CALIFORNIA BUDGET PROJECT

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EXPANDING OPPORTUNITIES: WHAT THE FEDERAL HEALTH LAW MEANS FOR CALIFORNIA

On March 23, 2010, President Barack Obama signed into law the Affordable Care Act (ACA) enacting the most significant restructuring of the country's health care system in more than four decades.[1] The new law strives to dramatically reduce the ranks of the uninsured by establishing protections for consumers with privately purchased coverage and providing economic security by establishing that the cost of health care should be based on an individual's ability to pay. On the ACA's one-year anniversary, policies included in new the law have already provided tangible benefits to millions of California seniors with high prescription drug costs, young adults who need affordable coverage, and persons with health conditions who were previously denied health coverage by insurers. In addition, California has moved swiftly toward full implementation of the law, becoming the first state in the country to pass legislation to establish key foundations of a new health system.

By 2019, the ACA aims to expand coverage to more than nine out of 10 non-elderly California residents, a significant increase from the 78.8 percent of non-elderly California residents currently with coverage.[2] This *Brief* describes the law's impact on coverage – both for individuals who purchase coverage privately and for those who obtain coverage through public programs, such as Medi-Cal – as well as consumer protections and coverage options for those individuals who must purchase coverage on their own or through an employer.

Expanding Affordable Options to Californians With Privately Purchased Health Coverage

More than 20.5 million nonelderly Californians (61.6 percent) purchase private health insurance either through an employer or on their own directly from an insurer (Figure 1). While most of the broad market reforms in the ACA do not take effect until January 1, 2014, a number of significant changes in the private market took effect on September 23, 2010 – six months after the law's enactment – and benefit this population (Table 1).

Enhancing Coverage for Californians With Medicare

More than 4.3 million Californians have Medicare coverage.[3] The ACA includes a number of provisions aimed at making that coverage more affordable for seniors and persons with disabilities, including:

- **Closing the prescription drug coverage gap.** Despite having Medicare Part D prescription drug coverage, many seniors encounter a coverage gap, which requires them

to spend as much as $4,550 annually out of pocket for medications.[4] The ACA will close that gap, ultimately making the cost of prescription drugs less costly for seniors. In 2010, individuals with Medicare Part D who fell into the coverage gap received a $250 rebate check to help pay for medications. Beginning in 2011, individuals with high prescription drug costs will receive a 50 percent discount on certain medications while they are in the coverage gap. Over the next decade, the coverage gap will narrow gradually until it is closed in 2020.

- **Increasing coverage for preventive and community-based care.** Beginning in 2011, Medicare will cover certain preventive services, including annual wellness exams, without coinsurance or a deductible. Beginning in October 2012, seniors will be able to enroll in coverage that will help to pay for assistance with shopping or personal care while they live at home or with family. Without this coverage, certain seniors may only have access to these services through more costly nursing homes.

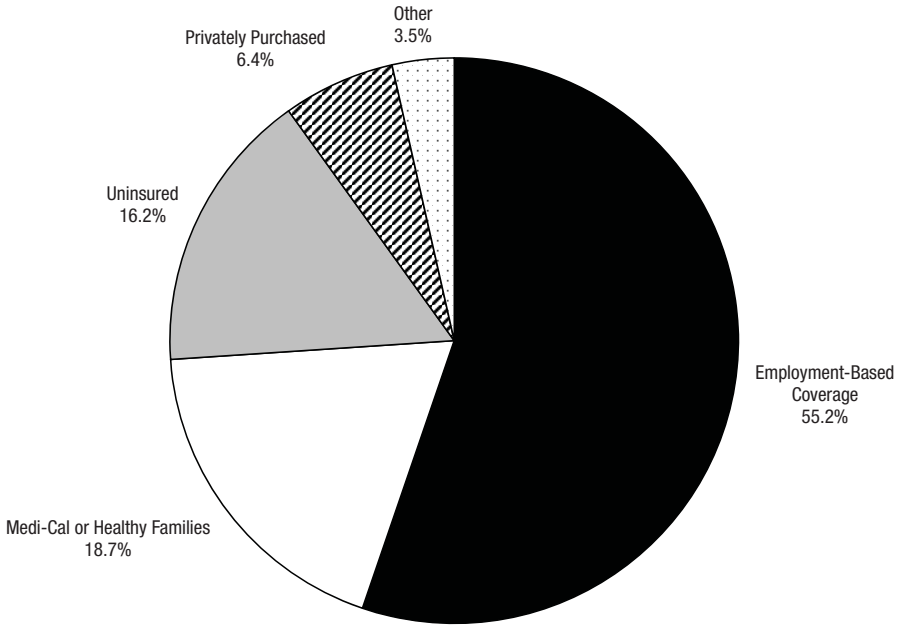
Expanding Affordable Health Coverage to More Californians

One of the primary goals of the ACA is to reduce the number of Americans who lack health coverage. In California, 7.1 million individuals lacked coverage for all or part of 2009.[5] Once fully implemented, the ACA could potentially expand coverage to more than four out of five uninsured Californians (Figure 2). Strategies for achieving this goal include:

- **Increasing access to affordable coverage for individuals with pre-existing health conditions.** Approximately 200,000 to 300,000 Californians who have health problems may be uninsured because health plans have declined to cover them.[6] As of October 2010, uninsured individuals who have been denied private health coverage due to pre-existing conditions may purchase coverage in a temporary high-risk pool, called the California Pre-Existing Condition Insurance Plan (PCIP). This coverage will be available through December 31, 2013, after which insurers will be required to issue coverage to all individuals, regardless of pre-existing conditions.[7]

- **Expanding Medi-Cal to Californians with incomes at or below 138 percent of the poverty line.** Beginning in January 2014, individuals with incomes at or below 138 percent of the federal poverty line – $25,571 for a family of three in 2011 – will be eligible for Medi-Cal, the federal-state program for low-income California families.[8] This new guideline would extend Medi-Cal coverage to an estimated 1.1 million Californians (Figure 3).[9] Under current law, childless adults under age 65 who have low incomes and

Figure 1: More Than Half of Non-Elderly Californians Obtained Health Coverage Through an Employer in 2009

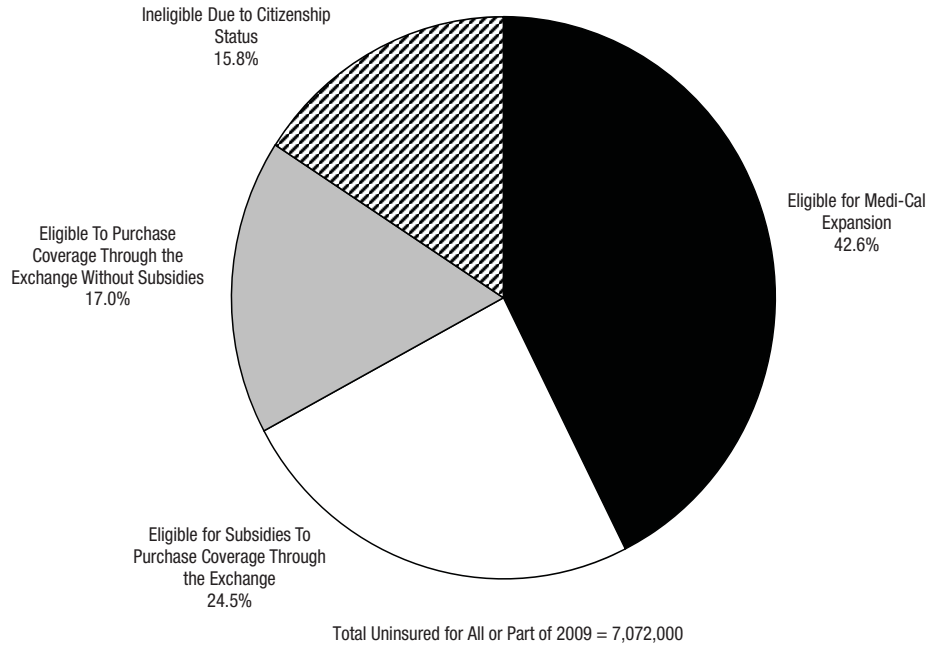


Total Number of Non-Elderly Californians in 2009 = 33,291,000

Source: UCLA Center for Health Policy Research

Table 1: Timeline of Changes to Private Health Coverage		
Implementation Date	Provision	Summary
January 2010	Small Business Tax Credits	Businesses with fewer than 25 employees will be encouraged to offer coverage to workers. Tax credits will pay as much as 35 percent of for-profit employers' contribution to employees' health coverage, beginning in the 2010 tax year.[10]
August 2010	Oversight of Premium Increases	The Departments of Managed Health Care and Insurance will coordinate oversight of premium increases sought by health plans and require premium filings to be certified by an independent actuary. The state and insurers will post proposed increases online. California received a $1 million grant to begin its premium oversight program.
September 2010	New Rules for Health Insurers Effective September 23, 2010	Insurers may no longer: • Retroactively cancel coverage after a policyholder becomes ill. • Impose lifetime caps on individuals' medical expenses. • Deny coverage to children with pre-existing medical conditions. • Sell new insurance policies that impose copayments and other out-of-pocket expenses for preventive care. Insurers must also allow young adults to remain on their parents' coverage until age 26 if they are not offered coverage by an employer.
October 2010	Temporary Insurance for Adults Denied Coverage Due to Health Status	Individuals who have been denied coverage or offered coverage at extremely high rates because of pre-existing health conditions may apply for insurance coverage through California's new Pre-Existing Condition Insurance Plan.
January 2011	Minimum Share of Premiums To Be Used for Health Care	Insurers must spend at least 85 percent of premium dollars on medical care for coverage purchased in groups of 101 or higher and 80 percent of premium dollars on medical care for coverage purchased in groups of 100 or fewer or in the individual market. Health plan purchasers will receive rebates if health plans fail to meet this standard.
March 2012	Standardized Plain-Language Explanation of Benefits	Insurers must develop uniform, plain-language explanations of covered benefits under guidelines developed by the US Department of Health and Human Services, which include a "coverage facts" label illustrating coverage and out-of-pocket costs under common scenarios, such as maternity, labor, and delivery.
January 2014	Additional Consumer Protections Begin January 1, 2014	Insurers may no longer: • Deny coverage to any person due to pre-existing health conditions. • Charge higher premiums to women or individuals with pre-existing health conditions. • Impose annual dollar limits on health coverage. Insurers will also have limited ability to charge different rates based on a policyholder's age.
January 2014	Standardized Health Benefit Tiers	Health plans must categorize health policies into four standard "tiers," making it easier for consumers to make "apples-to-apples" comparisons. "Bronze" plans will be the lowest cost and least comprehensive; "Platinum" plans will be the highest cost most comprehensive.[11]
January 2014	Standardized, Minimum Health Benefits	Health plans must provide coverage for office visits, hospitalization, chronic disease management, maternity and newborn care, mental health and substance abuse treatment, and prescription drugs.
January 2014	Limited Out-of-Pocket Expenses	Workers who purchase health coverage from a small employer will not have to pay deductibles of more than $2,000 per individual or $4,000 per family subject to annual increases based on the average growth in premiums. Individuals who purchase coverage on their own will see out-of-pocket expenses limited to the maximum allowable under the law as it applies to High Deductible Health Plans. In 2011, out-of-pocket expenses for those plans are limited to $5,950 for an individual and $11,900 for a family.

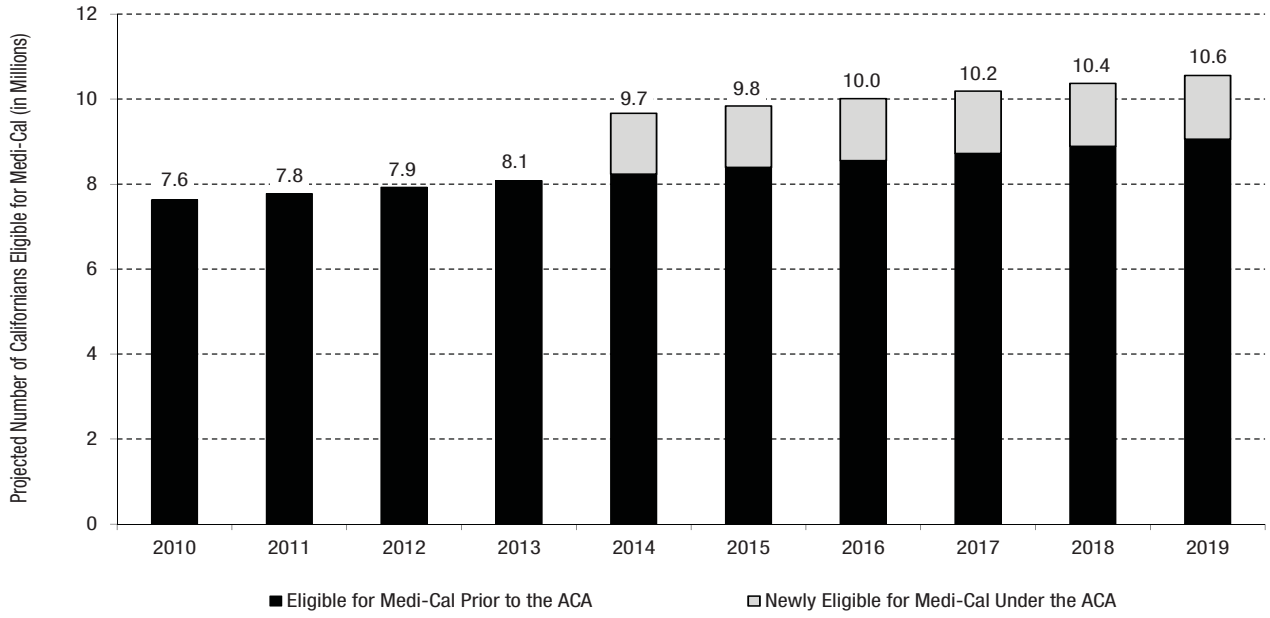
Figure 2: The Affordable Care Act Could Expand Coverage to More Than Four Out of Five Uninsured Californians



Total Uninsured for All or Part of 2009 = 7,072,000

Source: UCLA Center for Health Policy Research

Figure 3: The Affordable Care Act Will Substantially Increase Medi-Cal Eligibility



Note: Medi-Cal expansion under the ACA begins January 1, 2014. Children transferred from Healthy Families to Medi-Cal are considered newly eligible for the program.
Source: Affordable Care Act and CBP analysis of Department of Finance, Department of Health Care Services, Legislative Analyst's Office, Managed Risk Medical Insurance Board, and UCLA Center for Health Policy Research data

who are not disabled, as well as parents whose incomes are higher than the poverty line, are excluded from Medi-Cal.[12]

- **Extending subsidies and tax credits to middle-income families and small businesses to make health coverage more affordable.** The health law provides financial assistance to families with incomes below 400 percent of the poverty line – $74,120 for a family of three in 2011 – and who do not qualify for Medi-Cal to purchase qualified health coverage.[13] The health law also encourages small businesses to offer workers coverage by providing a tax credit to offset a portion of the businesses' share of the health premium.

Health Insurance Exchange Will Link Consumers to Affordable Health Coverage

The ACA establishes an entity called an "exchange," which will ensure that coverage is affordable for individuals and small businesses. The exchange will be required to certify that health plans offered meet new minimum standards regarding benefits and that out-of-pocket costs are "reasonably priced" by requiring justification of premium increases. Pooling together individuals and small businesses into larger groups would spread health care costs across a more diverse group, making comprehensive coverage more affordable and reducing overhead costs. These purchasing pools could give individuals and small businesses access to policies that are more typical of larger job-based health plans.[14] Health coverage sold through the exchange must meet certain standards regarding the marketing of health plans, the adequacy of providers available in the plan's network, and formatting of plan documents.

While individuals and small employers will not be required to purchase health coverage through the exchange, coverage available in the exchange is expected to be more affordable for two reasons. First, pooling a larger group of consumers should result in lower overall premium costs. Second, federal subsidies and tax credits to help reduce the cost of coverage only apply to coverage purchased through the exchange.

Subsidies Will Help Families Afford Health Coverage in the Exchange

Families with incomes up to 400 percent of the poverty line – $74,120 for a family of three in 2011 – representing an estimated 2.3 million individuals in California will be eligible for subsidies that offset the cost of health coverage premiums (Table 2).[15] In addition to subsidies to reduce the cost of the premium, families with incomes of less than 250 percent of the poverty line – $46,325 for a family of three in 2011 – will be eligible for subsidies to help pay for the cost of copayments and other out-of-pocket expenses.[16]

Table 2: Subsidies Will Limit the Share of Family Income Spent on Health Premiums

Federal Poverty Line	Percent of Income To Be Paid Toward Premiums	Premium Contribution for a Family of Three
100%	2.00%	$371
133%	3.00%	$739
150%	4.00%	$1,112
200%	6.30%	$2,335
250%	8.05%	$3,729
300%	9.50%	$5,281
400%	9.50%	$7,041

Note: Premium contribution estimates are for 2011.
Source: CBP analysis of Health Care and Education Reconciliation Act of 2010 (Public Law 111-152)

Tax Credits Help Small Businesses Pay for Employee Health Coverage in the Exchange

The escalating cost of health coverage has been particularly burdensome for small businesses. As a result, increasing numbers of small businesses have shifted health care costs to workers through higher premiums, copayments, and deductibles, while others have considered dropping coverage altogether.[17]

Under the ACA, certain small businesses will be eligible for tax credits to help defray the cost of providing health coverage to workers. Firms may claim this credit for a total of six years. A business is eligible if it:

- Employs fewer than 25 workers;
- Pays workers an average wage of less than $50,000 annually; and
- Contributes at least 50 percent of the premium cost for its employee's coverage.

Tax credits vary depending on whether the business is a for-profit or non-profit. In tax years 2010 through 2013, for-profit businesses are eligible for credits of up to 35 percent of the employer's share of premium costs. Beginning in tax year 2014, the credit for for-profit businesses will increase to up to 50 percent of premium costs. Nonprofit businesses are eligible for credits of up to 25 percent of the employer's premium share for tax years 2010 through 2013, increasing to credits of up to 35 percent of the employer's share of premium costs beginning in tax year 2014.

Who Can Buy Coverage Through the Exchange?

The exchange, which could make it easier for individuals and businesses to find affordable and comprehensive coverage, could enroll as many as 8 million Californians.[18] Eligibility to purchase coverage through the exchange, however, will be limited to:

- Individuals who do not have access to coverage through an employer and are not eligible for public programs; and
- Small-business employees whose employers have elected to purchase coverage in the exchange.[19]

Individuals generally may not purchase coverage through the exchange if their employer offers them coverage – even if that coverage is more costly or less comprehensive than plans available in the exchange. The exception is if job-based coverage is considered insufficient or unaffordable, in which case the worker could purchase subsidized coverage in the exchange and the employer would face a penalty.[20]

Shared Responsibility for the Health System

The ACA relies on the notion that everyone, as a patient, provider, employer, regulator, or insurer, must play a role in helping to reshape the health care system. Beginning in 2014, individuals and businesses will have new responsibilities under the ACA.

Requirement for All Californians To Obtain Coverage

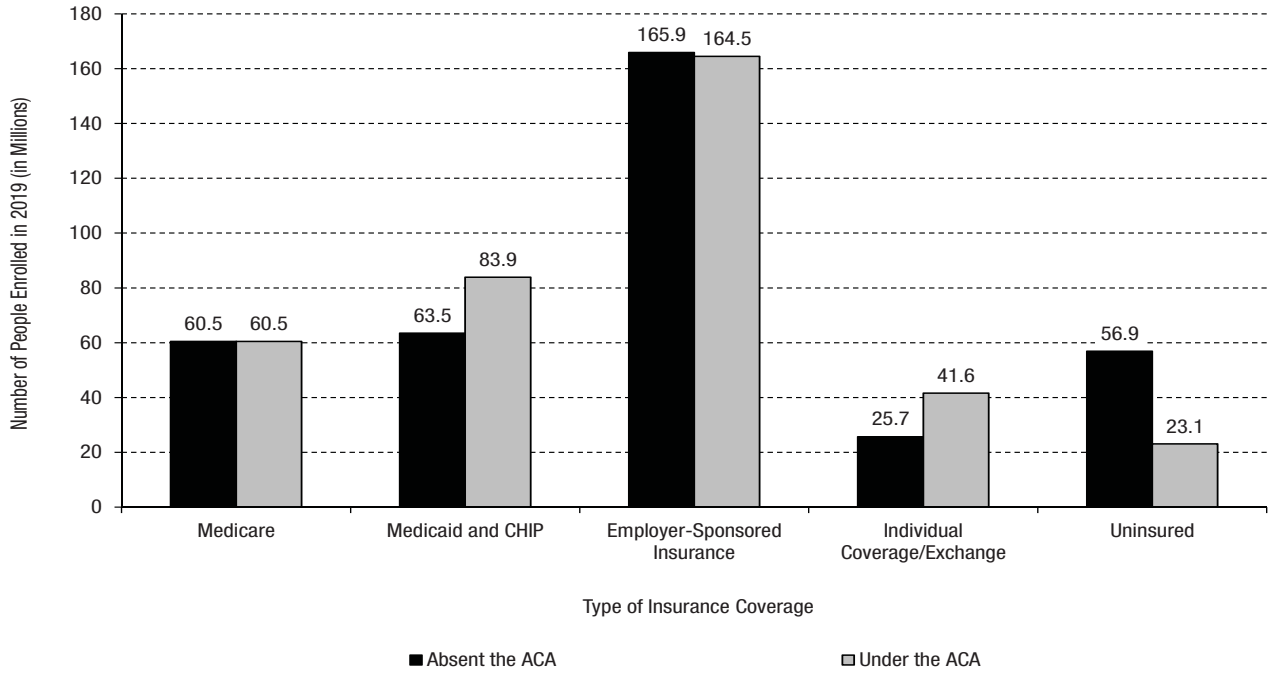
The ACA requires all US citizens and legal residents to maintain a minimum level of health coverage beginning in 2014 or face financial penalties. The mandate for individuals to carry coverage complements the requirement that health insurers provide coverage to all individuals starting in 2014. Pooling nearly all US residents into the health system – both healthy and less healthy – is designed to spread the cost of medical services across a broader population. Without requiring all individuals to have coverage, an insurance pool may only include less healthy enrollees who require more health services, resulting in higher health care premiums in the system. Most Californians are unlikely to be affected by the mandate because they already receive coverage through their jobs or through public programs (Figure 4).

The ACA exempts certain individuals from having to purchase coverage. Individuals who would not be required to have health coverage include:

- Individuals for whom the cost of the least expensive coverage through the exchange exceeds 8 percent of their family income;[21]
- Individuals in families with incomes less than 100 percent of the poverty line;
- Undocumented immigrants;
- Religious objectors;
- Native Americans; and
- Incarcerated persons.

In 2016, individuals who are not exempt and decline to purchase coverage will face a penalty equal to the greater of 2.5 percent of taxable income or $695 for each individual, adjusted for inflation

Figure 4: Health Care Reform Will Not Change How Most Americans Obtain Health Coverage



Source: Centers for Medicare and Medicaid Services

annually.[22] While the penalty is designed to encourage individuals to purchase coverage, the amount of the penalty will likely be far less than the cost of a plan that meets the law's requirement. Currently, a modest plan for a 30-year-old woman that does not meet the law's minimum coverage requirements costs $1,248 per year.[23] As a result, some individuals may decide to pay an annual penalty, rather than obtain coverage. The Centers for Medicare and Medicaid Services estimates that 18 million individuals nationwide would choose to remain uninsured in 2019 and pay the penalty.

Employer Responsibility

The country's health coverage system relies heavily on employers providing health care to their workers. More than half of Californians rely on employers for health coverage.

Beginning in 2014, the ACA encourages businesses with 50 or more employees to offer adequate health coverage to workers. If they do not offer sufficient coverage and one or more of their uninsured employees subsequently obtains subsidized health coverage through the exchange, then businesses will face a fine.

Large employers that offer coverage that their workers cannot afford or that does not meet ACA standards will also face fines (Table 3). However, as with penalties levied against individuals who do not comply with the law, the penalty for businesses that fail to provide coverage will likely be less than the cost of coverage. As a result, some businesses may opt to pay the penalty, rather than provide affordable coverage – or any coverage at all – for their workers.

Table 3: Large Employers Face Penalties if Workers Obtain Subsidized Health Coverage Through the Exchange (Begins 2014)

Annual Penalty if One or More Employees Seek Subsidized Coverage Through the Exchange	
Employers Who Offer Insufficient or Unaffordable Coverage	Employers Who Offer No Coverage
The lesser of either $3,000 per employee with subsidized coverage or $2,000 for each full-time employee beyond the first 30. These amounts will be adjusted annually to reflect the national increase in insurance premium costs.	$2,000 for each full-time employee in the company beyond the first 30, with the penalty amount adjusted annually to reflect the national increase in insurance premium costs.

For More Information

Consumers interested in tracking the implementation of health reform both in California and nationally may find the following resources helpful:

- For information about federal implementation of the ACA, visit www.healthcare.gov.
- For California-specific information about implementation of the ACA, visit www.healthcare.ca.gov.
- For information about obtaining coverage through the PCIP, visit http://www.pcip.ca.gov/Home/default.aspx.
- For a summary of tax provisions in the ACA, visit http://www.ftb.ca.gov/law/legis/2010FedHealthCareActs.pdf.

Millions of Californians Will Remain Uninsured

The combination of subsidies to purchase coverage and public program expansions in the ACA should reduce the number of uninsured individuals in California by approximately two-thirds – or 4.7 million individuals.[24] Additionally, an estimated 1.2 million uninsured Californians will be eligible to purchase health coverage through the exchange, though without the assistance of federal subsidies, potentially increasing the law's reach to four out of five uninsured Californians. However, some of these individuals may still find coverage unaffordable, and therefore be exempt from purchasing coverage under the ACA. The ACA does not require individuals for whom the lowest-cost plan in the exchange exceeds 8 percent of their family income to purchase health insurance. The Centers for Medicare and Medicaid Services estimates that approximately 16 percent of the non-elderly population – those whose incomes fall between 400 percent and 542 percent of the poverty line – will be exempt from purchasing coverage.[25] In addition, approximately 1.1 million uninsured undocumented immigrants will not be required to have health insurance, nor will they be eligible to enroll in public programs or to purchase unsubsidized coverage through the exchange.

California will need to maintain a "safety net" network of community clinics and public hospitals, which have been providing services to low-income and uninsured Californians for decades. These health care providers will continue to serve Californians who remain uninsured and fill the gaps in coverage for services not covered by Medi-Cal.[26]

Hanh Kim Quach prepared this Budget Brief. *The California Budget Project (CBP) was founded in 1994 to provide Californians with a source of timely, objective, and accessible expertise on state fiscal and economic policy issues. The CBP engages in independent fiscal and policy analysis and public education with the goal of improving public policies affecting the economic and social well-being of low- and middle-income Californians. General operating support for the CBP is provided by foundation grants, subscriptions, and individual contributions. Please visit the CBP's website at www.cbp.org.*

ENDNOTES

1 This *Brief* uses the phrase "Affordable Care Act" (ACA) to refer to the two bills that enacted federal health reform: the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

2 UCLA Center for Health Policy Research, California Health Interview Survey.

3 UCLA Center for Health Policy Research, California Health Interview Survey.

4 In 2011, a senior would reach the coverage gap once she and her insurer have spent a combined $2,840 in prescription drug costs. Once in the coverage gap, the senior must pay all of her drug costs until she has paid a total of $4,550 out of pocket in a year. At that point, the drug plan will pay most of the costs and the senior will be responsible for a small copayment. See US Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicare & You: 2011* (October 2010), p. 77.

5 Shana Alex Lavarreda and Livier Cabezas, *Two-Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform* (UCLA Center for Health Policy Research: February 2011).

6 Estimate from the Managed Risk Medical Insurance Board, *Facts About California's High Risk Pool and the Federal High Risk Pool* (April 22, 2010).

7 California has operated its own program for uninsurable Californians since 1991, called the Major Risk Medical Insurance Program (MRMIP). MRMIP is limited to 7,100 Californians – a fraction of the estimated need. Premiums for these plans are set at 125 percent to 137 percent of standard rates in the commercial market and the plans have an annual coverage cap of $75,000. In contrast, premiums for coverage through the PCIP must be the same as for an individual without pre-existing conditions and there are no benefit caps. To qualify for the federal program, applicants must have been uninsured for at least six months and explicitly denied coverage due to a pre-existing condition. California will receive an estimated $761 million of $5 billion available nationwide for this purpose.

8 The new law changes how eligibility is calculated. While the health reform law specifies an income threshold of 133 percent of the poverty line, it disregards the first 5 percent of income, effectively raising the income eligibility level to 138 percent of the poverty line.

9 Federally funded Medi-Cal will be available to US citizens or legal residents who live in the US for longer than five years.

10 For non-profit firms, the maximum tax credit from 2010 through 2013 is 25 percent of employers' share of premium costs.

11 Bronze plans will have an actuarial value of 60 percent, meaning that health coverage would pay, on average, 60 percent of health costs, while consumers would pay, on average, 40 percent of medical expenses out of pocket. Silver plans will have an actuarial value of 70 percent, Gold will have a value of 80 percent, and Platinum will have a value of 90 percent.

12 Under current law, counties are required to provide health services to low-income, childless adults who have no other source of care, although eligibility and scope of services varies by county. Since September 2007, 10 counties have participated in a Medicaid waiver project enrolling approximately 130,000 low-income Californians in county-based health programs. These adults would not have otherwise qualified for public health programs. The waiver enables California to continue to receive federal Medicaid funds despite using different guidelines for coverage. In November 2010, California renewed its Medicaid waiver as a "bridge to reform" to expand upon the previous waiver's efforts extending local health services to low-income adults. Under the newest waiver, nearly every county would participate and aim to enroll an estimated 512,000 low-income Californians in local health service programs. The state estimates that as many as 385,000 individuals with incomes at or below 133 percent of the poverty line may receive some type of health coverage through local county programs. These individuals could be directed into the Medi-Cal Program in 2014. See State of California, "California Section 1115 Comprehensive Demonstration Project Waiver – A Bridge to Reform: A Section 1115 Waiver Proposal" (June 2010). For more on the Medi-Cal expansion under the ACA, see California Budget Project, *New Federal Health Law Will Significantly Expand Medi-Cal Eligibility and Enrollment* (October 2010).

13 Certain individuals and families with incomes below 138 percent of the poverty line will qualify for Medi-Cal coverage and therefore not be eligible for subsidies. Legal immigrants who have resided in the US for fewer than five years will qualify for subsidies.

14 Large employers generally have access to more comprehensive health coverage because the larger size of their employee pools allows them negotiate lower prices.

15 Certain families who have incomes below 133 percent of the poverty line, but who do not qualify for Medi-Cal due to immigration status, will also qualify for subsidies. The amount of the subsidy is tied to the second-lowest cost "Silver" plan available through the exchange, which has an actuarial value of 70 percent. Actuarial value helps consumers identify the comprehensiveness of the plan and describes the share of claims that would be covered for a typical population. Shana Alex Lavarreda, et al., *National Health Care Reform Will Help Four Million Uninsured Adults and Children in California* (UCLA Center for Health Policy Research: October 2009).

16 Families with incomes below 150 percent of the poverty line will receive subsidies that would bring the actuarial value of their coverage to 94 percent, compared to 70 percent for a Silver plan. Subsidies for families between 150 percent and 200 percent of the poverty line will bring the value of the plan to 87 percent, and subsidies for families between 200 percent and 250 percent of the poverty line will bring the value of the plan to 73 percent.

17 California HealthCare Foundation, *California Employer Health Benefits Survey 2010* (December 2010).

18 Ken Jacobs, Laurel Lucia, and Dave Graham-Squire, *Eligibility for Medi-Cal and the Health Insurance Exchange in California Under the Affordable Care Act* (University of California, Berkeley Center for Labor Research and Education: August 2010).

19 Small businesses are defined as having fewer than 100 employees. Employers must allow all full-time workers to purchase coverage in the exchange. Larger businesses will be able to participate in the exchange beginning in 2017.

20 Insufficient coverage is defined as coverage with an actuarial value of less than 60 percent, meaning that it covers 60 percent of health expenses for a typical population, or the premium cost is more than 9.5 percent of a worker's income.

21 The Centers for Medicare and Medicaid Services estimates that approximately 16 percent of nonelderly individuals will fall under this category. Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Memorandum From the Office of the Chief Actuary (Centers for Medicare and Medicaid Services: April 22, 2010).

22 The penalty will be phased-in until 2016.

[23] The mandate to maintain basic minimum coverage will require individuals to purchase a plan that covers doctor visits, prescription drugs, maternity care, and mental health visits, among other services. Currently, there is no minimum standard for coverage. It is likely that an individual's annual health coverage costs will continue to exceed the annual penalty she would incur for declining to purchase coverage.

[24] Shana Alex Lavarreda and Livier Cabezas, *Two-Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform* (UCLA Center for Health Policy Research: February 2011).

[25] Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Memorandum From the Office of the Chief Actuary (Centers for Medicare and Medicaid Services: April 22, 2010).

[26] California eliminated Medi-Cal coverage for a number of benefits in 2009-10, including adult dental services. Federally qualified health centers are required to provide a range of services, regardless of whether the state includes those services as Medi-Cal benefits.