The Affordable Care Act in many ways represented the triumph of Republican ideas (dating back to President Richard Nixon, Senator Bob Dole and ultimately enacted by Governor Mitt Romney), passed by a narrow margin with Democratic votes only and implemented amidst enormous partisan criticism and unparalleled scrutiny. It was not perfect in its inception or in its implementation, but it was a vast improvement on the status quo ante and a welcome step towards universal coverage after 100 years of trying. Like many new programs (remember the early challenges in California’s implementation of Healthy Families or the nation’s slow implementation of Medicaid), it will take at least five years to work out the bugs without any help/interference by Congress – an unlikely scenario. California has made enormous strides in implementation and in improved affordability, but we are likely to reach an enrollment plateau in the next two to three years.

First, we must do a better job of educating California’s public, which has been saturated with a stew of misinformation, inadequate information and accurate information and does not know what to believe. Most are still confused: how the ACA works, how benefits are accessed in their health plan, the value and importance of preventive and primary health care, the interplay between the costs of premiums, deductibles and copays, the tax implications of timely reporting income changes or of dropping health coverage, and the importance and opportunity of patient engagement to achieve healthier outcomes.

In this article, we will discuss next steps for California to consider towards a better system. ACA §1332 allows us to begin this effort with ACA waivers as soon as the year 2017; we need to begin the thinking now. Section 1332 allows states to waive any or all of the following: the Exchanges, tax credits, qualified health plan requirements, individual and/or employer responsibility. It allows for a consolidation of waivers for Medicaid, Medicare and CHIP; this offers a state an unparalleled opportunity to “get it right”. States must provide coverage that equals or exceeds the ACA, and the costs may not exceed what the federal government is already spending. What could California do – examples would be a modern hybrid of Medicaid, the Exchanges, CHIP and Medicare or a public option or a Basic Health Plan or single payer or consumer-directed coverage or aligned payment incentives and integrated care for all. Below we review needed changes in the major sources of health coverage for Californians.

**Medicaid** (Medi-Cal), a federal/state program in California offers comprehensive coverage to all below 138% of FPL – about 12.2 million Californians projected in year 2015-16. The ACA expanded coverage to individuals and parents, which California has implemented to cover over 3 million new subscribers. Enrollment is likely getting close to its peak, and as wages improve and new jobs are created, enrollment may decline somewhat.
Subscribers are in managed care, but in a somewhat incoherent fashion where their teeth are in one program, their bodies in a second and their minds in a third. Nearly every county has a different managed care system, a different mental health system and a different system to treat and care for substance abuse disorders; some work much better than others and in some cases, there is no choice and no competitive incentives to improve.

Children’s coverage and care is bifurcated for those most seriously ill. Seniors’ care is bifurcated, but differently than children – i.e. between a federal agency (Medicare) and a state agency (Medicaid). Care for the mentally ill with substance abuse disorders may be trifurcated. Care for individuals with developmental difficulties is bifurcated. We urgently need to integrate care and coordinate coverage so managed care can achieve the program’s objectives.

Providers are sub-divided between the safety net haves and have-nots. Most safety net hospital revenues are still in fee for service mode even though most Medi-Cal patients are now in managed care delivery systems. We will need managed care incentives throughout the safety net.

Selective contracting in both Medi-Cal and commercial PPO markets has helped to create, deepen, widen and perpetuate a two-tiered health system in some urban areas due to the wide variance in the level of Medi-Cal physician reimbursements between the safety net and other providers. We will need to better level the playing field of physician reimbursements to improve Medi-Cal access and provider participation.

Much of the program is confusing, obfuscated and obscure except to the highly initiated -- from the intricacies of physician billing, FQHC rates, Safety Net Care Pool supplements; multiple administrative tiers from the state to the local health plans to the IPAs to the providers; between county social services’ IT system, the new CalHEERS system and the state MEDS system, and the multiplicity of AID codes through which program eligibility flows. The complexity results from 50 years of incremental improvements without a consistent, unifying or strategic vision. The program needs to be and can be radically simplified, made transparent, and thus accountable and aligned.

The program has an understandable and long standing institutional bias towards hospitals, nursing homes, counties, emergency departments, trauma centers and big clinic systems. The shift to primary care and preventive services is a huge and wrenching delivery system change that needs to be reflected in changing policies at the state and the local managed care levels.

Some Republicans would like to freeze and block grant Medicaid, and some Democrats would like to expand it to all low income regardless of immigration status but as yet lack a viable financing strategy to pay for it. State and federal budget pressures, particularly during recessions do force program change, mostly towards expanded managed care – albeit in fits and starts and usually with little coherent or consistent direction with the other major health programs.
We must engage in the hard work to improve the performance of Medi-Cal managed care. While we recognize that diverse factions are fiercely protective of their share(s) and configurations of the pie, we think the next steps are improved transparency of prices, quality, metrics and outcomes so that plans and providers know where and what to improve and subscribers can exercise meaningful choices of plan and provider. xviii We think the next steps are plan, payment and delivery system reforms leading to more effective primary care, better integration of care, and improved patient outcomes.

**Medicare** is a federal program for virtually all seniors and some of the disabled – covering over 5 million Californians. xix Medicare consists of one program (Part A) for hospitals, a second (Part B) for doctors, a third (Part D) for prescription drugs and an optional program (Part C) that combines all three under the auspices of a private managed care company. About 38% of California subscribers enroll in Part C. xx Oddly though, most long-term care services to seniors and the disabled are offered and paid for by Medicaid, not by Medicare.

ACA improvements in payment structures to plans and providers have reduced the recent rate of growth in per Medicare capita costs to close to zero. xxi Program enrollment will grow with baby boomer retirements. xxii The ACA’s per capita spending cap for the Medicare program assures that we will see a steady stream of payment reforms designed to assure that the growth in per capita spending stays under the Medicare growth cap.

Some Republicans xxiii would like to voucher-ize it, possibly using an Exchange for subscribers to purchase private insurance with their vouchers. Some Democrats would like to expand it to all Americans/Californians, but lack a viable financing strategy to do so. xxiv While the ACA slowed the growth in per capita Medicare spending, the baby boomer retirements will eventually create inexorable pressure for a new financing model (such as a Value Added Tax) as the ratio of retirees to workers changes; this needs to be thought through, discussed and developed.

We need to combine Medicare and Medicaid coverage of California’s dual eligibles into expanded Part C coverage. xxv And we need to expand covered long-term care benefits with sliding fee premiums and out of pocket responsibilities to pay for it. xxvi

**Employment-based** coverage extends to nearly 16 million Californians. xxvii Individuals working full time, full year, for larger or higher wage firms are commonly covered. xxviii Individuals working part time, part year, or for small low wage firms are not typically covered. xxix

Employer coverage has been slowly eroding over the past 40 years, xxx particularly for dependents, in part due to rising health costs and premiums, to wage stagnation and to the hourglass growth of the American economy. The ACA’s employer mandate may stanch the decline in coverage among large employers. xxxi The ACA’s small business tax credits may slightly slow the decline in the already far lower offer rate for lower wage, smaller employers. xxxii Early indications are that there has been no decline in employers’ offer rates, no decline in employees’ take-up rates and no change in coverage rates nationally. xxxiii
Premium growth has been slow for the past 4-5 years due to the recession and improvements in plan design. Plans have been offering innovative benefit designs to better align provider and subscriber incentives for better health outcomes; nevertheless premium growth in California has outpaced the nation over the past decade – increasing unaffordability for California's employers and employees. Some of these new benefit designs shift greater cost sharing to employees with incentives to better manage their own care and choose with greater cost consciousness (e.g. the Health Savings Accounts); however, the transparency of information on prices, quality and outcomes that would allow subscribers to make informed and educated choices about providers and courses of treatment has not kept pace with the shift in costs to employees. Provider reimbursement incentives vary from payor to payor and from health plan to health plan, thereby blunting and negating their intended impacts and adding greater confusion and administrative cost burdens to providers. The recent reduction in uncompensated care as more Californians have become insured offers an important opportunity in an imperfect market to negotiate price reductions as hospitals' "cost shift" is reduced.

Enrollment in employment-based will expand somewhat with the recovery of the economy and to the extent that high wage jobs return. However the reverse Robin Hood incentives of pre-tax purchasing severely limit the ability of employment-based coverage to expand enrollment for lower wage workforces.

Some Republicans would like to transform the tax subsidies of employment based coverage into vouchers to be used to purchase individual insurance. Some Democrats would like to expand the ACA’s employer mandates while others would prefer to replace employer’s premiums with employer taxes to finance Medicare for All. Republicans and some Democrats want to increase the threshold for the employer mandate from 30 to 40 hours, thereby making it easier for those employers wishing to evade the mandate to do so, by reducing their worker's hours to 39 per week.

We could do better by pro-rating employer contributions by hours worked in order to eliminate the cliff effects of setting the threshold at either 30 or 40 hours, which acts as an incentive to limit employee hours to avoid the mandate. The same applies to the numbers of employees, setting the mandate at 50 encourages some employers close to the margin to keep their size at 49 employees; this is not a big issue because most employers 50 and above already offer coverage due to the tax advantages of pre-tax purchasing through employment, which mitigates the cliff effects.

We eventually need to apply the mandates to all sizes of employers and all types of employment and pro-rate it for hours worked. We need to flip the tax subsidies 180 degrees to more appropriately support coverage of lower-wage workers. We need to build a better floor under the coverage of low wage workforces – i.e. less out of pocket exposure for those who can least afford it. We need to give every employer small or large the ability to join purchasing pools such as SHOP, PBGH or CalPERS so that employers as payors can negotiate and align consistent payment incentives appropriate for plans, subscribers and providers. This is extremely difficult as an effort.
by either political party; it would require a bi-partisan consensus initiated by strong business and labor support – unlikely in our nation’s near future, but possible over the longer term in California.

**Covered California** coverage extends to 1.2 million Californians, of whom 85% qualify for subsidies and about 90% of those with subsidies have selected bronze or silver coverage – the lowest premium cost tiers offering the least coverage unless one qualifies for enhance silver.\(^{xlvii}\) Subscribers are extremely cost conscious and price sensitive, in many ways the obverse of Medicaid, Medicare and private employer’s coverage and they are for the most part picking the PPO plans with the lowest premiums (and highest cost sharing). In the first year’s renewals, almost all subscribers have stayed with their initial plan choices, only 6% changed plans, with Kaiser leading the way with 99% retention.\(^{xlviii}\)

Covered California has reached about half of its target market in its first year, and enrollment will likely continue to grow for the next two to three years as the program becomes better known and accepted.\(^{xlix}\) The program’s enrollment will not likely grow further than that unless affordability is further improved – particularly at the cliffs: 138% of FPL, 250% of FPL and 400% of FPL where there are abrupt changes in individual and family premiums and subsidies.\(^1\) Another approach would be an enhanced bronze such that individuals with low and moderate incomes could combine the lower premiums of bronze with lower cost sharing as offered by the enhanced silver.\(^{li}\)

Subscribers have a choice of three to five competing insurance plans in most regions, including a few county-organized Local Initiatives. For the first two years, negotiated premium levels were promising;\(^{lii}\) however there has been great concern expressed about the program’s narrow networks.\(^{liii}\) These networks could in fact be the focal point to develop better quality at lower prices if the providers and plans align effectively. Covered California’s choice and competition models have not worked as well in those rural communities with few providers, as they have in the urban communities with more providers and the potential for strong competing provider networks.\(^{liv}\)

Some Republicans support the Exchanges but would like to reduce the eligibility for subsidies to individuals with incomes less than 300% of FPL.\(^{lv}\) Other Republicans\(^{lvi}\) would like to expand the Exchanges and the availability of favorable tax treatment to move more workers from employment-based coverage into the Exchanges. Some Democrats\(^{lvii}\) would like to expand Medi-Cal to individuals with lower incomes in Exchanges; others would like to increase the tax credits to make coverage more affordable. Others want a public option offering like Medicare within the Exchanges.\(^{lviii}\) There has been some bi-partisan interest in covering all Americans in Exchanges.\(^{lix}\)

We need to build the electronic and programmatic interfaces between Covered California, Medi-Cal\(^{lx}\) and employer coverage\(^{lxi}\) so individuals seamlessly maintain coverage and courses of treatment. We need to build a better model for rural Californians – possibly single, local integrated delivery networks.\(^{lxii}\) We need to use the opportunities of a §1332 waiver to develop better affordability of premiums, particularly
and we need to enlist the support of plans, providers and county governments to help those subscribers with financial hardships through premium assistance.

**County Indigent Health** programs are being nearly completely replaced by the Medi-Cal expansion in all but the provider counties. Full access to care for the undocumented is only available in the 10 counties with large public hospital systems. The future of the public hospital systems depends on their ability to compete effectively in Medi-Cal managed care while retaining adequate revenues to pay for their care to the still uncertain numbers and costs of the remaining uninsured.

Local safety net funding has been already reduced with the health realignment cuts, will be further reduced with the DSH cuts scheduled for 2017, and could take further hits as part of the 2015 waiver renewal. There is to this point quite limited data available on the ongoing financial needs of local safety nets to care for the remaining uninsured.

Most Republicans support a limited safety net and would favor reducing safety net funding as the ACA’s coverage expansions insure the uninsured. While many Democrats favor a safety net for the remaining uninsured, they are uncertain what funds are still needed and which can be re-allocated to better uses. There is little data yet available in California on the extent of unreimbursed care in California’s safety nets to and unmet needs of the uninsured subsequent to the ACA’s roll out.

We need to use this opportunity to build stronger local public health systems that complement the coverage expansions and convene local shareholders to plan effectively for the improved health of their communities. We need to support the evolution of public facilities so they can both compete effectively in the Medi-Cal managed care market and accountably partner with local private clinics, doctors and hospitals that care for the remaining uninsured.

**Niche state programs** like CHDP, CCS, Family PACT, GHPP, IMPACT, Every Woman Counts and ADAP pay for limited, condition-specific care to the uninsured and for vital connective and supportive services not otherwise covered under the basic Covered California and Medi-Cal programs. As ACA coverage for the previously uninsured increases, the expenditures and enrollment will decrease quite substantially.

The 2015-15 Proposed Governor’s Budget would require individuals eligible for coverage under these limited benefits to apply for Medi-Cal or Covered California if otherwise eligible. We should use this opportunity to integrate and link these programs together with Emergency Medi-Cal and Medi-Cal share of cost; this will reduce administrative costs, make them easier to access for uninsured patients and providers and begin to offer an integrated system, albeit imperfect, of safety net care for Californians who remain uninsured in all 58 counties until such time as we achieve truly universal coverage for every California resident.
facilities while concentrating care for the privately insured in different facilities. As job creation continues and unemployment continues to drop more Californians will likely qualify for Covered California as opposed to Medi-Cal. Under its enhanced scenario, the most recent CalSIM projections are that California will max out in enrollment in both programs by the end of the 2016-17 open enrollment. See CalSIM Version 1.91 Statewide Data Book 2015-19 (May 2014) at www.healthpolicy.ucla.edu.

**Footnotes:**

i California expects to enroll 3.2 million in Medi-Cal and 2 million in Covered California by the end of 2015-16 for a total of 12.2 million. See, Legislative Analyst’s Office, 2015-15 Budget: California’s Fiscal Outlook (November 2014) at www.lao.gov and 2015-16 Governor’s Budget Summary (January, 2015) at www.ebudget.ca.gov. As job creation continues and unemployment continues to drop more Californians will likely qualify for Covered California as opposed to Medi-Cal. Under its enhanced scenario, the most recent CalSIM projections are that California will max out in enrollment in both programs by the end of the 2016-17 open enrollment. See CalSIM Version 1.91 Statewide Data Book 2015-19 (May 2014) at www.healthpolicy.ucla.edu.


iii Ibid. The ACA revenues for the Medi-Cal (Medicaid) expansion are projected to be over $15 billion and the state General Fund contribution would be $1 billion in 2015-16 according to the 2015-16 Governor’s Budget Summary.

iv Ibid.

v Ibid.

vi CCS is a fee for service program for specialty hospital care children with designated serious illnesses. Medi-Cal managed care pays for primary care, medications and other program components not related to the condition on which eligibility is based. In most COHS counties, the programs are merged into managed care. The last waiver authorized pilots to test different models of care to these children to improve their care and outcomes; none have really come to fruition. See Coleman, Children’s Health Coverage Under the Affordable Care Act (ITUP, February 7, 2014) at www.itup.org for recommendations to consolidate the different children’s health programs.

vii Medi-Medis or dual eligibles have both federally administered Medicare and state administered Medi-Cal. Medicare pays mostly for their acute care and Medi-Cal pays for much of their long-term care. The last waiver included eight local pilots to see how the two programs could be integrated to provide better health outcomes. The implementation has just begun and there is as yet no data or evaluations to report how they are working. The Governor’s budget proposal suggests that improvements will be needed to demonstrate the cost effectiveness test necessary for the programs to continue. See 2015-16 Governor’s Budget Summary.

viii Care and coverage is split between the local managed care plans (physical health and mild and moderate mental illness) and the local county health department (mental health for the chronically and severely mentally ill). Treatment for substance abuse disorders is assigned to the county substance abuse program, which in Los Angeles is housed in the Department of Public Health. Each has separate and non-intersecting funding streams.

ix Care and financing for individuals with developmental difficulties is divided between the local managed care plan and the local Regional Center(s). The recent disputes about who pays for ABA autism therapies are a classic example of the confusion about who pays for and who delivers which services and the degree of scientific evidence supporting particular treatments.

x For example, community and many county clinics are paid at a PPS rate based on their costs that adjusts for rising costs. Private doctors are generally paid far less for the same basic services and their payment rates are rarely increased and more commonly reduced. However the switch to managed care obfuscates these comparisons as each plan negotiates its own rates with local doctors. The use of P4P incentives also may enhance reimbursements and make it difficult to make apples to apples comparisons.

xi For example, less than a quarter of county hospitals’ Medi-Cal revenues are from managed care while over 3/4 of Medi-Cal patients are enrolled in managed care. See Yoo, 2013 Hospital Financing Overview by County Type (ITUP, January 2015) at www.itup.org. By comparison in non-profit hospitals, 7/8 of their private insurance revenues are from managed care. Ibid.

xii See Acosta and Washington, Solo and Small Group Practices in California (ITUP, February, 2015) at www.itup.org. The causes of California’s diverging two tier health systems may date back to the selective contracting reforms of the early ‘80s which introduced “price competition” to California. As a highly unfortunate side effect, it concentrated care and reimbursements for the Medi-Cal insured in particular facilities while concentrating care for the privately insured in different facilities. DSH, Safety Net Care
Pool, and FQHC reimbursements were all important advances designed to help the safety net survive and care for the uninsured in competitive markets that were squeezing out the “cost shift” for uncompensated care; however they further cemented the dividing lines. Compare the percentages of Medi-Cal and uninsured days, visits and revenues in county hospitals to private non-profit hospitals, and likewise the respective percentages of Medicare and private insurance days, visits and revenues between the public and non-profit facilities at Yoo, OSHPD Hospital Data Summary by Hospital Type (ITUP, January 2015) at www.itup.org

County hospitals are reimbursed based on their cost reports since the 2005 waiver; however counties must pay the match for their Medi-Cal inpatient days. Hospitals have reduced their reimbursement differentials through a hospital tax that seeks to assure Medicare levels of reimbursement for hospitals serving Medi-Cal patients. There is nothing comparable to reduce the disparities for physician services.

California ranks 46th or 47th in physician reimbursement fee schedules under Medicaid. See Zuckerman et al, Medi-Cal Physician and Dentist Fees: a Comparison to Other State Medicaid programs and Medicare (California HealthCare Foundation, 2009) at www.chcf.org. However, not all Medicaid visits are reimbursed equally poorly. For example ED visits, electrocardiograms, hospital visits, surgeries and radiology are reimbursed by Medi-Cal at or above the national averages for Medicaid programs while office visits for established patients and psychotherapy services are among the visits reimbursed at 70% or less of the national Medicaid average. For a routine vaginal delivery and prenatal care, Medicaid pays at 82% of the national Medicaid average. Yet in many ways, these fee comparisons are meaningless since most patients and their doctors are reimbursed through Medi-Cal managed care plans and there is no data available that catalogues and compares these payments.

We need to look at increasing primary care reimbursement rates, primary care medical homes and health homes, telemedicine, specialty e-consults, moving beyond the visit, moving beyond the four walls, co-locating with behavioral health, co-locating with specialists, medical assistants, roles of nurse practitioners, opportunities for teaching health centers, gain sharing, consistent metrics and greater flexibility for care in medically underserved rural areas with significant provider shortages.

See for example, the block grant proposal at The State Health Flexibility Act, HR 4160 at www.rsc.flores.house.gov/solutions/statehealth. By contrast, see Republican Governors’ Public Policy Committee, A New Medicaid: a Flexible Innovative and Accountable Future (August 30, 2011) which advocates for repeal of the ACA’s Medicaid expansions, greater flexibility for states to innovate without federal review and approval, value purchasing principles, simplified eligibility processes, greater patient cost-sharing, greater choices of plans, the ability to offer reduced benefit levels, greater flexibility in eligibility, financing and delivery systems to provide long term care at www.rga.org

See SB 1005 (Lara), which expands Medi-Cal to full scope for the undocumented and creates a parallel to Covered California for the undocumented and creates a parallel Medicare advantage fact sheet (May, 2014) at www.kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet. Of note is that Medicare Advantage enrollment has grown by nearly 30% despite projections of demise when the ACA reformed payment rates to reflect actual costs and quality outcomes.

The fiscal analysis suggests a cost of about $900 million annually. To start to pay for these costs, it will be necessary to consolidate and integrate funding streams and programs. See Wulsin, Thoughts on Financing Care and Coverage for the Undocumented (ITUP, October 10, 2014) at www.itup.org

See, Connolly and Coleman, Medi-Cal Managed Care, Raising the Bar for Quality and Outcomes (ITUP, January 2015) at www.itup.org

See Kaiser Family Foundation, Total Number of Medicare Beneficiaries (2012) at www.kff.org/medicare/state-indicator/total-medicare-beneficiaries. This has been a steady growth from roughly 4 million beneficiaries in 1999.

See Kaiser Family Foundation, Medicare Advantage Fact Sheet (May, 2014) at www.kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet. Of note is that Medicare Advantage enrollment has grown by nearly 30% despite projections of demise when the ACA reformed payment rates to reflect actual costs and quality outcomes.


Medicare enrollment is projected to grow at 3% a year during this decade due to baby boomers reaching age 65. See Holahan and McMorrow, Medicare, Medicaid and the Deficit Debate (Urban Institute, April, 2012). www.urban.org/health

See Van de Water, Medicare in Ryan’s 2015 Budget (Center on Budget and Policy Priorities, April 8, 2014) at www.cbpp.org
Employment which then phases down and out as wages and employer size increase. See Wulsin, ITUP’s Analysis of “employer mandate” for employers over 100 takes effect in 2015 and for employers over 50 in 2016.

91% of employers over 50 and fewer than 200. California Employer Health Benefits Survey

Employer Health insurance Coverage (Commonwealth Fund, January 2015) at www.commonwealthfund.org

Medicare Part C does not cover much long-term care. In our vision, the expanded Part C would combine Medicare and Medi-Cal in the same managed care plan for the dually eligible. This would incentivize provider networks in both programs to reduce avoidable and preventable care in hospitals and nursing homes.

Medicare Part C does not cover much long-term care. In our vision, the expanded Part C would combine Medicare and Medi-Cal in the same managed care plan for the dually eligible. This would incentivize provider networks in both programs to reduce avoidable and preventable care in hospitals and nursing homes.

California is trying to do this as pilot programs in 7 counties under a §1115 waiver format, which keeps Medicare in fee for service mode and Medi-Cal in a managed care format using a partnership of the local managed care plans in each county. We are suggesting that all services and providers need to be a part of the same managed care networks and we think that IHSS and other LTC alternatives need to be part of the expanded Part C. One of the big questions is which managed care plans (Medi-Cal managed care plans or Medicare Part C plans) should undertake this. We would urge that it be open to both types of plans and the state and federal agencies would jointly choose the best qualified. This might reduce the heavy opposition to the Medi-Connect pilots, as Part C is a familiar, trusted and growing option for many seniors and their providers.

Currently, Medi-Cal (or Medicare) covers the costs of long-term care or families pay out of pocket or try to take care of their aging parents at home with little to no financial help from government. Medi-Cal pays for about 70% of nursing home residents. There is a small but growing enrollment in private long-term care insurance and a California Partnership for Long Term Care program that wraps around Medi-Cal. While the need for long-term care can arise at any age from accidents or circumstances of birth, the use of long-term care is most common among the elderly. One approach is to add a California Part E to Medicare that would be financed by sliding fee scale premiums from the elderly, an inheritance tax or a small, dedicated portion of California’s sales tax. Copays and deductibles would be necessary to prevent over-use.


Ibid. 64% of full time workers are covered through employment and 22% are uninsured.

Ibid. 40% of part time workers are covered through employment and 33% are uninsured.

California Health Care Almanac, California Employer Health Benefits Survey: Workers Feel the Pinch (January 2014) at www.chcf.org In addition to a declining rate of coverage, workers are paying a higher share of the premium and having higher copays and deductibles. See Schoen, State Trends in the Cost of Employer Health Insurance Coverage (Commonwealth Fund, January 2015) at www.commonwealthfund.org The decline in offer rates is mostly among employers of less than 50, but the increase in employee costs and out of pocket is among all sizes of employers.

The Affordable Care Act requires employers of 50 of more to offer coverage; the “offer” must be to cover 60% of the cost of the lowest cost bronze plan – a relatively low hurdle. In California, 100% of employers with over 1,000 employees offer coverage; 98% of employers over 200 and fewer than 1000 and 91% of employers over 50 and fewer than 200. California Employer Health Benefits Survey The “employer mandate” for employers over 100 takes effect in 2015 and for employers over 50 in 2016.

The small business tax credits are for 35% of the employers’ premium, but are only good for two years. The tax credits are sliding fee scale so that the smallest and lowest wage employers get the full tax credit, which then phases down and out as wages and employer size increase. See Wulsin, ITUP’s Analysis of Employment-Based Coverage under the Affordable Care Act (ITUP, September 3, 2013) and
We think the model is a good one, but the time frames too short and the credits too small to offset costs for those small employers with very narrow profit margins.


See Cheney, In Hawaii, Firms Like the Long Time Employer Mandate (Politico, Sept. 9, 2013) at http://www.politico.com/story/2013/09/hawaii-employer-mandate-96422.html. The Hawaii mandate extends to employees working with 20 hours or more. Hawaii has the nation’s second lowest uninsured rate, only trailing Massachusetts. See also Brigham, San Francisco’s Leg Up on the Affordable Care Act (ITUP, Feb. 6, 2013) and Wulsin, ITUP Draft Recommendations for the San Francisco Universal Health Council (ITUP, November 27, 2014) at www.itup.org on San Francisco’s fee options for non-offering employers and their employees.

In essence, this comes down to a choice, do we prefer government to pay with direct tax subsidies or do we want employers and employees to pay premiums with indirect tax subsidies? With all the limitations on the ability and willingness to raise taxes at the state and federal level, it seems more prudent to rely on the private sector with appropriate targeted tax subsidies. Employment based coverage is supported by state and federal governments between 30 and 35% of premiums through pre-tax purchasing; self-employed individuals’ premiums are tax deductible. Subsidies are far higher for better-paid workforces due to the effects of the progressive federal and state income taxes. Medicaid and Covered California are supported by the federal and state governments at much higher subsidy rates for low and moderate-income workers. In concert these policies create incentives to create private coverage for middle to upper income employees and to cover low, moderate and middle-income employees through public programs. Congress established the employer mandate at 50 employees to prevent employers from dropping coverage. This creates a subsidy cliff where for small employers, the state and federal governments will pay directly for your low, moderate and middle-income worker’s health coverage up to 50 employees if you do not offer coverage or subsidize indirectly your middle and higher income employees if you do offer coverage. The arguments for exempting small employers are 1) affordability and 2) job creation. The affordability issue is very real for small low wage firms in that family coverage premiums can equal a minimum wage worker’s salary, but it is a red herring as applied to higher wage small employers where pre-tax purchasing offers ample financial assistance to covering the workforce. This issue can be mitigated as described in the next footnote. Comparable cliffs occur wherever the hourly threshold for offering is set – workers above the threshold get the advantages of pre-tax purchasing while those below the threshold must apply for Medicaid or the Exchanges to get some help paying for their coverage. Healthy San Francisco has a better alternative of pro rata contributions per hours worked that both improves program affordability and obviates the incentives to game the system at the cliff edges whether by hours or days worked.

The tax subsidies of pre-tax purchasing increase with increases in employees’ incomes and their marginal tax brackets. Thus the tax subsidies for the CEO’s premiums are far higher than the subsidies for

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the janitor and his/her family. These subsidies could remain linked to the businesses, but turned on their head to give better subsidies to the lower wage workers through a refundable tax credit administered through employer plans that equals a sliding percent of employee wages. Or they could be delinked from employment and simply made available to every American as a contribution towards their costs of coverage as has been proposed by a number of the conservative think tanks, such as Heritage Foundation and American Enterprise Institute. See the excellent analysis detailing many salient issues and design options by Nina Owcharenko, Health Care Tax Credits, Designing an Alternative to Employer Based Coverage, Heritage Foundation Backgrounder #1895 (November 8, 2005) at www.heritage.org/research/reports/2005/11 An interesting variant she discusses is using the refundable tax credits in the small employer market where offer rates are lower. The ACA has such a provision, but it was little used, and past experiments did not yield promising results. See for example, Helms et al, Mending the Flaws in the Small Group Health Insurance Market (Health Affairs, 1992) 11:7-27:doi:10.1337/healthaff.11.3.227 and McLaughlin and Zellers, The Shortcomings of Voluntarism in the Small Group Market (Health Affairs, May 1992) vol. 11 no. 2 28-40, doi: 10.1337.hlthaff.11.2.28 However, if paired with an employer mandate, this could resolve affordability difficulties. Politically, it would be very challenging to shift existing favorable tax benefits from higher to lower wage workforces.

For example, Hawaii sets the employee responsibility for premiums under its employer mandate at 1.5% of wages. By contrast most employers set employee’s responsibilities at a percent of premium, for example 20% for individuals and 30% for families, so that the high wage worker pays the same percent as the low wage working family. In California, the average employee pays 27% of premium or $4,518 towards the cost of their family’s coverage. Plus there is an average annual deductible of $1,069, plus copays and coinsurance. On average, the median income California family pays 9.7% of income towards their share of premium plus their deductible. In Hawaii by contrast, the median family pays 6.0% of family income.

The ACA sets a minimum floor such that the employer must pay 60% of the lowest priced bronze plan – i.e. the employer must contribute towards 36% of the expected medical expenses and the employee is at risk for 64%.

SHOP will expand in 2016 to employers up to 100 and could expand to larger state options. Its choice of plans feature is highly attractive. The challenges are to adopt underwriting reforms so that it is not the bad risk pool for high-risk, high cost businesses and to upgrade its customer service significantly, to offer a full service, highly responsive on-line electronic portal and to increase plan participation. It should over time upgrade its services to offer integrated HR services and 24-hour coverage for small employers.

See Pacific Business Group on Health, 2014 Annual Report at www.pbgh.org PBGH has in the past operated purchasing pools for small employers and for large employers. The challenge is the same as for SHOP, how to avoid becoming the bad risk pool for the industry.

CalPERS purchases for about 39,400 active state and local government employees and 165,000 retirees; about 37% are enrolled in Kaiser and 28% in Blue Shield.

See 2014 Covered California Data, Metal Level by Subsidy Status at www.hbex.coveredca.com/data-research Twenty-seven percent of the unsubsidized chose gold or platinum as opposed only 9% of the subsidized; 7.5% of the unsubsidized chose catastrophic as opposed to 0.5% of the subsidized. 55% of subsidized enrollees have incomes less than 200% of FPL and 45% have incomes between 200 and 400% of FPL.

Terhune, Covered California Renewal Rate Tops 90% (Los Angeles Times, January 28, 2014) at www.latimes.com

Ibid. See also CalSIM Version 1.91

An individual living in San Francisco with income at just above 400% of FPL could purchase the second lowest cost bronze coverage at 16% of income and the second lowest cost silver at 21% of income as opposed to his neighbor with income just under 400% of FPL who pays 9.5% of income while Covered California pays the rest of the premium. At about 250% of FPL, a family loses its Medi-Cal coverage for the children and must pay their premiums through Covered California and the parents lose their tax credit subsidies for out of pocket expenses. At about 138% of FPL, an individual loses fully subsidized Medicaid coverage and has a choice of paying negligible premiums for a bronze plan covering only 60% of expected medical costs or paying 2% of income for the second lowest cost silver plan with cost sharing subsidies that pay for 92% of expected medical costs. We would suggest for example that the tax credits assure that all individuals and families pay no more than 9.5% of income for the premiums of the lowest cost available bronze plan. This could be done as part of a §1332 waiver or through local or state premium
assistance. For the local assistance option, see Coleman, Assistance with Premium Payments and Cost Sharing (ITUP, May 2014) at www.itup.org

There is another affordability cliff or glitch for families who can neither afford their share of employer offered health coverage for the family nor be eligible for premium assistance in Covered California due to the employer offer; it is referred to as the kid glitch, but really is a family cliff/glitch. See Coleman, Children’s Health Coverage under the ACA (ITUP, February 2014) at www.itup.org for a full discussion of this issue.

Bronze currently offers low premiums with high copays and deductibles. This is particularly attractive and appropriate for higher income, healthier individuals; however lower income individuals who were attracted by the low premiums are finding the out of pocket responsibilities so high as to render their coverage unusable. An enhanced bronze would offer the low premiums and a subsidy for out of pocket parallel to the enhanced silver but maintaining the 10% actuarial variance – e.g. if the enhanced silver offered at 93% AV, the enhanced bronze would offer an 83% AV. This could be cost neutral to the federal government and might be an element in a §1332 waiver proposal.

In year 2 (2015), negotiated premium increases averaging 4.2% with some plans offering premium decreases of as much as 8.5%. See Covered California Press Release of July 31, 2014. In Year 1 (2014), Covered California negotiated initial premiums that were between 2% and 30% below the average small business premiums in those regions for 2013. See Covered California Press Release of May 23, 2013 at www.news.coveredca.com See Connolly and Coleman, What’s Ahead for Covered California (ITUP, October 13, 2014) at www.itup.org

PPO networks in Covered California plans have been narrower than those in the pre-existing individual plans. Some of the differences are that the plans may have chosen the provider networks with the best combinations of price, quality and alignment, that doctors were unaware that they had signed up, or that they were reluctant to enroll in a brand new product surrounded by partisan public controversy. It appears that in 2015 the networks are broader due to a higher level of provider comfort with the product, a year’s experience and the efforts of plans to broaden their networks. Covered California’s Medical Advisor indicates that 75% of California physicians are participating in at least one Covered California plan.

Professor Alain Enthoven was a strong proponent of narrow aligned provider networks competing on price and quality – e.g. UCSF would compete with California Pacific Medical Center in San Francisco; Sutter would compete with UC Davis in Sacramento; Mercy, Scripps and Sharp would compete in San Diego, and Cedars Sinai would compete with UCLA in Los Angeles. It is possible but too early to tell whether this is occurring in competitive urban markets under Covered California’s plan offerings. Outside the Covered California market, some plans have been offering benefit designs with tiered networks so that subscribers who choose the highest priced providers pay the incremental cost differences in the form of higher copays or co-insurance.

One approach would be a region-wide local managed care plan like Partnership that already covers many rural counties; that would be our preferred option since a local COHS could reinvest and enhance the local delivery system’s infrastructure. Another would be a public option that pays Medicare rates. A third would be for Covered California to self-insure and set rates in rural communities with no viable competition models at a level comparable to the rest of the state.

See Senators Burr, Coburn, and Hatch plan discussed by Capretta and Antos, A Senate GOP Health Reform Proposal (Health Affairs, Feb. 12, 2014) at www.healthaffairs.org/blog/2014/02/12/ See House Conservatives Submit Bill to Replace ObamaCare (Fox News, Sept. 18, 2013) at www.foxnews.com/politics/2013/09/18 The proposal from the House Republican Study Committee would offer a $7500 tax deduction for every American who purchases insurance through the Exchanges and a high risk pool for those with pre-existing medical conditions. Deductions are not of great value to those who pay low or no income taxes, but are of great value to those in high marginal income tax brackets. Also see Owcharenko, Health Care Tax Credits, Designing an Alternative to Employer Based Coverage.

Schwartz, Two Plans (New York and Minnesota) on the Path to the Basic Health Program (Georgetown Center for Children and Families, April 2, 2014) at www.ccf.georgetown.edu See SB 703 (Hernandez) and Wulsin, ITUP’s Thoughts on the Basic Health Plan Option (Insure the Uninsured Project, May 2, 2012) at www.itup.org

Where Are We Going: Where Should We Be Going?
Leaders such as Vermont’s ex-Governor Howard Dean and Senator Bernie Sanders were strong supporters of the public option (i.e. Medicare) as one of the choices offered through the Exchange. Some of the thinking behind this proposal was that it would promote competition in the marketplaces of the Exchange, would be less administratively expensive and would be highly popular with potential subscribers. The disadvantage is that Medicare is a fee for service system with none of the delivery system advantages offered by the better-integrated care systems already developed and operational in California. An alternative approach is to encourage the development of Co-ops that would be home grown provider networks to compete in rural areas and other communities where there is insufficient competition; Intermountain in Utah or Geisinger in Western Pennsylvania are examples of Co-ops. Co-ops have not as yet been successful under the ACA and their funding has been removed.

Another alternative is the participation of local Medicaid managed care plans; their advantage is that they offer a well-organized existing network with strong local roots and support. As local entities, they can and do re-invest their savings in improved care in the local communities. To date, only local plans from Los Angeles and Santa Clara are participating, but the doors of Covered California are open to these plans. Some of the challenges are the absence of local marketing, unfamiliarity with the high deductible plans such as silver and bronze and my “plate is too full” responsibilities with the expansions of Medi-Cal managed care.

The electronic interfaces between Covered California and Medi-Cal have been a challenge that has eluded an easy technological fix and made it difficult to assure seamless coverage between the two programs, leading to lengthy processing delays and lots of confusion. We would recommend that as CalHEERS improves, it should make the eligibility determinations for all Medi-Cal MAGI cases; its simpler and more accountable.

Due to five decades of important incremental improvements in eligibility, the Medi-Cal program does not readily mesh in a smooth bright line with Covered California. Instead we have children in one program, parents in a different program and pregnant women with opportunities to be in either program. In the past year, the interface for pregnant women was improved so that the enhanced Medi-Cal benefits and lower out of pocket are available as a wrap-around for those with Medi-Cal eligibility who opt for Covered California. Children with incomes up to 250% of FPL are in Medi-Cal while their parents with incomes between 138% and 250% are in Covered California. Our goal should be to re-unite parents and their children in a single program; we will have better medical outcomes when providers are treating the entire family. See Coleman, Children’s Health Coverage under the ACA (ITUP, February 7, 2014) at www.itup.org In the next budget year, Congress has to decide whether to re-authorize the CHIP program, which we hope will go smoothly unlike past debates. The budgetary issues for California are highly consequential – a federal matching rate of 88/12 if the status quo is retained and a potential matching rate of 50/50 if CHIP is not re-authorized. The cost to the California budget is $500 million according to the Legislative Analyst’s Office. See Wulsin, Summary of the Legislative Analyst’s Office November 2014 Fiscal Outlook for the 2015-16 Budget (ITUP, January 5, 2015) at www.itup.org

We think that a clear and consistent bright line is needed with all family members in the same program; a less abrupt cliff between 138% and 193% of FPL is urgently needed as well; and finally we should provide ready opportunity for subscribers to retain plan, provider and course of treatment as their incomes and eligibility fluctuate back and forth between the two programs.

We could use the $1332 waiver option to create a hybrid of the best features of Medi-Cal and Covered California or to create a Basic Health Plan or to create seamless coverage with a clear bright line between the two programs or to give subscribers between 100 and 150% of FPL a choice between the two programs.

SHOP adds real value to the small employer market by offering a choice of plans and refundable tax credits. The refundable tax credits ought to be expanded so that they do not expire after two years and ought to be extended to improve affordability for low wage small employer workforces of up to 50 employees. The offer rates for small, low wage employers are low and that should be a target for improvement. The advantage of an employer offer is that it reaches all employees of the business regardless of their income and immigration status.

Where Are We Going: Where Should We Be Going?
Covered California offers coverage for part time, part year, new hires, laid off and early retirees where most employers do not offer coverage. Employer associations and Covered California will need to work collaboratively to explain these features to the employers and employees. Covered California should also offer the option of “premium assistance” to employers who wish to pay for a share of their flex employees’ premiums through Covered California and we should encourage “premium assistance”. Many small employers offer coverage for their employees, but not their dependents, Covered California needs to work with these small employers to offer dependent coverage for the family members through Covered California while skirts the “family glitch”. Administration of SHOP needs to steadily improve for the employers who select this option. We need to enact underwriting reforms of employers with up to 100 employees so that SHOP does not become a pool for high-risk employers shunned by the commercial market. Ultimately SHOP needs to become so well administered and cost effective that it becomes the on-line shopping destination of choice for most smaller and moderately sized employers and their health plans.

Covered California and the commercial markets have yet to design a good coverage model for rural Californians where there is a dearth of providers, little to no competition, and long travel distances. We would recommend a choice between two options: 1) a single well-integrated local managed care plan, like Partnership, or 2) a model built on Medicare payments and provider networks – the so called public option; we prefer the former.

Payor counties do not cover the undocumented while provider counties for the most part do so. In hybrid counties, the public clinics typically offer services to all regardless of immigration status but do not pay the private sector for their care to the undocumented. In payor counties like San Diego and Orange, the counties operate a residual program for the indigent uninsured eligible but not enrolled in Covered California; subscriber participation is quite small.

In provider counties, the public system must compete successfully in managed care with the private sector for the enrollment of the Medi-Cal subscribers. While there are real advantages of language, culture, geographic location and familiarity in public systems, the system’s disadvantages of high cost, travel, individual provider accountability and excessive dependence on a fee for service oriented reimbursement system must be overcome.

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Ibid. We should consider a choice between two options: 1) a single well-integrated local managed care plan, like Partnership, or 2) a model built on Medicare payments and provider networks – the so called public option; we prefer the former.

AB 85 should provide some of this data for county hospitals. We need to have reliable, verifiable and comparable data on county health systems; this is sorely lacking and impairs the sound policy and decision-making capacity of local, state and federal policy makers.

Ibid. While the county role in indigent health is much diminished, the central local building blocks of behavioral health, public managed care plans and the local health departments are salient, have been and can be further enhanced.

Ibid. San Diego’s County Health Department, advocates and providers are working collaboratively on models of care and wellness for the entire community – Live Well San Diego. Los Angeles Departments of Mental Health, Public Health, Health, LA Care Health Plan, the Sheriff’s Department and local providers and researchers are working closely on the concepts of Health Neighborhoods. Comparable efforts are underway among the local plans, providers and county Departments in the Inland Empire counties.

Ibid; see also Wulsin, Summary of New York’s New DSRIP Waiver (ITUP, July 23, 2014) at www.itup.org The evolving shape of county hospitals will likely vary quite widely; some may become fully integrated competitive delivery systems like Kaiser serving the Medi-Cal and uninsured; others may merge with neighboring non-profits and become community or district hospitals serving local communities that are otherwise without adequate medical care resources; others may become academic medical centers like UCSD, UCI or UC Davis; some might become specialty centers of excellence like Rancho Los Amigos. They are not going to all follow the same evolutionary arc of change. The close funding and delivery system relationships between the community clinics and the county hospitals in Los Angeles (e.g. My Health LA), Santa Clara, Alameda or San Mateo are quite different from Contra Costa, Kern, Ventura or Riverside.
CCS, for example, pays for seriously ill uninsured children regardless of immigration status and for the connective tissue of case management services so that families can get the care their children need. ADAP performs comparable roles for persons with HIV and AIDS. Each program has its network of specialists and its own identity, eligibility and enrollment system.

See Wulsin, Governor’s Proposed Budget 2015-15 – ITUP Summary (ITUP, January 12, 2016) at www.itup.org

Emergency Medi-Cal is the component of the Medi-Cal program that pays for emergencies, deliveries and prenatal care for those not eligible due to immigration status. It makes sense to link its eligibility with programs such as CHDP, CCS, GHPP, Family PACT and Every Woman Counts to organize and simplify the delivery of care to the undocumented. An application for one of these programs should suffice as an application for all. Do we absolutely need separate programs and distinct applications for family planning and prenatal care? Do we truly need separate programs and applications for the screening, diagnosis and treatment and then for treatment of the most costly conditions? Existing programs woven together would cover emergencies, deliveries, family planning, prenatal care, screening and diagnosis for children and treatment of the CCS/GHPP/Breast, Prostate, Cervical Cancer, HIV/AIDS conditions.

Medi-Cal Share of Cost pays primarily for hospital care for those eligible but not enrolled in Covered California. It makes sense to link together the programs for individuals with incomes over 138% of FPL not yet enrolled in Covered California into a single integrated system for care during the interim between open enrollment systems.

We need to disabuse ourselves of the misconception that the general population and the undocumented population understand our health programs and policies and instead simplify them in ways that can be readily communicated and easily administered.

Ibid. SB 4 (Lara) when (and if) it passes and is signed will offer coverage for the undocumented; however the $900 million price tag projected by the Legislative Analyst’s Office is going to need to be reduced substantially for the measure to succeed. Incorporating the niche programs and the special institutional subsidies, such as DSH, could be California’s best way to fund this measure. See Wulsin, Financing Care and Coverage for Those Who are Uninsured and Ineligible for Covered California and Full Scope Medi-Cal due to their Immigration Status (ITUP, October 14, 2014) at www.itup.org

In the interim, we need to integrate existing limited benefit programs as discussed above and build an integrated safety net system that looks more like a managed care system, albeit with holes. We may want to revive the state’s EAPC (Early Access to Primary Care) program, using Prop 99 funds, so we can assure primary care for the remaining uninsured in all 58 California counties and avoid using the emergency room as the venue for primary care needs much better met and at a lower cost in community settings.