



The Patient Protection and Affordable Care Act: An Overview of Its Potential Impact on State Health Programs

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (PPACA), often referred to as federal health care reform, is far-reaching legislation that will change how millions of Californians access health care coverage. The scope of PPACA is so broad that it will be years before all of its provisions will be fully implemented and its ramifications fully understood.

Overview of PPACA

The PPACA intends to make coverage more accessible and in order to do this it does the following:

- ***Creates an Individual Mandate.*** Imposes an individual mandate requiring most U.S. citizens and legal residents to have health insurance coverage or pay a penalty.
- ***Establishes American Health Benefit Exchanges.*** In order to make coverage more accessible and affordable, PPACA creates new entities called American Health Benefit Exchanges through which individuals who generally do not have access to affordable employer coverage, as well as small businesses, can purchase coverage.
- ***Changes Private Health Insurance Coverage.*** The PPACA establishes new requirements for health plans and insurers designed to expand access to affordable coverage, and prevent individuals from losing coverage.
- ***Expands Medicaid.*** The PPACA significantly expands the Medicaid program (known as Medi-Cal in California) primarily by mandating coverage of certain population groups not previously required—such as low-income, childless adults.
- ***Establishes New High-Risk Insurance Pool.*** The PPACA establishes a federal high-risk health insurance coverage pool program to provide coverage to individuals who are unable to purchase coverage and who are commonly referred to as hard-to-insure or medically uninsurable.

Implications for State Health Programs in the Near and the Long Term

Some of PPACA's provisions are already in effect, while others will go into effect in the near term. In some cases, the state will need to react quickly in order to take full advantage of chances to improve state health care programs and to obtain federal funds the state needs to help carry out the new law. Other provisions of PPACA will not go into effect for two or three years or more. Nevertheless, in a number of cases, it will be important for the Legislature to begin considering soon what initial steps should be taken to implement some of these measures. For example, based on our initial review, the PPACA will substantially increase future health

program costs that the Legislature should begin planning now to address. Some new grant and program opportunities are available that could generate additional federal funds to support activities to improve health outcomes in California. Other significant programmatic changes will be needed to help establish the new programs called for in the federal law, to integrate them with existing state health programs, or to comply with federally mandated eligibility and enrollment processes.

Thinking Broadly About Implementing the New Federal Law

Beyond responding to the specific requirements in PPACA, the Legislature should think broadly about the state's role in the implementation of expanded health insurance coverage over the next few years. In carrying out and adapting to PPACA, for example, the Legislature has the opportunity to improve the structure of the state's patchwork of state programs. We believe the Legislature should consider the following issues:

- ***Address Future Health Care Costs.*** We think the Legislature should consider addressing future health care costs by: (1) maximizing receipt of federal funds, (2) leveraging the state's purchasing power, and (3) reducing the cost of care for high-cost individuals.
- ***Structural Changes to State Programs Are Warranted.*** We believe that PPACA provides an opportunity for the Legislature to reexamine the structure of the state's health programs going forward.
- ***The PPACA Should Prompt a Reevaluation of the State-Local Partnership.*** In light of the interactions between local government and state programs, it will be critical for the Legislature to reassess the state and local relationship as part of its deliberations on the implementation of PPACA.
- ***New Strategies Could Bolster Health Care Quality and Outcomes.*** The PPACA does not make dramatic changes to the health care delivery system, however, it makes available grants and demonstration project opportunities to assist states in addressing certain problems in a gradual manner.
- ***Future Workforce and Health Infrastructure Needs Should Be Assessed.*** The individual mandate and expanded coverage options created under PPACA will likely create a surge in demand for health care services statewide. Successful implementation of PPACA will depend on the state's response to access issues including workforce and infrastructure capacity as well as the regional variation of supply of health services.

INTRODUCTION

The PPACA, as amended by the Health Care Education Reconciliation Act of 2010, is far-reaching legislation that will change how millions of Californians access health care coverage. The PPACA, often referred to as federal health care reform, will also change the structure and availability of coverage, thereby making it easier for more Californians to purchase and maintain it.

The scope of PPACA is so broad that it will be years before all of its provisions will be fully implemented and its overall ramifications fully understood. Furthermore, the federal government will promulgate regulations over the next few years that will clarify PPACA and give more detailed guidance on how many of its provisions are to be implemented. The California Legislature has already begun taking steps to develop legislation that would enact various specific provisions of PPACA into state law, as well as proposing broader measures intended to help guide the state's implementation of PPACA.

This report begins by providing a broad overview of PPACA and its key elements, such as the establishment of health benefit "exchanges," the expansion of publicly funded health programs, and other major changes to the health care system. We subsequently explore both the important short- and long-term implications of PPACA for the state's array of health programs, including the potential multibillion dollar annual cost of these federal mandates to the state. In this report, we have focused on the implications of the new law for the state's public health care programs, but PPACA also has broad policy impacts in other areas. (See the text box on the next page for a discussion of these other impacts.) Finally, we encourage the Legislature to think more broadly about the opportunities PPACA provides the state to improve the financial sustainability and structure of the state's health programs and improve health care quality and outcomes.

OVERVIEW OF THE NEW FEDERAL HEALTH CARE LAW

PPACA INTENDS TO MAKE HEALTH COVERAGE MORE ACCESSIBLE

In order to make coverage more accessible and affordable, PPACA creates new entities called American Health Benefit Exchanges, through which individuals and small businesses can purchase coverage. A few years after these exchanges are established, they can be opened to allow purchases of coverage by larger employers. The PPACA places requirements on certain employers to provide coverage, and provides

some subsidies to encourage the expansion of employer-based coverage.

To make coverage more accessible for low- and modest-income individuals and families, the federal law contains provisions limiting the premiums and lowering cost-sharing obligations such as copays and deductibles that can be charged to those who purchase coverage. The PPACA also imposes various new standards on health insurers. For example, the law requires insurers to offer and renew coverage on a guaranteed issue basis,

meaning that an insurer must accept every applicant for coverage with certain exceptions.

The PPACA provides low-income persons greater access to health coverage by expanding the Medicaid program (known as Medi-Cal in

California). The new federal law also establishes a temporary high-risk insurance pool that will allow persons with preexisting medical conditions to purchase coverage.

MEASURE WOULD HAVE SWEEPING POLICY IMPACTS

The scope of this report is mainly limited to a discussion of the effect the Patient Protection and Affordable Care Act (PPACA) will have on state health programs, due to the immediacy of many changes in this area and the major fiscal implications of the new federal law for these programs. However, PPACA's impact will reach far beyond state health programs and include:

- **Workforce Development.** As access to health care coverage expands to new populations, the demand for health care services will increase. It will be important to assess whether the current and projected size of the health care workforce, including for particular types of clinicians and for particular regions, will be sufficient to meet this demand. Some federal funds will be available for states and other entities to expand their health care workforce—including student loan repayment and forgiveness programs as well as grants for enhanced training programs for a variety of health care professionals (such as nurses and social workers).
- **Health Insurance Oversight and Regulation.** New health insurance oversight requirements may create additional workload for the Department of Insurance and the Department of Managed Health Care. The Legislature will need to carefully consider how its statutes and regulations governing health insurers and health plans align with these new federal rules as well as the standard packages of benefits that are to be offered to individuals participating in the health benefit exchange.
- **Federal Tax Changes and State Revenue Impacts.** The PPACA imposes various taxes and penalties that may have an impact on businesses and individuals. These changes, as well as the expansion of health coverage could have significant implications for the state tax system and revenues. For example, as more persons obtain coverage and pay premiums, state insurance premium tax revenues could increase.
- **State Employee and Retirement Benefits.** Various provisions of PPACA, including some important changes to the federal Medicare program, may impact the costs of providing state employee and retiree health benefits.

The impacts identified above are not analyzed in this report. However, we intend to examine many of these impacts in the future, and, in many cases, recommend approaches that the Legislature may wish to consider to address these matters.

KEY PROVISIONS OF THE NEW FEDERAL LAW

As outlined above, PPACA is designed to create a health coverage purchasing continuum that is accessible to persons with low, middle, and high incomes. As individuals' incomes rise and fall, as they become employed, change employers and become unemployed, and as they age, they are to have access to different sources of coverage along the coverage continuum. The PPACA also seeks to impose greater standardization on the coverage that is offered. Creating this continuum requires the modification of existing health programs with new programs, and integration of these programs with new programs created by PPACA. Below, we describe in more detail the key elements of PPACA that are intended to establish the health coverage purchasing continuum.

Individual Mandate to Obtain Coverage

The PPACA imposes an individual mandate requiring most U.S. citizens and legal residents to have health insurance coverage or pay a penalty. There are exceptions to this requirement for financial hardship, religious objections, American Indians, those without coverage for less than three months, incarcerated individuals, and certain low-income individuals. Beginning January 1, 2014, a penalty for not having coverage will be phased in over three years and will be calculated based on a specified percentage of a person's taxable income. In order to make coverage widely available so that people can comply with the new mandate, PPACA makes sweeping changes to how health insurance coverage will be offered and purchased.

Health Insurance Exchanges

Simplifying the Purchase of Coverage. The primary function of the exchange is to make coverage accessible and to simplify the process of obtaining it. United States citizens and legal immigrants who generally do not have access to affordable employer coverage can use the exchange to obtain coverage. Additionally, small businesses with fewer than 100 employees can use the exchange to obtain coverage for their employees. Prior to 2016, states can limit exchanges to businesses with up to 50 employees. Beginning in 2017, states can allow any business to purchase coverage from the exchange. One recent study estimates that by 2016 up to 8.4 million individuals in California would be eligible to participate in the exchange, even if employers with over 100 employees are not included.

The major functions of the exchanges are to:

- ***Certify Health Plans.*** The exchanges will certify the "qualified health plans" that will be offered through the exchange. Certification will be based upon the plan's ability to meet federal requirements regarding: (1) benefit design; (2) marketing practices; (3) provider networks, including community providers; (4) plan activities related to quality improvement; and (5) the use of standardized formats for consumer information.
- ***Maintain Consumer Access to Information.*** Each exchange is to maintain an Internet website through which individual consumers may obtain comparative information on participating health plans. They will also operate a toll-free telephone hotline to respond to requests for assistance.

- **Perform Premium Reviews.** The exchanges will review the premiums that are being charged by health plans to determine whether the plan should be made available through the exchange.
- **Outreach and Exemption Functions.** Individuals who contact the exchange will be provided information on various public health coverage programs as well as the plans available through the exchange. The exchanges will also establish a “navigator program” to conduct outreach and facilitate enrollment in qualified health plans. They will certify whether certain individuals qualify for an exemption from the individual mandate and determine when employers are subject to penalties for failing to provide coverage to their employees.

Figure 1 provides more detail on the health benefits offered through the exchange.

How Will the Exchanges Be Structured?
States have significant

flexibility in the design of the exchange. For example, the exchange may be operated by a state entity or a nonprofit entity established by the state. States may choose to operate regional exchanges, or to share an exchange with one or more other states. Additionally, within certain limits, states have the choice of providing a single exchange for individuals and businesses, or establishing a separate Small Business Health Options Program exchange for qualified employers.

Figure 1

Health Benefits Offered Through the Exchange

Uniform Benefits Package: Qualified health plans are required to offer a uniform benefits package as defined by the secretary of the federal Department of Health and Human Services. At a minimum, the package must include the following “essential health benefits”:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health benefits
- Substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory devices
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including oral and vision care

Levels of Coverage: In general, qualified health plans must offer various plans based on the portion of the health care costs that would be covered by the plan.

- Bronze: 60 percent of actuarial value
- Silver: 70 percent of actuarial value
- Gold: 80 percent of actuarial value
- Platinum: 90 percent of actuarial value

Catastrophic Plan: A plan covering all of the essential benefits, as well as a minimum of three primary care visits for individuals under the age of 30 (as well as certain individuals exempt from the individual mandate) once a certain level of cost sharing is reached.

Child-Only Plan: Any qualified health plan offered under the exchange must also be available as a plan available only to individuals who have not attained the age of 21.

Annual Cap: May not exceed the cost sharing for high-deductible health plans in the individual market in 2014 (currently \$5,950 individual/\$11,900 family). The limitation on cost sharing is indexed to the rate of average premium growth.

Deductibles: For plans in the small group market deductibles are limited to \$2,000 individual/\$4,000 family, indexed to average premium growth.

Implementation Timelines and Funding.

Federal law requires the establishment of the exchange no later than January 1, 2014. If a state chooses not to establish an exchange, the federal government may establish and operate an exchange within the state. The federal health care reform law establishes “planning and establishment grants” to states. The secretary of the federal Department of Health and Human Services must award these grants to states no later than one year after enactment of the act, with the funding available until January 2015. Thereafter, the exchange is required to be self-supporting through administrative fees charged to participating insurers.

Subsidies to Low-Income Persons To Obtain Coverage

The PPACA provides several forms of financial assistance to low- and moderate-income persons to help them to obtain coverage. For example, the PPACA generally extends Medicaid coverage to persons with incomes up to 133 percent of the federal poverty level (FPL). In addition, citizens and legal residents with incomes between 133 percent and 400 percent of the FPL are eligible for a federal premium subsidy to help them to purchase coverage through the health benefits exchange. Persons with incomes up to 250 percent of FPL will also be eligible for reduced cost sharing, such as lower deductibles and copayments, with the amount of the reduction varying based on their income. Persons who are offered coverage through their employer also may be eligible for the subsidies provided through the exchange. However, they are only eligible to receive them if their employer’s plan fails to meet certain specifications or if the premium would exceed 9.5 percent of the employee’s income.

Employer Requirements

Under PPACA, employers are not directly required to offer coverage to their employees. However, the measure contains strong incentives for many of them to do so. Beginning in 2014, large employers (defined as those with at least 50 full-time employees during the preceding calendar year) will face financial penalties if one or more of their full-time employees obtain a premium credit through an exchange. Full-time employees are defined in the new federal law as those working 30 or more hours per week, except that full-time seasonal employees who work for less than 120 days during the year are excluded. If the employer does not offer coverage to its workers, or if the employer offers coverage that is not affordable based on PPACA standards, an employee may be eligible for a premium credit that would trigger a penalty on the employer.

Employers that provide coverage will be required to provide a “free choice” voucher to low-income employees that meet certain requirements to enable them to enroll in a plan offered through an exchange. Employers that offer coverage and have more than 200 employees will be required to automatically enroll their employees in the company’s health plan, although employees can subsequently opt out of the employer’s coverage.

Changes in Private Health Insurance Coverage Practices

The PPACA establishes new requirements for health plans and insurers designed to expand access to affordable coverage and prevent individuals from losing coverage. The requirements are phased in over time as referenced below. The major changes include:

- ***Guaranteed Availability of Coverage.*** An insurer must accept every employer and individual in the state that applies for coverage, permitting annual and special enrollment periods for those with qualifying lifetime events (such as a change in marital status). This is sometimes referred to as a “guaranteed issue” requirement. (Effective January 2014.)
- ***No Preexisting Conditions, Exclusions, or Refusals Based on Health Status.*** No group health plan or insurer offering group or individual coverage may exclude anyone based on a preexisting medical condition or refuse to cover persons due to past illness. (Effective January 2014.)
- ***Prohibition on Rescissions and Guaranteed Renewability.*** Insurers will not be permitted to rescind health coverage once the enrollee is covered under the plan, except in cases of fraud or misrepresentation. The PPACA also requires guaranteed renewability of coverage regardless of health status, utilization of health services, or any other related factor. (Effective September 2010.)
- ***Extension of Dependent Coverage.*** Plans providing dependent coverage of children must continue to make such coverage available until the child turns 26 years of age. (Effective September 2010.)
- ***Health Insurance Premiums.*** Premiums in the individual and group markets may vary only by family structure, geography, the actuarial value of the benefit, age, and tobacco use. In effect, this provision prohibits insurers from charging persons with certain medical conditions more than others for coverage. (Effective January 2014.)
- ***No Lifetime or “Unreasonable” Annual Limits.*** A group health plan and insurance issuer offering group or individual health insurance coverage may not establish lifetime limits on the dollar value of benefits or unreasonable annual limits on the dollar value of benefits. (Effective September 2010.)
- ***Coverage of Preventive Health Services.*** Plans must provide coverage for certain preventive health services, such as immunizations, without cost sharing. (Effective September 2010.)
- ***Comprehensive Health Insurance Coverage.*** The new federal law requires health insurers in the small group and individual markets to include in their coverage certain defined essential benefits. These insurers must also provide coverage that has a specified actuarial value and complies with limitations set forth in the law on cost sharing for the parties purchasing coverage. (Effective January 2014.)

Expansion of Medicaid

The new federal law significantly expands the Medicaid program. This is accomplished primarily by mandating coverage of certain population groups not previously required, such as childless adults. Until this mandate takes effect, Medicaid beneficiaries generally have needed both to have a low income and to be in certain

specific categories, such as being pregnant or having a disability. Beginning January 1, 2014, federal law will require coverage of all individuals under age 65 (children, parents, and childless adults) with incomes at or below 133 percent of the FPL regardless of disability or other categories. Furthermore, states will be eligible for federal reimbursement at existing matching rates if they chose to expand their programs earlier to this new population. Taken altogether, we estimate various provisions of PPACA could ultimately add up to two million beneficiaries, or more, to the 7.3 million now on Medi-Cal rolls.

Basic Health Plan

Beginning on January 1, 2014, PPACA allows states the option of establishing a so-called Basic Health Plan as an alternative to providing coverage through the exchange for certain individuals. Specifically, the plan would provide coverage to individuals with incomes from 134 percent to 200 percent of the FPL who do not qualify for Medicaid or have access to employer-sponsored coverage. The persons receiving coverage under a Basic Health Plan also must otherwise have been eligible for coverage through the exchange. For example, this program would assist legal immigrant families with incomes that are still somewhat too high to qualify for Medi-Cal, even after the eligibility changes made by PPACA.

If the state chose this option, it would contract with plans that provided a specified level of benefits and met cost-sharing limits, and these plans would be offered as choices to Basic Health Plan enrollees. The contract negotiations would have to consider such factors as the extent to which plans engaged in care coordination and had other attributes of managed care.

If the state meets federal requirements for the establishment of this program, the federal government would transfer to the state 95 percent of the funds that would otherwise have been available to the individuals eligible for the Basic Health Plan as premium and cost-sharing subsidies to purchase coverage through the exchange. These funds would be deposited into a trust fund and could be used to enhance benefits and reduce cost sharing for those enrolled in the Basic Health Plan.

New High-Risk Insurance Pool

One of the major early implementation items is the establishment of a federal high-risk health insurance coverage pool program. The program is intended to provide stopgap coverage to eligible individuals until major insurance market changes, such as the implementation of the exchange, are implemented in 2014.

What Are High-Risk Pools? High-risk pools are health insurance coverage programs for individuals who are generally unable to purchase insurance in the individual market due to a pre-existing health condition. These individuals are commonly referred to as hard-to-insure or medically uninsurable. There is currently no national high-risk pool, but 35 states, including California, currently operate their own high-risk pools. Until recently, only very limited federal grant funds have been available to risk pools that meet certain federal guidelines, and California has historically not qualified for these funds due to the state's unique benefit design. The state currently serves approximately 7,000 individuals through its high-risk pool program, a small proportion of medically uninsurable individuals in the state.

New Federal Program. The new federal law directs the U.S. Secretary of Health and Hu-

man Services (HHS) to establish a high-risk pool program not later than 90 days after the date of enactment (March 23, 2010), and gives the Secretary the option to administer the program either directly or through contracts with states or private nonprofit entities. On April 2, 2010, the Secretary of HHS sent a letter to states indicating that federal funds would be available beginning July 1, 2010 for states that choose to contract with HHS to administer the program. The HHS has also asked states to declare by April 30, 2010 whether they intend to participate in the program. If the state chooses not to administer the program, HHS is required to administer a program in that state. On April 29, 2010, the Governor indicated the state's willingness to contract with HHS to administer the new program. However, a contract must be finalized and legislative authority to operate the new program must be granted before the program is begun.

The PPACA appropriates \$5 billion to the Secretary for the high-risk pool program. Initial

guidance from HHS suggests that California's share of this total would equal \$761 million over the next four years, or about 15 percent of the total funding. At this time, it is difficult to estimate precisely how many individuals could be served by this level of funding. Our preliminary analysis indicates that this program may be able to serve approximately 30,000 individuals annually.

Other Opportunities to Improve Health Care

Through grants and other authorized programs, federal law includes many incentives for states, health providers, researchers, and others that are generally intended to help improve health care quality, access, delivery, and outcomes. For example, federal health reform also includes grants targeting improvements in emergency services and trauma systems. Furthermore, significant funding opportunities are available for public health improvements and programs including state demonstration projects for Medicaid.

IMPLICATIONS FOR STATE HEALTH PROGRAMS IN THE NEAR TERM

Some of PPACA's provisions are already in effect, while others will go into effect in the near term. In some cases, the state will need to react quickly in order to take full advantage of chances to improve state health care programs and to obtain federal funds to help carry out the new law. As summarized in Figure 2, the measure has various implications in the short term for the state's budget situation and the way it provides coverage to persons who are hard to insure. We also discuss the near-term opportunities available to the state to use a federal Medicaid waiver

process and various new grant programs to help during this transition period. We discuss the ramifications for California in more detail below.

MOE Requirements Limit State Budget Flexibility

The PPACA requires the state to maintain eligibility standards, methodologies, and procedures for Medicaid until an exchange is operational in the state. Similar maintenance-of-effort (MOE) requirements apply to the state's Healthy Families Program (HFP) for children. These MOE

requirements, in effect, extend the requirements imposed by the American Reinvestment and Recovery Act passed in 2009 for the Medi-Cal Program. They would continue to constrain the Legislature's options for reducing General Fund expenditures in these programs. For example, as part of its January "trigger" solutions, the administration proposed to achieve about \$477 million in annual General Fund savings in 2010-11 by excluding certain Medi-Cal beneficiaries from the program. This is now effectively off the table for consideration. The same is true for the Governor's proposal to eliminate HFP. In addition, the Children's Health Insurance Program (CHIP)-funded Access for Infants and Mothers (AIM) program may also be preserved by these MOE provisions. We anticipate that additional federal guidance will clarify what types of program changes are allowable under the new federal law.

Similar MOE restrictions could also apply to the existing state-run high-risk pool, known as the Major Risk Medical Insurance Program (MRMIP). If the state contracts with HHS to operate the new federal high-risk pool program, a separate MOE provision would prohibit the state from reducing the annual amount the state expends for MRMIP.

State's Prescription Drug Rebates Could Be Reduced

States collect federally required Medicaid rebates from drug manufacturers in exchange for allowing their products to be provided to program beneficiaries. Many states—including California—negotiate additional rebates, known as state supplemental rebates, on top of those that are federally required. The PPACA changes the Medicaid rebate rules for prescription drugs in two major ways by (1) increasing the minimum amount of federal rebates required from pharmaceutical companies effective January 1, 2010, and (2) allowing states to collect federal rebates from managed care organizations providing care to beneficiaries in the Medicaid program effective March 23, 2010. Federal law generally requires states to return to the federal government 100 percent of the additional increase in minimum federal rebates.

These are significant changes. Currently, the state receives rebates from pharmaceutical companies and returns a portion to the federal government that is consistent with its federal matching percentage. The federal law change will result in a significant loss of funds to the state because a greater percentage of the rebate

amounts will be returned to the federal government. This loss will be partly offset by another change in the federal law that will allow the state to collect federal rebates from state Medi-Cal managed care organizations. As a result, these new federal rules will

Figure 2

Key Findings

Implications for State Health Programs in the Near Term

- Maintenance-of-effort requirements limit state budget flexibility in Medi-Cal and Healthy Families Program.
- State's Medi-Cal prescription drug rebates could be reduced.
- State faces major choices regarding setup of new federal health insurance risk pool program.
- Federal waiver could expedite Medi-Cal coverage expansion.
- New programs and grants could generate additional federal funds.
- Federal payments will be prohibited for health care-acquired conditions.

likely trigger changes to the state's rebate contracts and require adjustments to managed care capitation rates. Preliminary estimates from the Department of Health Care Services (DHCS) estimate that the impact of these federal changes will be a net loss of \$50 million General Fund annually.

State Faces Major Choices Over Setup Of New Federal Risk Pool Program

As noted earlier, the state currently operates MRMIP, its own high-risk pool program. It now faces the choice of stepping in to also operate a similar new federal program, assigning that responsibility to a nonprofit entity, or leaving it to the federal government to administer such a program within California. While the administration has indicated its intent to the federal government that the state operate the new high-risk pool itself, many steps remain before this decision is final.

The Legislature should consider some significant tradeoffs as it weighs what approach to take. Administering the new program directly would give the state more control over the program, may result in more rapid implementation, and offers the state a better opportunity to integrate the new program with its existing programs. While the HHS intends to offer an option directly to hard-to-insure individuals in states that do not choose to administer a program themselves, it is unclear at this time what type of program HHS will offer to these individuals and when it would be implemented.

On the other hand, the Legislature should consider potential challenges the state may face should it choose to administer the program. Although the program is supposed to be entirely federally funded, it is not yet clear that the \$5 billion appropriated in PPACA for this program nationally will be sufficient to last until

2014. Moreover, the new program may pose operational challenges. There are significant differences between the state's current MRMIP program and the new federal program regarding benefits, eligibility, and subscriber cost sharing. The state is in discussions with HHS to identify areas of flexibility, but based on the new federal law and current HHS guidance, it seems unlikely that the state can merge its existing high-risk pool program with the new federal program without making significant changes to existing programs. For example, the federal program requires that individuals be uninsured for six months prior to applying for coverage, whereas the state program has no such requirement. Finally, as mentioned above, an MOE requirement would limit the state's flexibility to reduce state spending on its hard-to-insure population.

Thus, regardless of whether the state chooses to administer the program, it seems likely that there will be a new federal program operating alongside the existing high-risk pool programs. Regardless of whether the state chooses to administer the pool directly, there may be ways to modify MRMIP in order to optimize coverage for hard-to-insure Californians once the new pool is operational. For example, MRMIP eligibility could be restricted to future applicants who do not qualify for the federal program, thereby preserving limited state funding in order to assist those who cannot purchase coverage elsewhere.

Federal Waiver Could Expedite Expansion of Medi-Cal Coverage

As noted above, the state has the option to expand Medi-Cal to non-elderly adults and children up to 133 percent FPL before the 2014 date when such coverage will become mandatory. However, the federal government's funding con-

tribution for the cost of these individuals would be at the state's current federal matching percentage. This will be 50 percent of benefit costs, as of December 2010, unless a higher federal contribution rate is extended by federal law. The 100 percent federal matching rate allowed under PPACA for "newly eligibles" would not take effect until 2014. Such an early expansion of Medical eligibility would be costly and difficult for the state to achieve, especially given the state's now dire fiscal situation. However, it may be possible for the state to roll out some or all of the expansion on an earlier timetable using federal funding obtained through a federal "waiver" program. We provide more information about how waiver programs work, and discuss this option to use the waiver to allow a better transition to the expansion of coverage required by 2014, in more detail in the box on the next page.

New Programs Could Generate Additional Federal Health Care Funds

As discussed in more detail later in this analysis, the state's implementation of PPACA could result in some significant increases in state health program costs. However, the new federal law also establishes a number of new federal grant programs—some monies distributed by

formula, others awarded through a grant application process. Given the significant fiscal challenges ahead for the state, it will be important for the Legislature to ensure that state agencies maximize their opportunity to obtain additional federal funds, particularly in cases where doing so could offset state General Fund costs or assist the state with the transformation of California's health care system under PPACA. We discuss some of these opportunities in more detail in the box on page 18.

Federal Payments Prohibited for Health Care-Acquired Conditions

Federal reimbursement to the state for health care-acquired conditions will be prohibited under the new federal law effective July 1, 2011. This term generally refers to conditions, such as an operation on the wrong body part and certain infections, that were caused by poor care of patients or failure to follow guidelines or standards of patient care. The measure directs the federal government to identify current state practices that prohibit payments for such conditions and apply these practices, as determined appropriate, to the entire Medicaid program. The state will need to conform to these requirements to achieve state cost savings in this area.

THE LONG-TERM IMPLICATIONS FOR STATE HEALTH PROGRAMS

Some provisions of PPACA will take effect almost immediately, but will take time to have a major effect on state health care programs. Others will not go into effect at all for two or three years or more. Nevertheless, in a number of cases, it will be important for the Legislature to begin considering soon what initial steps should

be taken to implement some of these measures. By beginning the planning process far in advance of the implementation dates prescribed in PPACA, the Legislature can ensure that it is making informed decisions and allowing a smooth and more efficient implementation of the new federal law.

WHAT IS THE SECTION 1115 WAIVER?

Medicaid 1115 Waivers Allow Flexibility and Provide Federal Funding. The federal government generally grants states flexibility in administering their Medicaid programs through “waivers,” such as those allowed under Section 1115 of the federal Social Security Act. These permit a state to waive certain requirements, in order to further the purposes of the program. Additionally, under 1115 waivers federal funds can be used for program costs that might not otherwise be federally reimbursable. These waivers are typically approved for five-year periods. Many states have used 1115 waivers in their Medicaid programs to test new approaches to expand coverage and benefits.

California’s 1115 Waiver Will Expire in August 2010. California currently has an 1115 waiver, also commonly called the “hospital financing waiver,” that was approved by federal authorities in June 2005 and implemented through Chapter 560, Statutes of 2005 (SB 1100, Perata). California’s current 1115 waiver expires on August 31, 2010, and renewal negotiations are currently in progress. Key components of the current 1115 waiver include:

- Financing for designated public hospitals primarily by requiring the use of certified public expenditures, instead of the state General Fund or other funds, to meet federal matching payments.
- Funding for uncompensated hospital care to support a “safety net care pool” established by the waiver to assist uninsured persons, as well as changes in so-called disproportionate share hospital funding that assists hospitals that care for a high number of Medi-Cal beneficiaries and the uninsured.
- Support for certain state-funded programs including the Medi-Cal Breast and Cervical Cancer Treatment Program and California Children’s Services. Monies are also available under the waiver to expand health care coverage for uninsured adults not eligible for Medi-Cal, under what are known as Health Care Coverage Initiatives (HCCI) established in ten counties, and to expand Medi-Cal managed care.

Next Waiver Could Help Finance PPACA Implementation. Given California’s tight fiscal situation and limited resources, the waiver currently being developed is an opportunity for the state to think strategically about how to maximize federal funding to implement the requirements and options provided under federal Patient Protection and Affordable Care Act (PPACA). For example, many of the individuals currently participating in the HCCIs will be eligible for the Medi-Cal Program under federal coverage rules that take effect in 2014. The administration proposes to expand these coverage initiatives statewide as part of the next waiver. Using the HCCIs as a transitional tool for statewide implementation of the required Medicaid expansion is one way the state may be able to address implementation costs while also maximizing federal funds—if federal authorities agree to these changes.

In reviewing the long-term implications of the new law for state health programs, we identified a number of significant issues. For example, our analysis indicates that the measure contains a number of provisions that could increase state costs, eventually by the low billions of dollars annually. Funding for certain hospitals will be affected. The state will face challenges in coordinating the new health benefits exchange with other state health programs and in changing eligibility processes to conform to new federal requirements. Further changes will need to be considered in children’s health coverage and high-risk pools, as well as the provision of coverage to those who remain uninsured. We summarize these long-term implications of PPACA in Figure 3 and explore them in more detail below.

Expansion Will Substantially Increase Future State Medi-Cal Program Costs

Additional Medi-Cal Costs May Eventually Be in the Low Billions of Dollars. Many of the major health reform provisions impacting Medi-Cal take effect in 2014. These include eligibility expansions, as well as changes in how the state determines program eligibility and payments for services. For some of these requirements, the federal government has provided enhanced funding to facilitate the state’s implementation.

Nevertheless, these required changes will put significant fiscal pressure on the state in the out-years, particularly as the enhanced federal funding is somewhat reduced. The exact cost to the state of these provisions cannot be determined with precision at this time because in a number of cases (1) federal authorities have not issued federal regulations and other types of guidance that could greatly affect the way they are implemented, and (2) the state has some leeway in how these federal mandates are implemented. Nonetheless, our initial assessment is that the state eventually faces the risk of additional state costs in the low billions of dollars annually. (We note that our estimate does not take into account other possible beneficial or negative fiscal effects of PPACA outside of its impact on state health care programs, such as changes that could affect state costs for health coverage for state employees or that could increase state insurance premium tax revenues.)

Below, we describe several major changes to the state Medi-Cal Program that are likely to result in: (1) increased enrollment by individuals currently eligible but not enrolled in the program, (2) expansion of eligibility to persons up to 133 percent of the FPL, (3) expansion of coverage to former foster children, and (4) increased payments to primary care providers. We also

provide our preliminary estimates, where possible, of the implications for future state costs.

Increased Medi-Cal Enrollment by Persons Currently Eligible, but Not Enrolled. It is likely that the new individual mandate for health insur-

Figure 3

**Key Findings
Implications for State Health Programs in the Long Term**

- Expansion will substantially increase state Medi-Cal Program costs.
- Reduction in federal hospital funding could affect some hospitals.
- New exchange needs integration with other programs.
- Changes will be required in Medicaid eligibility processing.
- Coverage for some children could be shifted to the exchange.
- State and federal high-risk insurance pools could eventually be phased out.
- Certain populations will continue to be uninsured.

ance, which takes effect in 2014, will increase the demand for Medi-Cal by persons who are currently eligible, but have chosen not to be enrolled in the program. It is impossible to know exactly when the state would begin to experience the full impact of these additional enrollments in Medi-Cal. This is because, among other

reasons, it is still unclear how effective the new individual mandates for coverage will be, and how aggressively federal authorities will enforce these requirements. In our analysis, we assumed that these mandates for individuals to obtain coverage will eventually have a significant effect on the Medi-Cal caseload.

PPACA CREATES NEW FEDERAL FUNDING OPPORTUNITIES

A number of new federal funding opportunities were created by the new federal law, including the following:

Medical Homes for Persons With Significant Health Needs. States can receive additional federal funding to provide comprehensive care management and transitional services to Medicaid beneficiaries with certain chronic conditions if the individual's care is coordinated through a "medical home." Medical homes are proposed as a model of care where a person's care is coordinated through a central hub rather than a person being directed to seek care from a jumbled network of providers. Support is available at a 90 percent federal and 10 percent state funding rate beginning in 2011.

Optional Attendant Services Benefit. Beginning in 2011, states can establish an optional Medicaid benefit to offer community-based attendant services and supports, such as assistance to accomplish activities of daily living. States that chose this option will receive an enhanced federal match of 6 additional percentage points.

Bundled Payments for Care Around Hospitalization. Up to eight states will have the opportunity to test using bundled payments for the provision of integrated care to Medicaid beneficiaries beginning in 2012. Bundled payments are an alternative to fee-for-service payments, in which each physician receives reimbursement for the individual services provided. In contrast, a bundled payment makes a single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings, such as the hospital and follow-up care in a physician's office.

Incentives for Pediatric Accountable Care Organizations (ACOs). States can participate in a Medicaid project that allows pediatric medical providers to be recognized as an ACO. An ACO is a local health care organization with a set of related providers (at a minimum, primary care, physicians, specialists, and hospitals) that can be collectively held accountable for the cost and quality of care delivered to a defined population. The intent of an ACO is to reduce costs by delivering coordinated care. This project is authorized in 2012 through 2016.

Additional Funding for Primary Care Clinics. It is estimated that the approximately 1,100 federally funded community health centers, or clinics, in California will receive \$1.4 billion

It is important to note, however, that while the state will receive 100 percent federal funding to expand Medi-Cal to certain new populations beginning in 2014, it will not receive this high federal cost-sharing ratio for persons eligible but not enrolled under today's eligibility requirements. The ongoing state-federal split of costs for

currently eligible enrollees would be 50-50. We estimate that this increase in enrollment could eventually cost the state in the high hundreds of millions of dollars annually. However, actual costs could be significantly higher or lower than we estimated, and would depend on such key factors as the rate at which additional eligible

PPACA Creates New Federal Funding Opportunities (continued)

in new funding over five years. These funds are available to expand operations to serve more patients and for capital improvements to build new facilities and expand existing ones. The new federal funds could help relieve fiscal pressure on the state to maintain funding for uncompensated care historically provided by these clinics.

Prevention and Public Health Fund. The Patient Protection and Affordable Care Act (PPACA) appropriated \$500 million in the 2009-10 federal fiscal year to a new Prevention and Public Health Fund, which is intended to provide ongoing support to public health and prevention programs at the national, state, and local levels. These funds can be used to promote community-based preventive health activities as well as other activities permitted under the previously enacted Public Health Services Act (such as immunizations, public health preparedness, and cancer detection programs). The PPACA also appropriates additional money for this fund in future federal fiscal years: \$750 million in 2010-11, \$1 billion in 2011-12, \$1.25 billion in 2012-13, \$1.5 billion in 2013-14, and \$2 billion annually in 2014-15 and beyond.

Maternal, Infant, and Early Childhood Home Visiting Program. The PPACA appropriates \$100 million for the 2009-10 federal fiscal year for state Maternal, Infant, and Early Childhood Home Visiting Programs. Specifically, the measure authorizes grants for home visitation programs following models that have been proven to improve health outcomes for mothers and babies. Home visitation programs provide low-income pregnant and parenting families such services as smoking cessation programs, advice on nutrition and exercise, basic information on newborn care and child development, and family planning. The PPACA also appropriates additional funding for this program in future years: \$250 million in 2010-11, \$350 million in 2011-12, and \$400 million annually in 2012-13 and 2013-14.

Planning Grants for Health Benefit Exchange. Should the Legislature decide to establish such a health benefits exchange, the state could apply for federal grants that will be available to offset the costs of planning and establishment of such an entity. Later in this analysis, we discuss some of the long-term planning issues associated with the development of an exchange system in California.

persons enrolled in the program and the cost of the services provided to them.

Expanded Eligibility to 133 Percent FPL. As noted earlier, beginning January 1, 2014, PPACA requires expansion of eligibility to all individuals under age 65 (children, parents, and childless adults) with incomes at or below 133 percent FPL. (After taking into account a technical adjustment to eligibility required under the federal law, the income limit is about 138 percent of the FPL.) As shown in Figure 4, the federal matching rate for coverage of this expansion population will slowly decline between 2014 and 2020, with the state eventually bearing 10 percent of the additional cost of this program expansion. Early estimates indicate that up to two million additional people could be enrolled in Medi-Cal as a result of the expansion of eligibility. We believe that this newly eligible population would cost the state several hundreds of millions of dollars annually upon the full implementation of this provision for its 10 percent share of benefit costs. Again, actual costs could vary significantly from our estimates, depending on the rate of enrollment and the cost of the services provided.

Expanded Coverage for Former Foster Children. The PPACA creates a new mandatory Medicaid eligibility category by requiring coverage for former foster children up to age 26 beginning January 1, 2014. These children may have incomes greater than 133 percent of FPL but they must have been in state foster care at age 18 or older. These individuals are eligible for all children’s benefits, including specialty mental health coverage available under a federal mandate for Early and Periodic Screening, Diagnosis, and Treatment. These costs would probably eventually amount to the low tens of millions of

dollars. The state’s actual share of these costs would depend on the federal matching rate that is ultimately determined to apply to these new beneficiaries.

Increased Primary Care Provider Payments. Currently, it is estimated that the Medi-Cal rates paid to physicians are, on average, about 60 percent of Medicare rates. Under the new federal law, payments made to physicians and managed care organizations for primary services provided by primary care doctors must be at least 100 percent of Medicare rates in 2013 and 2014. The federal government will pay 100 percent of the incremental cost in these two years; thereafter, the state would have to maintain the higher rate on its own or reduce rates. However, it is possible that California will be required to maintain the greater level of reimbursement rates, given the history of legal cases that have thwarted or hindered past budgetary efforts to reduce Medi-Cal provider rates. If the state were subsequently unable to scale back the rate increases required in 2013 and 2014 because of intervention by the courts, this new provision could potentially cost the state hundreds of millions of dollars annually in the future.

**Figure 4
Federal Funding for
Newly Eligible Populations**

Calendar Year	Federal Medical Assistance Percentage (FMAP)
2014	100%
2015	100
2016	100
2017	95
2018	94
2019	93
2020 and thereafter	90

Reduction in DSH Funding Could Affect Some Hospitals

As noted above, the federal government annually provides capped federal funds, known as DSH funds, to hospitals that serve a disproportionate share of the Medicaid beneficiaries and uninsured. Medicaid DSH payments in federal fiscal year (FFY) 2008-09 nationally were about \$11.3 billion. Currently, California receives over \$1 billion in Medi-Cal federal DSH payments annually.

Beginning in FFY 2013-14, PPACA requires over several years an \$18.1 billion total reduction in the Medicaid DSH allocations now being made to states, as shown in Figure 5. The reduction to each individual state is to be based on a methodology to be determined by the federal government that takes into account the state’s uninsured rate, its volume of Medicaid inpatients, and the amount of uncompensated care that is provided.

The main fiscal impact of this change will be felt by counties that operate DSH-supported hospitals. However, because these hospitals are an important component of the health care delivery system of the Medi-Cal Program, the Legislature

will need to consider the impact of these reductions on the total resources available for hospitals’ uncompensated care.

Legislature Has Policy Options on the Design and Role of the Exchange

As we previously discussed, the PPACA requires that a health insurance exchange be established in each state. Our preliminary analysis of this complex component of PPACA indicates that the Legislature has an important opportunity to determine what form the exchange takes, how it is governed, and the role it should play in California’s health care marketplace. We elaborate on each of these key policy considerations below.

Should the State Establish an Exchange?

Under the new federal law, states have the option of establishing the exchange or allowing the federal government to do so. If the state does establish the exchange, it may operate it directly through a state department or assign this responsibility to a nonprofit entity. It may also establish multiple exchanges within the state or join with other states in creating an exchange.

Leaving the creation of an exchange to the federal government would relieve the state of a formidable administrative task. However, establishing it as a state entity in some form has some important potential advantages that the Legislature may wish to consider. The state would be able to design the exchange to address any unique features of California’s insurance marketplace, for example, and would also have the flexibility to modify the exchange as needed to respond to market conditions. It would also be in a stronger position to ensure that the activities of the exchange are well-coordinated with the state’s existing health care programs.

**Figure 5
Medicaid Disproportionate Share
Hospital Funding Reductions**

(In Millions)

Federal Fiscal Year	Reduction Amount
2013-14	\$500
2014-15	600
2015-16	600
2016-17	1,800
2017-18	5,000
2018-19	5,600
2019-20	4,000
Total	\$18,100

These same considerations probably make it unlikely that the state will want to consolidate a California-operated exchange with those in other states. Similarly, creating multiple exchanges within California, as permitted by PPACA, would allow more local autonomy for such operations, but also likely poses some significant problems. For example, this approach would likely increase the overall administrative costs and complexity of a California exchange system. Because its operations and policies would inherently be less uniform, a multi-exchange approach would probably be less likely to carry out the Legislature's statewide policy goals for the exchanges.

How Would An Exchange Be Governed?

Another critical decision for the Legislature is the governance structure of the exchange. The insurance exchange could be placed under the authority of an independent public agency governed by a state board, akin to the Managed Risk Medical Insurance Board (MRMIB) that oversees the state's HFP. The MRMIB is subject to a high degree of legislative control as well as direct oversight and accountability. One tradeoff, however, is that this model would make the exchange subject to the state budget process as well as other governmental processes that might make the entity less flexible. Alternatively, the Legislature may wish to consider more of a public-private partnership model, akin to the State Compensation Insurance Fund (SCIF), which offers workers' compensation insurance policies. The SCIF model would seem to offer the exchange greater flexibility and ability to respond quickly to changes in the insurance marketplace but, conversely, less legislative control. Under either approach, it would be important for the Legislature to establish a high degree of transparency and accountability in the operations of the

exchange, such as by requiring public meetings of the board.

What Role Should the Exchange Play in the Health Insurance Market? The new federal law provides the Legislature a significant degree of flexibility to decide what type of exchange it wishes to establish. This role could range from being a "connector" to a "purchaser" of coverage. More specifically, the exchange could have the more limited role of connecting eligible persons to coverage via an Internet portal that provided standardized information on qualified plans and prices and then referred individuals and employers to the plan of their choice. Alternatively, the exchange would play a more expansive role and operate as a purchasing alliance, negotiating the best rates for exchange participants and enrolling individuals in plans, as well as administering subsidies, collecting and paying premiums.

A purchasing alliance could allow the exchange to flex its negotiating power on behalf of a large number of potential enrollees. In theory, health insurers and provider networks would have a stronger incentive to discount their rates under such an arrangement. Administrative costs per enrollee might also be lower, since the fixed costs of such an operation would be shared among a larger number of enrollees. On the other hand, it is by no means a certainty that this more expansive involvement in the health care marketplace would achieve these desired results in the long term. A more limited operation that made it easier for consumers to compare the features and price of policies—making the marketplace more transparent—may be sufficient to achieve the desired purpose of creating more competition in the health insurance marketplace.

In evaluating these policy issues, it will be important for the Legislature to also examine the existing state laws that govern the individual and group health insurance markets. Among other issues, it should consider whether those laws will need to be changed to help ensure the success of the type of exchange it may choose to establish.

Changes Will Be Required in Medicaid Eligibility Processes

The PPACA makes several changes to how states determine Medicaid program eligibility that generally simplify these processes and, in some cases, make program eligibility more generous. Most changes take effect January 1, 2014. It is unclear at this point whether some of these changes could make eligibility more restrictive. At this time, the net fiscal impact of these changes is unknown. These required changes include:

- Standardization of income determination by requiring the use of a new income standard, known as Modified Adjusted Gross Income (MAGI), to establish eligibility for certain individuals. As part of this change, various deductions to applicant income that are now permissible would end.
- Asset tests for certain individuals to determine their eligibility will be eliminated.
- Enrollment procedures must be simplified and coordinated with the state-based exchange and the HFP.

Coverage for Some Children Could Be Shifted to Exchanges

The PPACA extends funding for the federal CHIP, (known in California as the Healthy

Families Program) through September 30, 2015 (an additional two years as compared to current law) and authorizes the operation of the program through the 2018-19 FFY. The PPACA also provides states a 23 percentage point increase in the CHIP match rate from 2016 through 2019, increasing California's federal matching rate for CHIP from 65 to 88 percent. This change would result in state savings in the hundreds of millions of dollars annually in those years, provided that funding is reauthorized for this purpose.

The PPACA also includes provisions that allow states to enroll CHIP-eligible children into plans offered through the exchange, under certain conditions. This could occur before October 1, 2015, if the state exhausts its federal funding for CHIP; or after October 1, 2015, if the state (1) ensures that the children are not Medicaid eligible, and (2) that plans available through the exchange provide benefits and limits on cost sharing comparable to those provided through HFP.

These provisions appear to be specific to children covered under CHIP-funded programs. At this time, it is unclear whether or when California could eventually enroll pregnant women currently covered through the CHIP-funded AIM into plans offered through the exchange.

State and Federal High-Risk Pools Could Eventually Be Phased Out

As described earlier in this report, the state has the option to contract with the federal government (HHS) to administer the new federal high-risk pool program. A MOE requirement will apply that prevents the state from reducing spending on high-risk pools in the budget year. It is likely, though not certain at this time, that

this MOE will also apply in some form during the period of 2010-11 through 2013-14.

Under the new federal law, funding for the new federal high-risk pool will cease in 2014. This would also probably be the point in time at which the state could discontinue the state MRMIP program without violating MOE requirements. Moreover, it is widely anticipated that, by January 1, 2014, neither the state's current MRMIP program nor the federal high-risk pool will be needed any longer. At that point, under the insurance-related provisions of PPACA, insurance companies will be required to issue a policy to anyone who applies. The premiums charged could not take into account their medical condition and subsidies would be available through the exchange to make coverage more affordable. The Legislature may wish to act well before 2014 to ensure that there is an orderly phase-out of the state program and a careful transition of individuals with serious medical conditions to private coverage.

Certain Populations Will Continue To Be Uninsured

Under federal health care reform, certain populations—such as undocumented persons—will continue to be ineligible for Medi-Cal (except for emergency medical assistance and certain other services) and will be prohibited from purchasing coverage from the new health insurance exchanges. It is estimated that California has 1.2 million uninsured, undocumented immigrants. An unknown, but likely substantial, number of other individuals are likely to remain uninsured despite the enactment of the new federal mandate that they obtain health coverage. Some will be determined eligible for hardship exemptions, while others will probably remain uninsured for a variety of reasons. One key issue for the Legislature to consider is where and how individuals who are uninsured will be provided care, and how such care will be paid for when the patient is indigent. We discuss this issue in more detail in the next section.

THINKING BROADLY ABOUT IMPLEMENTING THE NEW FEDERAL LAW

Beyond responding to the specific requirements in the new federal health care law, as we have discussed earlier in this report, the Legislature should “step back” and think broadly about the state's role in the implementation of expanded health insurance coverage over the next few years. In carrying out and adapting to the new federal law, for example, the Legislature has the opportunity to improve both the fiscal sustainability and structure of the state's patchwork of state programs. The new federal law makes it essential that the Legislature reexamine the state-local relation-

ship regarding the delivery and funding of health care services. Other broader issues before the Legislature include how PPACA can be used as an opportunity to improve the quality of the care that is provided and ensure the adequacy of the state's health care workforce and medical infrastructure. Figure 6 summarizes these issues. We elaborate on these matters below.

Addressing Future Costs for State Health Programs

In general, growth in state health programs has outpaced growth in the state's revenues. As

we highlighted in our 2010-11 budget report, *Health and Social Services Budget Primer*, total spending for the major health departments (including DHCS, MRMIB, the Department of Developmental Services, the Department of Mental Health, and the Department of Public Health) has increased from \$24.5 billion in 1999-00 to an estimated \$57.8 billion in 2009-10. This is an increase of \$34 billion, or 136 percent, over the ten-year period. The primary cost drivers for this growth are increased costs and utilization of services and caseload growth. Given this growth, it is important that, as the Legislature takes actions to implement PPACA, it considers strategies that would help to make the state's health programs as efficient as possible. Below, we briefly discuss some strategies with this purpose that we think are worthy of further consideration.

Maximize Receipt of Federal Funds, Minimize Use of General Fund. The Legislature should consider using federal funds to the greatest extent possible to carry out PPACA, with state General Fund resources used as a last resort. We believe there may be additional opportunities to match the myriad of currently available funding streams—including funds generated as a result of past ballot measures—to draw down federal funds to implement the new law. For example,

the Legislature could seek to use funds that are now dedicated to various health programs through past ballot measures to the state's advantage to restructure financing for health programs. Specifically, some of the additional state income tax revenues made available under Proposition 63 for community mental health programs could in theory be tapped to help pay for specialty mental health services for lower-income persons who would now qualify for Medi-Cal services. The Legislature should consider this and other such opportunities to maximize the use of federal funds and minimize General Fund spending to implement PPACA.

Leverage State's Purchasing Power. The state's current approach to purchasing health care services for people enrolled in state programs is fragmented. We estimate that the state covers roughly 9.5 million lives through health care plans in Medi-Cal (7.3 million), the HFP (900,000), and the California Public Employees' Retirement System (1.3 million). However, even though some of the same health plans serve each of these groups of beneficiaries, the state separately negotiates rates with health care plans for each of these programs. As the state implements PPACA, the number of covered lives in Medi-Cal, in particular, is likely to grow even more,

adding even more to the state's bargaining power. Our analysis indicates that there may be some significant opportunities for the state to leverage its purchasing power by consolidating its purchases of health care services for these various state programs, thereby

Figure 6

Key Findings Thinking Broadly About Implementing the New Federal Law

- Future costs for health programs should be addressed.
- Structural changes to state health programs are warranted.
- The PPACA should prompt a reevaluation of the state-local relationship.
- New strategies could bolster health care quality and outcomes.
- Future workforce and health infrastructure needs should be assessed.

PPACA=Patient Protection and Affordable Care Act.

enabling a more efficient implementation of the new federal law.

Consider Revenue Sources. One way to help finance the implementation of the changes required by PPACA would be to identify revenue sources that could help offset state costs for these federally mandated activities. For example, the existing fee on hospitals that expires this year could be extended and used to fund the implementation of health care reform.

Reduce Cost of Care for High-Cost Individuals. The cost of health care for some individuals, such as seniors and persons with disabilities, is relatively high because of their sometimes-extensive health care needs. Yet, the number of such individuals enrolled in Medi-Cal could grow significantly in future years because of the mandate that all individuals obtain health coverage. We believe that one way to help offset these potential additional costs is to continue to expand programs to improve the coordination of the health care of the high-cost medical population. For example, as we have recommended in the past, the state could enroll additional seniors and persons with disabilities in systems of care, such as managed care. In addition to potentially having beneficial fiscal effects, these changes could also improve the quality of their care.

Structural Changes to State Health Programs Are Warranted

The new framework for the expansion of health insurance has broad implications for the structure and function of the state's health care programs. The current patchwork of public programs has evolved over decades, largely in response to federal funding opportunities and the identification of gaps in health care coverage for various populations and conditions. We believe

that PPACA provides an opportunity for the Legislature to reexamine the structure of the state's health programs going forward.

The dramatic expansion in access to comprehensive health care coverage envisioned by PPACA will likely eliminate the need for some health programs and significantly change others. For example, some disease- or population-specific programs may prove to be less important to continue given the much wider availability of public and private coverage that, under the new federal law, must provide comprehensive coverage. Likewise, as the state responsibility to provide coverage to certain populations expands, local responsibilities to do the same may contract. After full implementation of the new law, some gaps in coverage will remain, but they will be narrower.

Thus, the modification, phase-out, or outright elimination of certain existing programs will be key legislative considerations over the next several years. The Legislature should also consider the implications of these programmatic changes for the administrative and information technology structures that support these programs.

PPACA Should Prompt Reevaluation Of the State-Local Relationship

In California, local governments, primarily counties, share the responsibility with the state for the delivery of health care services. Counties are statutorily required under Welfare and Institutions Code Section 17000 to provide health care for indigents, a population now consisting mainly of childless adults but also including children. The expansion of health coverage and mandate for individuals to maintain coverage required by PPACA has the potential to significantly reduce the number of indigent adults in the state without health insurance coverage and reduce the finan-

cial burden on counties. In light of this and other effects of the new federal law on county responsibilities for providing health care services, it will be important for the Legislature to consider the state and local relationship as part of its deliberations on the implementation of PPACA.

The administration and financing of various health programs has evolved over the years in response to fiscal crises and efforts to achieve better program outcomes. The existing allocation of state and local responsibilities and funding for health and social services programs is complex, and reflects, in part, the programmatic and fiscal circumstances that existed during the mid-1970s. The 1991 legislation to realign state and local funding and program responsibilities to the counties represents the last time the Legislature took a hard look at how state and local responsibilities for health care are divided. Since that time, state and local programs have changed. For example, in 2004 voters passed Proposition 63, which provided a significant new source of funding for the expansion of local mental health services.

In the past, we have recommended the Legislature align program responsibilities and funding in a way that promotes program efficiency, effectiveness, and accountability. These principles will continue to be a useful guide for the Legislature, especially as it makes decisions about which level of government will be responsible for providing health care services to populations that are either not eligible for health insurance or for other reasons remain uninsured.

New Strategies Could Bolster Health Care Quality and Outcomes

Many systemic problems have been identified in the nation's health care system that include:

- Fragmentation of services and a lack of care coordination among providers.
- Treating diseases, but not necessarily focusing on improving the overall health of patients.
- Financial incentives that reward the quantity of services provided rather than the quality of that care.

The PPACA makes available various grants and demonstration project opportunities to assist states in addressing these problems. For example, certain demonstration projects provide the opportunity for states to reduce their reliance on paying providers for each service delivered (also known as fee-for-service) and expanding the use of new payment structures that provide a fixed rate to providers or health plans to manage all the health care an individual requires. Such models may improve coordination of care, and result in better health outcomes. Other grant opportunities, such as the Maternal and Child Home Visiting Program described earlier, attempt to improve the health and well-being of target populations, in order to detect health problems early and prevent other health problems from developing.

In addition to these two, many other prevention programs and demonstration projects are authorized in PPACA. Taken together, these new opportunities will provide a variety of ways for states to experiment with strategies to improve health outcomes for the populations they serve, by providing appropriate incentives for quality care and an increased focus on early detection and prevention of disease. Eventually, if demonstration programs prove successful, the state may be able to drive changes in the health care

marketplace that improve the quality of care and health outcomes broadly.

In assessing these opportunities, the Legislature should critically evaluate the capacity of the state to successfully administer new programs and the potential benefit of the program to the state. In some cases, additional state resources may be required up front in order to apply for and administer new programs. These up-front costs should be balanced with long-term goals of improving health and purchasing higher-quality care. As more details become available, the Legislature may also wish to express preferences in prioritizing some opportunities over others.

Future Workforce and Health Infrastructure Needs Should Be Assessed

The individual mandate and expanded coverage options created under PPACA will likely create a surge in demand for health care services state-wide. However, health coverage alone does not ensure access to health care services. Individuals who have a source of payment for care may still be unable to find a provider to meet their needs. Successful implementation of federal health care reform will depend on the state's response to access issues including workforce and infrastructure capacity, as well as the regional variation of supply of health services described below.

Workforce Capacity Pressures. A number of studies report that California's health care workforce in certain localities and specialties, such as primary care, nursing, and behavioral health, is already in short supply. The Legislature will need to consider the number, type, and distribution of California's health care professionals and how well they can meet the current and future needs of Californians. The Legislature will also need to consider how well it is educating, training, recruiting, and retaining health professionals, particularly those needed for preventative and primary care given PPACA's focus to promote these services.

Infrastructure and Other Issues. Access to health care will also depend on the adequacy of the state's health care infrastructure, such as clinics and hospitals, as well as on the available technological resources and systems. For example, certain rural areas in California already have limited access to hospitals and trauma centers. The Legislature will need to grapple with how well the current infrastructure will be able to meet the needs of Californians once the new federal health care law is implemented. It should also consider the role of alternative ways to deliver health care services, such as telemedicine.

LAO Publications

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