The future of Healthy Families: Transitioning to 2014 and beyond

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Urban Institute
Washington, DC

MRMIB Board Meeting
February 15, 2012
Sacramento, CA
Many thanks to the 100% Campaign for supporting our research. And many thanks to the many interviewees and officials who reviewed earlier versions of this presentation.

Neither the Campaign, those interviewees and officials, the Urban Institute, nor any of the Urban Institute’s trustees or funders are responsible for the opinions expressed in this report, which are the presenter’s.
Outline of Presentation

I. Context
II. Summary
III. Research questions and methods
IV. Analysis of scenarios
V. A suggested approach
I. CONTEXT
As the state moves toward full implementation of the Patient Protection and Affordable Care Act (ACA) in 2014, what approach to the Healthy Families Program (HFP) would best meet children’s needs?

Several scenarios have been discussed in the state:

1. *Status quo.* HFP continues as is, for children who will qualify in 2014 and thereafter
   - This is the “baseline” against which other scenarios are compared
2. *Full Medi-Cal shift.* All HFP children move to Medi-Cal
3. *HFP administration shifts to Exchange*
   - HFP remains a separate program, as currently
   - Run by the Exchange Board, rather than the Managed Risk Medical Insurance Board (MRMIB)
4. *Exchange plans provide HFP-level benefits*
   - Commercial plans in the Exchange’s individual market
Which children are most directly affected?

• Background information: Medicaid eligibility under the ACA
  ❖ Medicaid covers children and adults with modified adjusted gross income (MAGI) up to 138% of the federal poverty level (FPL)
  ❖ Maintenance of effort (MOE) requirements forbid reductions in children’s eligibility until 2019

• Who is directly affected by what happens to HFP?
  ❖ Group 1: HFP children not shifted to Medi-Cal
  ❖ Group 2: Medi-Cal children who move to HFP because of MAGI

• Unknown how many children in each group
  ❖ Federal government has not announced “MAGI-equivalent” income eligibility standards for MOE purposes
    ○ Standards for Medi-Cal and HFP could exceed 138% FPL and 250% FPL, respectively
## A hypothetical: How MAGI moves 10-year-old Harriet from Medi-Cal to HFP

<table>
<thead>
<tr>
<th></th>
<th>Harriet</th>
<th>Harriet’s Mom</th>
<th>Harriet’s Step-Dad</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td>$0</td>
<td>$1,110</td>
<td>$1,300</td>
</tr>
<tr>
<td><strong>Eligibility under 2009 rules</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part of Harriet’s household?</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Family size</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household income</td>
<td>$1,110</td>
<td></td>
<td></td>
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<tr>
<td>FPL</td>
<td>90%</td>
<td></td>
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<tr>
<td><strong>Eligibility under MAGI</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Part of Harriet’s household?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Family size</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household income</td>
<td>$2,400</td>
<td></td>
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<tr>
<td>FPL</td>
<td>155%</td>
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*Note: Assumes 2011 FPL levels.*
Unresolved questions

• **Current questions** about the number of children affected by various factors, including:
  - Some aspects of Medi-Cal vs. HFP provider networks and access
  - Early and periodic screening, diagnosis, and treatment (EPSDT)
  - Children losing coverage in transition between programs
  - All family members enrolling in a single plan and program

• **Future uncertainties**
  - Eligibility determination, enrollment, and retention under the ACA
  - The future operation of California’s Exchange
II. SUMMARY OF FINDINGS AND A SUGGESTED POLICY APPROACH
Findings

1. Full Medi-Cal shift (Scenario 2)
   - Major trade-offs – some children gain, others lose
   - Many key questions not resolved by available evidence

2. HFP administration shifts to Exchange (Scenario 3)
   - Not in children’s interests to replace the Managed Risk Medical Insurance Board (MRMIB) with a new, untested body that has challenging missions going far beyond HFP
   - Administrative savings may not be large

3. Exchange plans provide HFP-level benefits (Scenario 4)
   - If commercial plans provide HFP-level benefits and cost-sharing for HFP-level capitated payments, bigger provider networks and better access likely to result
   - Feasibility unknown

Note: our analysis of the Basic Health Program option is not included in this presentation.
A suggested three-part approach: partial shift, monitor, make a bigger decision

1. **Partial shift, with safeguards.** In the near term, shift into Medi-Cal the lowest-income HFP children (i.e., those with incomes at or below 133-150% FPL, under current income rules)

   - Why these children?
     - These are HFP children most likely to receive Medi-Cal starting in 2014
     - Some Medi-Cal advantages are more pronounced for these than for other HFP children

   - Include safeguards to—
     - Improve access to care
     - Test and refine approaches that will be needed for effective ACA implementation in 2014 and beyond
Suggested approach, continued

2. **Monitor**
   - Rigorously and independently evaluate the effects on children who shift from HFP to Medi-Cal
   - Add Medi-Cal mechanisms for robust public reporting
   - Observe the Exchange in operation

3. **Make a bigger decision**, after learning about—
   - Effects of partial shift
   - Exchange implementation
III.

RESEARCH QUESTIONS AND METHODS
Questions

• What advantages and disadvantages do the above-described scenarios present to low-income children?

• Assumptions for purposes of this analysis:
  ❖ HFP children continue to receive HFP-level coverage
    ○ ACA’s MOE rules remain intact
  ❖ Federal allotments under the Children’s Health Insurance Program (CHIP) continue after 2015, with the current Federal Medical Assistance Percentage (FMAP)
Primarily qualitative methods

• Key informant interviews
  - Current and former state and local officials
  - Eligibility contractors
  - Consumer advocacy groups
  - Health plans
  - Providers
  - Academic experts

• Approach
  - Each interview lasted 1 hour or longer (some needed 2 or 3 calls to complete)
  - Most interviews were held in July through October 2011
  - Structured interview protocols addressed each scenario
  - Ground rules
    o No comment will be attributed to a particular informant without that informant’s advance consent
    o All informants will be listed
Interviews outside the 100% Campaign

- Current and former government officials and eligibility contractors
  - Lanee Adams, MAXIMUS
  - Kim Belshé, Exchange Board
  - Janette (Lopez) Casillas and Laura Rosenthal, MRMIB
  - Toby Douglas and Len Finocchio, DHCS
  - Richard Figueroa, MRMIB Board, The California Endowment
  - Cathy Senderling-McDonald, County Welfare Directors Association of California
  - Sandra Shewry, California Center for Connected Health
  - Srija Srinivasan, San Mateo County

- Consumer advocacy groups
  - Beth Capell, Health Access California
  - Jack Dailey, Legal Aid Society of San Diego
  - Erin Aaberg Givans, Children’s Specialty Care Coalition
  - Marilyn Holle, Disability Rights CA
  - Elizabeth Landsberg, Western Center on Law and Poverty
  - Alison Lobb and Suzie Shupe, California Coverage & Health Initiatives

- Health plans
  - Susan Fleischman and Bill Wehrle, Kaiser Permanente
  - Patrick Johnston and Abbie Totten, California Association of Health Plans
  - John Ramey, Local Health Plans of California

- Providers
  - Tahira S. Bazile, California Primary Care Association
  - Charity Bracy, California Children’s Hospital Association

- Academic experts: Andy Bindman, Cathy Hoffman (UCSF)
Quantitative analysis and document review

• Actuarial estimates from Towers-Watson illustrating the difference between HFP-level coverage and subsidies available in the Exchange under the ACA

• Microsimulation modeling, using the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM)

• State and federal administrative data

• Reports and papers analyzing child health issues
IV. ANALYSIS OF SCENARIOS
Scenario #2

THE FULL MEDI-CAL SHIFT: ADVANTAGES, DISADVANTAGES, AND NONFACTORS
Six advantages
1. Coverage and care more affordable

- No copays or premiums < 150% FPL
  - Research shows that, with low-income families—
    - Premiums can reduce enrollment
    - Copays can reduce utilization of necessary care
  - Eliminating premiums should reduce “churning”
    - Cost, disorganization, confusion cause some HFP termination for nonpayment of premiums
  - On the other hand—
    - Some informants report that families like paying HFP premiums as providing a sense of pride and ownership
    - Does such support apply to current HFP premiums?

- If the Center for Medicare and Medicaid Services (CMS) rejects Department of Health Care Services (DHCS) waiver proposal, no copays > 150% FPL

- Medi-Cal covers bills incurred during three months before application
  - Lowers family health care costs
  - Increases providers’ incentive to help with enrollment
  - Unknown how many HFP children incur preapplication bills
2. Fills gaps in employer-sponsored insurance (ESI)

• Legal difference
  ❖ HFP does not cover children who now receive or recently received ESI
  ❖ For children who receive ESI, Medi-Cal—
    o Covers benefits outside the ESI package
    o Pays ESI copays and deductibles
    o Pays worker premiums for Medi-Cal beneficiaries

• Number of children affected
  ❖ In 2007, 5.5% of Medi-Cal children also had ESI, according to DHCS data reported to the federal government (analyzed by Urban Institute)
  ❖ At the higher income levels that apply to HFP, more eligible children could have access to ESI

• Impact on families
  ❖ Children with special health care needs (CSHN) can obtain EPSDT services not covered by commercial insurance
  ❖ Medi-Cal dental/vision coverage could help many children, given the limits that apply under typical ESI
  ❖ Medi-Cal pays some ESI costs charged to low-income families
  ❖ Note: over time, ESI has been getting less generous and more costly to families

• Note: state costs would rise, as some children ineligible for HFP will qualify for Medi-Cal
3. Mental health care

- Consensus of informants: mental health care is covered more broadly by Medi-Cal than by HFP
- Data are consistent with that consensus
  - 6% vs. 2% utilization
  - But data not determinative—populations differ
- Causes
  - In Medi-Cal, EPSDT covers all necessary care
  - County coverage of children with serious emotional disorders (SED) prioritizes Medi-Cal over HFP children
4. EPSDT services (beyond mental health)

• Differences in covered benefits
  - HFP covers most Medi-Cal services, including preventive care
  - The federal EPSDT guarantee gives Medi-Cal children the right to all necessary treatment, including care outside HFP benefits
    - A knowledgeable provider or advocate can use this right to obtain care a particular child needs
    - Systemic advocacy (including litigation) can use EPSDT to secure benefits for numerous children

• Key informants agreed that—
  - Most HFP children are healthy and do not need services outside those provided by HFP plans
  - Many HFP children who need such additional services can receive them through SED and California Children’s Services (CCS)
EPSDT, continued

• Under today’s HFP, which children could benefit from EPSDT?
  ❖ They need services unavailable from HFP plans and HFP carve-outs
  ❖ Under Medi-Cal, they could receive these services because of individual or systemic advocacy based on EPSDT
  ❖ Unclear how many HFP children fit this profile

• EPSDT also protects children from future state benefit cuts
5. One rather than two child health programs

• Some children “lost in transition” between programs
   Happens at initial application and renewal
   “Paper handoff” via Federal Express
   Cushioned by—
    o Unlimited fee-for-service (FFS) transitional coverage in Medi-Cal
    o One month’s transitional coverage in HFP
   National research finds lower participation levels and much higher coverage losses at renewal in states with separate CHIP programs
   Interviewees did not agree on how many California children are lost in transition these days—is the problem significant or small?

• At renewal, fewer demands on families
• In 2014, new subsidies will be offered in the Exchange
   Full Medi-Cal shift will mean two rather than three programs
• Interprogram transitions should improve under ACA—but by how much?
6. More rigorous due process safeguards

• More protections if grievances cannot be resolved amicably
  ❖ Rapid access to in-person hearing
  ❖ Chance to ask questions, review written records

• HFP
  ❖ 2 initial rounds of paper appeals
  ❖ HFP appeals process more confusing, according to some informants
    o More intermediate steps than with Medi-Cal appeals
    o Appeals procedures differ, depending on the issue
  ❖ Almost no hearings

• Unknown how many HFP children need these safeguards
  ❖ Several informants believe that HFP problems are almost always resolved satisfactorily through paper appeals
  ❖ No hard data showing consumer satisfaction with appeals procedures in the two programs
Four disadvantages
1. Smaller provider networks inhibit access

• Areas of agreement
• Areas of disagreement
• Other uncertainties
Areas of agreement

- Historically, HFP has provided better access, according to most informants
  - Many causes, including higher reimbursement for nonclinic providers
- Rural access: By contracting with Blue Cross to use its commercial managed care network, HFP provides better access than Medi-Cal FFS
  - Affects 49,600 HFP children (per Senate Budget Subcommittee)
  - Not just an issue of lower capitated payments in Medi-Cal. With managed care organizations (MCOs):
    - Consumers have a place to get help finding a provider
    - MCOs are subject to provider network requirements
    - Medi-Cal MCOs that lower hospital or other costs can pay doctors > Medi-Cal FFS
Areas of agreement, continued

• Kaiser: major source of HFP care; may not continue to participate in the care of these children at the same level if they move to Medi-Cal
  ❖ Kaiser covered 174,221 HFP children—20% of all HFP children—during the average month in 2010, more than any other plan
  ❖ Less Kaiser participation could trigger broader reductions, given low Medi-Cal reimbursement rates. In deciding how much public coverage to accept, other systems, wanting to do their share but not more than their share, sometimes ask what Kaiser is doing.

• Outside CCS and children’s hospitals, many fewer specialists and private docs in Medi-Cal than HFP, according to multiple informants
Areas of disagreement

• Dental care
  ❖ Different views about which program now provides better access
  ❖ No statistically significant difference in the proportion of children receiving at least one dental service during the year in HFP vs. Medi-Cal (California Health Interview Survey, or CHIS)
    o Just one data point
  ❖ Further wrinkle, could increase access (and state costs) under both programs—
    o Federally Qualified Health Centers may be able to extend relatively high, cost-based clinic rates to community dentists who contract with clinics

• Going beyond dental care, questions about the extent to which—
  ❖ Plans that participate in both programs have different provider networks for each program
  ❖ Gaps between HFP and Medi-Cal reimbursement recently shrank
  ❖ New Medi-Cal members will shift services away from current Medi-Cal kids
Other uncertainties

• Some important numbers are hard to compare
  ❖ Capitated rates
    o HFP does not make rates public
    o Medi-Cal pays family rates, not child rates
  ❖ Plan payments to providers
    o Plans often consider this information proprietary
    o May be able to get information from providers

• Only Medi-Cal will experience a primary care provider bump in 2013-2014
  ❖ Based on 2008 data, some primary care fees will rise by 113%
  ❖ Time-limited: how big an impact on provider networks?

• Further research needed
  ❖ Issues of Medi-Cal provider participation and access are important more broadly than with the proposal to move HFP children to Medi-Cal
Differences in reimbursement levels have apparently eroded in recent years

Changes to average capitated payments, 1998-2011:
HFP vs. Medi-Cal

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>HFP</td>
<td>38% total increase</td>
<td>9% total decrease</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>23% total increase</td>
<td>Average annual increases of 3% to 4%</td>
</tr>
</tbody>
</table>

Note: Does not include costs of CCS and mental health carve-outs.
2. Procedural obstacles to enrollment and retention

• Most informants agree that, overall, county social services offices have provided less streamlined enrollment than HFP’s single point of entry (SPE)
  ❖ Many factors outside county control, including—
    o Complex Medi-Cal eligibility rules for multiple categories
    o State funding levels for administration
  ❖ Retention
    o Percentage of children on program for 18 months
      – HFP: 50%
      – Medi-Cal percentage of poverty children: 40%
    o Why?
      – HFP prepopulates renewal forms with some information
      – HFP contractor paid based on enrollment, so incentive to retain
• Should improve under ACA—but by how much?
3. Loss of MRMIB’s role

Most (but not all) informants found MRMIB’s structure important and positive for children as follows:

• Major focus on children
  - HFP is MRMIB’s largest program
  - By contrast, DHCS has multiple, complex missions

• MRMIB’s monthly meeting structure promotes—
  - Transparency
  - Accountability

• Small state-level agency, relatively nimble, able to innovate
4. Risks of transition

- Many children would need to change plans or providers
  - DHCS: 27-28% of HFP children would need to change plans
  - MRMIB: almost 58% would need to change plans
  - Differences apparently relate to classification of subcontractors
Transition risks, continued

- Some children are likely to fall through the cracks and lose coverage
  - If counties fail to receive necessary resources and implementation time, that would likely increase the number of children who fail to transition smoothly
  - Already, counties receive insufficient administrative resources to fully meet consumer demand
    - Expanding Medi-Cal eligibility should further increase future demand
    - But economic improvement should reduce future demand for other benefits
  - Less work needed, hence fewer transition losses, if counties can use MRMIB findings rather than redetermine eligibility for transferred children

- Time and effort required from many parties
  - E.g., billing mix-ups with providers, address errors, etc.
  - Plans may need to renegotiate provider relationships

- Public confusion a significant possibility, based on past experience, according to several informants
Two nonfactors
1. Medicaid as entitlement

• Theoretical advantages of entitlement program
  ❖ Eligible children guaranteed enrollment—can’t freeze enrollment or create a waiting list
  ❖ Enforceable legal rights under federal law
    ◦ But a pending U.S. Supreme Court case may change this

• In practice, no clear difference
  ❖ Under ACA maintenance of effort (MOE) requirements, the state can’t impose HFP waiting lists, trim eligibility, or raise premiums unless federal CHIP money runs out after 2015
  ❖ Right to sue HFP and Medi-Cal exists under CA law

• But what if Congress repeals the MOE?
  ❖ Moving HFP children into Medi-Cal now would offer only limited protection against future changes to federal law
2. HEDIS and CAHPS indicators show relatively small differences

<table>
<thead>
<tr>
<th>Publicly reported indicator</th>
<th>Medi-Cal</th>
<th>HFP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthcare Effectiveness Data and Information Set (HEDIS): 2009</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent well-care visits</td>
<td>43.1%</td>
<td>46.3%</td>
</tr>
<tr>
<td>Appropriate treatment for children with upper respiratory infection</td>
<td>84.8%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Childhood immunizations, combination 3</td>
<td>74.9%</td>
<td>77.7%</td>
</tr>
<tr>
<td>Well-child visits in 3rd, 4th, 5th, and 6th years of life</td>
<td>76.9%</td>
<td>76.8%</td>
</tr>
<tr>
<td><strong>Consumer Assessment of Healthcare Providers and Systems (CAHPS): 2007</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not a problem getting needed care</td>
<td>80%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Customer service not a problem</td>
<td>79%</td>
<td>78.4%</td>
</tr>
</tbody>
</table>
Additional CAHPS indicators furnished by MRMIB also show little difference

Percentage of English- and Spanish-speaking respondents who report “always”

<table>
<thead>
<tr>
<th>CAHPS indicator: How often—</th>
<th>Medi-Cal</th>
<th>HFP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your child gets care quickly</td>
<td>38%</td>
<td>38%</td>
</tr>
<tr>
<td>Doctors communicate well</td>
<td>55%</td>
<td>57%</td>
</tr>
<tr>
<td>Office staff are courteous and helpful</td>
<td>55%</td>
<td>55%</td>
</tr>
</tbody>
</table>

*Source: MRMIB 2011.*
Quality issues, continued

- Not easy to do “apples to apples” comparisons
  - The two programs use different approaches to reporting common measures
  - Populations vary
- Can’t “zero in” on CSHN—more data needed
- HFP allows a clearer analysis of quality
  - HFP reports individual-level quality data (e.g., age, gender, race, etc.), so one can disaggregate
  - Medi-Cal does not do this
    - Can’t compare, e.g., care received by Spanish-speaking teenage girls in the two programs
  - Bindman and colleagues obtained disaggregated data from Medi-Cal plans
    - Forthcoming publications will show results, potentially including comparisons to HFP
## Scenario 2 summary: Full Medi-Cal shift

<table>
<thead>
<tr>
<th>Advantages for children</th>
<th>Disadvantages for children</th>
<th>Nonfactors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Coverage and care more affordable</td>
<td>1. Reduced access because of smaller provider networks</td>
<td>1. Medicaid entitlement</td>
</tr>
<tr>
<td>2. Fills ESI gaps</td>
<td>2. Procedural obstacles to enrollment and retention</td>
<td>2. Quality indicators</td>
</tr>
<tr>
<td>3. Broader coverage of mental health care</td>
<td>3. Loss of MRMIB’s role</td>
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<tr>
<td>4. EPSDT coverage of all necessary care</td>
<td>4. Transition effects</td>
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<td>5. One rather than two child health programs</td>
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<td>6. More rigorous due process safeguards</td>
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Scenario 3

HFP ADMINISTRATION SHIFTS TO THE EXCHANGE: ADVANTAGES FOR CHILDREN, DISADVANTAGES FOR CHILDREN, AND OTHER FACTORS
Advantages for children

• Children not covered by what may be a smaller MRMIB
  ❖ In 2014, some HFP children will move to Medi-Cal
  ❖ However—
  o Some children will move from Medi-Cal to HFP
  o Some children may move from ESI to HFP
  o Access to Infants and Mothers Program (AIM) may continue, due to federal MOE requirements
  o Other states may continue high-risk pools until Exchanges are seen in operation
  ❖ Size of HFP-eligible population in 2014 affected by MAGI-equivalent thresholds—not yet known

• More continuity with 2 rather than 3 administering agencies—however:
  ❖ Still separate eligibility, plans, and benefits for HFP vs. ACA subsidies in Exchange
  ❖ Continuity should improve under ACA—but by how much?
Disadvantages for children

• Children’s issues may get short shrift
   Some issues will be unique to children in general and HFP children in particular
    ○ Example of latter: MRMIB’s focus on mental health access in HFP
   These issues will likely get less attention from the Exchange Board than from MRMIB, given the Exchange’s other responsibilities

• The Exchange has no track record
   MRMIB runs HFP effectively, according to most informants
   Moving administrative responsibilities to a new and unknown entity is inherently risky
    ○ Risks could be lessened—though not eliminated—by incorporating existing MRMIB staff within the Exchange’s administrative structure
Factors other than children’s well-being

• The Exchange gains leverage to reform health care delivery and lower premiums, since it obtains more covered lives that are attractive to insurers
  ❖ Some interviewees worry that these children may not benefit from this use of their leverage

• Efficiencies from jointly performing common functions
  ❖ Common functions include
    o Enrollment
    o Plan certification and negotiations
  ❖ Some functions differ
    o Many current HFP plans are outside today’s commercial market; some of these plans may not join the Exchange
    o Some important federal requirements and state budget issues are more like Medi-Cal than like commercial coverage
Other factors, continued

- Contrast to efficiencies from a full Medi-Cal shift
  - HFP now mixes commercial and public models
  - That mixture would continue if HFP administration were shifted to the Exchange, lessening efficiency gains
  - If all HFP children shift to Medi-Cal, HFP will lose many commercial features, allowing greater efficiency gains

- Program consolidation and simplicity
How important is program consolidation and simplicity?

• Massachusetts provides a useful example
  ❖ The only state with an ACA-like Exchange
  ❖ Template on which much of ACA was based
  ❖ By far the country’s most successful state in covering the uninsured

• Key “take-aways” from Massachusetts
  ❖ Old programs were retained as new ones were added, like new layers of sedimentary rock
    ○ The result: an incredibly complex program structure
  ❖ Sophisticated enrollment and retention mechanisms created simple and streamlined processes for consumers
  ❖ State very successful in covering residents, lowering administrative costs, and gaining popular support
Some of Massachusetts’s programs

- **Children**
  - MassHealth Standard to 150% FPL, without premiums or copayments
  - The Children’s Medical Security Program (CMSP) to 400% FPL
    - More limited than MassHealth Standard
- **Subsidies for nonpregnant, nondisabled adults under age 65**
  - Parents receive Medicaid up to 133% FPL
  - Premium support for ESI, with some populations
  - Several limited benefit programs for certain categories of unemployed and for people with particular health conditions
  - Other adults qualify for “Commonwealth Care” up to 300% FPL
    - Limited copayments, comprehensive benefits (but narrower than Medicaid)
- “Commonwealth Choice” offers unsubsidized commercial coverage in an Exchange that serves individuals and small firms
- Safety Net program funds uncompensated care
- 2010 state population: 6.5 million—67% the size of L.A. County
Program complexity is not a problem in Massachusetts

• Powerful mechanisms streamline the system for consumers
  ❖ One application form for nearly all programs, including uncompensated care payments to safety net providers
  ❖ One statewide office at Medicaid determines eligibility for all such programs, putting each applicant and family member into the appropriate “bucket”
  ❖ Most applications are filled out, documented, and filed, not by consumers, but on-line by their authorized representatives (AR)
    o Community organizations receive “mini-grants” from state and foundations
    o Providers cannot get paid for a patient’s uncompensated care unless an application is successfully completed for that patient
    o As ARs, community-based organizations, and providers receive correspondence when follow-up is needed

• Results include—
  ❖ Lower per capita administrative costs: before 2006, state more than doubled annual eligibility determinations with a staff increase of < 10%
  ❖ In 2010, < 1% of children and 2% of all residents were uninsured
  ❖ In 2009, reform was supported by 67% of surveyed adults, 52% of employers, and 75% of physicians

THE URBAN INSTITUTE
Scenario 3 summary: HFP administration shifts to the Exchange

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<tr>
<th>Advantages for children</th>
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<th>Other factors</th>
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<td>1. Children not covered by what may be a smaller MRMIB</td>
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Scenario 4

EXCHANGE PLANS PROVIDE HFP-LEVEL BENEFITS AND COST-SHARING: ADVANTAGES FOR CHILDREN, DISADVANTAGES FOR CHILDREN, AND OTHER FACTORS
Background

• Why did Congress choose to continue CHIP, rather than fold CHIP children into the Exchange’s standard subsidy system?

• What is the difference between HFP-level benefits and cost-sharing and the subsidies ACA provides in the Exchange?

• Short answer: CHIP, including HFP, provides low-income children with much more generous subsidies. E.g., family health expenses with ACA subsidies would be:
  - For the average child at 175% FPL, 3 times the cost under HFP
  - For the average child in the top 10% of health care expenses at 225% FPL, 11 times the cost under HFP
More background: effects if various HFP children received only ACA subsidies in the Exchange, 2010

<table>
<thead>
<tr>
<th>Family income</th>
<th>The child’s health care costs</th>
<th>Annual costs a family pays for one child in HFP</th>
<th>Costs in the Exchange, with tax credits and cost-sharing subsidies instead of HFP</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Premiums</td>
<td>OOP</td>
<td>Total</td>
</tr>
<tr>
<td>175% FPL</td>
<td>Average</td>
<td>$153</td>
<td>$43 $196</td>
</tr>
<tr>
<td>225% FPL</td>
<td>Average</td>
<td>$216</td>
<td>$43 $259</td>
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<td>175% FPL</td>
<td>Top 10%</td>
<td>$153</td>
<td>$161 $196</td>
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<tr>
<td>225% FPL</td>
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<td>$216</td>
<td>$161 $259</td>
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Source: Towers-Watson, 2010 (applying HFP 2009 premiums, trended forward with a 6% annual increase, and 2009 HFP OOP cost-sharing). Note: “OOP” refers to out-of-pocket costs. The table shows what would happen if federal law changed, or federal CHIP allotments ended, and California could legally move children from HFP into the Exchange’s individual market, where they would receive the ACA’s standard subsidies.
Going beyond background questions: What would the federal government pay if HFP children were covered through Exchange plans?

• So long as federal CHIP allotments and MOE requirements continue, HFP children are ineligible for tax credits and other federal subsidies in the Exchange

• So Title XXI funding must cover all costs not paid by the family
  ✓ Federal/state cost split is 65/35, as with HFP today
How could Exchange plans serve HFP children without reducing HFP benefits or increasing HFP cost-sharing?

• The Exchange will already be signaling plans about the coverage that particular enrollees must receive
  ❖ Actuarial value and out-of-pocket caps will vary based on income
  ❖ Premiums will vary based on income and potentially other characteristics (including age)
  ❖ Medicare similarly varies coverage among a plan’s members

• With HFP children, the Exchange could tell silver-level plans to apply HFP benefits and cost-sharing limits
  ❖ These plans will already be providing differential coverage to adults with various cost-sharing subsidies
  ❖ Avoids a new HFP “wrap-around” structure
  ❖ CCS and SED continue playing a back-up role, as with current HFP plans

• Federal law may or may not allow Title XXI dollars to cross-subsidize adult coverage
  ❖ Contracts could thus require separate pooling of HFP children
Advantages for children

• Provider networks are likely to be broader with many of the Exchange’s commercial plans than in either HFP or Medi-Cal
  ❖ Our modeling suggests a significant potential difference
• Children more likely to gain access to well-known, mainstream commercial plans
  ❖ Some informants indicate that families feel good about enrolling in such plans
• Many children and parents will be in the same plan and program
  ❖ Not the case for some “blended” immigrant families
• Advantages from Scenario 3 (HFP administration moves to Exchange) apply to this scenario as well
  ❖ Not covered by an MRMIB that may be smaller than today
  ❖ Two programs rather than three in 2014 and beyond
How important is joint family coverage in a single plan?

• No research shows a benefit
  ❖ When parents receive coverage, their children benefit in various ways
  ❖ No evidence of benefit when parents are covered through the *same plan* as their children, rather than a different plan

• Nevertheless, joint coverage would probably help some children
  ❖ Parents need to learn only one health plan’s procedures for accessing care, which could increase access to care
  ❖ Parents must meet just one government program’s requirements for getting and keeping coverage, which could increase enrollment
  ❖ Some parents and children have colocated or common providers
    o Staff-model HMOs, community health centers, and family practitioners
    o Could sometimes allow a common visit for preventive care or a family-wide illness
    o Greater provider knowledge of the entire family could sometimes improve care
    o Unknown: how many parents and children share providers
  ❖ For political viability, health reform needs to make sense to consumers
    o Splitting families among programs reduces credibility – but by how much?
    o Massachusetts uses different programs for children and parents, and reform is very popular

• This scenario still leaves many parents and kids in separate plans. At HFP income levels, most parents are offered ESI that disqualifies them from subsidies in the Exchange.
Disadvantages for children

• Children may lose access to safety net plans
  ❖ Some informants indicate that these plans are better equipped, compared to commercial plans, to address the unique needs of low-income families

• Disadvantages from Scenario 3 (HFP administration moves to Exchange) apply to this scenario as well
  ❖ Exchange less likely to focus on children’s issues
  ❖ Exchange is a new and untested entity
Other factors: feasibility

• Not politically feasible to fund HFP-level benefits at current commercial provider rates, given state budget constraints
  - HIPSM estimates show this would increase state HFP costs by 40%-75%

• Perhaps the Exchange could negotiate with plans to pay HFP-level capitation for HFP children in Exchange for HFP-level benefits provided through the plans’ standard commercial networks
  - Feasibility questions
    - Would plans lose money under this approach? If so, would they find those losses acceptable?
    - Will the Exchange prioritize and have the leverage to succeed on this issue in negotiations with plans?
  - If feasible, this approach might greatly improve access
Other factors from Scenario 3 (HFP administration moves to the Exchange) also apply to this scenario

- Increased leverage for Exchange
- Administrative savings
- Program simplification
Scenario 4 summary: Exchange plans provide HFP-level benefits and cost-sharing

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<td>1. Broader provider networks, better access to care</td>
<td>1. Reduced access to safety net plans</td>
<td>1. Feasibility currently unknown</td>
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<td>2. Better access to mainstream, commercial plans</td>
<td>2. Compared to MRMIB, Exchange is likely to pay less attention to issues unique to children</td>
<td>2. More leverage for the Exchange</td>
</tr>
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<td>3. Covered together with parents</td>
<td>3. Moving HFP administration to an entity with no track record is inherently risky</td>
<td>3. Some administrative efficiencies</td>
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<td>4. Children not covered by what may be a smaller MRMIB</td>
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<td>5. More continuity with two rather than three programs in 2014 and beyond</td>
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• Full Medi-Cal shift
   Some children gain, some lose
   The magnitude of gains and losses is often unclear
• Moving HFP administration into the Exchange: currently not in children’s best interests
• Using the Exchange’s individual plans to provide HFP-level coverage
   Could improve children’s access to care
   Feasibility currently unknown
A SUGGESTED 3-PART APPROACH:

Partial shift, monitor, make a bigger decision
#1: Partial shift, with safeguards—In the near term, the lowest-income HFP children move to Medi-Cal

- Begin with “bright line children,” who have MAGI at or below 138%
  - Can’t currently implement MAGI. Proxy with current income methods.
    - 150% FPL: cost-sharing gains
    - 133% FPL: administrative simplicity, less likelihood of returning to FHP in 2014
  - Most will wind up in Medi-Cal anyway
  - These children are more likely than others to benefit from Medi-Cal
    - Reduces the number of families with children split between Medi-Cal and HFP
    - Copays and premiums will be eliminated for this group, who can least afford them
    - In 2014 and beyond, most of their parents will be in Medi-Cal
  - Less work for counties to handle the shift with lower-income children, as many already have files through—
    - Other family members on Medi-Cal
    - Past Medi-Cal receipt
    - Receipt of other benefits
- With this initial group of children, apply safeguards
  - Use some of the state savings to fund these steps
Safeguards to improve coverage and care for both transition and other Medi-Cal children

1. Medi-Cal managed care plans cover rural areas
   - Blue Cross already contracts with CMSP and HFP, so may be feasible to extend to Medi-Cal children
   - Could consider other managed care arrangements, including primary care case management

2. Satisfactory arrangements developed with Kaiser

3. County performance standards
   - To facilitate transition to 2014, “fine-tune” existing standards related to eligibility determination, enrollment, and retention
   - Publicly report performance by each county and statewide

4. Extend HFP provider search function to Medi-Cal
   - At state website, family can name their plan and obtain a provider list
   - May help with monitoring as well as increasing consumer access

5. Public process at DHCS—e.g., “Advisory Council for Children and Families,” perhaps including key legislators
   - Monthly meetings, modeled after MRMIB
Safeguards, continued

6. Transition management
   - For children with chronic or complex conditions, clinical transitions that retain old providers and treatment regimens for a defined period
   - For counties
     - Adequate funding for increased staffing
     - Adequate time for transition
     - Perhaps through Express Lane Eligibility, authorize reliance on MRMIB findings when making Medi-Cal eligibility decisions
   - Strong system of consumer assistance and public education
   - Retain FFS coverage as a backstop

7. Build toward 2014 eligibility systems
   - Use Medi-Cal/HFP eligibility interface to test and develop strategies for Medi-Cal/Exchange interface
   - Structure new system to build on strengths and avoid weaknesses of current systems
#2: Monitor

- Public reporting of key Medi-Cal statistics, including:
  - Enrollment and retention data
  - Quality data, individualized like HFP
  - Data showing wait times, utilization, and other access measures
- Independently evaluate transition
  - Compare to a control group of children staying in HFP
  - Consider pre- and post-transition encounter data, consumer focus groups, provider/plan surveys, key informant interviews
  - Analyze “spillover effects” on other Medi-Cal children
Monitoring, continued: Do not move children into the Exchange during its first years of operation

• Let the Exchange master its current missions before asking it to serve HFP children
• Let policymakers and the public observe Exchange performance before deciding whether HFP children would benefit from coverage through the Exchange
• See whether the Exchange persuades its individual-market plans to provide HFP children with HFP-level coverage in Exchange for HFP-level capitated rates
#3: Make a bigger decision

- The long-term approach that best serves HFP children will become clearer as policymakers learn more about—
  - What happens with the partial shift from HFP to Medi-Cal
  - How eligibility determination will change under the ACA
  - Whether plans in the Exchange will provide HFP-level benefits through standard commercial networks
  - How the Exchange operates in California
Conclusion

• HFP has generally served low-income children well
• Each approach to change confronts important unresolved questions
• Policymakers seeking to meet the needs of low-income children and families would do well to move cautiously with HFP in the near term as they gather further information that will allow better-informed, potentially bolder choices in the future