

Introduction

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law, laying the groundwork for many health reforms, including the expansion of Medicaid, increasing coverage of pre-existing conditions through guaranteed issue, and the establishment of statewide and/or regional health insurance exchanges. Although these expansive reforms will provide coverage to previously uninsured millions, a sizeable population will remain uninsured.

This paper describes those who may remain uninsured in a post-reform world, as well as means to provide coverage/care to this population utilizing different models: county health programs, bolstering the safety net (Healthy San Francisco, Healthy Way LA, school-based health centers, public-private partnerships), employer and industry based care (SHOP Exchanges, pay-or-play mandates, on-site clinics, binational plans), supplemental public programs (AIM, Family PACT, CHDP, CCS, GHPP, ADAP, cancer screening/treatment), and mental health.

The Patient Protection and Affordable Care Act

Two of the largest reforms include state and federal exchanges and Medicaid expansion, which will expand affordable access to insurance to over 30 million Americans.

The California Health Benefits Exchange

Individuals with incomes under 400%¹ of the federal poverty level (FPL) will be eligible for sliding scale premium subsidies based on the premium for the second lowest cost “silver” plan in the Exchange. Their contributions are capped between 2.0 and 9.5% of their household incomes. Individuals must be lawfully present residents of the state; those that are not citizens, nationals of the U.S. or aliens lawfully present in the U.S. are not only ineligible for premium subsidies, but also ineligible to purchase Exchange insurance plans without subsidies.² New legal permanent residents (LPR) can participate in the Exchange with full federal subsidies for those eligible.

<i>Income Level</i>	<i>Premium as a % of Income</i>
0-133% FPL	2%
133-150% FPL	3-4%
150-200% FPL	4-6.3%
200-250% FPL	6.3-8.05%
250-300% FPL	8.05-9.5%
300-400% FPL	9.5%

Table 1. Exchange Premium Caps by Federal Poverty Level.

Source: Patient Protection and Affordable Care Act §1401.

To make coverage obtainable for individuals/families who could not otherwise afford it, the ACA includes provisions to lower cost-sharing obligations as well. The limits are based on the maximum out-of-pocket limits for Health Savings Account-qualified health plans (\$5,950 for single coverage and \$11,900 for family coverage in 2010), which will be indexed to the change in the Consumer Price Index until 2014.³ If the provision were in effect in 2010, an individual with an income of 250% of FPL purchasing coverage through the Exchange would have their out-of-pocket maximum limited to \$2,975 instead of \$5,950.

¹ Individuals with incomes under 133% of FPL will be also eligible for full-scope no-cost Medi-Cal.

² ACA §1312(f)(3).

³ 26 U.S.C. § 223(g).

<i>Income Level</i>	<i>Reduction</i>
100-200% FPL	2/3 of Maximum
200-300% FPL	1/2 of Maximum
300-400% FPL	1/3 of Maximum

Table 2. Reduction in Out-of-Pocket Liability by Federal Poverty Level.

Source: Patient Protection and Affordable Care Act §1402(c)(1)(A).

Medi-Cal and Medicaid Expansion

The Medi-Cal program provides health care coverage for low income Californians with specific categorical linkage. In 2010, there were 7.4 million beneficiaries, which constituted a fifth of all Californians. This program provides retroactive eligibility for 3 months.

Currently, US citizens and legal permanent residents⁴ (LPRs) are eligible for full scope benefits,⁵ with the undocumented eligible only for emergency-only and pregnancy/perinatal Medi-Cal. The pregnancy and perinatal care portion of the Medi-Cal program only provides pregnancy-related services, including conditions which complicate pregnancy, and all pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy.⁶ Infants born to mothers enrolled in this program are eligible for full-scope benefits up to one year of age as the child is a US citizen.⁷ Pregnant women with incomes up to 200% of FPL⁸ are eligible regardless of documentation status.

A key component of the ACA is the expansion of Medicaid to include childless adults with incomes under 133% of FPL. This expansion includes parents, children and medically indigent adults, some of whom may already have Medi-Cal, Healthy Families and county health coverage. A UCLA study⁹ estimates that 3 million Californians ages 0-64 will become eligible for Medi-Cal coverage and 3 million will be eligible for the Exchange.

⁴ Unlike other states, California does not impose a five-year LPR requirement. If otherwise eligible, LPRs with less than five years of residency are eligible for full-scope Medi-Cal. Federal funds, however, cannot be used to treat this population.

⁵ 22 CCR §50301

⁶ 22 CCR § 50260.

⁷ Ibid.

⁸ 22 CCR § 50262.

⁹ UCLA Center for Health Policy Research, Lavarreda SA and Cabezas L. "Two-Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform," February 2011, at <http://www.healthpolicy.ucla.edu/pubs/files/twothirdspb-2-16-2011.pdf>.

The Residually Uninsured: Who Are They?

Despite federal reforms, many will continue to be uninsured. About 900,000 are projected to be exempt from the individual mandate, while 660,000 are projected to not purchase insurance despite being subject to the mandate.¹⁰

Type of coverage	Millions of people in California		
	Without the law	With the law	Impact of the law
Employer-sponsored	18.90	18.03	-0.87
Traditional nongroup	2.24	0.87	-1.37
Exchange	0.00	4.01	4.01
Public	6.58	8.29	1.71
None	6.53	3.10	-3.43

Figure 1. Projected Changes in Insurance Coverage in California by 2016 as a Result of the ACA.

Source: Long P, Gruber J, "Projecting the Impact of the Affordable Care Act on California," Health Affairs 30, No. 1 (2011): 63-70.

Among the projected uninsured population of 3.1 million, 332,000 (11%) are newly¹¹ uninsured, 1.24 million (40%) are undocumented, 868,000 (28%) are documented but not subject¹² to the individual mandate, and 660,000 (21%) are documented and subject to the mandate but choose to pay the penalty instead.¹³

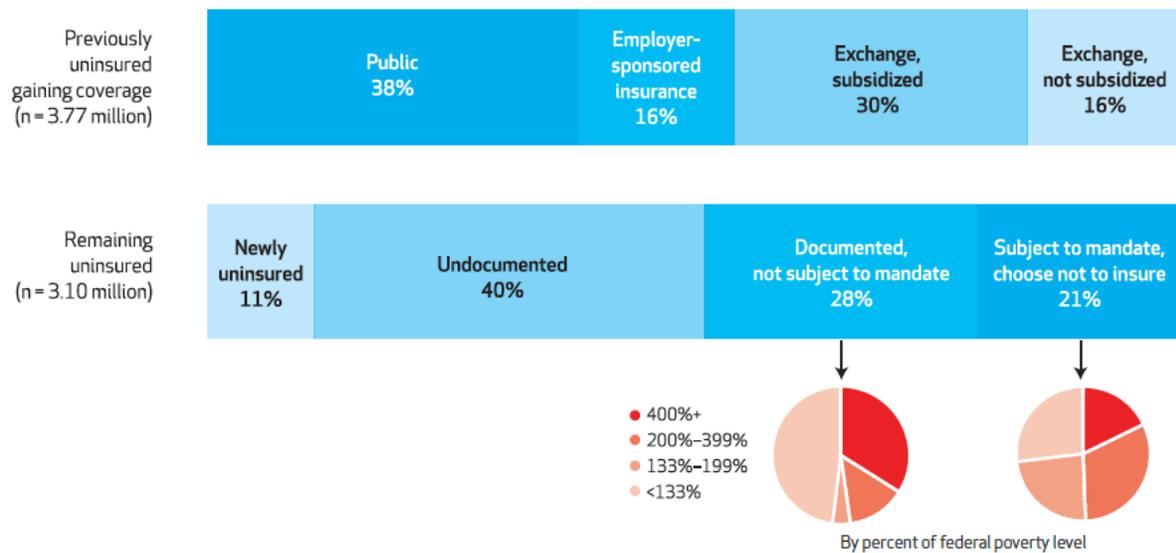


Figure 2. Projected Insurance Status in California After the ACA, 2016.

Source: Long P, Gruber J, "Projecting the Impact of the Affordable Care Act on California," Health Affairs 30, No. 1 (2011): 63-70

¹⁰ Ibid.

¹¹ This population would have been insured prior to federal reforms, largely due to employers dropping coverage or requiring higher employee contributions.

¹² If the cheapest insurance option exceeds 8% of an individual's income or if his/her income falls below the income tax filing threshold set for penalties, he/she is exempt from the mandate.

¹³ This population is expected to be evenly distributed across all income levels.

Newly Uninsured

In California, 600,000 previously uninsured are expected to gain coverage through their employers, while 332,000 previously insured are expected to lose their coverage, largely due to their employers dropping coverage or increasing the employee's contributions. This population can obtain affordable coverage through the Exchange, which will provide a virtual insurance marketplace for individuals and small businesses to shop for coverage. Many will be eligible for federal subsidies. Others will be eligible for coverage through the Medi-Cal program.

Documented & Formerly Uninsured

Over 1.5 million formerly uninsured individuals are expected to remain uninsured in 2016. This group is divided into two categories: those not subject to the individual mandate (868,000), and those subject to the mandate but choose not to seek coverage (660,000).

Not Subject to Mandate

This population is exempt from the individual mandate due to income limitations: the cheapest insurance option available exceeds 8% of their income or their income falls under the income tax filing threshold. Of this population, approximately half have incomes below 133% of FPL and a third have incomes over 400% of FPL.

The former would be eligible for the Medi-Cal program, which will expand in 2014 to provide full-scope coverage for adult US citizens and legal permanent residents (LPRs)¹⁴ with incomes under 133% of FPL. Although these individuals will not be forced to obtain coverage, this population must be made aware of the Medi-Cal program to receive timely primary/preventive care not only for the patient's benefit, but also for the state as well; preventive and primary care are significantly cheaper to administer than it is to treat severe/chronic illnesses and conditions.

In addition, because employers are expected to contribute less for employee health insurance,¹⁵ employee wages are expected to increase. While this would lead to more taxable income, those with incomes under 133% of FPL are projected to see lower taxes and see a savings of \$1,086 per household in 2016.¹⁶ These additional funds could be used to offset out-of-pocket health costs, either through public or private coverage. These individuals need to be aware of retroactive eligibility through the Medi-Cal program.

The second largest mandate-exempt income bracket (<400% of FPL) has the option of purchasing coverage through the Exchange, albeit without federal subsidies.

Subject to Mandate

The annual penalty for not having minimum essential coverage is the greater of the flat dollar amount per individual or a percentage of the individual's taxable income in excess of the filing threshold. The penalty for dependents under the age of 18 is half of the individual amount.

¹⁴ Unlike other states, California does not impose a five-year LPR requirement. If otherwise eligible, LPRs with less than five years of residency are eligible for full-scope Medi-Cal. Federal funds, however, cannot be used to treat this population.

¹⁵ Health insurance costs are expected to shift from employers to the federal government largely in the form of Exchange tax credits.

¹⁶ Long P, Gruber J, "Projecting the Impact of the Affordable Care Act on California," *Health Affairs* 30, No. 1 (2011): 63-70.

Year	Flat \$ Amount Per Individual	% of Taxable Income Per Individual
2014	\$95	1%
2015	\$325	2%
2016	\$695	2.5%
Post 2016	2016 Rate Indexed to Inflation	2.5%

Table 3. Individual Mandate Penalties

Source: Patient Protection and Affordable Care Act §1501 and §10106.

While there is not much that can be done about individuals/families who would rather pay a penalty, the combined costs of out-of-pocket care and penalties are designed to be enough of a deterrent to increase mandate compliance. If not, this population can seek care through safety net clinics and hospitals, emergency rooms, and private providers if they have the financial means.

This population is projected to be evenly distributed across the 4 income brackets studied (<133%, 133-199%, 200-399% and >400% FPL), and will be able to enroll in Medi-Cal or purchase coverage through the Exchange.

Undocumented

Despite health reform measures, 1.24 million undocumented, mostly-poor Californians will remain uninsured. This represents a disproportionately high share of the uninsured at 19%, compared to the national average of 10%. The undocumented cannot obtain full-scope benefits through Medi-Cal or purchase plans through the Exchange, with or without subsidies. The silver lining is that they will be exempt from the individual mandate and are eligible for emergency-only Medi-Cal services.

It is important to note that contrary to popular belief, the undocumented do *not* consume a disproportionately large share of health care services, but rather the opposite is true. A study¹⁷ by RAND found that although foreign-born adults in LA County constituted 45% of the county’s adult non-elderly population, they constituted only 33% of health spending in 2000. In addition, the undocumented made up only 12% of the non-elderly adult population but only 6% of spending. This population used disproportionately fewer services and contributed less to health care costs, likely because of their better relative health and/or lack of health insurance. These results were corroborated in another later study,¹⁸ which found that the cost of providing care to immigrants is lower than that of providing care to US citizens, and that immigrants are not contributing to disproportionately high costs in public programs such as Medicaid. Another study¹⁹ found that almost two thirds of utilization by the undocumented were for emergency department or perinatal services, which are already covered through the Medi-Cal program.

These findings suggest that expanding care to cover the undocumented may be more of a political landmine than a financial one.

¹⁷ Goldman DP, Smith JP, Sood N, “Immigrants and the Cost of Medical Care,” *Health Affairs*, 25, No. 6 (2006):1700-11.

¹⁸ Stimpson JP, Wilson FA, Eschbach E, “Trends in Health Care Spending for Immigrants in the United States,” *Health Affairs*, 29, No. 3 (2010):544-50.

¹⁹

Health Reform and Models for Care to the Residually Uninsured

The diversity of these residually uninsured groups makes it exceptionally difficult to have blanket strategies to provide coverage/care. An integrated combination of programs, approaches and funding mechanisms will be important in maintaining care to the uninsured, even after reform measures are implemented.

County Health Programs

Under Welfare and Institutions Code Section 17000, the State of California provides counties with an unusual amount of flexibility in providing care to their indigent population; they may set their own eligibility standards, covered benefits, reimbursement rates and design their own delivery systems. Care is often episodic, delivered through emergency departments, safety net hospitals and community clinics with little emphasis on the coordination associated with managed care.

This system is funded by a combination of local and state funds with federal subsidies for safety net hospitals and community clinics that largely serve the uninsured. These sources include realignment funds,²⁰ federal Disproportionate Share Hospital (DSH) and Safety Net Care Pool funds,²¹ Proposition 99 revenues,²² tobacco settlement funds and a county match.²³

To meet their residents' needs, counties provide and/or pay for care in different ways: 1) provide care in their own hospitals/clinics (provider counties); 2) pay for care delivered in private hospitals/clinics (payor counties); 3) provide outpatient care in their own clinics and pay for private hospital care (hybrid counties); or 4) collectively pay private providers for care in 34 small counties (CMSP counties).

Region	County	Type	Funding for Undocumented Care
Bay Area	Alameda	Provider	Y
	Contra Costa	Provider	Emergency/Inpatient Only
	Marin	CMSP	Emergency Only
	San Francisco	Provider	Y
	San Mateo	Provider	Y
	Santa Clara	Provider	Y
Central Coast	Monterey	Provider	Y
	San Benito	CMSP	Emergency Only
	San Luis Obispo	Payor	?
	Santa Barbara	Hybrid	Public Clinics
	Santa Cruz	Hybrid	Public Clinics
	Ventura	Provider	Y
Central Valley	Fresno	Block Grant	?
	Kern	Provider	Y
	Kings	CMSP	Emergency Only
	Madera	CMSP	Emergency Only
	Merced	Block Grant	?
	San Joaquin	Provider	Y
	Stanislaus	Hybrid	Public Clinics
	Tulare	Hybrid	Public Clinics

²⁰ Realignment funds are derived from a share of the state sales tax, as well as the vehicle licensing fee (VLF). These funds are used to pay for indigent health care, public health, mental health, social services and juvenile justice programs (WIC Section 17609).

²¹ These federal matching funds are used to pay for care to the uninsured in public and some private hospitals, counties, UC or District hospitals pay the match.

²² Proposition 99 increased the tobacco tax and designated care to the uninsured, anti-smoking education and research on cancer stemming from tobacco use as the recipients of these funds. The State of California has diverted virtually all the county Prop 99 funds to support state programs for the uninsured.

²³ County mandatory match is based on a calculation from 1988 that has not been updated since. County discretionary match is not reported.

North Central	El Dorado	CMSP	Emergency Only
	Napa	CMSP	Emergency Only
	Placer	Payor	?
	Sacramento	Hybrid	Public Clinics
	Solano	CMSP	Emergency Only
	Sonoma	CMSP	Emergency Only
	Yolo	Payor	?
North Rural	Butte	CMSP	Emergency Only
	Del Norte	CMSP	Emergency Only
	Humboldt	CMSP	Emergency Only
	Lassen	CMSP	Emergency Only
	Mendocino	CMSP	Emergency Only
	Modoc	CMSP	Emergency Only
	Nevada	CMSP	Emergency Only
	Plumas	CMSP	Emergency Only
	Shasta	CMSP	Emergency Only
	Siskiyou	CMSP	Emergency Only
	Sutter	CMSP	Emergency Only
	Tehama	CMSP	Emergency Only
	Trinity	CMSP	Emergency Only
Yuba	CMSP	Emergency Only	
Southern California	Imperial	CMSP	Emergency Only
	Los Angeles	Provider	Y
	Orange	Payor	N
	Riverside	Provider	Y
	San Bernardino	Provider	Y
	San Diego	Payor	N

Table 7. Indigent Program Type by County.

These programs have access to different revenue streams. For example provider counties (i.e. those with public hospitals) receive federal DSH and SNCP funds, which help support their care to the uninsured. CMSP, Payor and Hybrid counties have no access to this funding, but some private hospitals in these counties may receive these funds. Public hospital counties use their realignment and other local funds to match these federal funds.

	Provider	Payor	Hybrid	CMSP
Realignment	Yes	Yes	Yes	Yes
Proposition 99	Yes	Yes	Yes	Yes
DSH	Yes	No	No	No
SNCP	Yes	No	No	No
County Match	Yes	Yes	Yes	Yes

Table 8. County Health Funding by Indigent Program Type.

Source: Insure the Uninsured Project, "California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured: Counties, Clinics, Hospitals and Local Health Plans

Disproportionate Share Hospital

The federal disproportionate share hospital (DSH) reimbursement program pays for hospitals' uncompensated care to the uninsured.²⁴ These funds supplement hospitals that serve a significantly disproportionate number of low-income patients, including undocumented patients. Because the ACA provides coverage to US citizens and LPRs, DSH funding is anticipated to be drastically reduced under the rationale that uncompensated care will decrease with higher coverage rates. These funds must be redirected to continue providing care to the residually uninsured.

Safety Net Care Pool

The Safety Net Care Pool (SNCP) is a federal funding program aimed towards treating the uninsured. The new §1115 Medicaid Waiver provides \$7.6 billion in federal matching funds over five years, but cannot be spent on non-emergency care to the undocumented or new LPRs. These funds can only be used on specific state programs,²⁵ county LIHPs²⁶ or county Delivery System Reform Incentive Pool (DSRIP) programs.²⁷

While SNCP funds cannot be spent on non-emergency care to the undocumented or new LPRs, 13.95% of expenditures is assumed to be spent on non-emergency care to the undocumented or new LPRs.²⁸

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHC) are public and private non-profit health care organizations that meet specific criteria under Medicare and Medicaid Programs and receive federal funds under the Health Center Program.²⁹ These facilities receive higher reimbursement rates than non-FQHC clinics, and under the renewed §1115 waiver, each county must contract with at least one FQHC clinic.

County Services and the Undocumented

The nature of WIC §17000 allows counties to decide whether or not to provide care/coverage to the undocumented. Some counties therefore do not pay for such services, while others do to differing degrees. In the latter counties, residual care paid for by the county is likely to be largely for the undocumented as those uninsured who are eligible but do not enroll will be able to do so at the point of service.

The politically charged nature of providing care to this population might put already strained public funding allocations in jeopardy. Federal DSH funds are scheduled to decrease with modest reductions in 2014-16 and more severe reductions beginning in 2018 as the uninsured enroll in the coverage expansions; clinics' favorable FQHC reimbursements may change.

Regional differences and county system variations demand different approaches to providing care to the residually uninsured. Several California counties, cities and organizations have worked to provide different models of care, coverage or both.

²⁴ Federal law caps DSH payments at a hospital's actual cost for unreimbursed care to the uninsured plus the difference between this actual cost to Medi-cal reimbursement rates.

²⁵ These programs include: Breast Cancer and Cervical Cancer Screening and Treatment, Medically Indigent Adult Long Term Care, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Expanded Access to Primary Care (EAPC), AIDS Drug Assistance Program (ADAP) and the Department of Developmental Services (DDS). Up to \$400,000 can be spent annually on these combined programs.

²⁶ Up to \$600,000 can be spent annually on all county LIHPs.

²⁷ Through DSRIP, counties with public hospitals can receive federal matching funds for specified activities: infrastructure development, innovation and redesign, population-focused improvement, and urgent improvement in care. Funding is tied to measured progress and outcomes. Up to \$1-1.4 billion can be spent annually through DSRIP.

²⁸ California Bridge to Reform Demonstration §40.

²⁹ Public Health Service Act §330

Models of Care/Coverage to the Residually Uninsured

Strengthening the Safety Net

Safety net providers have been and will continue to be the most significant source of care for the under- and uninsured. As health reform efforts expand coverage, the strain on the safety net may be alleviated; conversely, this may leave safety net providers vulnerable to cuts in federal, state and local funding. Counties with existing strong safety nets are thus better equipped to provide services, oftentimes managed care, to the residually uninsured.

Healthy San Francisco and Healthy Way LA

In 2006, the city of San Francisco created a health care access program, Healthy San Francisco, for the uninsured by providing care for any uninsured adult city resident that are ineligible for other public programs, regardless of immigration status, employment status or pre-existing medical conditions. Healthy San Francisco provides medical homes and a primary care provider to each eligible³⁰ participant, as well as specialty care, urgent/emergency care, laboratory, inpatient hospitalization, radiology and pharmaceuticals, regardless of immigration status. This local program, which provides care regardless of immigration status, has experienced success and high patient satisfaction, with 86% of individuals reporting having a usual source of care, and a 94% satisfaction rate.³¹

Similarly, Healthy Way LA (HWLA) provides eligible US citizen/national or LPR county residents with medical homes at no cost at one of more than 100 clinic sites with federally matched funds. HWLA also has unmatched funds at their disposal, which are often used to provide care to the undocumented.

School-Based Health Centers

Additionally, school-based health centers (SBHC) provide a variety of services to students and their families, including primary care, mental/behavioral care, dental care, substance abuse counseling and case management. Services are provided at no or low cost, and are usually located on a school campus. SBHCs are funded through a mix of public/private insurance carriers, local/state/federal grants, philanthropic foundations, school contributions and through public programs.³² The ACA appropriated \$200 million for 2010-2013; in the first round of grants in July 2011, \$14 million went to more than 40 SBHCs in California.

Children's Health Initiatives and Healthy Kids

Children's Health Initiatives (CHI) also provide health coverage to all children, regardless of documentation status. Since 2001, CHIs across the state have helped enroll uninsured children in the Healthy Kids program through local public/private partnerships, now in 29 counties.³³ In October 2006, the Institute for Health Policy Solutions estimated a total enrollment of over 86,000 in 22 counties.³⁴ CHIs have additionally enrolled tens of thousands of additional children in Medi-Cal and Healthy Families.

Locally funded Healthy Kids programs provide health coverage to children ineligible for Medi-Cal or Healthy Families with family incomes up to 300% of FPL³⁵ regardless of immigration status,³⁶ and

³⁰ Participants must have a household income under 500% of FPL, be a San Francisco resident who can provide proof of SF residency, be uninsured for at least 90 days, between the ages of 18 and 64, and are ineligible for other public programs such as Medi-Cal or Healthy Families.

³¹ Kaiser Family Foundation, "Survey of Healthy San Francisco Participants," August 2009.

³² These programs include Medi-Cal, CHDP, Family PACT, Healthy Families and EPSDT (county mental health).

³³ CHI counties: Colusa, Del Norte, El Dorado, Fresno, Humboldt, Kern, Kings, Los Angeles, Marin, Mendocino, Merced, Napa, Orange, Placer, Riverside, Sacramento region, San Bernardino, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Yolo and Yuba.

³⁴ http://www.ihps-ca.org/localcovsol/_pdfs/CHI%20enrollment%200406_1006_rev.p

³⁵ Children with family incomes up to 400% of FPL are covered in San Mateo County.

³⁶ http://www.ihps-ca.org/localcovsol/_pdfs/WebsiteTableDocument_040607.pdf.

effectively act as a wraparound service to emergency-only Medi-Cal. These programs provide comprehensive care, including dental, vision, prescriptions and mental health benefits with modest premiums and co-pays. They do not receive any state or federal funding for services rendered.

Public-Private Partnerships

With state and local budgets dwindling and General Fund revenues flagging, public-private partnerships will be more important in bolstering the safety net.

To provide primary care to the millions of uninsured in Los Angeles County, the county established and expanded the Public Private Partnership (PPP) Program. The combined efforts of The California Endowment, the Community Clinic Association of Los Angeles County (CCALAC) and the County provided LA residents with incomes under 133% of FPL to access primary, specialty and dental services. A recent evaluation by UCSF found that the PPP program was an effective system for preventing morbidity, mortality, and the overuse of emergency services.³⁷

Another example is the In-Home Supportive Services (IHSS) Provider Plan, which offers qualified IHSS providers health coverage for \$1 per month. In Los Angeles County, this plan is sponsored by the Personal Assistance Services Council (PASC), which was established by the County Board of Supervisors.

Past pilot programs have also provided health care/coverage to the uninsured. SacAdvantage was a two-year pilot program that subsidized coverage to uninsured employees of small employers, and was jointly sponsored by PacAdvantage and funded by Sacramento County's tobacco litigation settlement funds.

Employer and Industry-Based Care

Large Employers

The pay-or-play requirements³⁸ in the ACA would extend coverage responsibilities to large employers (50+ full-time equivalents), who would be penalized if they do not offer full-time employees the opportunity to enroll in employer coverage, and at least one employee receives government subsidies for coverage in the Exchange. This provision is aimed to share coverage responsibilities with employers, and may indirectly benefit the undocumented, many of which are employed in the agricultural, garment, residential construction and landscape industries.

Some employers in these industries, such as the Western Growers Association (WGA), have taken on a proactive approach by not only providing insurance plans, but on-site clinics to provide primary care to their employees, regardless of documentation status. Additionally, WGA offers workers binational insurance plans that require patients to receive most of the costly care in Mexico. Due to enhanced security at border crossings, these plans are likely to be unpopular among those without proper documentation, but remain an option for new LPRs and those who receive the bulk of their treatment in Mexico.

Small Employers

Small businesses will not be subject to the pay-or-play provisions, but can purchase coverage through the Small Business Health Options Program (SHOP) in the Exchange. Unlike those purchasing individual coverage, employees of SHOP-participating employers generally do not qualify for premium tax credits. Instead, eligible employers will receive tax credits to subsidize the cost of coverage for their employees. To be eligible, an employer must have less than the equivalent of 25 full-time workers and pay an average wage of below \$50,000, in addition to providing coverage at least 50 percent of the cost of health care

³⁷ Geierstanger S, McCarthy L, "Expanding the Public-Private Partnership Program (PPP) to Meet the Needs of the Medically Underserved," Clinic Consortia Policy and Advocacy Program Evaluation, July 2010.

³⁸ ACA §1513

coverage for its workers based on the single rate³⁹. The tax credit is worth up to 35% of a small business' premium costs and up to 25% for tax-exempt employers. Beginning January 1, 2014 the credit will increase to 50% for taxable businesses and 35% for tax-exempt employers.⁴⁰

Because it is the *employer* who receives the credits and not the employees, small businesses may be able to provide coverage to their employees regardless of documentation status.

Additional Public Programs

Aside from public programs that provide full-scope coverage/care, there are a handful of programs that provide preventive care and screening/treatment for specific conditions.

Family Planning, Access, Care and Treatment

The Family Planning, Access, Care and Treatment (Family PACT) program provides no-cost comprehensive family planning services to men and women without coverage for such services. Eligible individuals must be California residents, ineligible for no-cost Medi-Cal, but with family incomes below 200% of FPL. They must also have no other source of health care coverage unless that use of coverage would create a barrier to access because of confidentiality.⁴¹ Services are provided regardless of immigration status.

Access for Infants and Mothers

The Access for Infants and Mothers (AIM) program provides low cost health insurance coverage to uninsured, middle-income (200-300% of FPL) pregnant women and infants up to age two who do not qualify for Medi-Cal or Healthy Families. Subscribers must be residents of California.^{42,43} The program provides comprehensive health care from the effective date of coverage until 60 days after the pregnancy has ended. Babies born to women enrolled in AIM are eligible for Healthy Families enrollment.

In 2014, maternity and newborn care must be covered through all Exchange plans, including catastrophic plans, and women with family incomes under 400% of FPL will receive a 100% federal match in the form of premium tax credits. Medi-Cal provides coverage of maternity services to pregnant women with incomes up to 200% FPL.⁴⁴ The state has recently proposed the integration of AIM into Medi-Cal, which will marginalize any undocumented moderate-income pregnant women enrolled in the program.

Child Health and Disability Prevention Program

CHDP is a preventive program that delivers periodic health assessments and preventive services (such as vaccines and immunizations) to low-income (0-200% of FPL) children and youth in California through private physicians, local health departments, community clinics, managed health care plans and some school districts. Undocumented children can receive services through CHDP, but are ineligible to participate in CHDP Gateway, which enrolls all eligible, uninsured children into Medi-Cal or Healthy Families.

California Children's Services

California Children's Services (CCS) provides diagnostic/treatment services, medical case management and physical/occupational therapy to children under the age of 21 with CCS-eligible medical conditions,

³⁹ ACA § 1312(f)(3).

⁴⁰ <http://www.irs.gov/newsroom/article/0,,id=223666,00.html>

⁴¹ Welfare and Institutions Code Section 24003,

⁴² 10 CCR § 2699.200.

⁴³ Insurance Code § 12698.

⁴⁴ Women with incomes between 0-133% FPL are eligible for full-scope Medi-Cal, while women with incomes between 133-200% of FPL are only eligible for restricted scope Medi-Cal, which includes maternity/prenatal services.

which include cystic fibrosis, hemophilia, cerebral palsy, heart disease and cancer. Much like GHPP, CCS' counterpart program for adults, CCS provides services towards the designated condition, not holistic health. Eligible children must be California residents⁴⁵ with family incomes less than \$40,000 in the most recent tax year with CCS-eligible conditions.⁴⁶ The projected caseload for FY2010-11 is 172,000, with an average cost of \$6,808.11 per enrollee.⁴⁷ CCS State Only, a small subsection of CCS, provides services to undocumented children with state and county funds, while citizen children are treated through CCS Healthy Families.⁴⁸

With guaranteed issue already in effect for children, the future of CCS is uncertain in a post-reform California. Cuts to the program may put severely ill undocumented children at even more risk.

Cancer Screening and Treatment Programs

Through the Every Woman Counts (EWC) program, women are eligible to receive free breast and cervical cancer screening services/treatment if their household income is less than 200% of FPL, have limited or no health insurance to pay for treatments, and are at least 40 years old (breast cancer) or 25 years old (cervical cancer). Women must also be California residents,⁴⁹ and the program is funded by tobacco tax revenues, the Breast Cancer Control Account (BCCA), and a 50/50 federal match. This program is projected to cost \$65 million in 2011-12 of which \$28 million is state General Fund.

Similarly, men are eligible to receive prostate cancer screening and treatment services as needed through IMPACT (IMProving Access, Counseling & Treatment for Californians with Prostate Cancer), which is operated under contract by the University of California – Los Angeles.

Genetically Handicapped Persons Program

The Genetically Handicapped Persons Program (GHPP) is a health care program for adults ages 21 and up with certain genetic diseases, such as cystic fibrosis, hemophilia, Huntington's Disease and sickle cell disease. Where there is no income limit for eligibility, applicants may be required to apply for Med-Cal, and some may be required to pay an enrollment fee based on income and family size. GHPP benefits are limited to treatment of the designated medical condition, and under the renewed §1115 waiver, GHPP is eligible for additional federal matching funds through the SNCP fund.

In 2014, the ACA bars exclusions due to medical conditions, and Medi-Cal and Exchange plans will provide treatment for adults with serious illnesses now covered by GHPP. The benefits provided through Exchange plans may not be as comprehensive as those provided by GHPP, which include reconstructive surgery; durable medical equipment and their upkeep, maintenance and care; transportation to other services; genetic and long-term psychological counseling; and case management.⁵⁰ The elimination of this program could exclude the residually uninsured with such conditions to the extent they participate in this program.

AIDS Drug Assistance Program

ADAP (AIDS Drug Assistance Program) covers the costs of authorized prescription drugs to adult California residents with AIDS who have household incomes under \$50,000;⁵¹ those with incomes under 400% of FPL have no payment obligations, while individuals with incomes between 400% of FPL and \$50,000 are responsible for cost-sharing.⁵² The estimated caseload for FY 2008-09 was 34,287.⁵³ This

⁴⁵ Government Code § 243-44.

⁴⁶ Health and Safety Code § 123870.

⁴⁷ State of California, Department of Health Care Services – Fiscal Forecasting and Data Management Branch, Family Health May 2010 Local Assistance Estimate for FY 2009-10 and 2010-11 – California Children's Services, Report Date: May 2010.

⁴⁸ CCS Healthy Families receives a federal match, and is eligible to receive additional federal SNCP funds, which cannot be used towards the care to the undocumented.

⁴⁹ Health and Safety Code Section 104162

⁵⁰ Health and Safety Code Section 125140

⁵¹ Welfare and Institutions Code Section 14149.3(a)

⁵² Health and Safety Code Section 120960

program is funded by General Funds (\$96.3 million in FY2009-10⁵⁴), federal funds (\$88.4 million⁵⁵), and the ADAP Special Fund (\$233.3 million⁵⁶). Under the new waiver, ADAP can receive federal matching funds through the SNCP. The undocumented are ineligible for this program.

Private Insurance Exchanges

Private insurance exchanges may be an alternative for coverage for the residually uninsured. Insurance providers such as WellPoint are creating private alternatives in the Midwest to not only compete with state exchanges, but to provide a marketplace in states whose governments will not operate exchanges.

Insurance providers may be opting for private alternatives to skirt the exchange provisions of the ACA regarding benefit levels and pricing; private exchanges may have higher prices, fewer benefits and laxer regulations to protect consumers than public ones. However, this may be an acceptable option for the undocumented, who cannot purchase plans through public state/federal exchanges.

Mental Health Services

California mental health services are funded in several different ways for different populations 1) by Medi-Cal and county mental health realignment for Medi-Cal patients with severe mental illness, 2) by Medi-Cal managed care plans for Medi-Cal patients with mild mental illness and 3) by county mental health realignment for the uninsured with severe mental illness. Counties organize and pay for community mental health services while the state mental hospitals care for a small number of individuals with civil or criminal commitments. County mental health responsibilities are targeted to the severely mentally ill, and mostly serve the Medi-Cal population and the medically indigent. These services are funded by a blend of local funds, realignment funds, Medi-Cal mental health service reimbursements for Medi-Cal beneficiaries, as well as state and local appropriations.⁵⁷ Realignment funds are derived from two 1991 tax subventions: a portion of the sales tax and vehicle licensing fees (VLF).

There is no statewide information on county mental health spending for the uninsured.

In the past, more realignment funds may have been spent for care to the Medi-Cal population due to the opportunity to maximize federal matching funds, potentially neglecting the behavioral health needs of the medically indigent uninsured. The implementation of the §1115 Medicaid waiver, however, incorporates mental health coverage as a mandatory benefit for those with incomes under 133% of FPL, and financially incentivizes counties to provide mental health services to those uninsured, who qualify for uncapped federal matching funds. The ACA also includes mental health and substance abuse treatments as a part of the essential benefits for every citizen and LPR.

It is unclear how mental health services will be provided to the residually uninsured. With such services covered through Medi-Cal and Exchange plans, more funding may be available to provide behavioral and substance abuse treatment to the indigent. Because federally matched funds will be used to treat patients, only citizens and LPRs may be eligible for county mental health services.

It is an understatement that the integration of physical and mental health is a complicated matter, and yet it manages to be an even more difficult one when considering a patient's documentation status. The confluence of highly stigmatized disorders and a low-utilization population makes this an almost Sisyphean task; how do we treat "invisible" disorders in an "invisible" population?

⁵³ State of California, Department of Public Health, AIDS Drug Assistance Program (ADAP) Estimate Package – 2009-10 May Revision.

⁵⁴ Ibid.

⁵⁵ Ibid.

⁵⁶ Ibid.

⁵⁷ Welfare and Institutions Code Section 5700(a)

Treatment for severe-enough cases with physical comorbidities can be covered by emergency Medi-Cal, but it is unsure how mild/moderate behavioral or substance abuse disorders will be treated/paid for in the undocumented population. Some community clinics, including FQHC clinics, have begun incorporating basic mental health screening, treatment and counseling services.

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