans and providers reported unpreparedness and being overwhelmed when assigned patients with complex care needs. Due to the challenges in recruiting both specialists and highly skilled primary care providers, individuals with disabilities experienced fragmented care and were even sent to emergency rooms to seek treatment.[28] Managed care plans have also expressed concern with their ability to take on the extensive costs of care for children affected by rare or complex conditions.[29] Yet the current system of carving-out specialty services through CCS interferes with holistic, whole-person care because provider networks differ between CCS and managed plans and there can be confusion about who pays for which services.[30] The CCS program is expected to remain intact in its current format while other service provision models are explored through pilots. Without legislative intervention, Medi-Cal managed plans cannot offer any CCS covered services as managed care benefits until 2016.[31,32]

Maryland has developed an interesting model for caring for individuals with complex conditions. While Maryland's Medicaid system is managed care based, a small fee-for-service program exists for high-risk, high-cost patients called the "Rare and Expensive Case Management Program" (REM). This program offers extensive case management, including face-to-face contact and status reports for each patient at least every 90 days, to approximately 4,000 patients with severe conditions.[33, 34] REM differs from CCS in that its enrollees and all of the

[26] Ibid.
[27] Health Management Associates (2009). *Considerations for Redesign of the California Children's Services (CCS) Program*.
[28] Kaiser Family Foundation (2013). *Transitioning Beneficiaries with Complex Care Needs to Medicaid Managed Care: Insights from California*. The Kaiser Commission on Medicaid and the Uninsured.
[29] Ibid.
[30] Op cit. Health Management Associates.
[31] Welfare and Institutions Code Section 14094.3
[32] County Organized Health Systems can provide these services however.
[33] Sanjay K. Pandey et al. *An Assessment of Maryland Medicaid's Rare and Expensive Case Management Program*. Eval Health Prof 2000 23:457.
[34] Maryland Department of Health and Mental Hygiene. Rare and Expensive Case Management RFP. Questions, January 22, 2013.

services they require, including primary care, are totally exempt from managed care, thus services are coordinated in a comprehensive manner, and the case management is designed to be much more extensive than what CCS offers. An early study of the program showed that people with complex diseases incurred significantly lower inpatient costs (nearly $1,000 less per patient per month) when provided with case management.[35]

Thank you to the Lucile Packard Foundation for Children's Health for funding this project.

[35] Op cit. Pandey.

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

Prepared by Carolina Coleman

Funded by the Lucile Packard Foundation for Children's Health
January 2014

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

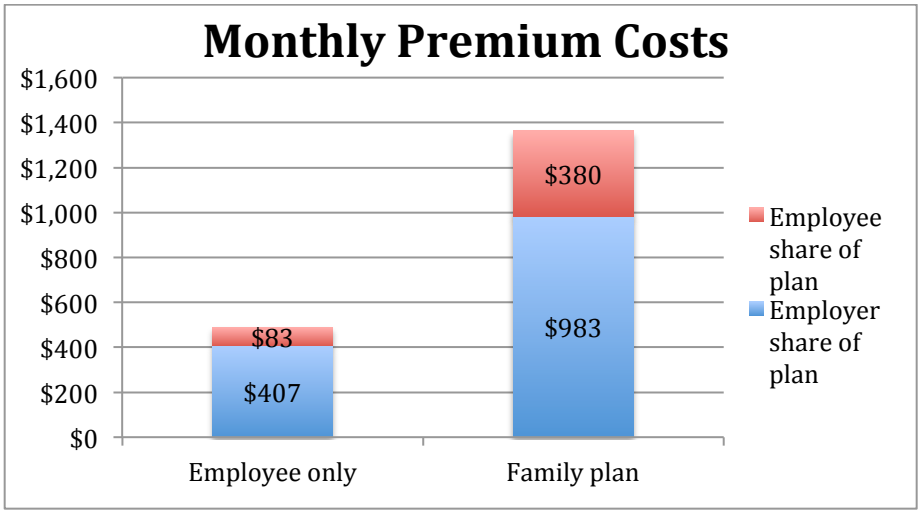
Employer-Based Coverage

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*.

Thank you to the Lucile Packard Foundation for Children's Health for funding this project.

ITUP
INSURE THE UNINSURED PROJECT

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

Prepared by Carolina Coleman

Funded by the Lucile Packard Foundation for Children's Health
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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

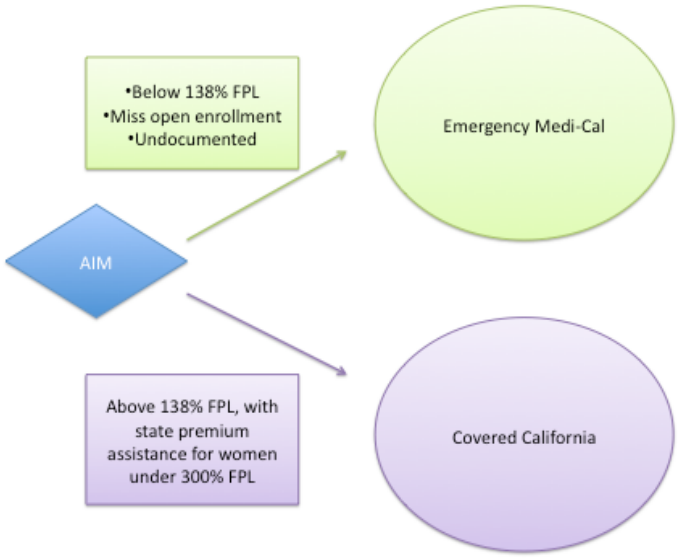
Some have suggested that the cost or even the offer of dependent coverage should not be the responsibility of employers, but rather the parents or society as a whole. This ideology would limit the responsibility of employers for dependents, instead shifting coverage for children to the Exchanges. While 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.

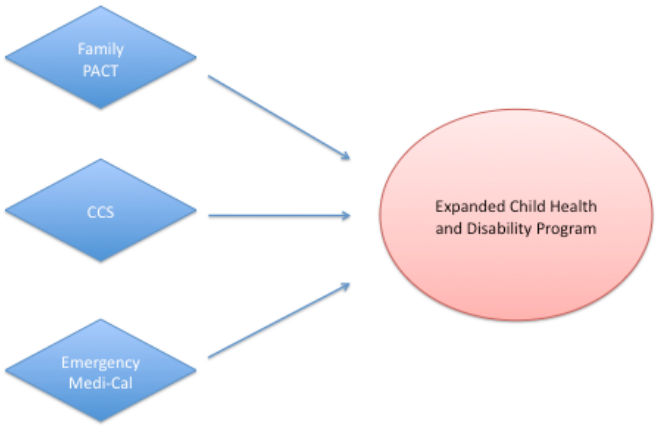
Recommendations

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

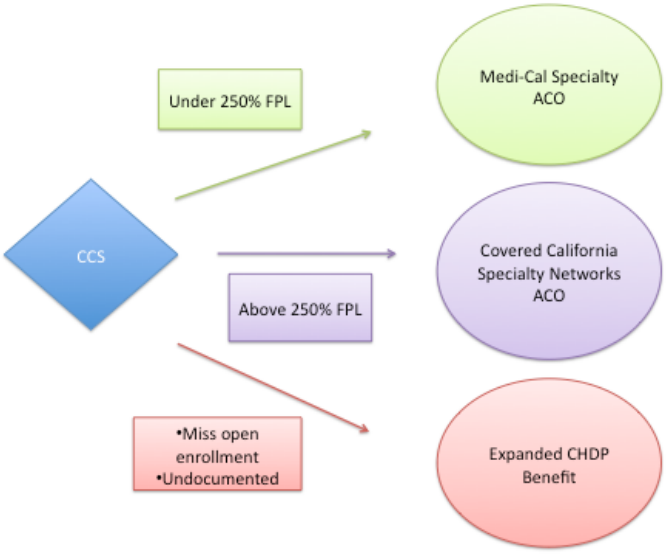
We recommend that AIM subscribers wherever possible be folded into full-scope insurance programs. All women should be enrolled in Medi-Cal, Covered California, employer-sponsored coverage, or another plan, and thus should have access to maternity and newborn care. The remaining uninsured pregnant women 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.

Thank you to the Lucile Packard Foundation for Children's Health for funding this project.

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