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The future of Healthy Families: Transitioning to 2014 and beyond

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**THANK
YOU SO
MUCH!**

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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 towards 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

		Harriet	Harriet's Mom	Harriet's Step-Dad
Income		\$0	\$1,110	\$1,300
Eligibility under 2009 rules	Part of Harriet's household?	Yes	Yes	No
	Family size	2		
	Household income	\$1,110		
	FPL	90%		
Eligibility under MAGI	Part of Harriet's household?	Yes	Yes	Yes
	Family size	3		
	Household income	\$2,400		
	FPL	155%		

Note: Assumes 2011 FPL levels.

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7

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



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II.

SUMMARY OF FINDINGS AND A SUGGESTED POLICY APPROACH

9

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

13

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
 - No comment will be attributed to a particular informant without that informant's advance consent
 - All informants will be listed

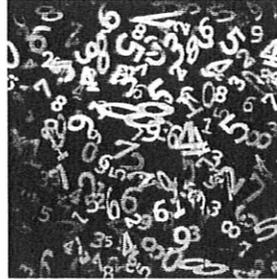


Interviews outside the 100% Campaign

- Current and former government officials and eligibility contractors
 - ❖ Lanee Adams, MAXIMUS
 - ❖ Kim Belshe, 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, CWDA
 - ❖ Sandra Shewry, California Center for Connected Health
 - ❖ Srijia 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, CAHP
 - ❖ John Ramey, Local Health Plans of California
- Providers
 - ❖ Tahira S. Bazile, CPCA
 - ❖ 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.

SCENARIOS

Scenario #2

THE FULL MEDI-CAL SHIFT: ADVANTAGES, DISADVANTAGES, AND NON-FACTORS

19



Six advantages

20

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 non-payment 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 DHCS’s 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 pre-application 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—
 - Covers benefits outside the ESI package
 - Pays ESI co-pays and deductibles
 - 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 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

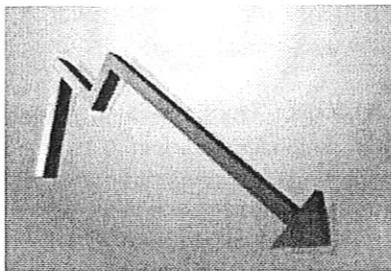


5. One rather than two child health programs

- Some children “lost in transition” between programs
 - ❖ Happens at initial application and renewal
 - ❖ “Paper hand-off” via federal express
 - ❖ Cushioned by—
 - Unlimited fee-for-service (FFS) transitional coverage in Medi-Cal
 - 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
- Inter-program 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
 - More intermediate steps than with Medi-Cal appeals
 - 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 non-clinic 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 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 (CHIS)
 - Just one data point
 - ❖ Further wrinkle, could increase access (and state costs) under both programs—
 - FQHCs 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
 - HFP does not make rates public
 - Medi-Cal pays family rates, not child rates
 - ❖ Plan payments to providers
 - Plans often consider this information proprietary
 - 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, primary care fees will rise by 113 percent
 - ❖ 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

	1998-2008	2008-2011
HFP	38% total increase	9% total decrease
Medi-Cal	23% total increase	Average annual increases of 3% to 4%

Sources: Kronick 2009; MRMIB 2009, 2011; DHCS, 2011.

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—
 - Complex Medi-Cal eligibility rules for multiple categories
 - State funding levels for administration
 - ❖ Retention
 - Percentage of children on program for 18 months
 - HFP: 50%
 - Medi-Cal percentage of poverty children: 40%
 - 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?

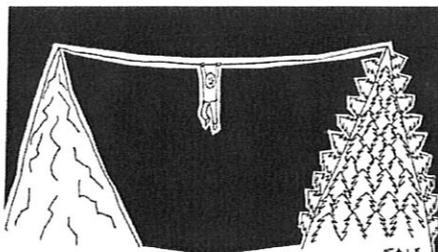
3. Loss of MRMIB's role

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

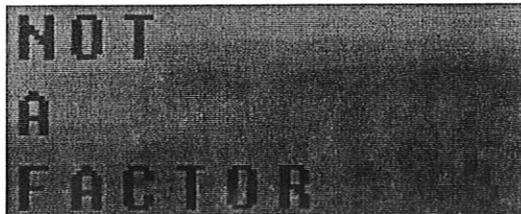


Change is good - it's the transition that'll kill you.

- 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



NOT
A
FACTOR

Two non-factors

39

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 MCL now would offer only limited protection against future changes to federal law

2. HEDIS and CAHPS indicators show relatively small differences

Publicly reported indicator		Medi-Cal	HFP
HEDIS (2009)	Adolescent well-care visits	43.1%	46.3%
	Appropriate Treatment for Children with Upper Respiratory Infection	84.8%	87.2%
	Childhood immunizations, combination 3	74.9%	77.7%
	Well-Child Visits in 3rd, 4th, 5th, and 6th Years of Life	76.9%	76.8%
CAHPS (2007)	Not a problem getting needed care	80%	87.6%
	Customer service not a problem	79%	78.4%

Additional CAHPS indicators furnished by MRMIB also show little difference

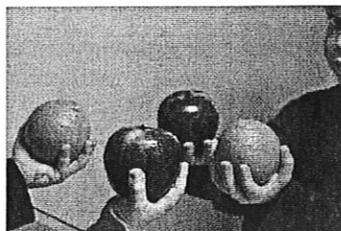
Percentage of English- and Spanish-speaking respondents who report "always"

CAHPS indicator: How often—	Medi-Cal	HFP
Your child gets care quickly	38%	38%
Doctors communicate well	55%	57%
Office staff are courteous and helpful	55%	55%

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

Advantages for children	Disadvantages for children	Non-factors
1. Coverage and care more affordable	1. Reduced access because of smaller provider networks	1. Medicaid entitlement
2. Fills ESI gaps	2. Procedural obstacles to enrollment and retention	2. Quality indicators
3. Broader coverage of mental health care	3. Loss of MRMIB's role	
4. EPSDT coverage of all necessary care	4. Transition effects	
5. One rather than two child health programs		
6. More rigorous due process safeguards		

Scenario 3

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

45

Advantages for children

- Children not covered by what may be a smaller MRMIB
 - ❖ In 2014, some HFP children will move to Medi-Cal
 - ❖ However—
 - Some children will move from Medi-Cal to HFP
 - Some children may move from ESI to HFP
 - AIM may continue, due to federal MOE requirements
 - 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
 - Enrollment
 - Plan certification and negotiations
 - ❖ Some functions differ
 - Many current HFP plans are outside today's commercial market; some of these plans may not join the exchange
 - 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

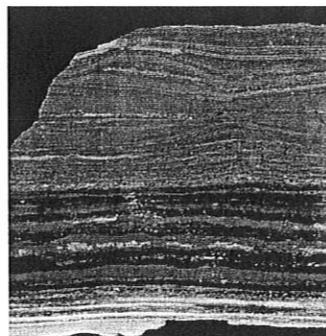
Simplicity
is the ultimate
sophistication.



-Leonardo
da Vinci

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
 - 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' 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 non-pregnant, non-disabled 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 by their authorized representatives (AR), on-line
 - Community organizations receive "mini-grants" from state and foundations
 - Providers cannot get paid for a patient's uncompensated care unless an application is successfully completed for that patient
 - As ARs, CBOs 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

Scenario 3 summary: HFP administration shifts to the exchange

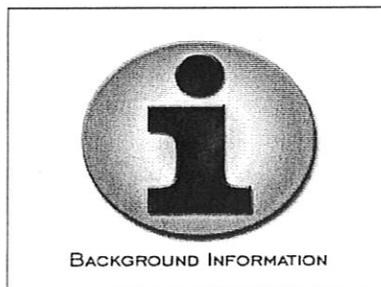
Advantages for children	Disadvantages for children	Other factors
1. Children not covered by what may be a smaller MRMIB	1. Compared to MRMIB, exchange is likely to pay less attention to issues unique to children	1. More leverage for the exchange
2. More continuity with two rather than three programs in 2014 and beyond	2. Moving HFP administration to an entity with no track record is inherently risky	2. Some administrative efficiencies for state 3. Simpler overall program structure

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



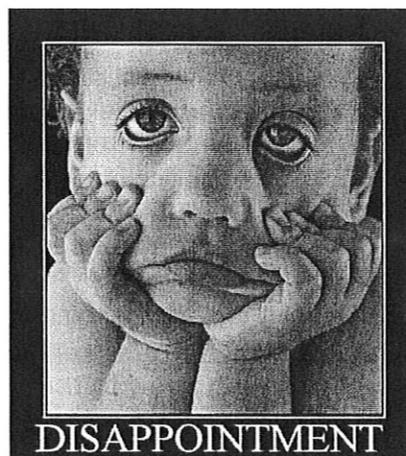
More background: effects if various HFP children received only ACA subsidies in the exchange, 2010

Family income	The child's health care costs	Annual costs a family pays for one child in HFP			Costs in the exchange, with tax credits and cost-sharing subsidies instead of HFP		
		Premiums	OOP	Total	Premiums	OOP	Total
175% FPL	Average	\$153	\$43	\$196	\$285	\$279	\$564
225% FPL	Average	\$216	\$43	\$259	\$513	\$579	\$1,092
175% FPL	Top 10%	\$153	\$161	\$196	\$285	\$1,255	\$1,540
225% FPL	Top 10%	\$216	\$161	\$259	\$511	\$2,355	\$2,866

Source: Towers-Watson, 2010 (applying HFP 2009 premiums, trended forward with a 6% annual increase, and 2009 HFP OOP cost-sharing). Note: 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
 - ❖ AV and OOP maximums 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 a 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 and essential care, 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 co-located or common providers
 - Staff-model HMOs, community health centers, and family practitioners
 - Could sometimes allow a common visit for preventive care or a family-wide illness
 - Greater provider knowledge of the entire family could sometimes improve care
 - Unknown: how many parents and children share providers
 - ❖ For political viability, health reform needs to make sense to consumers
 - Splitting families among programs reduces credibility – but by how much?
 - Massachusetts uses different programs for children and parents, and reform is very popular

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

Advantages for children	Disadvantages for children	Other factors
1. Broader provider networks, better access to care	1. Reduced access to safety net plans	1. Feasibility currently unknown
2. Better access to mainstream, commercial plans	2. Compared to MRMIB, exchange is likely to pay less attention to issues unique to children	2. More leverage for the exchange
3. Covered together with parents	3. Moving HFP administration to an entity with no track record is inherently risky	3. Some administrative efficiencies
4. Children not covered by what may be a smaller MRMIB		4. Simpler overall program structure
5. More continuity with two rather than three programs in 2014 and beyond		



- 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

V.

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 HFP 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 eliminated
 - 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 towards 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

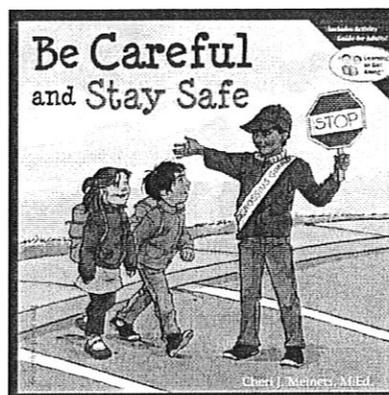
#2: Monitor

- 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



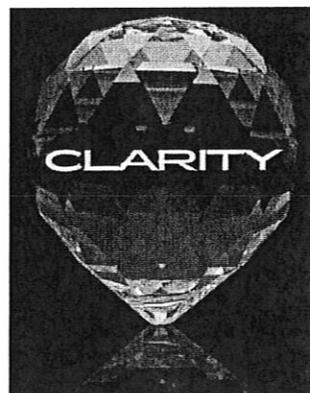
Monitoring, continued: Do not move children into the exchange during its first years of operation

- 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
- Our analysis is still a work in progress—feedback welcomed!

The future of Healthy Families: Transitioning to 2014 and beyond

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February 2012



Summary

Urban Institute researchers were asked to analyze the effects on low-income children of various possible scenarios for the future of the Healthy Families Program (HFP). After interviewing stakeholders and officials, reviewing state and federal data, and analyzing applicable literature, we concluded:

- If all HFP children moved to Medi-Cal, some would benefit and others would suffer, but the precise balance of gain and loss is uncertain.
- Low-income children would probably not benefit from keeping HFP as a separate program while moving HFP administration to the California Health Benefit Exchange (Exchange). With all of its other responsibilities, the Exchange Board is unlikely to give low-income children's unique issues the same focus that the Managed Risk Medical Insurance Board (MRMIB) now provides.
- If the Exchange's commercial plans furnish HFP-level benefits to HFP children, provider networks could greatly broaden, improving children's access to care. However, the feasibility of this arrangement is currently unknown.

Accordingly, we suggest the following approach:

- In the short-term, shift the poorest HFP children into Medi-Cal. With incomes at or below 133 or 150 percent of the federal poverty level (FPL), these are the children most likely to benefit from the move, among other reasons because Medi-Cal will not charge them premiums or copayments. Most such children will be required, under federal law, to receive Medi-Cal beginning in 2014. We suggest accompanying this shift with measures for safeguarding access to care and rigorously monitoring the results.
- Do not move HFP children into the Exchange until it has a chance to master its mandated tasks. Monitor whether the Exchange can persuade commercial plans to accept HFP-level payments for providing HFP children with HFP-level coverage.
- If experience with the poorest HFP children suggests that the remainder would benefit from Medi-Cal, consider moving the entire HFP population to Medi-Cal. If the Exchange appears likely to improve access to care by offering commercial provider networks without cutting HFP benefits or increasing costs to HFP families, consider shifting HFP children into the Exchange. If neither alternative seems better than the current arrangement, keep the remaining children in HFP.

The future of Healthy Families: Transitioning to 2014 and beyond

Introduction

Health care policymakers in California and many other states have two pressing priorities: implementing the Patient Protection and Affordable Care Act (ACA), much of which becomes effective in 2014; and addressing state budget woes.

In both contexts, the state's leaders have been wrestling with the fate of the Healthy Families Program (HFP). Four basic scenarios were under consideration in Spring and Summer 2011:

1. ***The status quo: HFP continues as is, for children who will qualify in 2014 and thereafter.***
2. ***Full Medi-Cal shift: All HFP children move to Medi-Cal. Under this scenario, HFP ends.***
3. ***HFP administration shifts to the Exchange: HFP continues as it is today, a stand-alone program. However, it is administered by the California Health Benefit Exchange (Exchange) Board, rather than the Managed Risk Medical Insurance Board (MRMIB).***
4. ***Plans in the Exchange provide HFP coverage to HFP children. Under this scenario, HFP children enroll in the same plans that serve the Exchange's individual market. These plans provide HFP children with HFP benefits and cost-sharing protections.***

In mid-2011, the 100% Campaign, a collaborative effort of The Children's Partnership, Children Now, and Children's Defense Fund-California, commissioned researchers at the Urban Institute to analyze these scenarios and identify their advantages and disadvantages for low-income children. On December 14, 2011, researchers presented their findings, which are summarized here. The full, detailed presentation is available for download at <http://bit.ly/UrbanInstitute1>.

We begin this Issue Brief by explaining our research methods and the policy context for this analysis. We then describe our findings about the effects of each scenario that involves a change from the status quo. We conclude by suggesting a policy direction that, in view of our findings, could safeguard and improve low-income children's access to essential health care.

Research methods

With each above scenario, we analyzed its advantages and disadvantages for low-income children. We generally did not focus on other factors, such as state budget effects, except where they made particular policy approaches clearly unfeasible.

Our primary research strategies were qualitative. We interviewed more than 20 key informants, who are listed in the Appendix to this Issue Brief. They included current and former state and local officials, eligibility contractors, consumer advocacy groups, health plans, providers, and academic experts. Structured interview protocols addressed each scenario. Each interview lasted at least an hour. The interviews were conducted by telephone during July through September 2011. In addition, we reviewed federal and state administrative data and reports about child health issues nationally and in California. We also conducted microsimulation modeling using

the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) and obtained actuarial estimates from Towers Watson.

The policy context

After the ACA is fully implemented, two groups of children will be affected by today's decisions about the future of HFP:

- HFP children whom the ACA will not require moving to Medi-Cal; and
- Medi-Cal children whose income, under the ACA's new eligibility methodologies, will exceed Medi-Cal's maximum income thresholds and so will transfer to HFP.

Under the ACA, some HFP children will shift to Medi-Cal in 2014. Medicaid eligibility nationally will rise to 138 percent of the federal poverty level (FPL), causing Medi-Cal to become responsible for the lowest-income children who qualify for HFP under current law.

At the same time, some Medi-Cal children will move to HFP, because current methods will no longer determine family income. Instead, income will be defined in terms of Modified Adjusted Gross Income (MAGI), which is based on federal income tax principles. Accordingly, some of today's Medi-Cal children will be found to have higher family income that qualifies them for HFP.

Because the federal government has yet to finalize applicable rules, we do not yet know how many children will move in each direction. The ACA's maintenance-of-effort (MOE) provisions require Medi-Cal to continue its 2009 eligibility for children until 2019. To accomplish this goal while shifting income determination methods to MAGI, the Center for Medicare and Medicaid Services (CMS) will produce guidelines for states to develop "MAGI-equivalent standards." These standards will limit the number of children who lose Medi-Cal because of the change to MAGI. Only after CMS's guidelines are published can Californians determine the precise income level at which Medi-Cal eligibility will end and HFP eligibility will begin. Once that threshold becomes known, it should be possible to estimate the number of children who would move in each direction if HFP coverage is preserved to the maximum extent permitted by the ACA.

Findings

Based on our interviews with key informants as well as our analysis of available data and documents, we made the following findings about each scenario.

Scenario 1: Status quo

The first scenario—the "status quo"—is the baseline against which we compared all other scenarios.

Scenario 2: Full Medi-Cal shift

If all HFP children shifted to Medi-Cal, some would gain and others would lose. It is not clear whether, on balance, benefit or harm would predominate. Following are some potential advantages and disadvantages to shifting all HFP children into Medi-Cal.

Advantages for low-income children

Affordability

Medi-Cal coverage would be more affordable than HFP for many children. Those in families with incomes at or below 150 percent of FPL would no longer be charged premiums and copayments, which could improve participation levels and access to care. Much research finds that even modest cost-sharing can reduce enrollment and delay or prevent utilization of necessary care. Those above 150 percent FPL will be charged premiums, whether they stay in HFP or move to Medi-Cal. However, such children will be relieved of copayments unless CMS approves California's proposed waiver to charge copayments to children in this higher income band.

Filling gaps in employer-based coverage

HFP disqualifies children who receive employer-sponsored insurance (ESI) either at the time of application or during the three previous months. By contrast, Medi-Cal supplements ESI benefits and pays ESI cost-sharing. In 2007, 5.5 percent of Medi-Cal children also had ESI, so this is not an uncommon situation. If Medi-Cal's income threshold rose to HFP levels, children who receive ESI and so are now barred from HFP would instead qualify for Medi-Cal supplementation of ESI, which could yield important gains:

- Children with special health care needs (CSHCN) would receive Medi-Cal benefits that are not covered by employer plans.
- Most children would qualify for much broader coverage of dental and vision care. ESI typically covers these benefits sparingly, if at all.
- Medi-Cal would lift financial burdens from low-income families by paying their ESI-related premiums and out-of-pocket cost-sharing, which have generally risen in recent years.

Mental health care

Compared to HFP, Medi-Cal provides better coverage of and access to mental health treatment. As guaranteed by federal law, Medi-Cal covers "Early and Periodic Screening, Diagnosis, and Treatment," or EPSDT. This includes coverage of all medically necessary care that is potentially reimbursable under the federal Medicaid statute. EPSDT provides a broader scope of mental health coverage than is offered by HFP. This comparative assessment includes not just HFP health plans but also HFP's contracts with county mental health departments to provide additional services to children with Serious Emotional Disturbance (SED). In addition to EPSDT's broader coverage, state officials report that county SED programs prioritize treatment of Medi-Cal children over treatment of HFP children.

More comprehensive benefits

Going beyond mental health care, EPSDT offers broader coverage than is available through HFP. That said, most Medi-Cal services, including preventive care, are also covered by HFP health plans. The latter plans' benefits meet the needs of most children, who are healthy. When CSHCN need additional benefits, they can often obtain them through HFP's supplemental "carve-out" contracts with counties to serve SED children and with the California Children's Services (CCS) program. Outside the mental health context, it is not known how many HFP children would benefit from EPSDT because they need services that are covered neither by HFP health plans nor the SED and CCS carve-outs.

Continuity of coverage

Serving low-income children through one rather than two programs would prevent children from "falling through the cracks" when they transition between programs. Such transitions happen today when families apply to one program but qualify for the other; when family income changes and eligibility shifts between programs; and when 5-year-olds with family incomes between 100 and 133 percent FPL celebrate their sixth birthdays. However, the number of children who currently lose coverage during such transitions is unknown, and the ACA's more streamlined and electronic administrative methods are likely to reduce the coverage gaps that accompany transitions between programs.

Stronger appeals mechanisms

Grievance and appeal procedures are more rigorous in Medi-Cal than in Healthy Families. Medi-Cal hearings are immediately available when families want to challenge a decision, and families can use those hearings to question decision-makers and review the records on which adverse decisions were based. However, it is not clear how many HFP children need these safeguards. According to several informants, HFP's hands-on approach to resolving beneficiary grievances leaves very few families with unresolved problems.

Disadvantages for low-income children

Reduced access to providers

Many HFP children would see their access to providers diminish under Medi-Cal. The latter program's provider participation shortfalls result in significant part from Medi-Cal's lower reimbursement rates. Outside of children's hospitals and CCS, fewer private physicians and specialists participate in Medi-Cal than HFP. Nearly 50,000 HFP children in rural areas would experience reduced access to providers if they moved from HFP managed care to Medi-Cal fee-for-service care. In addition, Kaiser Permanente covered 174,221 HFP children—20 percent of all HFP children—during the average month in 2010, more than any other plan. Kaiser may not continue to participate in caring for these children at the same level if they move to Medi-Cal.

On the other hand, differences between Medi-Cal and HFP payment levels eroded in recent years. Between 2008 and 2011, Medi-Cal capitation rates increased by approximately 3 to 4 percent annually, while HFP rates fell by a total of 9 percent. Our informants disagreed about which program provides superior access to dental care and the extent to which plans that participate in both programs have significantly different provider networks for Medi-Cal and HFP; available data do not resolve these disagreements. And while the ACA provides increased reimbursement for Medi-Cal coverage of certain primary care services in 2013-2014, it is not

clear how much impact this time-limited and targeted “bump” will have on Medi-Cal’s delivery system.

More cumbersome enrollment and retention procedures

For most families, enrollment into and retention of coverage is harder with Medi-Cal’s county-based eligibility system than with HFP’s single-point-of-entry. Much of this difference results from county obligations to administer a significantly broader range of eligibility categories than applies to HFP. County-based enrollment and retention is likely to improve under the ACA, but the full extent of that improvement is not yet known.

The loss of MRMIB

If HFP was replaced by Medi-Cal, children would lose the benefit of MRMIB, which most informants saw as a positive force for children. With HFP as its largest program, MRMIB has a focus on children’s needs that is not possible for the Department of Health Care Services (DHCS), given the latter’s multiple, complex responsibilities. MRMIB’s monthly, public meeting structure promotes transparency and accountability, and as a small and independent agency it has been nimble and innovative throughout much of its history.

Risks of transition

Whether or not children would ultimately be better off in Medi-Cal, the transition process will be disruptive and potentially problematic for many children. More than a quarter of HFP children will need to change health plans (and perhaps providers as well). In addition, some children will experience gaps in coverage as the state and counties attempt to transfer them between programs.

Factors that are not highly consequential

Medi-Cal as an entitlement program

Medi-Cal is an entitlement program, which means that eligible people are guaranteed benefits and cannot be placed on waiting lists. But under the ACA’s MOE requirements, HFP cannot, until 2019, put children on a waiting list, increase premium charges above a specified level, or take other steps that would reduce enrollment. So long as the MOE remains in place, it is the functional equivalent of entitlement status for HFP.

Currently reported performance measures

To the limited extent that publicly reported quality and access measures for Medi-Cal and HFP allow “apples to apples” comparisons, such measures do not show significant differences between the two programs.

Scenario 3: HFP administration shifts to the Exchange

Moving HFP administration to the Exchange while retaining HFP as a separate program has disadvantages for low-income children that outweigh applicable advantages, based on what we know today.

Advantages for low-income children

A higher-profile administrative agency

HFP might benefit from being housed in a larger, more powerful entity. In 2014 and beyond, the Exchange is likely to be a much bigger force than MRMIB, which will probably have fewer responsibilities than it does today.

Fewer agencies determining eligibility

Moving HFP administration to the Exchange would reduce the number of entities determining eligibility. Rather than DHCS, MRMIB, and the Exchange each playing a role, only DHCS and the Exchange would be involved. However, under the ACA, California may implement a single, integrated system of eligibility determination. Such a system could limit disruptions in coverage that otherwise might result from one additional administrative agency.

Disadvantages for low-income children

Less focus on children

The Exchange is unlikely to give the kind of attention to children's issues that MRMIB now provides, as HFP is MRMIB's largest program. The Exchange will have a broader mission, wider-ranging responsibilities, and a daunting workload in preparing to "go live" by late 2013. Unique issues involving low-income children's health care could easily suffer from relative inattention.

An administrative agency that has not been observed in operation

The Exchange does not yet have a track record. Shifting program administration to an entity whose performance has not yet been observed is inherently risky. If MRMIB were performing poorly, the risk might be worth considering, but the vast majority of our informants viewed MRMIB as doing a good job with HFP.

Factors unrelated to low-income children's health care needs

Although our research focused on each scenario's effects on low-income children, our key informants touched on other issues as well.

Increased leverage for the Exchange

Giving the Exchange the responsibility to administer HFP, along with its other roles, would give the Exchange control over more covered lives that appeal to insurers. This added leverage could help accomplish the Exchange's ambitious objectives for transforming California's insurance markets and health care delivery system.

Administrative efficiency

Administrative efficiencies could result from moving HFP administration into the Exchange, as common functions could be performed centrally. However, important aspects of HFP are unique and will probably require distinct administrative systems. For example, federal Medicaid requirements increasingly apply to HFP health plans. These requirements are quite different from the rules that govern private markets.

Simplicity

Health coverage programs in California would be simpler with just Medi-Cal and the Exchange, rather than Medi-Cal, HFP, and the Exchange. However, simplicity's advantages can be overstated. For example, Massachusetts's health benefits are highly complex, including multiple programs for children and many different programs for adults, in a state with two-thirds the population of Los Angeles County. But that state has been quite effective in covering its residents, despite those complications. In Massachusetts, 98 percent of nonelderly residents are insured, including more than 99 percent of children; and 67 percent of residents support the state's reform efforts.

Scenario 4: Plans in the Exchange provide HFP coverage to HFP children

Under this scenario, the health plans that offer individual coverage through the Exchange would give HFP children HFP-level benefits and cost-sharing protections. Additional services would remain available through the same SED and CCS carve-outs that today “backstop” HFP’s capitated plans.

The factors listed above in connection with Scenario 3 would apply to this scenario as well. But additional factors, described below, create the possibility of significant net gains for low-income children. The main question about this scenario involves its feasibility.

Advantages for low-income children

Broader provider networks

The most important potential advantage is that commercial coverage could substantially broaden the provider networks that are available to HFP children. This is suggested by HIPS modeling results, described below. However, additional research is needed to confirm the differences between provider participation in HFP and the kind of commercial coverage that will be offered in the Exchange.

Branded commercial coverage

This scenario would likely increase children’s access to “mainstream” commercial plans, which many low-income families value.

All family members within the same health plan

This scenario would permit a family with income above Medi-Cal levels to enroll both parents and children in a single health plan. While this result has considerable intuitive appeal, the extent to which children actually benefit from such “family unity” is unclear. Much research shows that children gain when their parents receive coverage. No research shows any added benefit from serving children and parents through the same plan, rather than two different health plans.

Despite the absence of conclusive research, some children would gain from being covered together with their parents. It is true that many if not most families have children and parents who see different providers. However, with family practitioners, general practitioners, community health centers, and staff-model HMOs, the identical or co-located providers may serve all family members. In such cases, covering parent and child in the same plan may allow simultaneous family visits. Care might improve, based on a provider’s knowledge of total family dynamics. If a parent needs to learn just one health plan’s procedures for obtaining covered services, access barriers would be lowered. And health reform may enjoy more credibility with the public if it does not force parents and children into different plans or coverage systems. On the other hand, such bifurcation of coverage did not preclude public support in Massachusetts, as indicated earlier.

Finally, many if not most HFP children have parents who are offered ESI that meets the ACA’s standards for affordability and minimum value. These parents will be ineligible for subsidies in the Exchange and so will be limited to ESI, as a practical matter. Such parents and their children are likely to be enrolled in different plans, whether HFP remains separate or moves to the Exchange.

Disadvantages for low-income children

Diminished access to safety-net coverage

In addition to the disadvantages described above in connection with Scenario 3, this scenario could reduce HFP children's access to safety-net plans that choose not to join the Exchange. According to some observers, such plans offer unique expertise in meeting the needs of lower-income families.

Feasibility

The biggest concern about this scenario involves its feasibility. It is not realistic to fund HFP-level benefits at current commercial provider rates, given state budget constraints. HIPSM estimates show this approach would increase state HFP costs by between 40 percent and 75 percent. However, the Exchange might be able to persuade its individual market plans to accept HFP-level capitated payments to provide HFP children with HFP-level coverage through the plans' standard commercial networks, using SED and CCS as residual sources of additional coverage for which plans are not responsible. It is currently unknown whether insurers would find this arrangement acceptable; whether the Exchange would view this as a priority in negotiations; and whether the Exchange's overall negotiating leverage would suffice to obtain health plans' agreement.

A suggested policy direction

Based on the above analysis, a three-step approach could maximize low-income children's gains and limit their risks.

Step 1: Shift the poorest HFP children to Medi-Cal, with safeguards to protect access to care and lay the groundwork for a successful transition to the ACA's streamlined eligibility procedures

The lowest-income HFP children—namely, those with incomes, as currently measured, at or below 133 or 150 percent FPL—would soon move to Medi-Cal, under our suggested approach. These are the HFP children most likely to benefit from Medi-Cal's absence of premiums and copayments. Shifting such children into Medi-Cal would also improve continuity of coverage, since children would no longer be forced to move from Medi-Cal to HFP on their sixth birthday. Further, the ACA will require transferring most of these children to Medi-Cal in 2014.

Our suggested shift of the lowest-income HFP children to Medi-Cal would be accompanied by the following policies to safeguard access to care and ease the transition to 2014:

- Medi-Cal managed care expands to include rural counties, perhaps using primary care case management or building on existing Blue Cross contracts with HFP and the County Medical Services Program.
- DHCS develops arrangements with Kaiser Permanente that continue the insurer's current general level of service to low-income children.
- County performance standards are updated to facilitate the transition to ACA's streamlined procedures for enrollment and retention, and each county's performance is publicly reported.
- The HFP provider search function extends to Medi-Cal, allowing both consumers and policymakers to assess the breadth of provider networks.
- A public process at DHCS—for example, an “Advisory Council for Children and Families” that includes key legislators, stakeholders, and experts—meets monthly and incorporates the transparency, accountability, and focus on children's needs now provided by MRMIB's regular monthly meetings.
- Disruptive transitions are avoided by—
 - For children with chronic or complex conditions, retaining former providers and treatment regimens for a defined period after the children move from HFP to Medi-Cal;
 - Increasing county capacity to handle the transition by providing adequate state funding for increased staffing, sufficient time to process incoming children, and, perhaps through Express Lane Eligibility, determining children's eligibility based on MRMIB's prior findings rather than requiring counties to reevaluate each case;
 - Supporting a strong system of consumer assistance, public education, and outreach to parents and providers; and
 - Offering fee-for-service care as an interim “fallback system” for children who temporarily lack other sources of coverage.

- To lay groundwork for the streamlined eligibility that ACA will require as of 2014—
 - Use the Medi-Cal/HFP eligibility interface to test and refine strategies for the future, much larger interface between Medi-Cal and the Exchange; and
 - Analyze both strengths and weaknesses of current county-based eligibility and MRMIB’s single-point-of-entry, then design 2014’s new systems to replicate prior successes and avoid past problems.

Step 2: Intensively monitor Medi-Cal’s transition and the Exchange

With intensive monitoring of what happens to the low-income children who shift from HFP to Medi-Cal, policymakers could learn whether, on balance, such a change is helpful or harmful. The suggested monitoring includes collection and public reporting of Medi-Cal data illuminating access to care, such as information about enrollment and retention, wait times, and utilization. In addition, independent evaluators could assess what happens to children shifted from HFP to Medi-Cal, comparing these children to slightly higher-income children who remain in HFP. This comparison could include health plan encounter data, consumer focus groups, surveys of providers and plans, and key informant interviews.

At the same time, the approach we suggest would keep children out of the Exchange until it has had a chance to master its basic responsibilities and has been observed in operation. Particularly important issues to track include the breadth of provider networks offered by the Exchange’s commercial plans; and whether the Exchange successfully negotiates with these plans to accept HFP-level payments for providing HFP children with HFP-level benefits and cost-sharing protections.

Step 3: Make a broader decision about the fate of HFP children

The suggested monitoring will help policymakers make a wise decision about the coverage that would best serve HFP children, over the long term. If it turns out that the HFP children transferred to Medi-Cal experience an overall improvement in access to care, policymakers could consider moving the remaining children to Medi-Cal. If it turns out that the Exchange’s commercial plans offer provider networks significantly broader than HFP networks and that the Exchange can persuade such plans to use these networks as the delivery system for HFP-level coverage, policymakers could improve HFP children’s access to care by moving them into the Exchange’s individual market. If both alternatives appear superior to the current HFP, policymakers would need to weigh their comparative advantages in deciding which direction to take. But if it turns out that HFP children would not benefit, on balance, from being switched to Medi-Cal and the Exchange does not offer realistic prospects for higher levels of provider participation, HFP could remain in place for low-income children who are not moved to Medi-Cal by the ACA.

Conclusion

Most of our interviewees viewed HFP as a successful program that does a good job meeting the needs of low-income children. Policymakers interested in safeguarding such children's access to essential health care would thus do well to move conservatively in restructuring HFP coverage, particularly given the limits on current knowledge about the relative merits of HFP, Medi-Cal, and the Exchange.

Our suggested approach would shift some children from HFP to Medi-Cal in the near-term, carefully monitoring how such children fare and how the Exchange unfolds. This would strengthen the state's knowledge base to allow a better-informed future decision about how best to meet HFP children's health care needs in the transformed health coverage system that will operate in 2014 and beyond.

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About the 100% Campaign

The 100% Campaign (www.100percentcampaign.org) is a collaborative effort of The Children's Partnership, Children Now, and Children's Defense Fund-California, created in 1998 to ensure that all of California's children obtain the health insurance they need to grow up strong and healthy.

Appendix: List of interviewees

- Current and former government officials and eligibility contractors
 - ❖ Lanee Adams, MAXIMUS
 - ❖ Kim Belshé, California Health Benefit Exchange Board Member
 - ❖ Janette (Lopez) Casillas and Laura Rosenthal, Managed Risk Medical Insurance Board
 - ❖ Toby Douglas and Len Finocchio, Department of Health Care Services
 - ❖ Richard Figueroa, Managed Risk Medical Insurance Board Member, The California Endowment
 - ❖ Cathy Senderling-McDonald, County Welfare Directors Association
 - ❖ 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 California
 - ❖ 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: Andrew Bindman and Catherine Hoffman, University of California at San Francisco
- Philanthropy: Eugene M. Lewitt and Liane Wong, David and Lucille Packard Foundation

Important note: Inclusion in this list should not be construed as representing agreement with any of the above findings or suggestions. In addition to the individuals and organizations listed in this Appendix, Urban Institute researchers interviewed staff from each of the 100% Campaign’s partner agencies—The Children’s Partnership, Children Now, and Children’s Defense Fund-California.

