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CLIENT ALERT

Outlook on California's Health Care Landscape After the 2016 Elections

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The Affordable Care Act (ACA) was enacted in 2010 and most of its provisions became effective by 2014. President Obama's signature law ushered in nation-wide health insurance reforms and new pathways for coverage, but also created controversy over some of its key provisions—like the mandate to purchase insurance.

As an early adopter of many of the ACA reforms, California's health care coverage system has undergone considerable restructuring and expansion, including creation of a state-based health insurance exchange and full implementation of the ACA's proposed Medicaid expansion. President-elect Donald Trump made repeal and replacement of the ACA a centerpiece of his domestic agenda on the campaign trail. Given Republican control of the White House and continued Republican majorities in Congress, repeal—or at least a substantial modification—of the ACA is highly likely. As a state that has fully embraced the ACA, any repeal and replace legislation or rulemakings will have a considerable impact on California's health care coverage systems.

Based on the passed and vetoed January 2016 repeal measure ("Reconciliation Bill"), the President-elect's campaign proposal and Speaker Paul Ryan's June 2016 "A Better Way" proposal ("House Republican Proposals"), we can expect considerable shifts in federal health care policies over the next several years. Notably, Rep. Ryan's proposal is similar in many ways to the newly appointed Health and Human Services Secretary nominee Rep. Tom Price's (R-GA) 2015 "Empowering Patients First Act", and may offer predictive guidance. Below is an assessment of the effects these proposals may have on California's health care coverage systems.

1. **Repeal and Replacement of the ACA Would Significantly Restructure California's Private Insurance Market and Create Major Challenges for Private Insurers and Covered California.**

The ACA expanded insurance coverage options by creating health insurance marketplaces and providing premium and cost-sharing assistance for qualifying lower-income individuals who purchase coverage on them. On September 30, 2010, California became the first state to authorize a state-based health insurance marketplace, known as Covered California, through the passage of two corresponding bills, AB 1602 and SB 900 (the "California Patient Protection and Affordable Care Act"). As of March 2016, Covered California has more than 1.4 million enrollees. Approximately 90 percent of these enrollees receive premium assistance and most also receive cost-sharing reductions.

Initially, Covered California relied heavily on federal and private grants for its operations. But in 2016-2017, Covered California is wholly self-sufficient for the first time, relying exclusively on saved federal funds and participation fees imposed on contracted issuers' commercial business. Because of Covered California's self-sufficiency, reductions in federal funding to the marketplace itself should not have a direct impact on its administrative operations. Covered California's sustainability, however, is heavily tied to the number of enrollees and, relatedly, the number of contracted issuers offering health plans within the individual and small group markets.

The private insurance expansion of the ACA rests on what has often been described as a three-legged stool, each peg of which is necessary for the expansion to survive. One leg is market reforms that prevent insurers from denying coverage or raising premiums based on preexisting conditions, coverage mandates such as the essential health benefits rules and the bans on annual and lifetime limits, and community premium rating. The effects of this first leg are to reduce insurers' ability to control risks and to increase premiums. The second leg counteracts this by increasing the size and reducing the average age of the insurance pool by requiring that everyone have insurance—via the individual and employer mandates—and by creating risk adjustment programs for insurers. The third leg deals with the reality that many individuals and small businesses simply cannot afford health insurance—particularly given the benefits mandated under the ACA—by providing subsidies, such as advance premium tax credits and cost-sharing reductions.

The House Republican Proposals scale back or eliminate elements from each of the three legs. On the first leg, they eliminate some market reforms such as the essential health benefits rules and they permit more flexibility, such as a modification to the age rating bands from 3:1 to 5:1. Although they retain the prohibition on exclusions for pre-existing conditions, the proposals nonetheless contain provisions that limit or counteract the risk from such enrollments. On the second leg, the House Republican Proposals appear to entirely eliminate the individual and employer mandates and insurer risk-adjustment programs. On the third leg, the proposals continue premium subsidies in the form of advance premium tax credits, but substantially reduce the amounts, including the elimination of cost-sharing reductions.

The intended effect of the House Republican Proposals would be to place more control over the health insurance market with the market participants—insurers and individual and group purchasers of insurance. While premium subsidies would likely be much lower, the intent is for plans to have greater flexibility to create low-cost plans to attract younger and lower-income adults even at the reduced premium support levels. On the other hand, individuals and employers would have no obligation to purchase coverage.

With the elimination or substantial modification of the ACA reforms, Covered California will need to adjust to remain viable. For example, Covered California (with legislative assistance) could encourage or at least permit insurers to offer benefit plans with less rich benefits that will attract enrollment at lower premium support levels and without cost-sharing subsidies. Covered California also could modify its approach to key factors that guide plan selection and offerings, including risk mix, administrative costs, benefit design and overall plan pricing. If Covered California is unable to adjust or if its adjustments are ineffective, it may require state funding to support continued operations. It remains unclear whether insurers in California, which have participated at levels greater than in other state exchanges, would continue to find Covered California a viable market for their products.

2. Repeal of the ACA Would Create Significant Uncertainties for California Health Care Laws.

The ACA and its promulgated regulations include significant market reforms, heavily regulating the benefits and costs of health insurance. While the House Republican Proposals retain some of these reforms, many others are left unaddressed and seem likely to be eliminated. These include coverage of essential health benefits (EHBs), zero-cost preventive coverage, maximum out-of-pocket limits, bans on annual maximums, and possibly the reporting and maintaining of medical loss ratios.

As part of its adoption of the ACA, the California Legislature enacted carbon copy legislation which made many ACA provisions also matters of California law. This permitted California's regulators, the Department of Managed Health Care, the Department of Insurance, Covered California, and Department of Healthcare Services (DHCS), to directly enforce them.

But many of these carbon copy acts directly reference ACA provisions. For instance, the Covered California authorizing legislation states that the Board must "meet[] the minimum requirements of Section 1311 of the federal act" and must establish a small business exchange "in a manner consistent with [] Section 1312 of the federal act." Other California statutes do not just reference the ACA, but are contingent on its continued existence. For example, the statute requiring all health plans operating in the individual and small group markets to provide the ACA's EHBs states it is to be "implemented only to the extent [EHBs] are required pursuant to PPACA."

Depending on how Congress enacts a modification or a repeal and replacement of the ACA, many of California's ACA implementation statutes may become open to interpretation or may be in effect repealed. Either way, California's health insurance regulatory approach faces significant uncertainties and will likely require significant legislative action to adjust to the new federal health care scheme. Further, the politics of health care reform are very different in the forthcoming Republican-controlled federal government and the Democrat-controlled California government. The reforms pushed at the federal level are likely to be unpopular with California legislators. This could create a push for California to pursue a legislative or initiative-based approach to retain some or all of the ACA reforms or even implement a single payer-type system.

3. New Proposals for Medicaid Would Not Significantly Affect Current Funding Levels for Medi-Cal's Pre-ACA Expansion Population.

Medi-Cal (California's Medicaid program) has served California residents since 1966. Established by Title XIX of the Social Security Act, the Medicaid program is a public health insurance program that provides services at no or low cost for certain low-income individuals. Although the program is administered by DHCS, Medi-Cal is jointly financed by the state and federal governments. Prior to the ACA, traditional Medi-Cal had 7.7 million enrollees. As of August 2016, Medi-Cal has over 11.8 million enrollees, many of whom became eligible under the ACA's Medicaid expansion.

Rep. Ryan's proposal envisions greater state flexibility in administering the Medicaid program, such as the ability to charge premiums for certain beneficiaries and for the delivery of optional benefits. He proposes a choice of two federal funding mechanisms for Medicaid: a default per capita allotment and an optional block grant. Per capita allotments would be available in four major beneficiary categories: aged, blind and disabled, children, and adults. State per capita rates would be adjusted based on their traditional Medicaid matching rates (FMAP). Alternatively, a block grant, which the President-elect has proposed as the sole Medicaid funding mechanism, would provide states with a federal grant as determined by traditional matching rates during a base year, with a requirement that states transition their Medicaid expansion population to other forms of coverage. Rep. Ryan's proposal also would provide for slower future rate increases than provided under current law.

While the different funding mechanisms offer various pros and cons, the per capita allotment option would likely permit California to maintain federal funding similar to the level it currently enjoys, although with slower future growth. The block grant, while potentially providing more flexibility, would likely lend to fluctuations in funding if Medi-Cal enrollment numbers rise above the base year. If California defaults into a per capita allotment-type funding mechanism, it is reasonable to expect its Medi-Cal program largely would maintain its current federal funding for the pre-ACA eligible population, and the program should remain unaffected—at least for that population. Further, should DHCS have a need to modify the Medi-Cal program, its increased regulatory control likely would provide such flexibility.

4. **Repeal and Replacement of the ACA May Reduce Funding to the Medi-Cal Expansion Population, Possibly Making it Difficult for California to Sustain its Current Structure.**

The ACA included a major expansion of the Medicaid program by opening it to adults with incomes up to 138 percent of the federal poverty level (FPL). Although the ACA initially made a state's receipt of existing Medicaid funds contingent upon its implementation of the expansion, the Supreme Court's June 28, 2012 decision in *National Federation of Independent Business v. Sebelius* declared the contingency unconstitutional and made Medicaid expansion by states voluntary. On June 27, 2013, California authorized a Medi-Cal expansion to cover nearly all nonelderly adults with incomes at or below 138 percent FPL through two corresponding bills, AB 1x1 and SB 1x1. The full expansion was implemented on January 1, 2014. Since then, Medi-Cal has grown from 7.7 to 11.8 million enrollees, with most new enrollees projected to be among the newly-eligible.

Under the ACA, the states are provided with federal support for the expansion population on a sliding scale. States are provided with 100 percent federal funding for 2014 to 2016, and eventually phasing down to 90 percent in 2020 and beyond. California's authorizing legislation makes the continued implementation of the Medi-Cal expansion contingent on the provision of these federal funds. Specifically, if funding falls below 90 percent, the reduction shall be addressed through the annual state budget or legislative process and the Director of Finance must notify specified state actors. If, prior to January 1, 2018, funding falls below 70 percent, the Medi-Cal expansion is statutorily required to cease 12 months after the effective date of the federal law or action reducing funding. As such, the viability of the program hinges upon continued federal funding for the Medi-Cal expansion population at near-current levels, unless state lawmakers find other sources of revenue.

Republican approaches to the Medicaid expansion population differ widely. The Reconciliation Bill would have eliminated federal funding for Medicaid expansion as of December 2017. While the details are unclear, Rep. Ryan's proposal would appear to grant states that select his proposed per capita allotment funding option the ability to continue to receive federal funding for the expansion population. Rates would remain at ACA levels until 2019. After then, they would be reduced to the state's standard FMAP. In either case, funding for the expansion population would seemingly not drop below 70 percent prior to January 1, 2018, avoiding the automatic termination of the expansion program under California law. Nonetheless, California's Medi-Cal expansion is at risk of significant reductions in federal funding over time. The financial sustainability of the Medi-Cal expansion may require a restructuring of the program, including potential modifications to benefit designs and eligibility. In addition, the California legislature may need to determine alternate funding sources to maintain current coverage levels.

5. **Repeal and Replacement of the ACA May Reduce CHIP Funding to Pre-ACA Levels, Making it Difficult for California to Sustain its Current Structure.**

The Children's Health Insurance Program (CHIP), formally the State Children's Health Insurance Program, was created by the Balanced Budget Act of 1997 and enacted as Title XXI of the Social Security Act. Under the ACA, the federal matching rate for CHIP was increased by 23 percent. On April 16, 2015, through bipartisan support, the Medicare Access and CHIP Reauthorization Act of 2015 was passed, extending funding for the program for two years.

Beginning in January of 2013, California transitioned CHIP (formally Healthy Families) eligible children into Medi-Cal under a four-phase approach. While now considered a part of Medi-Cal in California, children up to age 19 that are not otherwise eligible for traditional Medi-Cal, are covered through the enhanced CHIP federal matching rate up to 266 percent FPL.

Although the proposals generally maintain funding for CHIP, Rep. Ryan's proposal eliminates the ACA's 23 percent federal funding increase. If this proposal is enacted, California's Medi-Cal program would face a reduction in matching federal funding levels from 88 percent to 65 percent. Depending on the level of funding provided, California's legislature and DHCS would need to re-evaluate Medi-Cal benefit designs and eligibility to ensure the program is sustainable at lowered federal support.

6. Other House Republican Proposals Could Also Significantly Affect the California Insurance Market.

Other elements of the House Republican proposals could also have a major impact on the California insurance market. These include federal support for the creation of state high-risk pools, a federal statutory scheme permitting state insurers to sell health plans across state lines, and tort reform. While not a necessary part of a repeal and replacement bill, Rep. Ryan has also proposed structural changes to the Medicare program. Ryan's proposals are far-reaching, ranging from changes in coverage programs to changes in provider rules and could impact many California Medicare programs and entities. These proposals are best suited for a fuller treatment in a separate article or articles.

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It is clear that any effort to modify or repeal and replace the ACA will have wide-spread effects across the nation. As the most populous state in the U.S. with a holistic adoption of many of the ACA's health reform efforts, the ability to maintain affordable coverage pathways for Californians currently covered under ACA programs will depend on the state's ability to adapt to these shifting federal health care policies or chart its own course. Either approach may require the California legislature to raise revenues to cover additional state expenditures.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.