

The Washington Post

Employers save \$422 billion if they dump health coverage. Will they?

By Sarah Kliff, Published: May 1 | Updated: Wednesday, May 2, 6:00 AM

In the health reform debate, there's a lot of crystal-ball gazing about what employers will do when, in 2014, tens of millions of Americans become eligible for publicly-subsidized health insurance. Will they continue paying for workers' health plans, as they've done for decades? Or, will they save a lot of cash, and let the government fill that role?

A new report, out Tuesday from Republicans on the House Ways and Means Committee, estimates that America's 100 largest companies could save a collective \$422 billion over a decade.

Financially, there's a lot at stake. If workers use public subsidies at a higher rate than expected, the cost of Obamacare could skyrocket. So the looming question is: What will these large companies do?

To understand that — and game out whether large companies will, in fact, dump their employees in droves — it's worth understanding why employers offer insurance now, and how that might change under the Affordable Care Act.

Companies currently offer health benefits to stay competitive. A robust health plan can woo potential employees — especially the 122 million Americans with preexisting conditions who insurers can deny on the individual market. There's also a huge financial incentive: Employers get to pay for health insurance with pre-tax dollars, making a dollar of health-care benefits work more than a dollar of wages. There's also a wellness component: If workers are healthier, the thinking goes, they'll be more productive with fewer sick days.

There is one big reason, however, not to offer insurance: The cost. The average employer-based insurance plan costs more than \$15,000 a year, and has increased more than 112 percent over the past decade.

Rising health-care costs generally underlie predictions of employer dumping: Why bother paying \$15,000 for an insurance policy when the penalty for not doing so is a paltry \$2,000? Moreover, the insurance market in 2014 will look a lot different than what we have right now: The government will subsidize insurance for anyone earning less than 400 percent of the Federal Poverty Line. Insurers will have to accept all customers. The individual market, in short, will become a much more hospitable place.

But the best experience we have suggests that employers won't drop coverage. That comes from Massachusetts' experience under Romneycare, which, like the federal law, provided subsidized insurance for low-income Americans. There, employers have continued to offer coverage at the same level they did prior to the reform law.

What gives? To start, all those benefits of offering insurance — the competitive, financial and wellness aspects — don't disappear in 2014. Companies can still get more bang for their buck offering compensation as health insurance rather than wages.

The insurance packages that employers offer now are more comprehensive than what's expected on the exchange. The government subsidies, meanwhile, are less generous: An employee who gets dumped into the exchange can expect to pay 79 to 125 percent more in premiums, according to an analysis by consulting firm Lockton. That means employers will still have a competitive advantage from offering insurance rather than sending workers to publicly subsidized coverage.

Right now, employers do not face any penalty for not offering coverage: There's no \$2,000 fine from the government, as there will be in 2014. But the vast majority of them still do, even as costs keep rising, mostly because of other benefits they reap.

© The Washington Post Company



April 30, 2012 - Capitol Desk

Mixed Reviews at Basic Health Program Briefing

by David Gorn

The state Legislature is considering a bill to create a Basic Health Program in California. If adopted, SB 703 by Ed Hernandez (D-West Covina) would create low-cost health care insurance for as many as one million low-income Californians.

One of the options offered states in the Affordable Care Act, the Basic Health Program shares some goals with the Health Benefit Exchange, though the cost of insurance is expected to be significantly lower under the BHP.

That prospect would seem to be a slam-dunk proposition for patient advocates, but it's not as simple as that.

Experts and policy leaders gathered Friday in the Capitol to discuss the issue in a legislative briefing organized by the California HealthCare Foundation, which publishes *California Healthline*.

Experts and policy leaders gathered Friday to discuss the issue at a legislative briefing in Sacramento organized by the California HealthCare Foundation, which publishes *California Healthline*.

"When I first thought of BHP, I saw it as a clear choice, but now I see more to it," said Lucien Wulsin, executive director of the Insure the Uninsured Project, who was a panelist at the briefing.

"With Insure the Uninsured, our goal is to cover all of the uninsured in California. But ... I feel that a strong exchange is vital. ... And splitting them up into two [entities] could be negative."

The BHP is an alternative to the exchange's coverage for two sets of Californians -- adults with income between 133% and 200% of the federal poverty level, and for legal immigrants with income below 133% of the poverty level.

Wulsin said there are many good reasons to establish a lower-cost BHP; for instance, enrollment might be expanded because lower-income people may be more likely to sign up if the cost was reduced. But he is leery of shifting such a large pool of enrollees away from the exchange, since it is the primary vehicle for expanding enrollment in California. One possible alternative, Wulsin said, is to house the BHP within the exchange, rather than having it run by the Managed Risk Medical Insurance Board, as proposed in SB 703.

Nancy Wise, vice president for planning and strategy at HTMS, a health care consulting firm, painted a detailed picture of policy experts' and stakeholders' concerns and hopes for BHP.

Wise said the potential impact on the volume of the exchange's business is a big point of contention. She said some physicians are wary of a lower reimbursement rate under BHP. And, she said, the addition of a new federal program in the state -- along with Medicare, Medi-Cal and the exchange -- carries its own baggage.

"It's a program that could offer coverage of many people, but it would need significant coordination with other programs," Wise said.

Gerald Kominski, director of the UCLA Center for Health Policy Research, said the number of Californians eligible for BHP is theoretically about 3.1 million, "but in reality about 984,000 Californians would be eligible" for BHP, Kominski said.

"One concern is whether they present higher or lower levels of health risk," Kominski said. "BHP skews somewhat more likely to present poor health status, but when compared to potential exchange eligibles, we don't find much difference."

SB 703 was introduced last legislative session, and is currently in the Assembly Committee on Appropriations.

According to Wise, who called the BHP debate "a murky landscape," most experts and stakeholders don't hold a strong position one way or another about the program. She said most people see the strengths of it and have some concerns, as well.

"Few people were unilaterally for or against the BHP," Wise said, "but they had more of a considering tone."

© 1998 - 2012. All Rights Reserved. California Healthline is published daily for the California HealthCare Foundation by The Advisory Board Company.

April 2012

Patient Cost-Sharing Under the Affordable Care Act

There has been heated public debate over the requirement in the Affordable Care Act (ACA) that most people have health insurance or pay a penalty to the federal government. Yet, there has been relatively little attention focused on the type of coverage that people would have to buy and how much it would cost individuals to satisfy the so-called “individual mandate.”

This data note provides estimates of the potential cost-sharing levels for plans that will be available in the non-group market (including in new health insurance exchanges) when the ACA is fully implemented in 2014. It builds on previous work from Kaiser¹ and reflects recent guidance from the federal government on benefits and cost-sharing for plans offered in those markets.

ACA Rules for Benefits and Cost-Sharing

The ACA changes the structure of the non-group market to provide participants with a defined set of “essential health benefits” with standardized tiers of cost-sharing. The law specifies 10 categories of benefits to be included in the essential health benefit package, and provides that the scope of the package be equal to the scope of benefits in a typical employer-sponsored plan.

In recent proposed guidance², the federal government indicated that it plans to give states the option to choose an essential benefits package from among one of the following options: one of the three largest products in the small group market in the state, one of the three largest health plans offered to federal or state employees, or the Health Maintenance Organization (HMO) with the largest commercial enrollment in the state. States will need to fill in certain benefits specified by the ACA that are often not included in benefit plans today, such as habilitation and pediatric dental services. The guidance suggests that benefits are not expected to vary significantly across the different options. Under the guidance, health plans would be permitted to adjust the scope of benefits as long as the average benefit amount remains the same, as measured for a standard population.

In separate proposed guidance³, the federal government described an intended approach for how “actuarial value” will be determined for the purpose of establishing the different cost-sharing tiers. The actuarial value of a plan is the percentage of covered health care costs expected to be paid by the plan for a broad population. Under the ACA, plans in the non-group and small group markets must have an actuarial value of 60 percent (bronze plans), 70 percent (silver plans), 80

¹ <http://www.kff.org/healthreform/8177.cfm>

² http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

³ <http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>

percent (gold plans), or 90 percent, (platinum plans). For example, a bronze plan on average would pay for 60 percent of the costs for covered benefits and enrollees on average would pay the remaining 40 percent through cost-sharing such as deductibles, copayments and coinsurance.

The guidance states that actuarial values will be calculated using a publically-available actuarial value calculator based on claims data that will be weighted to reflect the expected population in the individual and small group markets. The calculator will reflect standard prices and use of services reflecting the population. Although essential benefits will vary somewhat from state to state, the guidance states that the variation is very small relative to the total amount of covered expenses and that the “variation is expected to have limited impact on the plan [actuarial value].” Insurers using straightforward designs will be able to calculate an actuarial value directly from the calculator; insurers with more complex cost-sharing or network designs may need to submit a separate actuarial analysis estimating the impact of their design on the plan’s actuarial value.

All plans are required to cap patient out-of-pocket costs at a specified level. Lower-income enrollees are eligible for lower out-of-pocket limits and higher actuarial value coverage.

Estimates of Patient Cost-Sharing

Because actuarial value is stated as a percentage, it is hard for most people to understand what cost-sharing in health plans will look like when the new rules take effect. To provide a more tangible picture of what coverage people would be required to buy, the Kaiser Family Foundation commissioned Aon Hewitt, a prominent benefit consultant, to estimate dollar values for several illustrative cost-sharing structures for non-group bronze and silver level plans when the ACA is fully implemented in 2014. Bronze plans are the least comprehensive of the four tiers, and represent the minimum coverage people purchasing non-group coverage could buy to satisfy the individual mandate. Silver plans are likely to be the most common level of coverage because premium tax credits are based on silver plan premiums and only people enrolled in silver plans will be eligible for cost-sharing subsidies.

These estimates update previous work and better reflect the federal guidance on essential health benefits and actuarial value. A detailed description of the methodology is provided at the conclusion of the brief.

We present two illustrative cost-sharing designs that were applied to each tier: one with a deductible and 20 percent patient coinsurance up to an out-of-pocket limit of \$6,350 for an individual, and a second with a smaller deductible and higher patient coinsurance of 40 percent up to the same out-of-pocket limit. The deductible and coinsurance were assumed to apply to all services except preventive services, which are available under the ACA without patient cost-sharing. This means that for most services covered by the plan under these designs, the patient would pay all of the

cost until the deductible is reached, and either 20 percent or 40 percent (depending on the option) of any additional costs until total patient cost-sharing reaches the out-of-pocket limit. Under the ACA, out-of-pocket limits for health plans are subject to the limit that currently applies to health savings account-qualified health plans, which is \$6,050 for single coverage in 2012, and we estimate it to be \$6,350 in 2014.

The results are shown in Table 1. All amounts are for coverage of a single individual under a preferred provider organization (PPO) plan. Deductibles and out-of-pocket limits would be double these amounts for families.

A bronze plan with 20 percent coinsurance – a typical level under coverage today – and an out-of-pocket cost-sharing limit of \$6,350 would have a single deductible of \$4,375. Increasing the patient coinsurance level to 40 percent would lower the deductible by \$900 to \$3,475. Under both scenarios the deductibles are significant and would be considered catastrophic plans, particularly for people without significant personal savings. These plans would also meet the requirements for tax-preferred Health Savings Accounts.

The deductibles are more modest for silver plans with the same coinsurance and out-of-pocket limits. A silver plan with 20 percent coinsurance and an out-of-pocket cost-sharing limit of \$6,350 would have a deductible of \$2,050. Increasing the patient coinsurance level to 40 percent would lower the deductible to \$650.

Table 1: Illustrative Plan Designs for Single Coverage

Tier	Actuarial Value	Deductible	Patient Coinsurance	Out-of-Pocket Limit
Bronze 1	60%	\$4,375	20%	\$6,350
Bronze 2	60%	\$3,475	40%	\$6,350
Silver 1	70%	\$2,050	20%	\$6,350
Silver 2	70%	\$650	40%	\$6,350

Discussion

The ACA seeks to standardize coverage options available in the non-group and small group markets, making it easier for consumers to compare plans and focusing competition on premium levels.

Coverage with cost-sharing levels comparable to current employer-based plans will be available through gold (actuarial value of 80 percent) and platinum (actuarial value of 90 percent) plans. The estimated actuarial value of typical employer-sponsored coverage is over 80 percent⁴, with coverage offered by small employers generally less comprehensive.

⁴ <http://www.kff.org/medicare/7768.cfm>

However, the minimum coverage people will be required to buy starting in 2014 will have much higher cost-sharing than typical employer-based coverage and than the average purchased now in the non-group market. With standard 20 percent coinsurance, a bronze plan would have an estimated deductible of \$4,375 for a single individual and double that for a family. This compares with an average single deductible of \$2,498 in 2010 in the non-group market⁵ and an average of \$675 in employer-sponsored PPO plans with deductibles in 2011. Deductibles in employer plans paired with tax-preferred savings accounts averaged \$1,908 in 2011.⁶

With much of the controversy over the ACA focusing on the individual mandate, it is noteworthy that the minimum coverage requirement is for insurance that is significantly less generous (and with a lower premium) than what most people have today. It is a level of coverage that most would consider catastrophic, providing protection in the event of an expensive illness while subjecting routine expenses (except for preventive care) to a relatively high deductible. While much of the opposition to the individual mandate is likely due to views about the appropriate role of government, a better understanding of how it works and what it requires could moderate some of the resistance to it.

People will have the option of buying more generous coverage than the minimum required, and lower-income enrollees will be eligible for cost-sharing subsidies that decrease their out-of-pocket costs. But, some may still find themselves with insurance that requires substantial cost-sharing. Policymakers will face the challenge over time of finding the right balance between the minimum level of insurance people should be required to have and providing an appropriate level of protection.

⁵ <http://www.kff.org/kaiserpolls/8077.cfm>

⁶ <http://ehbs.kff.org/>

Methodology

This data note was written by Gary Claxton and Larry Levitt of the Kaiser Family Foundation. Actuarial estimates were prepared by Ian Stark, FSA, MAAA of Aon Hewitt.

All estimates are based on the average 2011 premium for a PPO-type plan under employer-sponsored coverage, using an average population of people under age 65 covered by an employer plan. The gross claims distribution of health expenditures was developed based on a single adult premium of \$5,584 (from the Kaiser/HRET Employer Health Benefits Survey), as well as assumptions that the typical employer-sponsored PPO plan has an actuarial value of 82 percent and that 10 percent of premiums are related to administration and profit. Additionally, premiums are expected to grow 7.5% annually from 2011 to 2014.

The most recent guidance from the federal government on the definition of actuarial value (AV) for qualified health plans in the individual and small group markets was taken into account as part of this analysis. In brief, the guidance has suggested providing an AV calculator with a limited number of inputs based on a single dataset of health expenditures with the ability to adjust the dataset based on demographic or (limited) geographic variation. While plans were developed to achieve an AV as close to 60% and 70% as possible, the bulletin recommends a +/- 2% corridor in certifying plans for each tier. Finally, it was proposed that employer-funded Health Reimbursement Arrangement (HRA) and Health Savings Account (HSA) contributions could be included as part of the actuarial value but only to the extent that the funds would be expected to be utilized for claims payment during the plan year.

Given the single national dataset proposed for the AV calculator, we did not make any adjustments for non-standard state-mandated essential health benefits (EHB), such as in-vitro fertilization or autism therapy, as the potential cost impact of those additional benefits are likely to be small and within the 2 percent corridor. The bulletin states that "although the benchmark for EHB will vary by state, that variation is expected to have limited impact on plan AV."

The age distribution of the non-group and small group population – including the currently uninsured who would not be eligible for Medicaid – is similar to those who now have employer-sponsored insurance. Basing plan designs on that population would not vary the results significantly, particularly given the 2% corridor proposed in the bulletin.

The estimates do not account for cost-sharing subsidies available for people in silver plans with incomes up to 250 percent of the poverty level, which increase the actuarial value of the coverage.

All results are in 2014 dollars and are national estimates. States estimates may be different if states create an actuarial calculator based on state costs or if the national actuarial value calculator can be adjusted to account for state-specific costs.

This publication [#8303] is available on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION

www.kff.org

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800

Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274

The Kaiser Family Foundation, a leader in health policy analysis, health journalism and communication, is dedicated to filling the need for trusted, independent information on the major health issues facing our nation and its people. The Foundation is a non-profit private operating foundation, based in Menlo Park, California.



April 30, 2012 - The Think Tank

How Should California Respond if Part or All of ACA Is Struck Down?

Within the next six to eight weeks, the U.S. Supreme Court will issue rulings that will have a significant effect on health care nationally and in California.

If the Affordable Care Act is upheld in all respects, it will be full steam ahead for reform and the effects will probably be more significant in other states.

However, if part or all of the ACA is struck down, the effects will be considerable in California, which has embraced and prepared for reform more aggressively than most states.

We asked policymakers and stakeholders how California should respond if the court rules against part or all of the ACA. We got responses from:

- Diana Dooley, Secretary, California Health & Human Services Agency
- State Sen. Tom Harman (R-Huntington Beach), Vice-chair, Senate Committee on Health
- State Sen. Ed Hernandez (D-West Covina), Chair, Senate Committee on Health
- Betsy Imholz, Special projects director, Consumers Union
- Bill Kramer, Executive director national health policy, Pacific Business Group on Health
- Elizabeth Landsberg, Director of legislative advocacy, Western Center on Law and Poverty
- Assembly member William Monning (D-Carmel), Chair, Assembly Health Committee
- Anthony Wright, Executive director, Health Access California

Little in Dysfunctional System Is Actually Systemic

 Diana Dooley
Secretary, California Health & Human Services Agency

Notwithstanding all the heated rhetoric about the Affordable Care Act and the recent Supreme Court arguments, no one thinks our health care system works as well as it should. There is actually very little that is actually systematic. The ACA is a noble attempt to rationalize some of the dysfunction. Whether all or part of it survives, California will continue to be at the forefront of improving the health of its people.

When the law takes full effect in 2014, insurance companies cannot deny coverage because someone has a health condition that needs attention and in return, everyone must have some level of insurance. Without these interlocking provisions, the cost of providing health care to people without insurance is shifted to everyone else through higher premiums and higher health care charges. This mandate is the central focus of the law's opponents, but there are many other provisions that are already providing significant benefits: adult children up to age 26 continuing on parents' policies, companies can't deny coverage to children with pre-existing conditions, no lifetime coverage limits and certain preventive care provided without out-of-pocket costs.

California has gone even further through a federal-state-county partnership establishing Low-Income Health Plans for people to start getting care sooner than 2014. More than 350,000 Californians have enrolled in these new federally-funded plans that provide much-needed care and relieve some of the cost burden of the uninsured. California was the first state to authorize a Health Benefit Exchange -- a transparent, trusted marketplace for sellers and buyers of health insurance. And California is leading with a Coordinated Care

Initiative to improve the management and integration of care for people with chronic and complex health conditions who depend on Medi-Cal and Medicare.

The Affordable Care Act will provide health security to millions of Americans through insurance coverage; it encourages reform of the way health care is delivered and paid for; and it incentivizes prevention and personal responsibility for health. But none of this will be possible unless we can slow the unsustainable rate of growth in health care costs. The state budget deficits in California and other states are due in part to these costs and the states must take the lead in reforming and realigning the payment systems and incentives. Californians deserve an efficient, affordable, high-quality system of health care. The ACA will help us reach that goal.

Legislature Should Slow Down, Be Careful

State Sen. Tom Harman (R-Huntington Beach)
Vice-chair, Senate Committee on Health

If, as several experts anticipate, the Supreme Court strikes down some or all of the Patient Protection and Affordable Care Act, California will find itself in the untenable position of having promised services it cannot provide without federal funding.

California policymakers, in a rush to lead the nation in implementation, have given little attention to how California will fund the ACA, should it fail the constitutional sniff test. The California Health Benefit Exchange was created in 2010, operating under the assumption that massive federal subsidies will be available for low and middle income earners needing assistance to afford health coverage offered.

It is my belief the Democratic leadership will fully implement legislation concerning the ACA regardless of the court's decision. As vice chair of the Senate Health Committee, I have heard hours of testimony on legislation seeking to implement facets of the ACA. These measures are irresponsibly moved forward, often in the absence of definitive federal guidance, and without any plan to unwind the implementation should the court reject the ACA.

Just last week a bill dealing with Medi-Cal eligibility was amended to include language stating that it "is the intent of the Legislature to ensure full implementation of the Affordable Care Act ... It is further the intent of the Legislature to enact into state law any provision of the Affordable Care Act that may be struck down by the United States Supreme Court and that is necessary to ensure all Californians receive the full promise of the act."

Previous attempts by some California legislators to move in the direction of single-payer health care have been largely rejected due to the high price tag. Leveraging the ACA as cover to expand state-run health care, the Legislature is moving forward on programs we frankly can't afford on our own. It appears the Legislature will continue on this path, without a plan in place for funding, regardless of the court's decision.

The Legislature should slow down and proceed more cautiously on implementation. I intend to introduce legislation that would give the exchange 90 days to submit a plan documenting how it is going to continue operating if the ACA is struck down. In essence, the exchange board will have 90 days to share its "Plan B" - including alternate sources of financing -- or implementation grinds to a halt.

ACA implementation has put California on a collision course where no one wins -- not the medical community, the people in need of health care or the taxpayers. Let's get back on the rails.

Key to Proceeding Is Funding

State Sen. Ed Hernández (D-West Covina)
Chair, Senate Committee on Health

The Affordable Care Act is the culmination of decades of movement toward health care reform and is the most significant transformation of the United States health care system in 40 years. Although I remain confident the Supreme Court will uphold the ACA, it would be a travesty to see it blocked by the courts after so much progress has been made in California. In my heart, I truly believe that a majority of the justices will agree with the logic exercised by Senior Judge Lawrence Silberman of the United States Court of Appeals, District of Columbia Circuit, who argued, "The right to be free from federal regulation is not absolute and yields to the imperative that Congress be free to forge national solutions to national problems."

In the event that the Supreme Court does not uphold the entire ACA, I see two plausible scenarios:

The worst case scenario is that the Supreme Court exercises the nuclear option and strikes down the law completely; and

The other scenario would be for the justices to find portions of the ACA unconstitutional and invalidate only those portions of the act.

The real key to how California proceeds in the event of either of those two scenarios is funding.

If the Supreme Court strikes down the law entirely, the effects on California would be devastating. There are virtually no meaningful reforms that can happen in California without federal dollars. We could tinker around the edges at some market modifications, but without the funding that accompanies the ACA, Californians will not receive the full promise of health reform and millions of our state's residents will remain uninsured. Additionally, because many Californians are already benefiting from provisions of the law like the Pre-Existing Condition Insurance Program, thousands of citizens will lose that coverage and will be worse off than they are today.

Should the Supreme Court strike down portions of the law without affecting the federal funding available, I will work to enact into state law any provision of the ACA necessary to realize the full promise of the act for all Californians. That is why I have introduced **SB 1487**, which puts our state in a position to do just that. California needs to be ready to implement health care reform, no matter what the Supreme Court may decide in June.

Access to affordable, quality health care for millions of uninsured Californians is within reach, and we have made too much progress to turn back now.

Some Federal Standards Now State Law

 Betsy Imholz

Special projects director, Consumers Union

As the most populous state, and with six million uninsured, California has a huge amount to gain if the ACA is upheld. The state has already received \$41 million from the federal government to establish the California Health Benefit Exchange – the one-stop shop to buy health insurance coverage. Progress is well under way to start enrolling Californians in fall 2013, and provide tax credits and other subsidies to make policies more affordable for small business employees and individuals without employer coverage.

California is expected to receive another \$45 billion to \$55 billion in federal funds between 2014 and 2019 if the law is upheld. If the entire federal statute is found unconstitutional, the loss of federal funds for Medi-Cal and the exchange, including affordability subsidies, would be a huge blow.

Yet, we would not be back to square one. California has been proactive in writing some key federal standards into state law. These will remain in effect regardless of what the U.S. Supreme Court decides:

- 350,000 children under age 26 have already gotten coverage by being able to stay on their parents' policies under a 2010 California bill **SB 1088** (Price).
- Coverage for an estimated 575,000 California children under 18 with pre-existing conditions is protected thanks to **AB 2244** (Feuer), enacted in 2010.
- Bills last year, **SB 222** (Evans)/**AB 210** (Hernandez), require maternity coverage in all policies in California,

one of the basic services defined in the ACA and now a requirement of state law.

If the court strikes all or portions of the ACA, we would need to build on that platform. The momentum for reform in California is so strong that I am confident we would pick up the pieces to see what new state measures are needed. The Brown administration is signaling that we will move ahead without our "federal partners" if we must. A quick shift to the legislative arena would be needed and could throw open a wide range of possibilities from considering a state-based individual mandate -- which had been part of our comprehensive reform bill in 2007-2008 -- to revisiting a single-payer solution, and everything in between.

California's near-miss effort for comprehensive reform in 2007-08 was grounded in the fact that our health care system is broken. Health care costs have continued to rise and must be curbed. The ACA contains some steps toward that end, and without it, the cost of care would be ever more pressing. The related "elephant in the room" would be finding the money to ensure affordable coverage is available. Without curbing ever-increasing health care and insurance costs, no major "reform" will work and no individual coverage requirement will be viable.

Costs, Number of Uninsured Would Rise

 Bill Kramer

Executive director national health policy, Pacific Business Group on Health

The Supreme Court's decision about the Affordable Care Act will have enormous implications for California. If the ACA is upheld in its entirety, the state can continue to move ahead with the implementation of the Health Benefit Exchange and related insurance reforms. There are two other scenarios, however, in which California businesses, public sector purchasers and consumers would be seriously affected.

If the ACA's individual mandate and related insurance reforms are struck down, it will be much more difficult for small employers and individual consumers to get affordable health insurance. Consumers with pre-existing conditions will be unable to get coverage, and high-risk employer groups will continue to face high premiums. California has established itself as a leader in adopting the insurance reforms and setting up the California Health Benefit Exchange. Furthermore, the Exchange has embraced a vision of becoming a "catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities." If the mandate and related insurance reforms are rolled back, however, the Exchange is likely to be much smaller, and its ability to be a catalyst for broader health system improvement will be limited.

If the entire ACA is overturned, it would have a dramatic effect throughout the health care system. Most importantly from the perspective of businesses, the elements of the ACA that are likely to produce cost savings in the future will be rolled back. For example, the Medicare Accountable Care Organization (ACO) program, which has the potential to reduce costs and improve the quality and coordination of care, will be eliminated. California has a long history of high-performing integrated medical groups and health systems that are poised to become ACOs. While some ACO-type pilots have been launched by private insurers in collaboration with physicians and hospitals, it will be difficult to maintain these initiatives if the Medicare ACO program is eliminated. In addition, the ACA is changing the way that hospitals and physicians are paid by rewarding them for high quality of care, not just high volume of services. For example, under a series of new Medicare "value payment" models, up to 10% of a hospital's payments in 2017 will be based on its performance on quality indicators.

In California, we have been leaders in the development of innovative provider payment mechanisms. If the Medicare payment reforms are overturned, however, these initiatives may be stifled, and we may be stuck with the dysfunctional fee-for-service payment structure for the foreseeable future. Finally, one of the most important elements of the ACA is the expansion of Medicaid and the dramatic reduction in the number of uninsured.

If the ACA is overturned, the number of uninsured will grow significantly. This in turn will increase the volume of charitable care at hospitals, and it will exacerbate the "cost shift" to privately insured patients, thus driving

up insurance premiums. In sum, a full rollback of ACA would likely result in higher health care costs and further increases in premiums due to the cost shift.

State Should Pass Its Own Mandate, If Needed

Elizabeth Landsberg

Director of legislative advocacy, Western Center on Law and Poverty

We at Western Center on Law & Poverty remain optimistic that the U.S. Supreme Court will rightly uphold the constitutionality of the Affordable Care Act in its entirety, given the huge economic impact of the health care industry. But, even if the court finds the requirement that individuals have health coverage impermissible when enacted by Congress, the same requirement is plainly within state authority to legislate.

This "individual mandate" should be enacted in California if the national mandate is struck down, and I have been heartened by the strong statements by both administration and legislative leaders expressing their intent to implement health reform in California. Health and Human Services Agency Secretary Diana Dooley said, in no uncertain terms, that California will implement health reform and the chairs of both Senate and Assembly Health Committees have made similar declarations.

As an advocate for low-income Californians, I want to highlight the constitutionality and importance of the ACA's Medicaid expansion. Since its creation in 1965, the Medicaid program -- known as Medi-Cal in California -- has been a state-federal partnership where the federal government pays a portion of the costs of the program for states willing to abide by federal minimum requirements. States can choose to provide certain optional services and cover optional populations. The ACA's expansion of Medicaid to low-income adults without dependent children continues this framework with a notably higher match rate. The federal government will pay 100% of the costs of coverage for this new population in 2014-16, phasing down to a still-high 90% by 2020 -- hardly coercion, as argued by some states in the case.

California has already made important progress implementing the Medicaid expansion through the "Bridge to Reform" Medicaid waiver. To date, 47 counties have formed Low-Income Health Programs (LIHPs) providing Medicaid-like benefits to indigent adults with half the funds coming from the federal government. More than 335,000 poor Californians in LIHPs are already benefiting from affordable, comprehensive health coverage through the ACA in myriad ways: people who have been uninsured for years are now getting health coverage and necessary services; public health systems are receiving much-needed federal resources; and clinics are offering medical homes to patients with chronic health conditions.

This is but the beginning of what ACA implementation has to offer California through coverage expansion, federal investment, delivery system reform and eligibility simplifications. California has accomplished a lot already. I agree with our state leaders that no matter what, our state must continue on the path toward health care for all Californians.

Experience Puts State in Strong Position

Assembly member William Monning (D-Carmel)

Chair, Assembly Health Committee

I am confident the U.S. Supreme Court will uphold the ACA in its entirety. There are far too many people in California and all across the country who have already benefitted from many of the ACA's provisions. More than 12 million Californians no longer have a lifetime limit on their health insurance; more than 6.1 million Californians have had their coverage improved to include coverage of preventive care without cost-sharing; more than 355,000 young adults under age 26 can remain on their parents' coverage; and more than 319,000 California seniors have saved \$170 million in prescription drug costs.

I am proud to be working with others to implement the provisions of the ACA as quickly and thoughtfully as

possible. This year I am authoring legislation to implement aspects of the ACA. These bills would:

- Select an essential health benefit plan to set the floor on the benefits that people purchasing insurance in the individual and small group market can buy, ensuring that people have access to real, not junk insurance;
- Expand Medi-Cal to childless adults; and
- Reform the individual insurance market and the small group insurance market to prohibit pre-existing condition exclusions and adjust for ACA implementation.

If some or the entire ACA is held unconstitutional, we in California will have to assess the ruling and determine how to move forward to achieve the objectives of the ACA and continue our efforts to build a strong foundation for health reform. I am committed to reducing the number of uninsured in California.

The California State Assembly in the 2007-2008 session passed AB x1, which would have established a comprehensive health reform program that included a requirement for all California residents to carry a minimum level of health insurance coverage for themselves and their dependents; required health plans and insurers to offer and renew, on a guaranteed basis, individual coverage, regardless of the age, health status, or claims experience of applicants; and established new modified community rating rules for the pricing of individual coverage. While ABx1 did not become law, it did contain a framework consistent with the ACA. This experience puts California in a strong position to maintain the momentum created by the ACA.

Status Quo Is Unsustainable

Anthony Wright

Executive director, Health Access California

We have confidence the Affordable Care Act will be upheld in its entirety, but in case it is not, California can and must move forward with health reform regardless. The status quo in California's health care system without reform is unsustainable. The worsening problems in our health care system won't go away by themselves. Californians are more likely to be uninsured, more likely not to get coverage at work, more likely not to afford coverage and more likely to be denied for pre-existing conditions than residents of most other states.

If the court just strikes down the mandate and/or related provisions, those are easily fixable. For example, Congress could replace the individual mandate with a tax credit/penalty system that would be clearly constitutional under Congress' taxing powers. However, the current Congress, particularly the GOP-controlled House, lacks the political will to make this simple fix.

Where Congress fails, California can step in. This is a fixable policy issue, which is how to attract and retain healthy people into coverage, not just the sick. The act has several provisions to prevent "adverse selection" beyond the mandate, most importantly the tax credits and subsidies to help low- and moderate-income families better afford coverage. California could put in place its own mandate and/or its own tax incentives.

Other mechanisms to prevent "adverse selection" include open enrollment periods, which encourage people to sign up at a given time of the year. With or without the mandate, Health Access has been advancing legislation, **AB 714** (Atkins) and **AB 792** (Bonilla), to encourage pre-enrollment and seamless enrollment and make getting coverage as easy as possible. There are a range of policy options that California can pursue after the Supreme Court decision in June, but before the legislative year is out in August, to put in place a California fix.

It's another matter if the court strikes down the whole law, or the Medicaid expansion. This outcome would be stunning. California would lack the federal funds and the policy tools of the federal law to move forward with the same speed.

California has already been putting some policies and consumer protections in place in state law that will continue regardless of the fate of federal law, including addition of children up to age 26 on their parents'

coverage, free preventive care, and eliminating annual or lifetime caps on coverage. Health Access would work in the Legislature to salvage other consumer protections for Californians. But some of the provisions in the act are reliant on the federal funds and framework to function properly.

California would debate broad health reform, as we did before the passage of the Affordable Care Act, with proposals from an employer mandate to a universal children's coverage proposal, to single-payer universal health care. The problems don't go away, even if the law does.

© 1998 - 2012. All Rights Reserved. California Healthline is published daily for the **California HealthCare Foundation** by **The Advisory Board Company**.