ADVANCING NATIONAL HEALTH REFORM

A policy series from the Berkeley Center on Health, Economic & Family Security

POLICY BRIEF
August 2010

Gains, Gaps and New Choices: The Impact of the Affordable Care Act in California

Christian D. Phillips
Berkeley Center on Health, Economic & Family Security

BerkeleyLaw
UNIVERSITY OF CALIFORNIA
Berkeley Center on Health, Economic & Family Security

This brief was funded by a grant from The California Endowment

The California Endowment

ACKNOWLEDGMENTS

I would like to thank Annette Gardner, Melissa Rodgers and Ken Jacobs, co-authors of the original paper, "Addressing California's Health Coverage Gaps: The Impact of National Health Care Reform" (UC Berkeley, Center on Health, Economic & Family Security, November 2009).

I also thank Melissa Rodgers, Ann O'Leary, Ken Jacobs and Manjusha Kulkarni for their insightful feedback and thoughtful comments on this paper.

Finally, many thanks to Laurel Lucia, Miles Palley and Sarah Solon for their research and proofreading support.

Gains, Gaps and New Choices:

The Impact of the Affordable Care Act in California

INTRODUCTION

The urgency of the healthcare crisis took center stage in the U.S. Congress in 2009. For many California families however, the struggle to find affordable, consistent access to healthcare came clearly into focus long before. Nearly one-quarter of all non-elderly Californians are uninsured, and two million of those individuals lost their health insurance during the last two years.[1] The vast majority—87 percent—of the uninsured are working adults.[2]

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA)[3] emerged out of this bleak situation as a plan to bring hope and healthcare security to millions. The ACA was signed into law on March 23, 2010, and was designed to increase access to health insurance for individuals and families while mandating that most Americans obtain coverage.[4] To assist families with obtaining coverage and complying with the mandate, the law also contains provisions to expand public healthcare programs and establish the Health Benefit Exchange (Exchange),[5] a new venue for buying insurance with federal financial assistance.

The ACA creates many opportunities to achieve near-universal coverage. Whether or not that threshold will be reached will largely depend on how federal and state agencies, along with state and local governments, implement and build on the ACA's framework for coverage. If there is a sincere effort to make the new healthcare system practical and truly affordable, many of the current gaps in healthcare coverage may soon be significantly narrowed. However, if the federal law is minimally implemented without regard to the realities being faced by American families, current gaps may persist.

While the new healthcare reform law represents a step forward in many areas, it also carries relics of previous, unresolved issues. One of the key issues is healthcare for recent legal immigrants. Legal immigrants with less than five years of legal permanent residency will face the same requirement as native born U.S. citizens to have health insurance coverage. However, legal immigrants are subject to a "five-year bar" that makes them ineligible for federal health insurance programs like Medicaid.[6] Immigrants in this category will be eligible for some assistance in purchasing healthcare plans on their own, but it is unclear whether these plans will be as affordable as the Medicaid plans that will be available to non-immigrant families with the same income. Additionally, millions of undocumented immigrants will continue to be excluded from federal healthcare programs under the legislation, despite the fact that they live, work and pay taxes in the United States.

California has the highest number of uninsured individuals in the United States—6.7 million.[7] Due to its sheer size, the effects of the ACA here are sure to have national impact. By examining how the law will improve coverage in this state, and analyzing ways in which it

may still fall short, important lessons can be learned for advocates and lawmakers in California and elsewhere.

This paper will provide an overview of the impact of the ACA on Californians who currently face gaps in healthcare coverage. The first section is a review of the structural changes the ACA requires or allows states to make to the current healthcare system, in both public and private market insurance. The second section looks more closely at specific populations that will be directly impacted by healthcare system changes in the ACA: families that rely on employer-sponsored coverage, families that buy insurance on their own, unemployed adults, adults with income less than 133 percent of the Federal Poverty Level, low-income children, young adults, near-elderly adults and immigrants. The second section also presents policy recommendations for state lawmakers to consider when designing the implementation of the ACA in California, in order to ensure that affordable, consistent healthcare coverage is more widely available for these populations.

Part 1: Overview of the Affordable Care Act

The Affordable Care Act creates a new avenue for individuals and small businesses to acquire health insurance and is supported by a set of programs that match individuals with varying levels of access to low-cost and free health coverage, depending on their income. Families and individuals with incomes below 133 percent of the Federal Poverty Level or "FPL" ($29,326 for a family of four in 2010) will be eligible for an expanded Medicaid program. Most individuals with incomes between 133 and 400 percent of the FPL will qualify for premium and cost-sharing subsidies for plans in the Exchange.[8] Individuals with incomes above 400 percent of the FPL ($88,200 for a family of four in 2010) will not be eligible for subsidies, but will be able to buy health insurance through the Exchange.[9] Workers who already obtain their insurance through their employers can keep the plans they have.

This section will provide a structural overview of the ACA's required changes to health insurance plans acquired through both the private market and public programs. The private market includes employer-sponsored coverage and the Exchange, new venue for purchasing individual and small business group coverage. Public programs discussed in this paper include Medicaid (called Medi-Cal in California), the Children's Health Insurance Program (called Healthy Families in California) and healthcare services for the uninsured.

Changes to the Private Insurance Market

The private market for insurance includes two main components: group coverage acquired through employers and coverage purchased by individuals directly from insurers. The ACA restructures the venue for acquiring health insurance by creating the state-based Exchanges. This section will first review employer-sponsored coverage and new regulations for large and small employers. A discussion of the private market for insurance will follow, including a more in-depth review of the Exchange.

Employer-Sponsored Coverage

The nature of healthcare coverage for working Californians has shifted in the last two decades. In 1987, 64.6 percent of Californians with insurance obtained that coverage through their employer.[10] At the end of 2009, fewer than 50 percent of Californians were insured through employer-sponsored plans.[11] This overall decline was party caused by expansion in employment sectors that do not traditionally offer employee healthcare coverage, in tandem with rising healthcare costs and decreasing availability of affordable health insurance products.[12] Although some who have lost job-based coverage have found other sources like Medi-Cal and the individual healthcare market, many others have joined the ranks of the uninsured.

California's uninsured workers are employed by companies of all shapes and sizes. More than 30 percent of the working uninsured are employed by companies with 100 or more workers.[13] However, the vast majority (67 percent) of uninsured workers are either self-employed or work for small businesses.[14] Several components of the ACA are designed to expand the number of businesses—large and small—offering affordable coverage options to employees and create a more accessible individual insurance purchasing market for those who are self-employed or still find their employer's plan out of reach.

Large Employer Responsibilities

The ACA attempts to create financial incentives for employers with more than 50 employees to offer affordable coverage for full-time employees. The primary incentive will be to fine businesses whose employees are uninsured and receive federal assistance to pay for coverage on the Exchange. Specifically,

- if an employer *does not* offer insurance coverage to employees and at least one full-time employee applies for and receives premium credits for insurance purchased on the Exchange, the employer will be assessed a fine of $2,000 per full-time employee, or
- if an employer *does* offer insurance coverage, but
    - the plan is "unaffordable"[15] as defined by the ACA, and
    - at least one full-time employee chooses to purchase a plan on the exchange instead *and* receives premium credit assistance,

then the employer will be fined whichever is less—$3,000 per employee receiving credits or $2,000 per full time employee.

When calculating fines based on the number of employees, the first 30 employees will be exempted, and maximum fines will be capped at $2,000 multiplied by the total number of full-time employees in a firm.[16]

The law also creates several employer requirements designed to increase employees' access to employer-sponsored insurance and their knowledge about alternatives that may be available on the insurance Exchange. Employers with more than 200 full-time employees who offer health insurance are required to automatically enroll new full-time employees in one of their sponsored plans.[17] All employers are required to inform employees of the existence of the Exchange, as well as the fact that they may be eligible for premium credits, depending on their income and the nature of the employer-sponsored plan.[18] To aid enforcement of these provisions, large employers must annually report whether they offer healthcare coverage to full-time employees and if so, the length of time employees must wait before becoming eligible for this coverage.[19]

Finally, businesses who sponsor insurance coverage must offer full-time employees a "free choice voucher" if 1) their income is below 400 percent of the FPL, and 2) their share of the premium cost for the employer-sponsored plan is between 8 and 9.8 percent of their income. Employees can use this "free choice voucher" (valued at the amount that the employer would have contributed to the employer-sponsored plan) to obtain insurance on the Exchange, without penalty for the employer.[20] Additionally, if the employer offers an insurance plan that requires the employee to pay more than 9.8 percent of his or her income for coverage, the employee becomes eligible for subsidies and premium assistance to buy an individual plan on the Exchange.

Expansion of Coverage Opportunities for Small Businesses

In contrast to the penalty-based incentive system the ACA imposes on larger employers, the law contains several provisions to encourage small businesses to offer health insurance through penalty exemptions and tax credits. The vast majority of the uninsured

work for a small employer or for themselves, so any improvement in their healthcare access will have wide-reaching effects.

The U.S. Department of Health and Human Services estimates that 503,000 small businesses (with 25 employees or less) in California will be eligible for tax credits under the ACA.[21] The law provides for tax credits intended to help employers better afford their share of an employee's healthcare plan. However, the credits are available only to businesses with 25 or fewer employees and an average wage of $50,000 or less, and are calculated on a sliding scale that reduces the credit as the number of employees and average wages increase.[22] A recent report from the University of California Berkeley Center for Labor Research and Education estimates that the tax credits will bring over $4.4 billion to small businesses in the state through 2020. [23] The same report also estimates that in 2016, the number of Californians expected to benefit from this credit through small employers will reach 450,000.[24]

Figure 1. The ACA's Small Business Tax Credit

Eligibility Requirements

- Firm must have 25 employees or fewer.
- Average wage of employees must be $50,000 or less.
- Employer's share of healthcare coverage plan costs must be 50% or greater.
- The tax credit will cover up to 50% of an employer's share of healthcare coverage costs for employees.

Potential Benefits

- 450,000 Californians expected to benefit from a small employer receiving an ACA tax credit for employer-based coverage.
- 503,000 small businesses in California will be eligible for tax credits.
- $4.4 billion dollars for California businesses could be realized from the tax credit.

Small business employees will also have significantly expanded opportunities to obtain health insurance outside of job-based coverage. Small businesses will be able to purchase group plans for their employees through the Small Business Health Options Program or SHOP Exchange. Small business employees who are not offered affordable job-based coverage will be eligible to purchase individual coverage on the Exchange. Additionally, employers with 50 full-time-equivalent employees or fewer will not be subject to any penalties for employees who received subsidized Exchange coverage.[25] Nearly 1 million uninsured small business employees and self-employed individuals will be eligible for federal subsidies and credits for Exchange based healthcare coverage.[26]

Figure 2. Summary of Employer Responsibilities for Employee Coverage Under the ACA[27]

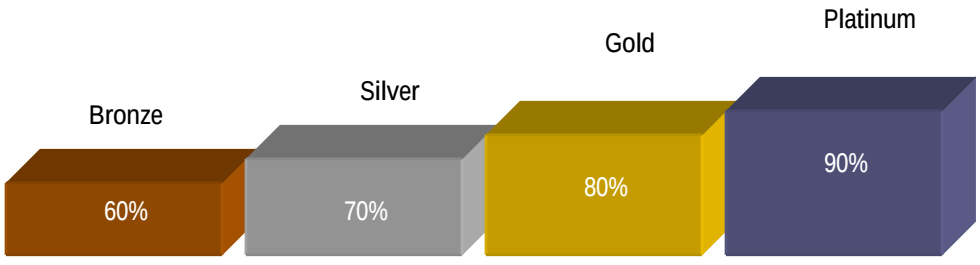
	1-25 Employees	26-50 Employees	51-100 Employees	101+ Employees	201+ Employees
Small Business Tax Credit Available	Yes, for employers with low-wage workforces.	No.	No.	No.	No.
Eligible to Purchase Plans for Employee Coverage on the Exchange	Yes.	Yes.	Yes, but State can opt to disallow.	No, but State can allow starting in 2017.	No, but State can allow starting in 2017.
Employer Penalties for Employees who Buy Exchange Coverage with Subsidies	No.	No.	Yes.	Yes.	Yes, also must auto-enroll employees.

Buying Insurance on Your Own: The Private Individual Market

The Health Benefit Exchange

The ACA mandates the creation of state-based Exchanges, through which individuals without access to affordable employer-sponsored coverage may purchase health insurance. Each Exchange is required to offer at least four benefit categories of essential benefits plans (Bronze, Silver, Gold and Platinum), plus an additional catastrophic coverage plan. Every plan on the Exchange must meet federal requirements for benefit design, provider network access, actuarial values, enrollment assistance and marketing practices.[28] "Actuarial value" refers to the percent of covered medical benefits that a health plan expects to pay for all its enrollees, with the balance paid by enrollees through co-payments and deductibles. The higher the actuarial value, the less individuals, on average, are paying out-of-pocket.[29]

Figure 3. Actuarial Value Requirements for Four Essential Benefits Plans



To make healthcare coverage more affordable, federal lawmakers crafted a system of premium credits and cost-sharing subsidies for plans purchased on the Exchange. **Approximately 1.4 million Californians who are currently uninsured will qualify for premium credits and cost-sharing subsidies.**[30] The credits and subsidies are designed to reduce the cost of premiums to a pre-determined percentage of participants' annual income and limit out-of-pocket expenses. According to the new federal law, the Exchange and related premium credits and cost-sharing subsidies must be operational by January 1, 2014.

California taxpayers must fall into one of two categories to be considered eligible for premium credits and subsidies. The first category includes any citizen or legal immigrant (who is not incarcerated) whose household income is above 133 percent of the FPL and equal to or below 400 percent of the FPL.[31] The second category includes any legal immigrant who is ineligible for Medicaid due to the five-year bar, and whose income is equal to or below 133 percent of the FPL. For the purposes of calculating premium credits and subsidies, recent legal immigrants in the second category are assumed to have an income of at least 100 percent of the FPL, even if their income is in fact lower.[32] In both categories, participants must be enrolled in a Silver tier plan on the individual market of the Exchange in order to be eligible to receive cost-sharing subsidies.[33]

Premium assistance credits will range in amounts that, when applied to a participants' health insurance bill, bring the cost of premiums down to between 2 and 9.5 percent of income. Separately, cost-sharing subsidies will be applied in two ways. The first will be a lowered cap on out-of-pocket expenses, depending on income level. For example, for someone with an income between 201-300 percent of the FPL, out-of-pocket expenses will be capped at $3,297 per year. The second cost-sharing subsidy will adjust the actuarial value of the individual's plan. The actuarial value reflects the insurer's average share of the benefit costs of the plan (the amount the insurer pays minus copayments and deductibles, not premiums). For example, if an Exchange participant has an income of 134 percent of the FPL, the federal government will provide a subsidy to the participant's insurer to ensure that the average participant is only paying 6 percent of the costs of benefits through copayments and deductibles. The other 94 percent of the costs of benefits (like services, office visits, etc.) will be covered by the insurer and the subsidy.

Figure 4 outlines the premium credits and subsidies plan participants will be eligible for, according to income level as a percent of the FPL.

Figure 4. Subsidies, Limits on Out-of-Pocket (OOP) Expenditures, and Plan Actuarial Values[34]

Under 100% FPL	Medi-Cal	
100-133% FPL[1]	Medi-Cal	
	Max Premium	2% of income
	Max OOP (Indiv/Family)	$2,196/$4,395[2] (1/3 of HDHP in 2014)
	Actuarial Value	94%
134-150% FPL	Max Premium	3-4% of income
	Max OOP (Indiv/Family)	$2,196/$4,395 (1/3 of HDHP in 2014)
	Actuarial Value	94%
151-200% FPL	Max Premium	4-6.3% of income
	Max OOP (Indiv/Family)	$2,196/$4,395 (1/3 of HDHP in 2014)
	Actuarial Value	87%
201-250% FPL	Max Premium	6.3-8.05% of income
	Max OOP (Indiv/Family)	$3,297/$6,593 (1/2 of HDHP in 2014)
	Actuarial Value	73%
251-300% FPL	Max Premium	8.05-9.5% of income
	Max OOP (Indiv/Family)	$3,297/$6,593 (1/2 of HDHP in 2014)
	Actuarial Value	70%
301-400% FPL	Max Premium	9.5% of income
	Max OOP (Indiv/Family)	$4,396/$8,791 (2/3 of HDHP in 2014)
	Actuarial Value	70%
Over 400% FPL	No Premium Credits or Subsidies	
	Max OOP (Indiv/Family)	$6,593/$13,187 (HDHP in 2014)
	Actuarial Value	70%

Notes:
1. The first tier of premium credits (2% of income) was designed for legal immigrants subject to the 5-year bar, who have incomes below 133%of the FPL, but are ineligible for Medicaid.
2. Out-of-pocket estimates are based on costs for the second lowest silver plan. These costs are pegged to High Deductible Health Plan's (HDHP) out-of-pocket limits. *See* Internal Revenue Code, 26 U.S.C. § 223(c). The limits ($5,950 for individual coverage and $11,900 for family coverage in 2010) increase annually and are indexed using cost-of-living adjustments. The amounts in this table are predicted using 2010 as a base year, assuming an annual increase of 2.6 percent. The ACA reductions in HDHP out-of-pocket limits are by 2/3, 1/2 and 1/3, for each respective income tier. ACA § 1402 (c)(1)(A).

The Patients' Bill of Rights

The "Patients' Bill of Rights," as described by President Barack Obama in an announcement in June 2010, will phase in the following new regulations for health insurance products over a four-year period:[35]

- **Retiree Reinsurance (June 2010)** Federal funds will be made available to help employers sustain a portion of the health plan costs for early retirees through 2013.[36]
- **Ban on Lifetime Limits for Essential Benefits (September 2010)** Insurers are prohibited from imposing lifetime limits on essential benefits.[37]
- **Restrictions on Annual Limits for Essential Benefits (September 2010)** Insurers may only impose restricted annual limits on essential coverage beginning in

September 2010. Beginning in January 2014, insurers will be prohibited from imposing any annual limits on essential benefits coverage.

- **Ban on Rescissions (September 2010)** Once an enrollee has acquired health plan coverage, the insurer is prohibited from rescinding that coverage, except in cases of fraud or abuse.[38]

- **No Cost-Sharing on Preventive Services (September 2010)** Insurers must cover certain preventive health services like immunizations, wellness visits and screenings without imposing cost-sharing.

- **Prohibition Against Discrimination Based on Salary (September 2010)** Insurers will not be permitted to discriminate against those with lower annual incomes in determining eligibility for enrollment.

- **Guaranteed Issue and Renewability (January 2014)** Insurers must issue policies to interested parties, regardless of risk or health status.

- **Ban on Excessive Waiting Periods (January 2014)** Waiting periods for coverage over 90 days will no longer be permitted.

- **Ban on Restricting Coverage Due to Pre-Existing Conditions (January 2014)** Insurers may not decline to issue policies due to pre-existing health conditions. Insurers will also be prohibited from issuing insurance policies containing exclusions that withhold benefits related to treatment of pre-existing health conditions.[39]

The Temporary High Risk Pool

For the medically uninsured—those who struggle or are unable to obtain health insurance coverage in the private market due to pre-existing health conditions—the temporary high risk pool provisions of the ACA have the potential to offer an immediate improvement. Since several of the provisions related to the Patients' Bill of Rights and the Exchange will not go into effect until 2014, the temporary high risk pool may fill the gap. Currently, the state of California runs a high risk health insurance program known as the Major Risk Medical Insurance Program (MRMIP). The program is notable in that it covers any resident of the state, but has limitations including a cap on enrollment (7,100 participants), benefit limits ($75,000 annually and $750,000 lifetime), very expensive premiums, and waiting periods for those with pre-existing conditions.

According to the ACA, the Secretary of Health and Human Services must create a high risk pool program in every state to serve as a transitional vehicle between the status quo and the Insurance Exchanges in 2014.[40] For citizens and legal immigrants with pre-existing conditions who have not been able to enroll in private market health insurance or the MRMIP program, this temporary pool may be an opportunity for coverage because it will have no restrictions for coverage based on health status. The federally funded pool will bring $761 million to California between July 2010 and January 2014 and may cover up to 35,000 individuals.[41] Although this program is in some ways an expansion of MRMIP, it will be run by the state as a separate program.[42]

The 7,100 participants who are currently in MRMIP may face uneasy decisions about coverage in the immediate future. The monthly premium rates for MRMIP currently are between 125 and 137.5 percent of the market rate. The Managed Risk Medical Insurance Board (MRMIB) that administers the program acknowledges that it may be unaffordable for most participants and reports that disenrollment forms often cite unaffordability as the primary cause for dropping coverage.[43]

The federally funded high risk pool will have premium rates that do not exceed 100 percent of the market rate and no annual benefit limits. As a result, there may be current MRMIP participants who would prefer to switch to the federal program, which state officials predict will begin coverage in September 2010.[44] However, the ACA states that eligibility for the federal program will only be granted to those individuals who have not had "creditable coverage" for the previous six months.[45] This stipulation includes MRMIP as creditable coverage, so there may be a temptation for some current MRMIP participants to drop their coverage for six months in order to qualify. In addition to the risk posed by limiting access to healthcare, participants who drop MRMIP coverage will not necessarily have a guaranteed spot in the new temporary high risk program.

Estimates indicate that there are between 200,000 to 300,000 medically uninsured Californians, a number which would far exceed the capacity of the current federal funding appropriation.[46] In order to ensure that medically vulnerable Californians do not fall through the cracks between 2010 and 2014, additional funding for this program must be discussed at the federal and state levels.

The Basic Health Plan

In order to close possible coverage gaps for adults with incomes between 133 and 200 percent of the FPL, the ACA gives states the option to create a Basic Health Plan. Eligibility for participation would be restricted to those with incomes between 133 and 200 percent of the FPL, but would not bar legal immigrants with five years or less of residency. The Basic Health Plan would minimally consist of an essential benefits package available for purchase, with limits on premiums and out-of-pocket expenditures tied to income. To help facilitate this coverage, the federal government will provide funds equal to 95 percent of what would have been paid as premium and cost-sharing subsidies for individuals in this income tier to buy subsidized health insurance on the Exchange.[47] Though this plan has not been the subject of much public discussion by California lawmakers at this point, it may be a tenable remedy for those who will be ineligible for Medi-Cal and unable to access or afford Exchange or employer-based options.

Public Coverage Programs

The ACA also contains provisions that may facilitate better access to public healthcare programs for the lowest-income families. Major changes to public healthcare programs that will significantly benefit the uninsured will occur within Medicaid and the Children's Health Insurance Program ("Medi-Cal" and "Healthy Families" in California, respectively). This section will first discuss the required expansion of Medicaid eligibility and then turn to provisions for stabilizing federal support of children's health insurance programs. A discussion of the state's role in these and other programs for the uninsured will follow.

Expansion of Medicaid

The ACA's central provision for providing healthcare coverage to low-income adults is an expansion of Medicaid in 2014. Medi-Cal, as the Medicaid program is called in California, currently determines eligibility based on a host of factors including family composition, disability, age, pregnancy, other specific health conditions, assets and income, and state residency and citizenship or immigration status. The new law fundamentally shifts the nature of Medi-Cal eligibility by requiring the program to cover all individuals whose modified, adjusted gross income (MAGI) is 133 percent of the FPL or below.[48] **The University of California Los Angeles Center for Health Policy Research estimates that nearly 1.7 million uninsured Californians will be eligible for Medi-Cal with this expansion**.[49] In order to help states accommodate these new Medi-Cal participants, the law also includes enhanced federal funding support above and beyond current levels.[50]

There are however, several caveats to the expansion of Medi-Cal for adults below 133 percent of the FPL. The health reform law calls for a new, standardized metric for determining income—the modified, adjusted gross income—which eliminates many of the deductions previously incorporated in calculating eligibility. Removing these deductions was intended to simplify the application process for Medi-Cal, but for some, it may result in reduced eligibility. To counteract any loss of eligibility due to the new metric, any individual whose income under this methodology is 138 percent of the FPL or less will be determined eligible.[51]

Applicants who are still ineligible for Medi-Cal after the five percentage point adjustment will be enrolled in programs through the Exchange. However, the cost-sharing burden for healthcare consumers is likely to be higher in the Exchange than under Medi-Cal, so those who lose eligibility due to the change in income calculation may face a net loss in benefits. The current data is unclear as to how many Californians may be negatively affected by the change in income calculation, but the issue should be carefully monitored to ensure that currently eligible Medi-Cal participants do not experience increased healthcare costs as a result.

To ensure that low-income adults are actually able to access the programs for which they are newly eligible under the law, the ACA also requires a simplification of the enrollment process. Because the complexity of the current Medi-Cal process is often cited as a roadblock to coverage, enrollment simplification has the potential to accelerate the closing of coverage gaps in California.[52,53] The new requirements include a single, standardized application form for all "state health subsidy programs," which include Medi-Cal, Healthy Families, the Basic Health Plan (if California chooses to create one) and Exchange subsidies.[54] If any individual applies for any particular program and is found to be eligible for a program that provides lower-cost coverage, he or she will automatically be referred to the lower-cost program for enrollment without having to submit additional paperwork.[55] A "single point of entry" screening and eligibility determination process could check eligibility for all programs, starting with the lowest-cost program. Additionally, the new law mandates that states perform targeted outreach to vulnerable populations and establish a website to inform individuals of the new health coverage options available as of 2014.

Children's Public Health Insurance: Healthy Families and Medi-Cal

Children who are or will be enrolled in public health insurance programs may experience changes in their coverage due to provisions in the ACA. The new, across-the-board eligibility for Medicaid for families at 133 percent of the FPL or below will mean that some children who are currently in Healthy Families will need to transition to Medi-Cal by 2014. Under the law, the Secretary of Health and Human Services is required to ensure that the new income calculation methodology will not result in the loss of Medicaid coverage for any children who would otherwise be Medicaid-eligible, until 2019.[56]

The ACA goes much further than other recent Congressional action to guarantee federal funding for CHIP programs like Healthy Families. Federal funding for CHIP is stabilized under the ACA, with pre-determined budget allocations set for 2013, 2014 and 2015 .[57] If the number of CHIP-eligible children attempting to enroll outpaces available funding, children will continue to be automatically screened for Medi-Cal and also screened for premium assistance credit eligibility in the Exchange.[58]

Figure 5: Affordable Care Act Changes to Public Healthcare Coverage Program Eligibility for Low-Income Children[59]

Family Income as % of FPL	Child's Age	**Pre-ACA, 2010**	**ACA**
0-100	0 to 1	Medi-Cal	Medi-Cal
	1 to 5	Medi-Cal	Medi-Cal
	6 to 19	Medi-Cal	Medi-Cal
	20 & 21	Medi-Cal	Medi-Cal
100-133	0 to 1	Medi-Cal	Medi-Cal
	1 to 5	Medi-Cal	Medi-Cal
	6 to 19	Healthy Families	Healthy Families through 2013, Medi-Cal in 2014
	20 & 21[1]	N/A[2]	Medi-Cal
133-200	0 to 1	Medi-Cal	Medi-Cal through 2019, Exchange[3]
	1 to 5	Healthy Families	Healthy Families through 2019, Exchange
	6 to 19	Healthy Families	Healthy Families through 2019, Exchange
	20 & 21	N/A[2]	Exchange
200-250	0 to 1	Healthy Families	Healthy Families through 9/2019, Exchange
	1 to 5	Healthy Families	Healthy Families through 9/2019, Exchange
	6 to 19	Healthy Families	Healthy Families through 9/2019, Exchange
	20 & 21	N/A	Exchange
250-400	All ages	N/A[4]	Exchange

Figure 5 Notes:

1. ACA § 2004 stipulates that young adults formerly in foster care will be eligible for Medi-Cal coverage up to age 26 as of January 1, 2014, as long as they were enrolled in Medi-Cal when they were under state care.
2. Some 20-21 year olds—e.g., pregnant women—may qualify for Medi-Cal at these income levels. This table focuses on basic age-based eligibility.
3. Whether or not these children shift to the Exchange or will remain eligible for Medi-Cal will depend on decisions made by the state regarding Medi-Cal eligibility after 2019.
4. Several California counties administer Healthy Kids coverage programs for children ineligible for Healthy Families and Medi-Cal. Healthy Kids programs have higher income eligibility levels than the programs listed in this table. Children ineligible for the Exchange after 2014 could be served by Healthy Kids programs. This is true for ineligible children at all income levels.

After 2015, the ACA does not set out specific budget amounts for federal participation in CHIP programs like Healthy Families. However, the law does stipulate the federal match rates for CHIP and requires that the same maintenance of effort by states that is described below also be applied to CHIP through late 2019.[60] The ACA is silent on exactly what will happen to CHIP programs like Healthy Families after 2019. According to the enrollment simplification provisions, children who apply for Healthy Families and Medi-Cal but are found ineligible will be automatically screened for premium assistance credits and enrolled in the Exchange.[61] This implies that if Healthy Families and Medi-Cal are no longer available for anyone over 133 percent of the FPL, children in those programs will automatically transition to the Exchanges, but the exact procedure has yet to be clarified. The impact of transitioning low-income children from public plans to private market plans also remains to be seen. With one-third of California's children currently enrolled in either Healthy Families or Medi-Cal, changes to these programs will have widespread impact.[62]

Maintenance of Effort

The ACA requires "maintenance of effort" (MOE) by states with regard to current Medicaid and CHIP eligibility standards and thresholds. In order to comply, the state cannot further restrict eligibility for public health programs for adults until 2014 or for children until 2019. This prohibition on reducing eligibility is meant to bridge the gap between programs in place at the time the law was signed in 2010 and the time when the Exchange will be operational in 2014. However, it may be possible for the state to change the nature of the Medi-Cal program in other ways in 2010-2013 while still complying with the MOE. One method may be to further cut the optional but much-needed Medi-Cal benefits—like prescription drug coverage and vision services—that California currently provides. Starting in 2014, Medi-Cal can limit coverage for new Medicaid expansion populations, and for some populations who currently have Medi-Cal, to a new "essential benefits" package. The "essential benefits" cover fewer services than the Medi-Cal program does today but may not differ drastically from what the state may offer by 2014.

Finally, the ACA may not prohibit the state from eliminating state-only programs, such as funding for Medi-Cal participants who are legal permanent residents with fewer than five years of residency. Federal law prohibits federal funds from being used to provide several public programs to legal immigrants with fewer than five years of residency, so California currently uses state dollars to fund Medi-Cal services for this population.[63] It should be noted that Governor Schwarzenegger's May 2010 Budget Revision includes cutting state funds for Medi-Cal services to this population. In 2014, legal immigrants with fewer than five years of residency will still be ineligible for federally funded Medi-Cal services, but they will be eligible for premium credits and subsidies to purchase healthcare coverage in the Exchange and through the Basic Health Plan (if the state creates one).

Healthcare Services for the Uninsured

The ACA, while a large step forward in increasing access to healthcare coverage, may still leave some Californians behind. The healthcare safety net that many of the uninsured rely on now will still need to be in place once all of the ACA reforms occur.

Local hospitals and clinics that serve a large proportion of Medicaid and uninsured patients are an essential component of the healthcare safety net in California. Currently, these hospitals and clinics receive federal funds to help cover the costs of providing

Medicaid services and care for patients who are unable to pay. The predicted expansion of Medicaid coverage (and increased federal funding for new Medicaid patients) is expected to reduce the number of patients who are unable to pay for hospital-based care, and based on that assumption the ACA also reduces the amount of payments to hospitals that serve a disproportionate number of low-income patients. The reductions in these Disproportionate Share Hospital (DSH) payments are not scheduled to begin until late 2013, and the Secretary of Health and Human Services will have the ability to determine how the payments are distributed among states, according to progress in reducing the number of uninsured. The theory underlying the reduction is that the increase in reimbursements for additional Medicaid eligible patients will offset the costs of providing care to the uninsured. Whether this will occur as intended will be determined by many factors, including the geographic concentrations of newly eligible Medicaid patients and low-income families who are still ineligible for premium assistance or Medicaid.

It will be important to carefully monitor which areas have the highest need for the additional payments, since expanded Medicaid and subsidized access to Exchange plans might shift population needs quickly. Additionally, further evaluation should be conducted to ensure that the new payment system does not create perverse incentives for hospitals that would prefer to retain their current level of DSH payments.

The operating assumptions guiding the reduction in DSH payments are untested, and do not account for other challenges facing the safety net system. Several of those challenges— development of the healthcare workforce, promotion of preventive services, and availability of primary care—are addressed in other sections of the ACA. Other challenges, like care management for the chronically ill and individuals facing both mental health and physical health issues, will be addressed through regulation.

Finally, the ACA increases funding for Federally Qualified Health Centers (FQHCs) through 2015 and makes provisions for indexed increases in funding thereafter. The role played by these clinics will continue to be critical for the uninsured. For those who will be exempt from the ACA individual mandate, or acquire a hardship waiver and do not have insurance, the FQHCs will be an important source for primary and urgent care, and may help to keep those patients from using emergency rooms for non-life-threatening issues.

Part II: The Impact of the Affordable Care Act on California Populations & Policy Recommendations

The ACA creates new opportunities for access to the American health insurance system, while simultaneously requiring that most individuals and families obtain coverage. The premium credits and subsidies discussed in the previous section are designed to give families without affordable employer-sponsored coverage or Medicaid an option for accessible coverage in the Exchange. This section will explore the potential impact that these new systems may have on specific populations in California. The populations that this paper will pay particular attention to are: families that rely on employer-sponsored coverage, families that buy their own coverage, unemployed adults, adults with income less than 133 percent of the FPL, low-income children, young adults, near-elderly adults, and immigrants.

Families Relying on Employer-Sponsored Coverage

Overall Impact of the ACA: The 49.8 percent of Californians who currently obtain their insurance through their employer will feel little immediate impact from the ACA.[64] If their employer-sponsored coverage becomes unaffordable, as defined by the law, and they are under 400 percent of the FPL, more affordable options may be available on the Exchange. While healthcare coverage offerings by employers are declining, the Exchange may offer workers who lose their employer-based coverage an alternative source of coverage.

The ACA will improve health plan standards for many covered workers. The law also has the potential to reduce premiums for employer-sponsored coverage. The Congressional Budget Office projects that average large group premiums in 2016 would be 0 to 3 percent lower under the ACA compared to under current law,[65] while a recent Commonwealth Fund study estimated that private coverage premiums would be 9 percent lower in 2019 compared to under current law.[66]

Firms with primarily low-wage workforces will have less incentive to provide health coverage because subsidies will be newly available to low-wage workers and low-wage workers receive less benefit from the tax deductibility of health benefits. This could lead to a greater-than-anticipated shift into the Exchange. Additionally, employer penalties accrue only with respect to employees who work 30 hours a week or more, creating an incentive for some employers to reduce their employees' hours below 30 per week.

Possible Remaining Coverage Gaps: In the short term, there are no remaining coverage gaps for covered workers who remain with the same employer as a full-time employee, though rising costs continue to be a challenge.

Recommendations: These concerns may cause the Exchange to be a more popular option than lawmakers had originally anticipated, and underscore the need to carefully monitor shifts in employer coverage during the course of ACA implementation, as well as how any shifts affect coverage and plan quality.[67] Finally, workforce composition should be tracked to help ascertain whether employers are shifting workers from full- to part-time in order to avoid penalties. If adverse effects are found, employer penalties should be adjusted accordingly.

Families Buying their Own Coverage

Overall Impact of the ACA: Families lacking access to employer-sponsored coverage or public programs will be able to turn to the Exchange to purchase coverage beginning in 2014. The affordability of the Exchange for families buying their own coverage will depend to some extent on how California chooses to implement certain eligibility determination provisions and whether California chooses to supplement federal subsidies to assist families facing higher healthcare burdens.

According to a recent survey conducted by the Kaiser Family Foundation, among people who purchase family healthcare coverage on their own, the average person spends $6,821 on premiums and copayments per year. Eleven percent of the respondents in the same survey reported spending over $5,000 above the cost of their premiums every year.[68] The good news for those families is that the ACA will set a ceiling on future costs. And, for families who are not experiencing a high utilization year, federal assistance with premiums and cost-sharing can mean lowered costs and greater affordability. According to research by the UC Berkeley Center for Labor Research and Education, Californians with average health care use who purchase subsidized single non-group coverage in the Exchange will spend $904 to $5,159, or 15 to 88 percent, less per year under the law than they would on premiums and out-of-pocket costs in the current non-group market.[69]

Possible Remaining Coverage Gaps: The typical California family experiences some variation in healthcare service utilization from year to year. A family with young children for example, may have a relatively low number of doctor's office visits, until the year the youngest child is diagnosed with chronic asthma. For low or average utilization years, the ACA will improve coverage for families who do not have access to affordable employer-sponsored coverage. However, when families experience big changes—either in healthcare services utilization or income—the ACA as it stands may not go far enough to ensure that coverage is affordable.

Figure 6. Maximum financial exposure for families under the ACA[70]

	Single Adult		Single Parent, One Child		Single Parent, Two Children		Two Parents, Two Children	
% FPL	Annual Income	Max. % of Income for Healthcare	Annual Income	Max. % of Income for Healthcare	Annual Income	Max. % of Income for Healthcare	Annual Income	Max. % of Income for Healthcare
75	$8,123	26%	$10,928	38%	$13,733	31%	$16,538	26%
134	$14,404	16%	$19,379	23%	$24,353	19%	$29,327	16%
200	$21,660	20%	$29,140	26%	$36,620	22%	$44,100	19%
251	$27,183	19%	$36,570	24%	$45,958	21%	$55,345	19%
400	$43,320	21%	$58,280	29%	$73,240	25%	$88,200	23%

The healthcare cost burden falls most heavily on those families who are at the margins of eligibility for subsidies and children's health insurance assistance, and do not have access to affordable employer-sponsored coverage. In California, a single parent with one child who makes $36,570 a year (close to the typical salary for a pharmacy technician, for example) is ineligible for children's health coverage assistance from the state.[71] While the premium credit would enable this parent to spend no more than $2,954 annually on premiums, the total cost for healthcare coverage including out-of-pocket expenses for copayments and treatments could be as high as 24 percent of their total income. This is a clear improvement over pre-ACA conditions, with no cap on how much this family might pay in a high healthcare service utilization year. However, without knowing a family's other expenses and financial context, it is not safe to assume that having the cap will automatically translate into having affordable coverage. If, for example, the wage earner in a single-parent family has to reduce work hours in order to care for a sick child, that reduction in earnings will increase what portion of total income is absorbed by healthcare. Procedures under the ACA for changing a family's eligibility for subsidies and caps have not yet been determined, so it is not clear how quickly a change in financial circumstances will affect healthcare costs on the Exchange.

The healthcare coverage costs for families at 75 percent of the FPL are illustrative of the continuing challenges faced by recent, legal immigrants who do not have access to affordable employer-sponsored coverage.[72] Legal permanent residents who have held that status for less than five years are barred from accessing a number of federal public programs, including Medicaid.[73] In the Exchange, they will be eligible for premium credits, but the credits will be calculated based on an income of 100 percent of the FPL, regardless of how far below 100 percent of the FPL a family's actual income actually may be. [74] In California, the Department of Health Care Services estimated that there were about 49,000 "newly qualified legal immigrants" enrolled in Medi-Cal in 2009.[75] However, this group's Medi-Cal coverage is based on state funds which Governor Schwarzenegger has proposed cutting in the May 2010 Budget Revision.

Recommendations: One key task will be to ensure that the regulations developed for calculating premium assistance eligibility after a change in income or employment circumstances are practical and do not impose additional burdens on families already struggling to adjust. The ACA grants considerable flexibility to the Secretary of Health and Human services in developing a process for re-calculating eligibility. The process should accommodate life and income changes in real time, and take full advantage of simplifications for applicants that may become possible with the new electronic interface that will be developed as part of ACA implementation. As an example of electronic capabilities, Healthy San Francisco and other county-based programs store applicants' supporting documentation electronically for them, so that it can be easily recalled when renewal periods or eligibility questions arise. California should explore whether such a system could be implemented statewide.[76]

Further, the ACA requires insurers to grant a three-month grace period of coverage when participants fail to pay premiums. This grace period should be extended to cover the insured's failure to pay their portion of cost-sharing for benefit services as well. Finally, advocates and agencies should examine the interaction between re-calculation of eligibility procedures and changes in income while family members take time off from work covered by the Family and Medical Leave Act. During the leave period, a family will have less income

and may be eligible for increased assistance, but the federal law is unclear on how to ensure families pay the correct share of healthcare costs in those circumstances.

Underinsured

Overall Impact of the ACA: For the underinsured—those who have insurance coverage but find it inadequate to cover their medical needs—the ACA will mean long-run improvements in healthcare coverage. The ACA attempts to reduce underinsurance by abolishing pre-existing condition coverage bars, establishing coverage plan minimum standards and providing federal assistance to low-income adults to help pay for healthcare plans on the Exchange. Many of these provisions will aid future healthcare consumers who might otherwise face insurmountable healthcare bills due to catastrophic health events like cancer, injury or other life-threatening diseases.

Possible Remaining Coverage Gaps: Until the Exchange is implemented in 2014, many of the currently underinsured may remain in precarious financial territory. Once the exchange opens, some individuals enrolled in high-deductible exchange plans with high healthcare needs could be at risk of underinsurance. A 2009 study showed that 62 percent of all bankruptcies are related to medical expenses.[77] The same study also revealed that the vast majority of those filing for medical bankruptcy are middle-class, college-educated and insured. As employers reduce healthcare benefits in response to lost revenues resulting from the recent economic crisis, the number of people filing for medical bankruptcy may already be escalating. This trend could exacerbate an already harrowing problem, as it is currently estimated that one new person files for medical bankruptcy every 90 seconds in the United States.[78]

Recommendations: While ACA regulations require annual limit minimums to start at $750,000 in 2010 and increase each year, studies of the underinsured should continue to assess whether these limits are an effective mechanism to ease medical financial burdens. Additionally, states and the federal government must work together to coordinate enforcement mechanisms on the ground that will be in place and ready to go as new regulations become effective, in order to ensure that the underinsured can benefit from higher coverage standards.

Unemployed Adults

Overall Impact of the ACA: In May 2010, the Bureau of Labor statistics reported that California faced double-digit unemployment, and that 2,277,200 Californians were out of work.[79] Families in which a wage earner is laid off may lose access to an affordable employer-sponsored plan, and become eligible for premium credits on the Exchange. However, in order to avoid coverage gaps, the application and approval process for subsidized coverage on the Exchange must be much more simplified and efficient than, for example, the current process for acquiring Medi-Cal coverage. Otherwise, families may face coverage gaps that in turn drive up healthcare costs due to delayed care.

The ACA has several provisions that may help to ensure continuity of coverage for California workers facing an unstable job market. The law requires healthcare "navigators" as part of the Exchange, whose role will be to assist families through the application and enrollment process for Exchange plans. Requirements for simplified, standardized enrollment forms and a centralized process for premium credit applications for the

Exchange are also included in the law and may help families to bridge employment coverage gaps. California-specific implementation policies for these requirements will go a long way in determining how user-friendly the Exchange is for the unemployed.[80]

Possible Remaining Coverage Gaps: The Exchange will not go into effect until 2014, and in the short term, assistance for families facing employment-related coverage gaps appears grim. In February 2009, the American Reinvestment and Recovery Act instituted subsidies for COBRA continuation coverage, which allowed laid off workers to continue to purchase employer-sponsored healthcare at discounted rates. The subsidies were temporary, but were repeatedly extended to cover workers laid off through May 31, 2010. Those subsidies have now been allowed to expire, making COBRA coverage prohibitively expensive for most unemployed workers. A recent Families USA report estimates that the average unemployed worker in California would have to spend 84.5 percent of their monthly unemployment benefit check in order to purchase unsubsidized COBRA coverage.[81]

Recommendations: To avoid adding the recently unemployed to the ranks of the uninsured, Congress could reinstate the COBRA subsidies, but has failed to do so at this time. In the absence of federal action, the state of California could also act to make additional subsidies available for COBRA coverage. Additionally, analysts have recently suggested that incorporating applications for public program and assistance enrollment with certain employment transitions—such as filing for unemployment—could increase access and reduce coverage gaps due to changes in income.[82] State lawmakers and agencies responsible for implementing the Exchange application process should study the possible benefits of this approach.

Adults with Income Up to 133 Percent of the FPL

Overall Impact of the ACA: Low-income adults will experience a significant expansion of healthcare coverage venues under the ACA. The expansion of Medicaid eligibility to include almost everyone whose income is 133 percent of the FPL or below will have widespread effects on low-income adults in California. For Californians making less than 400 percent of the FPL, subsidies and premium credits available for purchasing individual coverage on the Exchange will also be available beginning in 2014.

Possible Remaining Coverage Gaps: Affordability issues that may arise for low-income adults under the ACA are similar to those discussed in the section on *Families Buying Their Own Coverage* earlier in this paper. Coverage gaps will persist for this population until the expansion of Medicaid eligibility and the establishment of the Exchange take place in 2014.

Recommendations: The state should commission a thorough, expedited study of the fiscal impact of early implementation of the Medicaid eligibility expansion. Early implementation could generate savings on future health services by increasing access to preventive care and preventing costs associated with delayed care but the enhanced federal match for the expansion populations will begin only in 2014.[83]

Low Income Children

Overall Impact of the ACA: In 2009, over one-fifth of the uninsured in California were 20 years old or younger.[84] Several of the trends in low-income children's health insurance coverage mirror the economic struggles being experienced by their parents and caretakers. Much like adults, a declining majority of children are covered by employer-sponsored plans.

In 2007, 52.2 percent of children were insured by employer-based plans, and that number may have diminished further due to the recent recession.[85] In some cases where employer-based insurance is not an option, the state and counties maintain programs to provide coverage to certain low-income children.

Healthy Families and Medi-Cal for Children will have more stable federal funding as a result of the ACA; however, families may experience increased cost-sharing through premiums and copayments. Additionally, the ACA's provisions requiring all health plans to end cost sharing for certain preventive health services coverage for children, standardize coverage eligibility for foster care and former foster care youth, and end pre-existing condition coverage denials for children are all significant steps forward for children's health coverage in California.

Possible Remaining Coverage Gaps: Enrollment procedures and eligibility standards for the array of public programs for children's health insurance are, like their counterpart programs for adults, complex. As many as 69 percent of the uninsured children in California are actually eligible for public programs like Medi-Cal and Healthy families, but are not enrolled.[86] The ACA's requirements for simplification of the Medi-Cal application and enrollment process may further simplify the existing joint application.

Additionally, Healthy Kids programs—county-based program that cover children who are ineligible for state programs like Medi-Cal and Healthy Families, cover children in 26 counties at a variety of income levels, regardless of immigration status.[87] However, recent budget cuts have forced some Healthy Kids programs, including the largest in Los Angeles County, to implement enrollment caps such as limiting enrollment to children 0-5 years of age.[88] Healthy Kids is not directly affected or supported by the ACA, but for many undocumented immigrant children, it is the only possible source of healthcare coverage.

Recommendations: The current number of children who are eligible for public programs but not enrolled indicates a need to seriously re-evaluate the current outreach and enrollment strategies used by the state. While this has been explored in the past, the new expansion of Medi-Cal eligibility and funding for Healthy Families should provide renewed impetus to develop pilot projects for innovative outreach, such as expanding school-based enrollment efforts, developing more streamlined processes, and simplifying renewals. Further, as the Medi-Cal expansion is implemented, and children are moved between public programs, more extensive parent education and outreach will be needed to ensure that children have seamless coverage.

The Healthy Kids programs must continue and expand to more counties in order to ensure undocumented immigrant children have some ability to consistently access healthcare services. In addition, the state of California in 2007 came close to expanding eligibility for public programs to all children, including undocumented immigrant children. Governor Schwarzenegger's proposal for universal health coverage in California in 2007 would have extended Medi-Cal and Healthy Families eligibility to all children up to 300 percent of the FPL regardless of immigration status.[89] The California Assembly embraced this plan as well in ABx1 1 (Núñez), demonstrating that there is some political will to move forward on this issue.[90] California lawmakers should keep on the table expansions of public programs to all children.

Young Adults

Overall Impact of the ACA: Young adults are uninsured at higher rates than all other age groups, and their frequency of emergency room visits is comparable to that of adults in their 30's, 40's and 50's.[91] This population will have at least two additional options for coverage under the ACA, in addition to those low-income young adults who will be eligible for the expanded Medi-Cal program or subsidized individual insurance available on the Exchange.

The first new option available to young adults stems from a provision in the ACA that mandates that insurers who offer dependent coverage make it available to all individuals younger than age 26, which would allow more young adults to receive coverage under their parents' healthcare plans.[92] Currently, "aging out" of a parents' plan has been associated with a five to eight percentage point drop in the likelihood that a young adult will have health insurance. This provision goes into effect in the fall of 2010, and several major insurers have voluntarily complied with the provision early.[93] A second option for young adults under 30 will be to purchase a catastrophic coverage plan on the Exchange.[94] The catastrophic plan will meet the same standards to provide minimum essential benefits as other plans on the Exchange, but will have less coverage for primary care.[95]

Possible Remaining Coverage Gaps: The remaining coverage gaps for young adults are greatly minimized by the ACA, as long as members of the population are well-informed about new coverage choices and penalties for non-compliance with the individual mandate.

Recommendations: Similar to ensuring coverage for low-income children, outreach and education for both young adults and their parents will be critical to help this population understand new options and decide what will be most appropriate for their budget and lifestyle.

Near Elderly

Overall Impact of the ACA: A recent survey of individuals buying healthcare coverage on their own in the individual market reaffirmed a long-standing pattern: 55-64-year-olds are paying substantially more for their health coverage than individuals in other age groups.[96] These near-elderly individuals are also more likely to develop illnesses or chronic health conditions than any other age group under 65.[97] Given these facts, it is unsurprising that the likelihood of being uninsured for Californians age 55-64 is on the rise, up from 16.6 percent in 2000 to 19.7 percent in 2008.[98]

For many of the near elderly who are uninsured, the next opportunity for health coverage will come when they turn 65 and qualify for Medicare. Those delays in coverage have been shown to yield much more severe outcomes and higher medical costs when Medicare coverage begins.[99] The guaranteed issue provisions of the ACA will help to ensure that pre-existing conditions do not prevent near elderly patients from acquiring insurance. Further, new restrictions on how much plan costs can vary based on participants' age will also make coverage more affordable for this population. However, the Congressional Budget Office estimates that in the short term, the average premium cost for everyone buying plans on the Exchange will be higher, in part due to higher-quality plans being available.[100] To determine whether near-elderly participants find the Exchange plans more affordable will depend on whether the higher average premium costs are outweighed by the availability of premium credits and subsidies.

Under the ACA, employers that provide health insurance coverage to retirees aged 55–64 can receive reimbursement for 80 percent of claims between $15,000 and $90,000 effective June 1, 2010. The program will end either when the $5 billion in appropriated funds are expended or the end of 2013, whichever is sooner. This funding will help employers that already offer this coverage to continue offering it.

Possible Remaining Coverage Gaps: For the near elderly, many of the remaining gaps in coverage will continue to be due to lack of affordability. Several provisions of the ACA are intended to mitigate those effects, including expanded eligibility for Medicaid and subsidies for Exchange plans. Coverage for this population should be closely monitored to ensure that insurers do not attempt to circumvent new premium variation limits based on age by steering near-elderly participants towards higher deductible plans. Near-elderly adults who still cannot afford or obtain coverage when ACA programs are fully implemented can apply for a hardship waiver to become exempt from the individual mandate, but still will not have health insurance.

Due to ongoing struggles for this population to obtain and afford coverage, the solution may lie with federal, instead of state, lawmakers. Proposals to extend the eligibility age for Medicare should be revisited with updated cost calculations for the growing number of near-elderly who delay care and savings estimates from the implementation of the ACA.

Recommendations: Insurance coverage trends and hardship waiver applications for this population should be closely monitored during the implementation of the ACA to ensure that near-elderly patients are not falling between the cracks before they are old enough to qualify for Medicare.

Immigrants

Overall Impact of the ACA: Despite frequent media attention to public healthcare usage by undocumented immigrants, the reality is that immigrants (both documented and undocumented) use far fewer public healthcare dollars per person than U.S.-born citizens.[101] While the vast majority of the uninsured are citizens, an estimated 1.07 million undocumented adults in California did not have healthcare coverage in 2007.[102] The net fiscal impact of undocumented immigrants on the federal budget is positive—their contributions through Social Security and other taxes far outweigh the federal cost of services for undocumented immigrants.[103] Regardless of these facts, however, the uninsured and undocumented are explicitly excluded from the ACA.

The ACA exempts those who are "not lawfully present" from the individual mandate to have health insurance. The law also excludes the undocumented from the insurance Exchanges and all attendant premium credits and subsidies.[104] Federally-funded Medicaid programs will continue to be off-limits for the undocumented as well.

Immigrants residing legally in the U.S. for fewer than five years will be eligible to apply for subsidized health insurance coverage on the Exchange, but will continue to be ineligible for Medicaid.

Possible Remaining Coverage Gaps: The 1.2 million undocumented, uninsured individuals living in California currently are likely to continue to be uninsured. Recent, legal immigrants who are currently uninsured may be able to purchase care on the Exchange in 2014, but may continue to go without coverage in the interim. If lawmakers cut state-funded

Medi-Cal coverage for recent, legal immigrants, many will be likely to join the ranks of the uninsured.

Recommendations: The state of California should continue to fund Medi-Cal coverage for recent, legal immigrants in order to ensure that this population does not experience coverage gaps between now and 2014.

By excluding the healthcare needs of undocumented immigrants from the ACA, the federal government continues to shift the costs of public healthcare services to state and local governments. California's ongoing budget crisis has resulted in some proposals to trim state programs and local clinic budgets. However, further limiting outlets for preventive and regular healthcare services will result in increased pressure on emergency rooms as care providers of last resort for the undocumented.

California cannot expect the federal government to lead the way on coverage for immigrants. California lawmakers should continue to study the economic impact of denying coverage to undocumented immigrants, and realistically consider the true demographics of the state's population. Proposals to cover low-income undocumented immigrants may more accurately reflect the healthcare needs of California's working adults, and should remain a possibility for future action.

CONCLUSION

A defining component of the ACA is the amount of leverage it provides to states in determining how healthcare access and delivery will be carried out during reform. This is a double-edged sword for California, a state that has traditionally served as a leader in promoting inclusive healthcare access programs. Currently, the state is engaged in a protracted budget crisis, exacerbated by legislative gridlock in Sacramento. Fiscal tensions between the need to prepare to insure thousands more Californians in the coming years and the desire of some lawmakers to balance the state budget via cuts to healthcare programs show no signs of easing any time soon. However, there are some signs of forward movement despite these challenges.

At press time, the state legislature is considering 22 bills that are directly related to enacting ACA provisions in California. The content of the bills ranges from health consumer protections, to establishing the framework and funding for the Exchange, to filing for additional funding to serve as a bridge for Medicaid patients until 2014, to requiring the state to apply for federal grants to develop and improve preventive services.[105]

The level of legislative activity and energy in Sacramento around implementing the provisions of the ACA (some of them years ahead of federal requirements) is a positive sign. However, the state is in the midst of what is becoming an annual event—deadlock over the budget and the threat of cuts to essential health services. Given that context, legislators can best serve the health needs of Californians by introducing legislation that goes beyond minimum implementation of the ACA, while also crafting policies that aim to proactively lower healthcare costs in the future and are grounded in the reality of the current budget situation.

The ACA, when fully implemented, will improve healthcare access for millions of Californians. Though the reform law does not cover everyone, it does provide a framework that narrows existing coverage gaps and creates opportunities for state action to finish the job. By grounding healthcare coverage in the notion of shared responsibility between employers, the insured, and the public, the ACA shifts the American healthcare system in a more sustainable direction.

While the passage of the ACA was historic, the implementation of the federal reform law at the state and local level will determine the true depth of its impact. Lawmakers, agency directors and advocates must continue to work together to ensure that the myriad of regulations determined at the agency and state level will be practical and relevant to the lives of California families. If the state is prepared to continue to play a leadership role in innovative and inclusive coverage, many of the potential pitfalls in the federal reform law around issues like consistency and affordability of coverage can be avoided.

The improvement of healthcare access for Californians could not come at a better time. As the state economy struggles to recover and the population continues to grow, consistent primary and preventive care will ensure that California's expansion in human capital is sustainable. However, increasing insurance coverage cannot be carried out at the cost of dismantling the already precarious healthcare safety net. Those who are explicitly left out of the ACA and those who may fall through the cracks of the new law must have

resources for care. The system will not be perfect on day one, and until access is truly universal and evenly distributed, the failsafe of the safety net must be preserved.

The ACA goes a long way to address many of the healthcare access issues that have been allowed to grow unchecked in California and across the United States. By uniting under the common goal of using the new health reform law to provide consistent, affordable access for everyone, this state can lead the nation in healthcare access expansion and innovation.

REFERENCES

[1] Shana A. Lavarreda, E. Richard Brown, Livier Cabezas and Dylan Roby, "Number of Uninsured Jumped to More than Eight Million from 2007 to 2009," UCLA Health Policy Research Brief, (Los Angeles, CA: March 2010), accessed at http://www.healthpolicy.ucla.edu/pubs/files/Uninsured_8-Million_PB_%200310.pdf.
[2] California Health Interview Survey, "CHIS 2007 Adult Public Use File," (Los Angeles, CA: UCLA Center for Health Policy Research, September 2009).
[3] The Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010) as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029.
[4] ACA § 1501. The combined, chaptered version of both the Affordable Care Act and the companion Reconciliation Act can be found at http://docs.house.gov/energycommerce/ppacacon.pdf.
[5] ACA § 1311.
[6] ACA § 1501.
[7] California Healthcare Foundation, "California Healthcare Almanac: California's Uninsured," (Oakland, CA: December 2009), accessed at
http://www.chcf.org/~/media/Files/PDF/C/CaliforniasUninsuredSnapshot2009.pdf.
[8] Under ACA § 1401, individuals will only be eligible for subsidies and premium credits if they do not have access to an employer-sponsored plan that has an actuarial value of at least 60% or an employee-share of less than 9.5% of income.
[9] ACA § 1401.
[10] California Healthcare Foundation, "California Healthcare Almanac: California's Uninsured."
[11] Lavarreda, et. al, "Number of Uninsured Jumped to More than Eight Million from 2007 to 2009." 49.8% of Californians (age 0-64) with insurance get it through the employer, which includes those who are purchasing it through COBRA.
[12] Brandalyn Patton, Susan Duerksen, and Murtaza Baxamusa, "The Working Uninsured: An Analysis of Worker Health Coverage among California Industries" (San Diego: Center on Policy Initiatives, 2007).
[13] California Healthcare Foundation, "California Healthcare Almanac: California's Uninsured."
[14] Ibid.
[15] An employer-sponsored plan is considered "unaffordable" in the ACA if the actuarial value of the plan is less than 60% or the employee-share is more than 9.5% of their income.
[16] ACA § 1513.
[17] ACA § 1511.
[18] ACA § 1512.
[19] The law also provides for penalties for businesses which impose extended waiting periods for employees to become eligible for coverage; $400 and $600 per employee for waiting periods over 30 and 60 days, respectively.
[20] ACA § 10108.
[21] "The Affordable Care Act: Immediate Benefits for California," (Washington, DC, U.S. Department of Health and Human Services Website), accessed at
http://www.healthreform.gov/reports/statehealthreform/california.html.
[22] ACA § 1421.
[23] Ken Jacobs, Laurel Lucia and Dave Graham-Squire, "Federal Health Reform: Impact on Small Businesses, Their Employees and the Self-Employed," (Berkeley, CA, UC Berkeley Center for Labor Research and Education: June 2010).
[24] Ibid.
[25] ACA § 1513.
[26] The 1.2 million uninsured Californians who are self-employed or small business-employees, and earn above 400 % of the FPL will also be able to purchase coverage on the Exchange without subsidies. Estimates for both the number of uninsured eligible for subsidies and for access to the Exchange are from Jacobs, et. al, "Federal Health Reform: Impact on Small Businesses, Their Employees and the Self-Employed."

[27] This chart is a modified version of a summary chart that appeared in Miles Palley, "Implementation Issues of American Health Benefit Exchange," document prepared for the UC Berkeley Law School Center For Health, Economic and Family Security, August 6, 2010.
[28] ACA § 1401. Additionally, there is a catastrophic health insurance plan available to individuals who are under 30 or exempt from the mandate. The catastrophic plan provides no coverage for preventive and primary care and has no federal requirements for subsidies or premium credits.
[29] See Lynn Quincy, "What Will an "Actuarial Value" Standard Mean for Consumers?" (Yonkers, NY: Consumers Union, December 2009), accessed at http://www.prescriptionforchange.org/pdf/Act%20Value%20Dec%202009.pdf; and Roland McDevitt, "Actuarial Value: A Method for Comparing Health Plan Benefits" (Oakland, CA: California HealthCare Foundation, October 2008), accessed at http://www.chcf.org/~/media/Files/PDF/H/HealthPlanActuarialValue.pdf.
[30] California Health Interview Survey, "CHIS 2007 Adult Public Use File," (Los Angeles, CA: UCLA Center for Health Policy Research. September 2009).
[31] ACA § 1402(b). The income calculation used for this portion of healthcare reform is modified adjusted gross income (MAGI). For premium credit and subsidy eligibility determinations, MAGI is adjusted gross income increased by any foreign income earned buy the taxpayer, housing costs while living abroad and tax exempt interest accrued by the taxpayer in a given year. ACA § 1401(d).
[32] ACA § 1401(c)(1)(B). The law orders the Secretary of Health and Human Services to conduct a study to determine whether it may be feasible to adjust the Federal Poverty Level to reflect geographic cost-of-living differences. The Secretary must report on the findings of the study to Congress by January 1, 2013, along with his or her recommendation as to the feasibility of regional adjustment of the FPL. ACA § 1416.
[33] ACA § 1402(b).
[34] ACA § 1402(c) describes both the actuarial value limits and the out of pocket cost limits.
[35] Julian Pecquet, "President Obama Unveils Patient's Bill of Rights," *The Hill*, (Washington, DC: June 22, 2010).
[36] ACA § 1102(a).
[37] ACA § 1001.
[38] ACA § 1001.
[39] ACA § 1331.
[40] ACA § 1101 (a).
[41] California Healthcare Foundation, "Implementing National Health Reform in California: Changes to Public and Private Insurance," (Oakland, CA: June 2010).
[42] SB 227, signed by Governor Schwarzenegger on June 29, 2010.
[43] California Major Risk Medical Insurance Board, "Note on SB 227 and AB 1887," (Sacramento, CA: Department of Health Care Services, June 2010), accessed at http://www.mrmib.ca.gov/mrmib/Agenda_Minutes_061610/Agenda_Item_6.a.i_ii_SB_227_analysis_6-16-10-FINAL.pdf.
[44] Robert Pear, "Insurance Pools Readied in Some States," *The New York Times*, (New York: June 27, 2010), accessed at http://www.nytimes.com/2010/06/27/health/policy/27insure.html.
[45] ACA § 1101(d)(2).
[46] California Managed Risk Medical Insurance Board, "Facts about California's High Risk Pool and the Federal High Risk Pool," (Sacramento, CA: Department of Health Care Services, April 2010) accessed at http://mrmib.ca.gov/mrmib/Facts_About_California_HR_Pool.pdf.
[47] ACA § 1331.
[48] ACA §§ 2001-02. The new law calculates income eligibility with a new, standardized set of metrics all states will be required to use. It is based on modified, adjusted gross income and eliminates the asset test.
[49] Shana Lavarreda and E. Richard Brown, "National Healthcare Reform will Help Four Million Uninsured Adults and Children in California," (Los Angeles, CA: UCLA Center for Health Policy Research, October 2009), accessed at http://www.healthpolicy.ucla.edu/pubs/files/HCR_FS_10-09.pdf.

[50] ACA § 2001.
[51] ACA § 2002. California Healthcare Foundation, "Implementing National Health Reform in California: Changes to Public and Private Insurance". According to the California Healthcare Foundation, state agencies have produced some analysis which says that some adults may lose eligibility for Medi-Cal due to shift from MAGI, but they will then be eligible for the Exchange. Cost sharing on the Exchange could be much higher than Medi-Cal, so there may be a net loss of benefits. This impact of this issue will not become clear until further development of the Medi-Cal program and the plans offered on the Exchange occurs.
[52] One example of the difficulties the current Medi-Cal enrollment process engenders is "churning," which occurs when a participant loses coverage, only to be re-enrolled within a couple of months. For more on this phenomenon and what counties have done to address churning and enrollment obstacles, see Vicki Grant and Laura Heller, "Slowing Medi-Cal Churn: Counties Collaborate to Improve Efficiency," (Sacramento, CA: California Healthcare Foundation, December 2008).
[53] The underlying complexity of the Medicaid program presents an even greater barrier to coverage. Achieving program simplification without eliminating coverage opportunities for individuals who currently rely on Medicaid should remain a goal.
[54] ACA § 1413(e).
[55] ACA § 1413(b). The language of ACA § 1311(d)(4)(F) seems to obscure the distinction between the enrollment and screening mechanisms in the Exchange. This must be clarified in California legislation targeting the construction of the Exchange in order to avoid enrollment delays. For more on this issue, see Melissa Rodgers, "Technical Assistance on California Proposed Legislation Creating the California Health Benefit Exchange," (Berkeley, CA: UC Berkeley Law School Center for Health, Economic and Family Security, July 2010).
[56] ACA § 2002(a), creating 42 U.S.C. § 1396a(e)(14)(E).
[57] ACA § 10203(c).
[58] ACA § 2101(b).
[59] ACA § 2201.
[60] ACA § 2101 maintains the CHIP program until 2019, provides a 23% increase in federal matching funds up to a 100% maximum, and requires a maintenance of effort by the states.
[61] ACA § 2201.
[62] Lavarreda, et. al "Number of Uninsured Jumped to More than Eight Million from 2007 to 2009."
[63] California Budget Project, "Governor Releases May Revision With, As Promised, 'Absolutely Terrible Cuts,' No Tax Increases", (Sacramento, CA: May 2010).
[64] Shana Lavarreda and E. Richard Brown, "National Healthcare Reform will Help Four Million Uninsured Adults and Children in California."
[65] Congressional Budget Office, Letter to Senator Evan Bayh, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act," November 30, 2009.
[66] David M. Cutler, Karen Davis, and Kristof Stremikis, "Issue Brief: The Impact of Health Reform on Health System Spending," Commonwealth Fund Publication 1405, Vol. 88, May 2010.
[67] Letter from Douglas W. Elmendorf, Director, U.S. Congressional Budget Office, to the Honorable Nancy Pelosi, Speaker of the U.S. House of Representatives, Re: H.R. 4872, Reconciliation Act of 2010, p. 21 (Mar. 20, 2010), accessed at www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.
[68] Kaiser Family Foundation, "Survey of People who Buy Their own Health Insurance," (Menlo Park, CA: Kaiser Family Foundation, June 2010).
[69] Ken Jacobs, Laurel Lucia and Dave Graham-Squire, "Federal Health Reform: Impact on Small Businesses, Their Employees and the Self-Employed," (Berkeley, CA, UC Berkeley Center for Labor Research and Education: June 2010).
[70] Analysis prepared with the UC Berkeley Center for Labor Research and Education, "How Much Will a Family Spend With National Health Reform?" Calculator, accessed at http://laborcenter.berkeley.edu/healthpolicy/index.shtml#calculator.

[71] According to the United States Bureau of Labor Statistics' May 2009 "State Occupational and Employment Wage Estimates," the median salary for a Pharmacy Technician in California is $36,310, accessed at http://www.bls.gov/oes/current/oes_ca.htm#31-0000.

[72] There are currently 23, 750 legal immigrants who have resided in the U.S. for less than five years who are now eligible for CalWorks, the California welfare to work program. California Budget Project, "The Governor's Proposed Budget Would Eliminate CalWorks cash assistance for more than 1.4M low-income Children and Parents," (Oakland, CA: May 2010). CalWorks income eligibility for the family sizes included in the CBP analysis ranges from 59-60% of the FPL. This group could pay an even higher share of their income for healthcare costs than the 75% example included in this paper.

[73] ACA § 403. For more information, see the Welfare Reform Act (HR 3724) passed by the 104th U.S. Congress in 1996.

[74] ACA § 1401.

[75] California Department of Healthcare Services, "Presentation to Budget Conference Committee," (Sacramento, Ca: June 5, 2009).

[76] For more on how electronic systems may help to increase health insurance access and improve enrollment methods, see Stan Dorn, "Applying 21st-Century Eligibility and Enrollment Methods to National Health Care Reform," (Washington, DC: The Urban Institute, December 2009).

[77] David U. Himmelstein, Deborah Thorne, Elizabeth Warren, Steffie Woolhandler, "Medical Bankruptcy in the United States," 2007: Results of a National Study, *The American Journal of Medicine*, (2009), accessed at http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf.

[78] Ibid.

[79] United States Department of Labor, Bureau of Labor Statistics, "June 2010 Economics News Release: Civilian Labor Force and Unemployment by State and Selected Area, Seasonally Adjusted," accessed at http://www.bls.gov/news.release/laus.t03.htm.

[80] The two primary bills which would establish the Exchange in California (SB 900 and AB 1602) are making their way through the 2009-2010 Session of the California State Legislature. For more information on important regulations that the legislature should consider including in these bills, see Melissa Rodgers, "Technical Assistance on California Proposed Legislation Creating the California Health Benefit Exchange," (Berkeley, CA, UC Berkeley Center for Health, Economic and Family Security: June 23, 2010), accessible at http://www.law.berkeley.edu/files/chefs/Exchange_Bills_June_2010.pdf.

[81] Families USA, "The Pending Jobs Bill: People Most in Need could Lose Health Care" (Washington, DC: June 2010). Families USA estimates that in California, the average monthly COBRA benefit premium without subsidy is $1103, and the average monthly unemployment benefit is $1305.

[82] Stan Dorn, "Applying 21st-Century Eligibility and Enrollment Methods to National Health Care Reform," (Washington, DC: The Urban Institute, December 2009).

[83] Some suggest an early expansion is unlikely in California. See Dan Diamond, "Early Expansion of Medi-Cal Probably Not in the Cards." *California Healthline*, May 19, 2010, accessed at http://www.californiahealthline.org/road-to-reform/2010/early-expansion-of-medical-probably-not-in-the-cards.aspx.

[84] California Healthcare Foundation, "California Healthcare Almanac: California's Uninsured."

[85] E. Richard Brown, et. al, "The State of Health Insurance in California: Findings from the 2007: California Health Interview Survey" (Los Angeles: UCLA Center for Health Policy Research, 2009).

[86] California Healthcare Foundation, "California Healthcare Almanac: California's Uninsured."

[87] Michael Cousineau, Gregory Stevens, Albert Farias, "Trends in Child Enrollment in California's Public Health Insurance Programs," State Health Access Reform Evaluation, (Minneapolis, MN: State health Access Data Assistance Center, October 2009).

[88] First 5 Los Angeles Program Website, http://www.first5la.org/Programs/Healthy-Kids, accessed August 5, 2010.

[89] Office of the Governor of the State of California, "Governor's Health Care Proposal," January 8, 2007, accessed at www.gov.ca.gov.

[90] ABx1 1 (Núñez) passed the California Assembly on December 17, 2007 on a party-line vote (46-31). The Senate Health Committee rejected the bill in January 2008.
[91] Michael Anderson, Carlos Dobkin, Tal Gross, "The Effect of Health Insurance Coverage on the Use of Medical Services," National Bureau of Economic Research Working Paper Series, Working Paper 15823, (Cambridge, Massachusetts: March 2010).
[92] ACA § 1001/PHSA ACA § 2714.
[93] In May 2010, Kaiser, Aetna and Cigna announced plans to implement extended dependent coverage before the ACA required effective date (September 23, 2010), in order to help graduating college students who might otherwise lose coverage. Francesca Lunzer Krtiz, "A Bigger Blanket to Cover Young Adults." *Los Angeles Times Online Edition*, May 17, 2010, accessed at http://www.latimes.com/news/health/la-he-your-money-20100517,0,2723726.story.
[94] Legislators' motivation for including the catastrophic coverage option for young adults may best be explained by the original title given to the plan when Senator Max Baucus included it in his proposed version of the healthcare reform law. It was titled the "Young Invincibles" plan. Shirley S. Wang, "More Baucus Bill: Subsidies and 'Young Invincible'" Plan, *Wall Street Journal Online: Health Blog*, Sept 16, 2009, accessed at http://blogs.wsj.com/health/2009/09/16/more-baucus-bill-subsidies-and-a-young-invincible-plan/ on July 19, 2010.
[95] ACA § 1302.
[96] Kaiser Family Foundation, "Survey of People Who Buy their Own Health Insurance," (Washington, DC: June 2010). The average premium cost for 55-64 year old respondents were $4822/$8667 (individual/family).
[97] John Sheils, "Statement of John Sheils, VP, The Lewin Group: Expanding Health Insurance Coverage for the Near Elderly," U.S. Senate Special Committee on Aging, (Washington, DC: April 3, 2008).
[98] California Healthcare Foundation, "California Healthcare Almanac: California's Uninsured."
[99] Li-Wu Chen, et. al, "Pent-Up Demand: Health Care Use of the Uninsured Near Elderly," Robert Wood Johnson Working Paper 26, (Washington, DC: July 2004), accessed at http://www.rwjf-eriu.org/pdf/wp26.pdf.
[100] Congressional Budget Office, "An Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act," November 30, 2009, accessed at http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.
[101] Sarita Mohanty, et. al, "Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis," *American Journal of Public Health*, Vol. 95, No. 8 (New York: August 2005), accessed at http://ajph.aphapublications.org/cgi/reprint/95/8/1431.
[102] Shana Lavarreda and E. Richard Brown, "National Healthcare Reform will Help Four Million Uninsured Adults and Children in California."
[103] Congressional Budget Office, "The Impact of Unauthorized Immigrants on the Budgets of State and Local Governments" (Washington, DC: December 2007), accessed at http://www.cbo.gov/ftpdocs/87xx/doc8711/12-6-Immigration.pdf.
[104] ACA § 1312.
[105] The non-profit group Health Access has an up to date list of California state legislature bills pending that are relevant to the implementation of the ACA, accessed at http://www.healthaccess.org/files/advocating/Reform%20Implementation%20Bill%20List%207-13-10.pdf.

University of California, Berkeley
School of Law
2850 Telegraph Avenue, Suite 500
Berkeley, CA 94705-7220
510.642.8527
www.law.berkeley.edu/chefs.htm

BerkeleyLaw
UNIVERSITY OF CALIFORNIA
Berkeley Center on Health, Economic & Family Security

Berkeley Center on Health, Economic & Family Security

The Berkeley Center on Health, Economic & Family Security (Berkeley CHEFS) is a research and policy center at the University of California, Berkeley, School of Law and the first of its kind to develop integrated and interdisciplinary policy solutions to problems faced by workers and families in the United States. Berkeley CHEFS works on increasing access to health care, improving protections for workers on leave from their jobs, supporting workers in flexible workplaces, and ensuring that seniors are secure during retirement.

Christian D. Phillips is a student at the Woodrow Wilson School of Public and International Affairs, Princeton University and Research Assistant for the Center on Health, Economic & Family Security.