Fact Sheet on Federal Reform:
What It Could Mean for Californians

Prepared by Lucien Wulsin, Jr.
January 28, 2010

- Coverage for 80% of California's 6.5 Million Uninsured
  - Coverage for uninsured working poor families and individuals with incomes up to 133% of FPL ($14,400 for an individual and $28,665 for a family of four) through expansion of Medi-Cal (Medicaid) [1]
    - Californians covered: about 1.7 million[2]
    - Benefit to California: $7-8 Billion a year in 2019[3]
  - Coverage for uninsured moderate and middle income individuals and families (incomes between 133% and 400% of FPL, between $28,665 and $88,200 for a family of four) through private insurance in the Exchange
    - Californians covered: about 2.3 million[4]
    - Benefit to California: $8 billion in 2019[5]
  - Who is not helped
    - Undocumented and new legal immigrants -- about 1.4 million workers and children[6]
- Federal assistance for those with private individual insurance (moderate and middle income individuals with incomes between 133 and 400% of FPL)[7] through the Exchange
    - Californians assisted: 0.9 million[8]
    - Benefit to California: $3 billion[9]
- Federal assistance with the costs of small business coverage (size: below 25 employees; average wages, less than $40,000 annually)
  - California's small employers: 637,700 small businesses with less than 20 employees[10]
  - Benefit to California: $600 million annually [11]
  - Benefit to the small business: up to 50% of the employers premium costs, depending on employer size and average wages
- Coverage for California's children and young adult workers and students
  - Helps parents with incomes up to 400% of FPL pay for costs of uninsured and private, individually insured children[12]
  - Allows young adults to stay on their parent's coverage through age 26 at parental option[13]

- End to insurance companies exclusions of those with pre-existing conditions. Federal assistance to help pay health insurance premiums in a high risk pool for those who cannot afford, get or keep coverage in the individual market due to their illness or injury.
    - Californians covered: 200,000 medically uninsurable Californians[14]
    - Benefit to California: $375 million annually[15]
- End of rescissions and terminations of coverage for those with private individual insurance who become ill or injured[16]
- Closing the prescription drug donut hole for 4 million California seniors and disabled on Medicare[17]
    - Benefit to Californians: $200 million annually.[18]
- Coverage for care at home for the frail and disabled elderly[19] [20]
- Coverage for proven preventive services with no copays and deductibles for those with Medicare and private insurance[21]
- Impacts on Californians with existing private coverage – increased freedom of choice, the end of job lock
    - If you like what you have, you can keep it.[22]
    - If you do not like your individual insurance, you can buy through the Exchange or you can buy any other plan on the market.[23]
- Slows the rise in Medicare spending, extends Medicare solvency; this is also called "bending the cost curve"
    - CBO projection: slows the spending growth rate of increase to 2-4% a year,[24] extends the solvency of Medicare for 10 years [25]
- Slows the rise in private insurance premiums for California businesses and workers
    - Council of Economic Advisors' projection: 1% annual decline in premium increases for those with coverage through employers[26]
- How is it paid for? Senate version:
    - Slowing rate of Medicare and Medicaid spending growth[27]
    - Taxes[28]
- Reduces the federal budget deficit: $130 billion reduction over the next 10 years[29]
- Impacts on California's state budget: $800-900 million cost in 2019[30]

[1] In California, this would increase Medi-Cal coverage for working parents and children from 100% of FPL ($22,050 for a family of four) to 133% of FPL. It would cover the MIAs (medically indigent adults) with incomes up to 133% of FPL; this group of working men and women without minor children living at home has not been eligible for Medi-Cal since 1983 as there is no federal match for their coverage. In California, Medi-Cal subscribers must enroll in managed care, but typically have a choice of enrolling in a public or private plan.

[2] The Exchange is a large purchasing pool, like the Federal Employee's Health Plan or CalPERS for state and local employees that offers a choice of plans and benefit designs. Under the federal reform, the pool will offer also help on a sliding scale with the cost of premiums, copays and deductibles for individuals and families with incomes up to 400% of FPL. Lavaredda and Brown, National Health Care Reform Will Help Four Million Uninsured Adults and Children in California (UCLA Center for Health Policy Research, October 2009)
http://www.healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=382

[3] California Department of Health Care Services, Health Care Reform Cost and Savings Estimate: Full Implementation (December 4, 2009), HR 3590 Patient Protection and Affordable Coverage Act (November 23, 2009 version) and HR 3962 Affordable Health Care for America Act (November 6, 2009 version). The analysis assumes a base rate of $111 pmpm (per member per month) for children, $187 pmpm for parents, and $254 pmpm for MIAs and a 6% per annum growth rate in per capita costs. The projected federal cost of the Medicaid/CHIP expansion in 2018 is $80 billion; this is distributed to states based on their matching rates, costs of care and numbers of eligibles enrolled. See CBO Analysis of HR 3590, Letter to Senator Harry Reid, November 18, 2009. If California received 15% of these funds, the state would receive $12 billion.

[4] Lavaredda and Brown, National Health Care Reform Will Help Four Million Uninsured Adults and Children in California (UCLA Center for Health Policy Research, October 2009)

[5] The Exchange pays for a share of the individual's premiums and copays and deductibles on a sliding fee scale, linked to the subscriber's reported income. We used the 2019 figures because these were the figures used by the Schwarzenegger administration in its recent analysis. The full provisions of bills actually begin in 2013 and 2014 respectively and important interim measures begin in 2010, 2011 and 2012. Assuming that California with over 15% of the nation's uninsured receives 15% of the Exchange subsidies, that amounts to $11.5 billion annually under the Senate bill and $13.5 billion annually under the House bill. See CBO Analysis of HR 3590, Letter to Senator Harry Reid, November 18, 2009 and CBO Analysis of HR 3962, Letter to Representative John Dingell. November 6, 2009. The letter to Senator Reid projects a cost for the premium subsidies through the Exchange at $76.6 billion annually over the three fiscal years 2017-2019. The letter to Rep. Dingell projects a cost of $90.6 billion annually over the three fiscal years 2015-17 ($107 for the comparable period 2017-19 as the Senate bill). For each bill,

we averaged the first three years of 100% implementation and assigned a 72% share to the uninsured and a 28% share to those with private individual insurance.
[6] National Health Care Reform Will Help Four Million Uninsured Adults and Children in California
[7] Persons with individual insurance may buy their coverage inside or outside the Exchange; however premium subsidies are only available within the Exchange; we assumed that all persons eligible for premium assistance would purchase in the Exchange.
[8] We asked CHIS for the numbers of Californians with individual private insurance by income, their answer is that 887,000 (45% of individuals with private individual insurance) had incomes below 400% of FPL. See Reckling and Wulsin, Improving Affordability under Federal Reform (November 13, 2009) at www.itup.org/reports
[9] See n. 5. This is a 28% share of California's share ($11 billion) of the premium subsidies through the Exchange.
[10] SBA Office of Advocacy, Small Business Profile: California (2008) at www.sba.gov/advo/research/profiles/08ca.pdf We are unable to determine what share of small employers have average employee wages of less than $40,000.
[11] We estimated that California's small lower wage businesses would receive 15% of the projected $4 billion in annual costs of this provision. CBO Analysis of HR 3590, Letter to Senator Harry Reid, November 18, 2009.
[12] California currently helps the parents of uninsured children through its Healthy Families program with income up to 250% of FPL ($55,125 for a family of four) to pay for the costs of coverage for their children. The reform legislation would help parents pay for the costs of coverage up to 400% of FPL ($88,200) through the Exchange. This provision extends to parents of uninsured children and to parents of children with private individual coverage.
[13] Typically, parents' ability to cover their children under the parent's policy ends at age 18 or when the child finishes college at age 22. This would extend the age limit through age 26 for those parents who have coverage and can afford to pay 100% of the additional cost of covering their adult child. The young adult may find that coverage is more affordable through the Exchange if his/her income is less than 400% of FPL ($43,320) for an individual than through their parent's policy.
[14] There are roughly 200,000 uninsured individuals who report being in poor health and are thus completely unlikely to pass medical underwriting with a health insurer. See www.chis.ucla.edu California has a high risk pool for the medically uninsurable that is capped based on the Legislature's allocation of funding ($40 million); about 7,000 medically uninsurable individuals participate in MRMIP (Manage Risk Medical Insurance Program). See www.mrmib.ca.gov. The proposed federal legislation would allocate $5 billion for two years to fund coverage for the medically uninsurable until the full scale reform takes effect in 2013 or 2014. See CBO Analysis of HR 3590, Letter to Senator Harry Reid, November 18, 2009
[15] We divided the $5 billion in half, multiplied by 0.15 to reflect California's share of the nation's uninsured.
[16] Individuals with private insurance may find their coverage rescinded by a carrier who claims the individual committed fraud by concealing a medical condition. This

practice known as rescission has been abused by some carriers in California and has been the subject of a series of administrative fines and penalties accompanied by orders to restore coverage to individuals adversely impacted. The federal legislation provides additional federal protections against this practice during the interim period until full-scale reform takes place in 2013 or 2014.

[17] The donut hole refers to an aspect of Medicare Part D coverage of prescription drugs in which the elderly or disabled individuals with Medicare are responsible for 100% of the annual prescription drug costs over $2700 and less than $6154 a year. http://en.wikipedia.org/wiki/Medicare_Part_D_coverage_gap

[18] See CBO Analysis of HR 3590, Letter to Senator Harry Reid, November 18, 2009 at http://www.cbo.gov/doc.cfm?index=10868&type=1. Closing the donut hole costs on average $2 billion annually; California's share of the nation's Medicare population is 10%.

[19] Medicare and Medicaid pay in some limited circumstances for long term care at home to the frail or disabled elderly, but an estimated $41 billion is paid out of pocket by seniors and their families. In California, IHSS (In Home Supportive Services program) spends about $4 billion on home care services to the frail elderly in home and community based settings, but the program is limited to low income persons. The Class Act is a component of health reform that would establish a voluntary group insurance program to cover care at home for the frail elderly; it is targeted to moderate and middle-income seniors with incomes too high to qualify for Medi-Cal and IHSS. To be eligible, a subscriber must pay premiums (estimated at between $123-145 per member per month) for five years before becoming eligible for coverage. See Advancing Long Term Services and Supports, Health Affairs (January 2010)

[20] It is unknown how many individuals will participate. If half did and the program covered half their costs of long term care, the benefits to future frail elderly Californians would be at least $1 billion annually (in today's dollars). We multiplied current out of pocket ($41 billion) by 0.10 to calculate California's share, then divided by four to adjust for 50% participation and coverage for half the costs of long-term care.

[21] Some private insurance plans, typically those with high deductibles, cover few or no preventive services. Under the reform proposal, all plans must cover the preventive services of proven effectiveness with no cost sharing (i.e. no copays and deductibles). The same rules would also apply to the public programs of Medicare and Medi-Cal (Medicaid).

[22] The proposals grandfather all existing private individual and private employment-based insurance and all public coverage.

[23] If you do not like your existing individual insurance, you can buy another policy either through the Exchange or from any carrier. All policies must be guaranteed issue, guaranteed renewal so you can shop for any policy you like.
If you do not like your employer's policy, you can also buy any individual policy through the Exchange or from any carrier; however there is a hitch, you cannot access the subsidies within the Exchange unless your employer's policy was

unaffordable – i.e. your share of the premium exceeded 8-10% of your income. Why not? The bill's architects did not want to destabilize the private employer market.

[24] See CBO Analysis of HR 3590, Letter to Senator Harry Reid, November 18, 2009 at http://www.cbo.gov/doc.cfm?index=10868&type=1

[25] See ITUP Blog for December 21, 2009 at http://www.itup.org/blog/ The concept of "bending the cost curve" means slowing the rate of growth in health spending. If health costs are going up 4% a year after adjusting for inflation; bending the cost curve by 1%, means slowing the rate of growth from 4% to 3%. The savings grow exponentially over the years as each year's spending growth starts from a lower base than otherwise.

[26] See ITUP Blog for December 14, 2009 at http://www.itup.org/blog/. The Council on Economic Advisors projects a 1% annual decline in health spending growth for Medicare and Medicaid as well as decline in the rate of growth in the costs of private insurance beginning at 0.5% annually, increasing to 1.0%. The primary contributors to slowing the rate of health spending increase are the "Cadillac" benefits tax on the private side and the Medicare and Medicaid payment adjustments for hospitals and health plans, the introduction of bundling, accountable care organizations and pay for performance reimbursement on the public side.

[27] The Senate version would reduce the growth in Medicare and Medicaid spending by $436 billion over 10 years, the primary contributors would be slowing the rate of growth in payments to hospitals, nursing homes and home health ($192 billion), competitive bidding for Medicare Advantage plans ($118 billion) and reductions in DSH uncompensated care payments to hospitals as the uninsured are covered and hospital uncompensated care is reduced ($43 billion). CBO Analysis of HR 3590, Letter to Senator Harry Reid, November 18, 2009

[28] The Senate version would collect $486 billion in new taxes over 10 years with the prime contributors being the Cadillac benefits tax ($149 billion) and the fees on medical equipment suppliers and insurers ($102 billion), and the 0.5% hike in the Medicare payroll tax for high income earners ($54 billion). Ibid. The House version collects most of its increased revenues from high income Americans with a 5% surcharge on their income taxes ($460 million). CBO Analysis of HR 3962, Letter to Representative John Dingell. November 6, 2009.

[29] CBO Analysis of HR 3590, Letter to Senator Harry Reid, November 18, 2009.

[30] This assumes 100% enrollment of all newly eligible parents and medically indigent adults and 100% enrollment of all currently eligible but not enrolled parents and children and no state recoup from counties for the costs of the state match for coverage of the Medically Indigent Adults (MIAs). MIAs are currently a county responsibility in California paid for in part with a share of the state sales tax and vehicle license fees (referred to as realignment). See California Department of Health Care Services, Health Care Reform Cost and Savings Estimate: Full Implementation (December 4, 2009), HR 3590 Patient Protection and Affordable Coverage Act (November 23, 2009) and HR 3962 Affordable Health Care for America Act (November 6, 2009). See ITUP Summary of Impacts of Federal Health Reform on California's State Budget (January 12, 2010) at www.itup.org.