The Future of Healthy Families

Summary of Report Prepared by Urban Institute

Overview:

The Affordable Care Act (ACA) provides an opportunity for states to locate its Children's Health Insurance Program (CHIP) in three different places: a stand-alone Healthy Families Program (an HFP similar to what we have today), an expansion of Medi-Cal, or within the Exchange. The Urban Institute explored these various scenarios in a report published February 2012. A summary of the findings is presented below.

All scenarios are compared to HFP continuing as is, for children who will qualify in 2014 and thereafter.

Full Medi-Cal Shift:

If all HFP children move to Medi-Cal, some would gain and some would lose. Although it is not clear if benefit or harm would predominate.

Gains in Affordability: Medi-Cal coverage would be more affordable than HFP for many children. Those in families with incomes at or below 150 percent of federal poverty level would no longer be charged premiums and copayments, which could improve participation and access to care.

Filling gaps in employer-based coverage: HFP disqualifies children who receive employer-sponsored insurance (ESI). By contrast, Medi-Cal supplements ESI benefits and pays ESI cost-sharing.

Better coverage of mental health care: Compared to HFP, Medi-Cal provides better coverage of and access to mental health treatment. As guaranteed by federal law, Medi-Cal covers "Early and Periodic Screenings, Diagnosis, and Treatment." EPSDT provides a broader scope of mental health coverage than is offered by HFP.

More comprehensive benefits: EPSDT provides a broader scope of coverage than is offered by HFP, as noted above. HFP's benefits meet the needs of most children, who are healthy. When children with special health care needs need additional benefits, they can often obtain them through HFP's supplemental "carve-out" contacts with counties.

However, outside the mental health context, it is not known how many HFP children would benefit from EPSDT because they need services that are not covered by either HFP or the carve-outs.

Continuity of coverage: Serving low-income children through one rather than two programs would prevent children from falling through the cracks when they transition between programs. However, the number of children who currently lose coverage in such transitions is unknown.

In addition, the ACA's more streamlined and electronic administrative methods should reduce the coverage gaps that accompany transitions between programs.

Stronger appeals mechanisms: Grievance and appeals procedures are more rigorous in Medi-Cal than HFP. Medi-Cal hearings are immediately available to families who want to challenge decisions. However, it is not clear how many children need these safeguards.

Reduced access to providers: Many HFP children would see their access to providers diminish under Medi-Cal. Provider participation shortfalls result in significant part from lower reimbursement rates under Medi-Cal.

Nearly 50,000 HFP children in rural areas would experience reduced access to providers if the moved from HFP managed care to Medi-Cal's fee-for-service care. In addition, Kaiser Permanente, which provided coverage to 174,221 HFP children during the average month in 2010, may not continue to participate to the same extent if children move to Medi-Cal.

And while the ACA provides increased reimbursement rates for Medi-Cal coverage of certain primary care services in 2013 -14, it is not clear how much impact this time-limited and targeted bump will have on Medi-Cal's delivery system.

More cumbersome enrollment and retention procedures: Enrollment and retention are harder with Medi-Cal's county-based eligibility system than with HFP's single point of entry. Although county-based enrollment and retention is likely to improve under the ACA, the full extent of that improvement is not yet known.

Loss of the Managed Risk Medical Insurance Board (MRMIB): With HFP as its largest program, MRMIB has a focus on children's needs that is not possible for the Department of Health Care Services (DHCS), given its multiple and complex responsibilities.

Risk of Transition: More than a quarter of HFP children will need to change health plans (and perhaps providers as well). In addition, some children will experience gaps in coverage as the state and counties make transfers between programs.

HFP Administration Shifts to the Exchange

The Urban Institute notes that based on what is known to-date, moving HFP administration, while retaining it as a separate program, has disadvantages for low-income children.

Fewer agencies determining eligibility: Moving HFP eligibility to the Exchange would reduce the number of entities determining eligibility – rather than the Department of Health Care Services (DHCS), MRMIB and the Exchange each playing a role, only DHCS and the Exchange would be involved.

However, California may implement a single, integrated system of eligibility under the ACA.

A high-profile administrative agency: HFP may benefit from being housed in a larger, more powerful entity. However, the Exchange is unlikely to give the kind of attention to children's issues that MRMIB provides because of the Exchange's wide-ranging responsibilities and daunting workload.

An administrative agency that has not been observed: Because the Exchange does not have a track record, shifting administration is inherently risky.

Increased leverage for the Exchange: Responsibility to administer HFP would give the Exchange control over more covered lives that appeal to insurers. This additional leverage could help accomplish the Exchange's objectives of transforming California's insurance markets and health care delivery system.

Administrative efficiency: Administrative efficiencies could result from moving HFP administration into the Exchange, with common functions performed centrally.

Simplicity: Having Medi-Cal and the Exchange versus Medi-Cal, HFP, and the Exchange would be simpler. However, simplicity's advantages can be overstated. Massachusetts's health benefits are highly complex but the state has been effective in covering its residents.

Plans in the Exchange Provide HFP Coverage to HFP Children

Under this scenario, health plans that offer individual coverage through the Exchange would give HFP children HFP-level benefits and cost-sharing protections. Additional services would be available through carve-outs similar to the ones we have today. The factors described below create the possibility of significant net gains for low-income children.

The factors listed under "HFP Administration Shifts to the Exchange" also apply to the scenario below.

Broader provider networks: Commercial coverage could substantially broaden the provider networks that are available to HFP children. Additional research is needed to confirm the differences between provider participation in HFP and the kind of commercial coverage that will be offered in the Exchange.

Branded commercial coverage: Access to "mainstream" commercial plans would likely increase under this scenario, which low-income families value.

All family members within the same plan: Families with income exceeding Medi-Cal's level would have the ability to enroll parents and children in a single health plan. However, the extent to which children will benefit is unclear. Though research indicates children benefit when their parents receive coverage, no research shows any added benefit to having both parents and children on the same plan.

Diminished access to safety net coverage: Having plans in the Exchange provide HFP coverage to HFP children could reduce children's access to safety-net plans that choose not to join the Exchange. According to some, such plans offer unique expertise in meeting the needs of low-income children.

Feasibility: It is not realistic to fund HFP-level benefits at current commercial provider rates, given the state's constraints. The Health Insurance Policy Simulation Model (HIPSM) estimates that this approach would increase state HFP costs between 40-75%.

The full report is available at: http://bit.ly/UrbanInstitute1