THE AFFORDABLE CARE ACT: CONTINUED IMPLEMENTATION

The California Health Benefits Review Program (CHBRP) is charged with providing the California Legislature with independent analysis of health benefits legislation proposed in California. In order to address initial implementation of the Affordable Care Act (ACA)[1] of 2010, CHBRP made alterations to its cost impact analysis approach, which are described in *The Affordable Care Act: Initial Impacts of Implementation*.[2] This document describes CHBRP's consideration of the continuing implementation of the ACA.

In order to fulfill its charge, CHBRP continues to assess the effects of enrollment changes, benefit design, and other federal requirements. As these changes emerge in California's health insurance markets through the ongoing implementation of the ACA, CHBRP analyses consider:

- *Medical effectiveness*[3]—through review of scientific literature and other relevant sources, CHBRP strives to determine whether or not medical interventions related to proposed health benefit bills have been proven to be effective. Based on current science, rather than law, CHBRP's evidence-based review process has not been affected by the ACA.

- *Benefit coverage, cost and utilization*[4]—through bill-specific analysis, based greatly on use of CHBRP's annually updated Cost and Coverage Model (CCM), CHBRP projects baseline enrollment, benefit coverage, premiums, and utilization, as well as enrollee cost sharing for noncovered benefits. This document is a discussion of how CHBRP is able to address changes in these baselines related to continuing implementation of the ACA.

- *Public health*[5]—through current information on the state's population and its health, as well as the bill-specific analysis of medical effectiveness and possible cost impacts, CHBRP projects effects on the health outcomes of Californians with health insurance that would be subject to a proposed health benefit law. Through its efforts to accommodate

[1] The federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (P.L 111-152) were enacted in March 2010. Together, these laws are referred to as the Affordable Care Act (ACA).
[2] Available at: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php
[3] More information on CHBRP's approach to analyzing medical effectiveness is available at: http://www.chbrp.org/analysis_methodology/medical_effectiveness_analysis.php
[4] More information on CHBRP's approach to analyzing cost impact is available at: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php
[5] More information on CHBRP's approach to analyzing public health impacts is available at: http://www.chbrp.org/analysis_methodology/public_health_analysis.php

the continuing implementation of the ACA in its cost impact analyses, CHBRP is also able to address those changes in its public health impact analyses.

For CHBRP's 2017 analyses, which will analyze bills that could become law in 2018, the CCM will be updated to project baseline 2018 enrollment and premiums. Each analysis will also consider the broader policy landscape, including continuing implementation of the ACA, as it will be in 2018. Below is a discussion of continuing ACA implementation and related factors that will, or may, affect CHBRP's 2017 efforts.

AutomaticallyAddressed in Updates to CHBRP's Cost and Coverage Model

A number of aspects of the continued implementation of the ACA will be automatically addressed through CHBRP's annual update of its Cost and Coverage Model (CCM). The CCM, which projects baseline enrollment and premiums, is a key part of CHBRP's approach to analyzing proposed legislation.[6] Every year, CHBRP updates the CCM so that a bill's impacts can be presented as changes from what would be, or the "baseline," if the bill did not pass.

Medi-Cal Expansion

Two changes to the ACA-related expansion of Medi-Cal (California's Medicaid program) are expected to be in effect in 2018.

Medicaid funding for the childless adult expansion of Medi-Cal. Through initial implementation of the ACA, California participated in the voluntary expansion of its Medi-Cal program to include childless adults earning up to 138% of the Federal Poverty Level (FPL).[7] Prior to this expansion, the Medi-Cal program included primarily low-income children, expectant mothers, parents, disabled adults, and the elderly (with Medi-Cal generally being only secondary insurance for the elderly). Federal funding for Medi-Cal beneficiaries who were eligible prior to the ACA expansion is 50%[8] with additional federal funding for Medi-Cal provided through California's participation in the Children's Health Insurance Program (CHIP).[9,10] Eligibility for theses beneficiaries is automatically addressed through CHBRP's annual update of its CCM, which projects a primary source of health insurance for all Californians.[11] Funding for the childless adult Medi-Cal expansion participants is mainly provided by the federal government,

[6] A summary of CHBRP's Cost and Coverage Model is available at: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php
[7] IC § 12698.30; W&IC modifying § 14005.60
[8] Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2016, through September 30, 2017. Department of Health and Human Services. December 29, 2015. Available at: https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages
[9] Through CHIP, the federal government pays 88% of the costs for children dually eligible for CHIP and Medi-Cal (the state pays the remaining 12%). This combined funding for some Medi-Cal beneficiaries results in approximately 57% of Medi-Cal's total funds coming from federal sources.
[10] LAO Report; The 2016-17 Budget: Analysis of the Medi-Cal Budget. Legislative Analyst's Office. February 11, 2016. Available at: http://www.lao.ca.gov/Publications/Report/3350
[11] More information on CHBRP's sources is discussed in CHBRP's document *Estimates of Sources of Health Insurance for California for 2017* available at: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php

and although eligibility for the expansion population is also expected to be unchanged in 2018, the federal contribution amount for the expansion population is scheduled to decline to 94%.[12] Table 1 below describes the annual changes in federal and state contributions for the expansion population.

Table 1. Annual Changes to Federal Funding for the Childless Adult Medi-Cal Expansion Population

Year	Federal Contribution	State Contribution
2014–2016	100%	0%
2017	95%	5%
2018	94%	6%
2019	93%	7%
2020 and beyond*	90%	10%

Source: Federal register, Vol. 77, No. 57.
Notes: *CHBRP is unaware of any current guidance suggesting further change after 2020.

Although not anticipated to drop below 90%, were federal contributions for the childless adult Medi-Cal expansion population to fall below 70%, California has legislated a "safety valve" that would trigger withdrawal from participation in the expansion.[13] As the federal match is scheduled to be above the trigger threshold in 2018, CHBRP expects California to continue participating in the Medi-Cal expansion, despite the planned gradual decrease in the federal contributions for the expansion population. California's continuing inclusion of the expansion population in Medi-Cal will be addressed through CHBRP's regular use of Medi-Cal administrative data, the California Health Interview Survey (CHIS) estimates, and the California Simulation of Insurance Markets (CalSIM) estimates to update CHBRP's CCM projections of Medi-Cal enrollment and premiums related to Medi-Cal beneficiaries enrolled in Department of Managed Health Care (DMHC)-regulated plans.

Expansion of Medi-Cal to include undocumented children. As of May 16, 2016, California is enrolling undocumented immigrants under the age of 19, if otherwise eligible, as Medi-Cal beneficiaries.[14] CHBRP is able to address the impacts on enrollment of changing eligibility through regular use of Medi-Cal administrative data, the CHIS estimates, and the CalSIM estimates to update CHBRP's CCM projections of Medi-Cal enrollment and premiums related to Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

[12] Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Final Rule. Federal Register, Vol. 77, No. 57. March 23, 2012. Available at: https://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm
[13] W&IC § 14103(a)(2)
[14] W&IC § 14007.8

Changes relevant to Covered California

Three changes relevant to health insurance associated with Covered California, the state's ACA-related health insurance marketplace (formerly referred to as "exchanges"), could be in effect in 2018.

Small-group expansion. Initially, the ACA required all states to define the small-group market as those groups with up to 100 employees by 2016. But the Protecting Affordable Coverage for Employees (PACE) Act of 2015 made the change optional, allowing states to extend the definition of small employer from up to 50 employees, to up to 100 employees, but not more.[15] For 2016, California altered its definition for small-group market health insurance to include employers with 51–100 employees. The change altered some aspects of California's health insurance markets, allowing for the possibility of a greater number of enrollees to have health insurance associated with Covered California. The change could also expand the number of enrollees whose health insurance is required to cover essential health benefits (EHBs), as EHB coverage is required in California, for much of the small-group market.[16, 17] Previous updates of CHBRP's CCM responded to California's change in the definition of small group. As per the PACE act, California (and other states) could again revise the definition of small group, potentially decreasing the number of enrollees with small-group market health insurance. At this time, CHBRP is unaware of any pending legislative action in California that would make further changes to the small-group definition. However, should such action occur, CHBRP could again address such changes through use of CalSIM and other sources to alter the CCM.

Large groups on Covered California. Starting in 2017, the ACA allows states the option of allowing large groups (those with more than 100 employees) to purchase health insurance through Covered California.[18] At this time, CHBRP is unaware of any pending legislative action in California that would make such a change. Even if legislative action were to occur, it is not clear how purchasers would react to such an opportunity. Health insurance purchased by large groups through Covered California would have to abide by Covered California's modified community rating and regional breakdowns, which could lead to comparatively higher premiums. Should such action occur, CHBRP could again address this change through the use of CalSIM and other sources to adjust the CCM accordingly.

Section 1332 Innovation Waiver Request. As permitted through a process created in the ACA, California is currently drafting a state innovation waiver request[19] to the federal government. With this waiver, California is requesting the ability to allow undocumented immigrants to purchase enrollment in Qualified Health Plans (QHPs) through Covered California. At this time, CHBRP is unaware of a federal response. However, should such action occur, CHBRP could address the change through use of CHIS, CalSIM, and other sources to adjust the CCM

[15] Protecting Affordable Coverage for Employees Act (PACE Act) § 2
[16] H&SC § 1357.500
[17] For more discussion of EHBs and relevant markets, see CHBRP's Document *California State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits"* available at: http://chbrp.org/other_publications/index.php
[18] ACA § 1312(f)(2)(B)
[19] Gov't. Code § 100522

accordingly. Currently, CalSIM estimates that the waiver approval would add an additional 17,000 unsubsidized beneficiaries to the individual market.[20]

Risk Corridors, Reinsurance and Risk Adjustment

Three programs—risk corridors, reinsurance, and risk adjustment—were created by the ACA[21] to mitigate risk, and to protect against adverse selection, while stabilizing premiums in the individual and small-group markets as market reforms and the health insurance marketplaces began in 2014. The ACA's risk corridor and reinsurance programs are set to expire at the end of 2016, while the ACA's risk adjustment program continues permanently.[22] Although expiration of the first two programs could lead to more volatile premiums, CHBRP will continue to address 2018 premium changes for all markets subject to regulation by DMHC and the California Department of Insurance (CDI) through data from its own Annual Enrollment and Premium (AEP) Survey, the National Opinion Research Center (NORC) survey, and informed actuarial judgment.

Grandfathering in the Individual and Employee Markets

The ACA allows health insurance products that existed prior to March 23, 2010, to continue as "grandfathered" plans or policies so long as significant changes impacting benefits or enrollee costs are not made. As of 2016, the ACA exempts grandfathered plans and policies, but places certain requirements on "nongrandfathered" plans and polices. Although grandfathered plans and policies are required to cover some preventive services,[23] the ACA requires nongrandfathered plans and polices to cover specific preventive services without cost sharing.[24,25] Additionally, the ACA requires some[26] nongrandfathered small-group and individual market plans and policies to cover essential health benefits (EHBs) and restrict cost sharing for emergency services.[27] The

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[20] The most recent draft (8/5/16) of Covered California's waiver application including CalSIM's estimates is available at: http://hbex.coveredca.com/stakeholders/Covered%20California%201332%20Waiver/Covered%20California%201332%20Application_FinalDraft%20%208-5-16.pdf

[21] ACA § 1342

[22] ACA § 1343

[23] As indicated in federal and California state law, nongrandfathered group and individual health insurance plans and policies must cover certain preventive services. More information is available at: http://www.chbrp.org/other_publications/docs/Federal_Preventive_Services_Mandate_and_California_Mandates_FINAL_012414.pdf.

[24] ACA § 2713

[25] See CHBRP's brief *Federal Preventive Services Mandate and California Benefit Mandates*, available at: http://www.chbrp.org/other_publications/index.php.

[26] The ACA specifies that this requirement is relevant to small-group and individual market QHPs associated with the state's health insurance marketplace, which currently includes only small-group and individual market plans and policies. California, through SB 43 (2015), has broadened the requirement to also be relevant to QHPs available outside of Covered California.

[27] The essential health benefits categories are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse services, including behavioral health treatment, prescription drugs, rehabilitation and habilitation services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. More information about EHBs is available at: http://www.chbrp.org/other_publications/docs/FINAL_EHB_Brief_Update_121213___BRIEF.pdf.

ACA offers no set end date for grandfathered status, and federal guidance suggests that their continuance (and associated enrollment figures) is based upon health plan and health insurer decisions and the sustainability of specific products.[28] Through CHBRP's own AEP survey, for 2018, CHBRP will continue to project the number of enrollees in DMHC-regulated plans and CDI-regulated policies that have grandfathered status.

Employer-based Insurance Excise Tax

The employer-based insurance excise tax or "Cadillac" tax would require employer-based health plans with total premiums exceeding $10,100 for individuals ($27,500 for families) to pay an excise tax equal to 40% of the difference between the actual total premium and the tax threshold.[29] Implementation of the Cadillac tax could affect enrollment in plans with premiums subject to the Cadillac tax, but federal legislation has delayed implementation of this tax until 2020.[30] As implementation is delayed, CHBRP's update to the CCM for projections of 2018 will not need to address the Cadillac Tax.

Addressed in Bill-Specific Analyses as Needed

Some elements related to continuing implementation of the ACA could be relevant to CHBRP's analysis of particular bills. CHBRP will continue to monitor the elements listed below and indicate their relevance in bill-specific reports as needed.

Essential Health Benefits

Some health insurance in California is required by the ACA to cover Essential Health Benefits (EHBs).[31,32] Currently, the federal government allows state-specific definitions for EHBs, which include selection of a state-specific "benchmark plan."[33] Current guidance indicates that the federal government intends to continue to allow state-specific EHB definitions through at least plan year 2017, rather than define EHBs themselves.[34] At this time, CHBRP is unaware of pending legislative or regulatory action in this area and anticipates that the California EHBs as defined in 2016 will be applicable through 2018. For this reason, CHBRP anticipates being able to use the 2016 definition of these during the next round of CHBRP bill analyses. However,

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[28] Department of Labor, Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act; Final Rules. *Federal Register*, Vol. 80, No. 222. November 18, 2015. Available at http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=28541&AgencyId=8&DocumentType=2.

[29] 26 U.S.C. § 4980I

[30] Consolidated Appropriations Act, 2016 § 101

[31] ACA § 2707(a)

[32] More information on EHBs can be found in CHBRP's document *California Sate Benefit Mandates and the Affordable Care Act's "Essential Health Benefits."* Available at: http://www.chbrp.org/other_publications/index.php

[33] Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. *Federal Register*, Vol. 78, No. 37. February 25, 2013. Available at: https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf

[34] HHS Notice of Benefit and Payment Parameters for 2016; Final Rule. Federal Register, Vol. 80, No. 39. February 27, 2015. Available at: https://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf

CHBRP will continue to monitor and address the most current guidance regarding the definition of EHBs.

USPSTF Mammogram Recommendations

Separately from requirements related to EHBs, the ACA includes a mandate related to preventive services that requires nongrandfathered health insurance to cover services issued either an "A" or "B" grade from the US Preventive Services Task Force (USPSTF) at no cost to the enrollee if delivered in-network.[35]

Through the Protecting Access to Lifesaving Screening (PALS) Act, the ACA makes an exception to the broader reference to current USPSTF guidelines. Instead, it refers to a 2002 USPSTF mammogram guideline that indicates mammography for women aged 40–49 is a "B" graded preventive service. This exception expires at the end of 2017.[36]

If the PALS Act is not extended beyond 2017, it appears that the ACA's mammogram requirement would reference the USPSTF's current guidelines. In 2009, the USPSTF changed its breast cancer screening guideline that suggested mammography for women aged 40–49 from a "B" to a "C".[37] This would mean that as of 2018, the ACA would no longer require coverage for mammography without cost sharing for women aged 40–49 (although the service at no cost sharing would still be required for women aged 50–74). Should CHBRP be asked to analyze any bills related to mammography during the next season, the analysis will address legislation as it would be in effect in 2018.

Conclusion

As always, and as noted throughout this document, CHBRP continues to monitor the broader health insurance landscape in order to provide the most accurate analyses of pending legislation.

[35] ACA § 2713(a)(1)
[36] Protecting Access to Lifesaving Screenings Act (PALS Act) § 2
[37] The full USPSTF Report on Breast Cancer Screening is available at: http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/breast-cancer-screening1

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Leads for completion of this document were Dylan Roby, PhD, of the University of Maryland, College Park, and the University of California, Los Angeles, as well as John Lewis, MPA, and Victoria Wertz, RN, both staff members at the University of California, Office of the President.

[38] CHBRP's authorizing statute, available at www.chbrp.org/docs/authorizing_statute.pdf, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact. There was a brief period of overlap between two firms at the beginning of 2016. In 2016, PwC became CHBRP's primary source of actuarial consultation.