HEALTH ACCESS

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Health Access California
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Committee on Budget and Fiscal Review
Implementation of the Affordable Care Act
And the Remaining Uninsured
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Good morning, Mr. Chair and members. My name is Anthony Wright, Executive Director of Health Access California, the statewide health consumer advocacy coalition, committed to the goal of quality, affordable health care for all Californians for more than 25 years.

Thank you for the opportunity to testify today on the implementation of the Affordable Care Act and our commitment to the remaining uninsured.

EVEN WITH HISTORIC PROGRESS, MILLIONS OF CALIFORNIANS WILL REMAIN UNINSURED: As you have already heard, the Affordable Care Act is the biggest expansion of health coverage in two generations, potentially reducing the number of uninsured by one-half to two-thirds, according to estimates by the Congressional Budget Office and others. Decisions made here in Sacramento this year will determine how successful we are in enrolling as many Californians in coverage—you have the power to make a big difference in how many Californians remain uninsured.

But in the best-case scenario, with millions of Californians newly insured and millions more with improved benefits and other consumer protections, there is likely to be three to four million remaining uninsured in our state, according to CalSIM estimates by the University of California and others.

The uninsured will, as now, be a fluid and diverse population. Some of these, around 1 million according to the UCLA California Health Interview Survey, will be undocumented Californians, who were explicitly and unfortunately excluded from subsidized coverage in the federal law. The undocumented make up about a fifth (20%) of the uninsured population now and may make up a third after 2014. The majority will be citizens or legal residents who will remain uninsured. Some will be exempt from the individual mandate for reason of lack of an affordable coverage options. Some will be homeless who don't have the basic documents to qualify for coverage. Some will drop off coverage during life and work transitions and need care before they get around to signing up anew. Some will be caught uninsured between the "open enrollment" periods. Some will not get the word about the new benefits and options for coverage no matter how hard we try.

ENSURING CALIFORNIA'S COMMITMENT TO THE REMAINING UNINSURED: So while we work to ensure a successful effort to enroll as many Californians as possible, we also need to ensure that we have a safety net that survives and thrives. The counties have traditionally played this role, and as the Governor seeks to have a conversation about realigning state and county costs and responsibility, we first need to re-establish our commitment to the remaining uninsured.

No shift of funds away from counties makes sense without an assessment of whether the remaining funds are sufficient to provide care to the remaining uninsured. Counties should not get a blank check, however--we agree with the need for greater accountability for these funds, and would propose that those funds are conditional on providing actual care and/or coverage.

What counties spend now was artificially constrained in 1982 when counties accepted responsibility for medically indigent adults at 70% of what the state spent then with no COLA for future cost increases. The Governor's budget estimates that counties now spend $3-$4 billion on care for the uninsured. Other estimates include an estimate by CSAC that counties receive $1.4 billion in health realignment dollars, to fund safety-net services as well as crucial public health functions.

Whatever the number, even the current funding level appears to be a fraction of what it would take to provide the cheapest level of coverage. A back-of-the-envelope estimate suggests that to cover the remaining uninsured in Medi-Cal, even with its very low per-patient costs, would require billions more—by an order of magnitude. The cost of coverage for the remaining uninsured could be on the order of $6-9 billion per year. This very rough estimate assumes that the remaining uninsured have similar costs to the children and adults now covered under Medi-Cal managed care at about $160-250 per member per month. We defer to our academic colleagues to provide a more sophisticated estimate based on population characteristics of the remaining uninsured, but we believe this is the right range and scale.

This rough estimate recognizes that some of those are currently eligible for Medi-Cal but not enrolled; that they may be healthier than those who overcome the barriers to enrollment in the current system; and that some remaining uninsured have incomes that would enable them to contribute. At the same time, this estimate of $6 billion to $9 billion to care for the remaining uninsured may be an underestimate of what is needed to provide care. We know from the research on California's early expansion through Low Income Health Programs that individuals who have been uninsured have nagging issues that need more care than those of us who have had coverage continuously.

So even with the significant reductions in the uninsured provided with the Affordable Care Act, the current funds used for the safety-net are likely not sufficient to provide base-level coverage for the remaining uninsured. We not only need to maintain these funds for this purpose, but use these funds efficiently and effectively, and incentivize and encourage counties to continue their investments in the safety-net.

A PROPOSAL: Absent a new statewide coverage program for the remaining uninsured, we propose that counties continue to provide this crucial safety-net function. We proposed that they retain the funding to meet this ongoing challenge, based on conditions.

Health Access proposes that counties retain this funding, along with maintenance of effort requirements to fund their safety-nets, and incentives or requirements that counties use those dollars in a more systematic and coordinated fashion to provide coverage and care for the residually uninsured—including using the infrastructure of the Low-Income Health Programs (or systems like it) to provide coverage to all local residents, regardless of documentation.

Health Access proposes that California build on the experience of 53 counties, in operating programs like Healthy San Francisco, Healthy Way LA, or other Low Income Health Programs to serve the uninsured. All currently enrolled in the program will be shifted into full Medi-Cal coverage in January 2014. We propose that counties can meet their obligations and continue their funding by continuing these LIHPs for the remaining uninsured.

In this way, we provide a continued funding stream for counties, based within and supporting their safety-net institutions; these Californians get not just episodic and emergency care but a medical home with cost-effective preventative services; and the state gets better accountability and transparency for these dollars, to ensure these funds are being spent in the most effective and efficient way.

We also propose that we track the remaining uninsured and the cost of their care, which using the LIHPs would facilitate. If California reaches that happy goal where the demand for safety-net services diminish, because there are so few remaining uninsured or those who remain uninsured are provided the care they need, then that could trigger a reassessment of funding and commitments. But even in Massachusetts, with its smaller percentage of uninsured and much-better funded health care system and safety-net, the decrease in use of uninsured use was much less under reform than expected. We need a policy that recognizes and is driven by the actual experience on the ground and in the health care system, to best meet the need of Californians, especially those for whom the safety-net is their last resort.

Finally, Health Access proposes that counties can use these dollars to help reduce the size of the remaining uninsured to begin with. Counties should be allowed to put up the non-federal share of match for outreach and assisting Californians in enrolling in Medi-Cal. Specifically, the federal rules provide for "application counselors" to assist low-income individuals in enrolling in all health insurance affordability programs, and will provide federal matching funds for this purpose. Covered California is getting significant federal dollars for outreach and enrollment assistance, but the Exchange can pay only for enrollment in the Exchange, not Medi-Cal. These "application counselors" are similar to "application assisters" that existed for Healthy Families and "navigators" that are proposed for the Exchange. Counties have a vested interest in signing people up for

Medi-Cal to reduce the number of remaining uninsured in their communities: by allowing counties to use these funds to draw down matching federal funds for "application counselors," our proposal would take advantage of that interest.

In defending the dollars that go to the county safety-net, Health Access does not propose that the implementation of the Affordable Care Act should be a windfall for the counties. Instead we propose that counties make commitments to provide care or coverage for the remaining uninsured, and to enroll those who are eligible for coverage into either Medi-Cal or the Exchange.

Thank you for your consideration.

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