ITUP
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Assistance With Premium Payments and Cost-Sharing: The Non-Federal Share

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Issue: Some Californians Will Remain Uninsured Due To Affordability Challenges

While the Affordable Care Act (ACA) extends health insurance to millions of Californians, not all will enroll. Between 3.1 and 4 million Californians may still lack health insurance in 2019.[1] Many of the remaining uninsured will cite costs and affordability of coverage options as the primary reason for not enrolling. The cost of insurance has long been reported as a barrier to gaining coverage, and the ACA does not greatly reduce cost for all.

The populations of the remaining uninsured citing affordability issues will likely be diverse, with varying ages, income levels, and family sizes and structures. Both consumers who do qualify for premium assistance from the federal government and those who do not meet the eligibility criteria may have difficulty paying premiums. Lower income Californians, particularly younger individuals who often have fewer extremely low-cost options compared to older Californians, may be unable to spare a monthly \$50 to \$100 of tight budgets for coverage.[2] A couple in their early sixties with a household income of just over 400% FPL may be unable to afford plans that run \$800 to nearly \$1,600. Families subject to the "kid glitch," in which an insurance offer from an employer is affordable for employee-only coverage but unaffordable for family coverage disqualifies the entire household from receiving tax credits, may also experience challenges affording either employer or Exchange plans.[3]

Additionally, those with cost concerns are likely to choose lower-cost Bronze and Silver plans that have deductibles - \$5,000 for Bronze and \$2,250 for Silver. Individuals may avoid utilizing care because they cannot afford the cost-sharing. Subsidies for cost-sharing available to individuals up to 250% FPL decrease the cost of utilizing care, but even relatively low deductibles and copays may still create affordability challenges. Delays in care could result in negative health outcomes, including the exacerbation of treatable or preventable conditions.

Opportunity: Use Third Party Premium Assistance To Lower Costs

For some individuals and families eligible for Exchange plans or coverage through employers, the cost may be unaffordable, even after contributions from employers or federal tax credits. To expand coverage amongst groups who face affordability challenges, various third parties have expressed interest in offering additional premium assistance to lower the cost of obtaining coverage as well as cost-sharing assistance to decrease the out-of-pocket cost to enrollees when they seek care. Premium assistance has been used by numerous entities in the past to expand access to affordable coverage. Some organizations, such as public coverage programs, may have a financial interest in enrolling consumers in private plans, as it reduces cost and risk. Federal regulations allow some third parties to provide premium and cost-sharing assistance to Exchange enrollees, but the rules have been clouded with confusion until recent clarification by the Centers for Medicare and Medicaid Services (CMS).

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[1] Laurel Lucia et al (2012). *After Millions of Californians Gain Health Coverage Under the Affordable Care Act, Who Will Remain Uninsured.* UCLA Center for Health Policy Research and UC Berkeley Center for Labor Research.

[2] See Howland & Pegany et al (2014). Remaining Uninsured: A Population Profile. Insure the Uninsured Project.

[3] See Carolina Coleman (2014). Children's Health Under the ACA – Part III: Issue Diagnosis – Evolutionary Challenges. Insure the Uninsured Project.

CMS has issued several statements and official rules regarding financial assistance for Exchange coverage provided by third parties. Then-Health and Human Services Secretary Kathleen Sebelius first stated that any payments made by third parties, including for-profit corporations, are not in violation of federal anti-kickback laws, because the Exchanges are not technically "federal health care programs."[4] However, shortly after this announcement, CMS issued a FAQ stating that assistance provided from hospitals, providers, drug companies, medical device makers, and other commercial entities should not be accepted by Qualified Health Plans (QHP), due to the conflicts of interest that could encourage misuse of care or negatively impact risk pools.[5] Follow-up guidance clarified that the previous FAQ does not apply to Indian tribes or tribal organizations, nor nonprofit organizations, although the latter can only offer assistance based on financial status, disregarding health status, and must offer assistance for the entire plan year.[6] A final rule was issued by CMS in March 2014 that requires QHPs to accept payments, both premium and cost-sharing, from state and federal programs, including the Ryan White HIV/AIDS program, as well as Indian tribes and organizations.[7] Refusal to accept payments from government entities is subject to daily fines of $100 per patient denied coverage.[8]

Despite the various clarifications from the federal government, several questions remain as to who can provide premium and cost-sharing assistance. Pharmaceutical companies have long used copay cards that offer discounted prices for brand name drugs to increase sales. Such drug discount programs are barred in Medicaid and Medicare because of anti-kickback statute, but as previously stated, the Exchanges and QHPs are not subject to the rules. While QHPs have been encouraged by CMS to reject payments from pharmaceutical companies, it is unclear if drug discount cards are included in this guidance. Typically payments are not made to QHPs directly but rather to pharmacies, thus the rules may not apply, although some of the same concerns about skewing incentives remain in play. Additionally, CMS has not issued any guidance about the legitimacy of premium and cost-sharing assistance from counties. Some county governments may be interested in offering assistance to beneficiaries of county health programs like the Medically Indigent Services Program (MISP) to enroll in Covered California. Finally, provider-affiliated foundations have urged CMS to provide additional guidance on their ability to offer premium or cost-sharing assistance.[9]

Existing Premium Assistance Programs

Numerous state and federal programs already use premium and cost-sharing assistance, because the model can be cost-effective compared to traditional public coverage. As of 2009, 29

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[4] Kathleen Sebelius. Letter to the Honorable Jim McDermott, October 30, 2013. Retrieved from http://mcdermott.house.gov/images/The%20Honorable%20Jim%20McDermott.pdf

[5] Center for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight (2013). *Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces.* Department of Health & Human Services. Retrieved from http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf

[6] Center for Medicare & Medicaid Services (2014). *Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces.* Department of Health & Human Services. Retrieved from http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-payments-of-premiums-for-qualified-health-plans-in-the-marketplaces-2-7-14.pdf

[7] Department of Health and Human Services (2014). *Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums*. 45 CFR Part 156. Retrieved from http://www.gpo.gov/fdsys/pkg/FR-2014-03-19/pdf/2014-06031.pdf

[8] Ibid.

[9] American Hospital Association & Catholic Health Association of the United States. Letter to the Honorable Kathleen Sebelius, April 28, 2014.

states operate Health Insurance Premium Payment Programs (HIPP), which provide premium assistance to Medicaid or CHIP eligible families to lower the cost of employer-sponsored and, in some areas, individually purchased plans in lieu of Medicaid/CHIP.[10] Eligibility varies from state to state, but cost savings must be demonstrated and benefits must be comparable to those under Medicaid/CHIP. California's program stipulates that individuals must have a high-cost diagnosed condition for which the cost of care in Medi-Cal can be estimated and compared to the price of employer premiums. Adequate cost effectiveness was initially defined as savings more than 200% or more than premium costs, but was reduced to 110% in 2010.[11] This policy change made more beneficiaries eligible for premium assistance and generated an estimated annual savings to Medicaid of over $1 million.[12] The full employee-share of premiums and partial cost-sharing expenses are paid by the State in California's HIPP program.[13]

Enrollment in state premium assistance programs is very low nationally, with the exception of a few states such as Massachusetts and Pennsylvania.[14] [15] In California, just 1,033 members were enrolled as of June 2009.[16] Low enrollment has primarily been due to the lack of access to employer coverage amongst low-wage workers and, when employer coverage is available, high cost-sharing obligations impede cost-effectiveness.[17] [18] It is possible that enrollment in HIPP programs will increase as a result of ACA implementation, as the more inclusive eligibility criteria under the Medicaid Expansion opens the program up to more individuals, some of whom may have access to employer-sponsored plans, particularly after the employer mandate goes into effect in 2015.

Individuals receiving premium assistance in lieu of Medicaid or CHIP and individuals who are enrolled in both Medicaid and employer-sponsored coverage benefit from wraparound services provided by the State. Often employer-sponsored plans do not provide full benefits equivalent to Medicaid/CHIP coverage, thus public wraparounds are needed to offer access to these non-covered services. Medicaid/CHIP serves as a "payor of last resort," in that it only covers services that have been denied or partially paid by the private coverage. This essentially serves as cost-sharing assistance, lowering the out-of-pocket cost to the beneficiary, although services must be obtained from providers that accept both the private plan and Medicaid/CHIP.

The Ryan White HIV/AIDS program, which provides care to individuals diagnosed with HIV, also utilizes premium assistance, authorized under §2615 of the Public Health Service Act. The program paid nearly $400 million in premium assistance last year to private plans on behalf of

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[10] Government Accountability Office (2010). Letter to the Honorable Max Baucus & Henry Waxman. *Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs.* Retrieved from http://www.gao.gov/assets/100/96518.pdf.
[11] California Department of Health Care Services (2009). *Health Insurance Premium Payment (HIPP) Program – Initial Statement of Reasons.* Retrieved from http://www.dhcs.ca.gov/formsandpubs/laws/Documents/DHCS-07-004FSOR.pdf
[12] Ibid.
[13] Op cit. GAO
[14] Joan Alker (2008). *Choosing Premium Assistance: What Does State Experience Tell Us?* Kaiser Commission on Medicaid and the Uninsured. Henry J. Kaiser Family Foundation.
[15] Op cit. GAO
[16] Op cit. GAO
[17] Kaiser Commission on Medicaid and the Uninsured (2003). *Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity.* Henry J. Kaiser Family Foundation.
[18] Kaiser Commission on Medicaid and the Uninsured (2013). *Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act.* Henry J. Kaiser Family Foundation.

52,568 people.[19] Ryan White is now paying premiums for Exchange eligible patients, after federal subsidies are applied.[20]

The cost-effectiveness of premium assistance has been debated and the results of state programs have been mixed. Per-member administrative costs can be high given low enrollment – administration is equivalent to 9% of costs of HIPP in California and is even higher in other states.[21] Less than half of state premium assistance programs report monitoring aggregate program cost effectiveness and very few programs monitor beneficiaries' utilization and access to care.[22] Despite this, long-term savings seem likely for the State if beneficiaries with health problems utilize premium assistance, given the high cost of care provided through Medicaid/CHIP relative to the employee share of private premiums.

Insurance carriers have at times resisted premium assistance efforts, claiming adverse selection and that states are shifting the costs of care to sicker beneficiaries to insurers. A legal dispute developed in Louisiana in early 2014 when carriers participating in the state's Exchange refused to accept payments from the Ryan White program, citing previous guidance from CMS that discouraged third party premium assistance from for-profit organizations and health care providers. The subsequent rules issued by CMS mandated that carriers accept payments from state and federal governments as well as Tribal organizations.

Potential Beneficiaries of Financial Assistance

Numerous groups could benefit substantially from non-federal premium and cost-sharing assistance, in that coverage and care would become more affordable, making them more likely to enroll in and retain coverage. Consumers can benefit from assistance in enrolling in QHPs through the Exchange, but assistance applied to employer-sponsored plans is also beneficial to those who have access.

Pregnant Women

While California has made significant progress in improving birth outcomes, the implementation of the ACA complicates eligibility for state programs like pregnancy-only (emergency) Medi-Cal and Access for Infants and Mothers (AIM). The income eligibility of both programs overlaps with that of subsidies within Covered California, thus it is unclear which program or programs pregnant women should enroll in. The Governor has proposed offering premium assistance to pregnant women who enroll in Covered California in lieu of pregnancy-only Medi-Cal or AIM.[23] Under this proposal, the State is interested in program simplification, limiting churning between programs, and improving birth outcomes. ITUP has previously recommended that the State offer reduced premiums and copays through Covered California during pregnancy and upgraded

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[19] 45 CFR Part 156.

[20] HIV/AIDS Bureau, Health Resources and Services Administration (2013). *Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance.* Retrieved from http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf

[21] Op cit. GAO

[22] Op cit. GAO

[23] *Governor's Budget Summary – 2014-15, Health and Human Services*. Retrieved from http://www.ebudget.ca.gov/2014-15/pdf/BudgetSummary/HealthandHumanServices.pdf?utm_source=March+2014+Newsletter&utm_campaign=March+2014+Newsletter&utm_medium=email

services equivalent to those available through State programs.[24] Preserving the same plan options for women before, during, and post pregnancy minimizes confusion and preserves continuity of care rather than shifting program eligibility and provider networks. It is extremely important that women maintain coverage and seek appropriate care during pregnancy; some families may struggle to make payments, particularly when facing the additional costs associated with the birth of a child. Premium and cost-sharing assistance would limit affordability issues, ensuring that women keep their original plan and provider and get adequate prenatal care.

Families
Some families may have difficulty paying Covered California premiums as costs increase with household size. Those who are ineligible for federal subsidies face very high costs: full-cost Silver family plans (two adults and three or more children) start at about $800 per month. A number of households are subject to the "kid glitch," in which families offered expensive coverage through an employer are locked out of subsidies. The ACA allows consumers to qualify for federal tax credits if their employer-sponsored coverage is unaffordable, exceeding 9.5% of income. However, the affordability test only takes into account premiums for the employee, and does not include the cost to insure dependent children or spouses.[25] If the offer of coverage to the employee is affordable, but becomes unaffordable to cover additional family members, all parties are ineligible for premium subsidies in the Exchange. Households that cannot receive tax credits may be more likely to forgo coverage for some or all family members due to cost. Additional premium assistance would benefit these families substantially, although the relative price of coverage should be examined closely before applying assistance to employer-sponsored versus Covered California plans.

Middle Income Consumers
Tax subsidies in the Exchanges provide extensive assistance to lower-income individuals and families, but assistance decreases as income increases. As a result, there are subsidy "cliffs," as the premium caps increase from 4% of income at 150% FPL, to 8.05% of income at 250% FPL, and 9.5% of income for 300-400% FPL (Tables 1 and 2).

Table 1. Exchange Premium Caps and Actuarial Floors by Federal Poverty Level

Income Level	*Premium as a % of Income*	*Actuarial Value Floors Silver Plan*
0-133% FPL	2%	94%
133-150% FPL	3-4%	94%
150-200% FPL	4-6.3%	85%
200-250% FPL	6.3-8.05%	73%
250-300% FPL	8.05-9.5%	70%
300-400% FPL	9.5%	70%

[24] See Lucien Wulsin (2013). *Improving Birth Outcomes: Better Coordinating Care and Coverage for Pregnant Women.* Insure the Uninsured Project.
[25] Internal Revenue Service 26 CFR Part 1.

Table 2. Premiums by Age & Income in Covered California, Region 16

Income	*Individual, age 60*		*Couple, ages 62 & 60*		*Family of 4, ages 42, 40, <18, & <18*	
	Lowest cost Bronze	Lowest cost Silver	Lowest cost Bronze	Lowest cost Silver	Lowest cost Bronze	Lowest cost Silver
200% FPL	$1	$84	$2	$87	$115	$212
300% FPL	$135	$236	$84	$292	$362	$507
375% FPL	$203	$304	$176	$384	$502	$646
405% FPL	$418	$519	$859	$1,067	$596	$740

Individuals with moderate incomes may still face challenges paying premiums that are 8-9.5% of income. Additionally, some consumers just over the income threshold for federal subsidies may face considerable costs in obtaining QHP coverage. The lowest cost Silver plan for a single 60-year-old individual living in Los Angeles at 400.3% FPL is equivalent to 13.5% of the individual's income. Some individuals may face personal circumstances and hardships such as caring for family members and student loan debt that limit their ability to afford coverage. These populations arguably have demonstrated financial need for assistance that could be provided by numerous entities.

Plan Members With High Cost-Sharing

Covered California enrollees have overwhelming selected the lowest cost coverage tiers - 26% of enrollees selected Bronze coverage and 62% chose Silver.[26] Compared to Gold and Platinum plans, Silver and Bronze plans have substantial cost-sharing obligations. Bronze members are subject to a $5,000 deductible and high copays - $300 for the ER, $120 for urgent care, and $70 for specialist visits. Households enrolled in family plans are subject to deductibles double the amount of that of individuals. Not all members fully understand the cost-sharing elements of lower-cost plans upon plan selection and may be unable to pay the deductible and copays. This could result in deferring necessary care, resulting in negative health outcomes. Cost-sharing assistance and wraparound coverage can mitigate this issue.

Cost-sharing assistance is a valuable tool to assist consumers with high deductibles in both Exchange and employer plans. Those with high health costs or specific health conditions could particularly benefit from assistance. However, only public entities will be able to offer assistance based upon care need.

Members of plans with less than comprehensive benefits may also be in need of assistance because they lack access to necessary services. To remedy this, organizations can offer wraparound coverage for services not covered by plans. For example, if a local safety net believes that acupuncture is an important benefit, but some employer plans and QHPs do not cover it, the safety net can offer the service to underinsured individuals, supplementing rather than duplicating coverage.

[26] Covered California's Historic First Open Enrollment Finished with Projections Exceeded. April 17, 2014. Retrieved from http://news.coveredca.com/2014/04/covered-californias-historic-first-open.html

Options Available
CMS guidance allows public and nonprofit organizations to provide premium and cost-sharing assistance to individuals enrolled in QHPs. Some entities are already exploring opportunities to provide assistance to individuals and families in need.

Governor Brown has proposed in the FY 2014-15 budget that coverage for pregnant women in Medi-Cal be restructured. Under the proposal, the Access for Infants and Mothers (AIM) program will become a part of Medi-Cal and coverage for pregnant women between 100% and 208% of the federal poverty level (FPL) will be provided through Covered California for women who are eligible and can enroll during open or special enrollment. The women who enroll in Covered California will receive premium and cost-sharing assistance beginning in January 2015. This shift is mutually beneficial, as the state will save an estimated $16.6 million in FY 2014-15 and the beneficiaries receive comprehensive coverage (only pregnancy-related services are covered for this income level in Medi-Cal) and continuity of care (rather than churning between Covered California and pregnancy-only Medi-Cal eligibility).[27] This is an innovative use of financial assistance that integrates and streamlines systems in a cost-effective manner.

Los Angeles based nonprofit organization A Better LA has launched a pilot program providing premium assistance for Covered California plans for low-income people in need. [28] The organization is paying the premiums of 50 individuals, after federal tax subsidies have been applied, amounting to $50-100 per person per month.[29]

These programs take advantage of the unique opportunity available through the creation of Covered California and availability of federal tax subsidies. State departments, county governments, philanthropic organizations, and employers can make health coverage more available to Californians who experience difficulties paying insurance premiums, for a relatively modest cost compared to the full price of coverage or care. These entities can also increase access to health care services for those already enrolled in Exchange or employer plans by providing cost-sharing assistance that decreases expensive deductibles and copays.

Opportunities for State Government
Niche state programs that cover populations with certain health care needs could be adapted to offer premium and cost-sharing assistance for members who enroll in QHPs, while preserving benefits for the undocumented and wraparound coverage for services not covered by Exchange plans. This shift could potentially generate substantial savings for the State while offering more comprehensive, long-term care to patients.

The Genetically Handicapped Persons Program (GHPP) is an apt example of this policy option. GHPP pays for care for adults with certain genetic diseases, include cystic fibrosis, Huntington's Disease, and sickle cell disease. As of November 2013, approximately 43% of beneficiaries have both GHPP and Medi-Cal, while the remainder are GHPP-only, meaning the cost of their care is paid for entirely by the State.[30] For FY 2013-14, GHPP was appropriated $24 million in State

[27] Op cit. *Governor's Budget Summary.*
[28] abetterla.org
[29] Louise Radnofsky & Christopher Weaver. *Insurers Fight Hospitals' Paying Premiums.* Wall Street Journal. December 16, 2013. Retrieved from http://online.wsj.com/news/articles/SB10001424052702304202204579252520347490190
[30] California Department of Health Care Services (2013). *Family Health November 2013 Local Assistance Estimate for Fiscal Year 2013-14 and 2014-15.*

General funds.[31] The cost of care for patients with specific diseases is very high in GHPP; the average cost of care for a hemophilia patient is more than $264,000.[32] With a caseload of less than 1,000 GHPP-only members, full premium assistance could be provided to each member for less than the annual cost of GHPP to the General Fund.[33]

The Breast and Cervical Cancer Treatment Program (BCCTP), which pays for the treatments for women with breast and cervical cancer, and IMProving Access, Counseling, and Treatment for Californians with Prostate Cancer (IMPACT), which pays for the treatment of men with prostate cancer, are also potential opportunities for the State. BCCTP already offers to pay Medicare and employer-sponsored plan premiums for women who do not qualify for Medi-Cal, at a cost of $254 per member per month, but the BCCTP and IMPACT could also offer premium assistance through Covered California.[34] This is beneficial to patients compared to diagnosis-based coverage offered by the State, because it provides broader full-scope coverage, promotes continuity of care, and prevents patients from being disenrolled from the plan after the completion of treatment.

Adding individuals with significant health issues to the population enrolled in Covered California could have a negative impact on the risk pool, given the high cost of care for these patients. However, the effect will most likely be relatively minor, because there are very few individuals enrolled in programs like GHPP (1,000) compared to the more than 1.4 million enrolled in Covered California.

Opportunities for County Government

California Welfare and Institutions Code §17000 requires county governments to pay for care for the medically indigent. Each county either operates a Medically Indigent Services Program (MISP) with varying eligibility criteria or participates in the 34-county coalition called the County Medical Services Program (CMSP). In 2014, most MISP and CMSP beneficiaries became eligible for either full-scope Medi-Cal or, for counties that cover individuals over 138% FPL, subsidized plans through Covered California. While it remains unclear what obligation counties have to provide care to the uninsured post ACA implementation, some counties may consider offering premium assistance to individuals who are eligible for both Covered California and local indigent services, while maintaining the indigent program for those ineligible for the Exchange. The cost of premium assistance is surely less than providing direct care. “Payer” counties that contract out services will likely be more interested in premium assistance than “provider” counties that operate public hospitals and clinics, as the public providers may not be in Covered California networks. Cost-sharing assistance should also be offered so that services covered by QHPs can actually be utilized. If there are any benefits available in MISPs/CMSP that are not covered in Covered California, the counties can continue to offer the services as supplemental coverage.

Opportunities for Nonprofits and Philanthropic Organizations

Nonprofits and foundations should explore offering premium and cost-sharing assistance programs, as well as wraparound benefits, because of the low per person cost relative to the major impact acquiring health coverage has on health and wellbeing. Existing nonprofit and

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[31] Ibid.
[32] Ibid.
[33] Some of these members are now eligible for full-scope Medi-Cal, but since GHPP has no income eligibility criteria, many beneficiaries are Covered California eligible.
[34] California Department of Health Care Services Fiscal Forecasting and Data Management Branch (2013). *bcctp*

philanthropically funded coverage programs, such as Healthy Kids and CaliforniaKids, could offer premium assistance to members who are eligible for Covered California. Compared to the cost of direct care provided by the nonprofit, premium assistance is likely cheaper. Assistance for Covered California enrollment can only be offered to legally present members, however the undocumented can utilize assistance in off-Exchange plans, which could still result in potential cost savings.

As mentioned earlier, unlike state and federal programs, nonprofits and foundations cannot offer premium assistance based on health status or specific diagnosis. Only financial status can serve as eligibility criteria, and assistance must be offered for the entire year. Covered California has welcomed a premium assistance program through nonprofit A Better LA, demonstrating that the opportunity is present for charitable organizations interested in helping consumers with financial need.

Opportunities for Employers

Employers can also assist employees who do not have access to employer-sponsored plans in purchasing health coverage through the Exchanges. Under the ACA, employers with 50 or more full-time equivalent employees must offer comprehensive medical coverage to full-time employees, beginning in 2015, or face fines. Small employers not subject to the mandate may still offer health benefits to employees, but some will be unable to incur the high cost of a quality health plan. Likewise, large employers are not required to cover seasonal workers or part-time employees working fewer than 30 hours a week, but may still wish to offer some level of health benefits. Employers in either situation may chose to offer employees a standard assistance amount to help them enroll in coverage through the Exchanges. Several large companies such as Target and Trader Joe's recently chose to drop coverage for part-time workers and instead offer them $500 per year to seek coverage through the Exchange or through a family member's plan. In some cases, employees may pay less for more comprehensive benefits under this scenario, compared to the often high cost of employer-sponsored plans available to part-time employees. While some may see this as firms avoiding their responsibility to pay for the health care of workers, premium assistance is an option worth offering to employers not subject to the mandate and for employees outside the full-time, full-year guidelines.

Limitations

Some stakeholders have argued that state programs should be preserved over premium assistance. Some advocates feel that AIM is affordable to moderate-income women and has an established network of providers, making it a more appealing option than premium assistance through Covered California. Some low- and middle-income consumers who have benefitted from programs like GHPP and BCCTP may wish to continue utilizing the safety net provider network, which may not contract with Covered California plans, thus continuity of care could be interrupted for some. This issue may lead the State to offer premium assistance at the option of the beneficiary, preserving the state programs. Certain benefits available in Medi-Cal or other state programs may not be available through Covered California or employer-sponsored plans, but providing wraparound benefits equivalent to the original program can mitigate this issue.

Conclusion

The State, county government, nonprofits and philanthropic organizations, and employers should consider offering premium and cost-sharing assistance to populations in need to enroll in

either employer-sponsored or Exchange plans. Financial assistance could minimize the number of uninsured Californians by making coverage more affordable. The State and counties can achieve cost savings by offering financial assistance in lieu of coverage through public programs, while improving access to and continuity of care for patients. Nonprofit organizations have an opportunity to improve the health and wellbeing of a large number of people for a relatively small cost per person. Employers can support more affordable coverage for their workers, even if not mandated to provide full-scope coverage. Financial assistance could boost enrollment and retention in private plans, ultimately reducing the number of Californians who remain uninsured.