March 1, 2016

Diana Dooley, Chair and Members
Covered California Board
1601 Exposition Boulevard
Sacramento, CA

Sent via email to 1332@covered.ca.gov

Re: § 1332 Waiver

Dear Members of the Covered California Board,

We appreciate the productive discussion in California about how § 1332 waivers can be used to improve health coverage. On behalf of Western Center on Law & Poverty, the National Health Law Program and the Legal Aid Society of San Mateo County, following are our suggestions for what California should seek in a § 1332 waiver. We propose several improvements to make the current system work – changes we would like in the near future to improve system functionality while the state develops potentially broader proposals for future waiver endeavors.

Access for Immigrants

We strongly support California applying through a § 1332 waiver to allow undocumented immigrants to purchase coverage through Covered California. Though undocumented immigrants are not eligible for Exchange subsidies, it is a matter of fairness and equity to allow all Californians access to coverage channels to the maximum extent possible. We think it important that a family applying for coverage together through the joint Covered California/Medi-Cal application be able to obtain or purchase coverage for every member of the family rather than the current reality where some members can get coverage through the Covered California portal and others have to buy coverage in the outside individual market.

Were California to pursue this element in a § 1332 waiver individuals would not be enrolled in qualified health plans (QHPs) *per se* as people can only enroll in QHPs if they meet the immigration eligibility requirements. Rather, they would enroll in parallel plans after applying through www.CoveredCA.com. Allowing all members of a family to enroll in some

form of health coverage through the same portal is valuable and sends a welcoming message to all Californians. It will also hopefully lead to some increased enrollment of people eligible for subsidies but unenrolled. In addition to providing needed health coverage to these families, this could bring additional membership into Covered California – likely younger, healthier individuals which would help the already strong risk mix.

§ 1332 Waiver Requirements:

The four guardrails for § 1332 waivers are met for this proposal:

- *Coverage*: this proposal would not decrease those eligible for coverage;
- *Affordability*: this make no change to affordability as undocumented immigrants are not eligible for subsidies currently or under the proposal;
- *Comprehensiveness*: there is no impact; and
- *Deficit Neutrality*: there will be no meaningful change to those receiving subsidies. To the extent that some already-eligible family members come into subsidized QHPs from the "welcome mat" effect they are currently eligible for such subsidies and could improve the risk mix.

<u>Encouraging Participation of Medi-Cal Plans in Covered California</u>

Because of the frequency with which people move between Medi-Cal and Covered California and the many "mixed coverage" families with parents enrolled in QHPs and children and/or pregnant women enrolled in Medi-Cal, we urge that California take steps in its § 1332 waiver to encourage participation of Medi-Cal plans in Covered California. Today, LA Care is the only public Medi-Cal plan that participates in Covered California. Contra Costa Health Plan originally participated but had to drop out of Covered California in part because of the onerousness of having to participate in the individual market outside the Exchange and collect premiums.

Some 10 million Californians are enrolled in a Medi-Cal health plan – 75% of the Medi-Cal population. For those who have an increase in income and move to Covered California many have to change to a different health plan because their health plan is not available in Covered California. This means an income and coverage change will likely also mean having to change doctors and other providers because of a new provider network. California can improve continuity of care for these individuals by taking steps to encourage Medi-Cal plans to participate in Covered California by removing several barriers discussed below.

Another advantage of making it more feasible for Medi-Cal plans to participate in Covered California is it would enable families where some members are in Medi-Cal and others are in Covered California to be in the same plan.

Specifically a § 1332 waiver should waive for Medi-Cal plans:

- The requirement to participate in the individual market outside the individual market.
- Needing to collect premiums if it would be feasible for Covered California to collect the premiums.
- The requirement to serve all consumers both subsidized up to 400% FPL and unsubsidized. One option would be to have the Medi-Cal plans only cover people through Covered California whose income goes over 138% who they had as Medi-Cal members and adults with children in Medi-Cal up to 266% (the Medi-Cal income cut-off for most children).

If this is included in California's § 1332 waiver application, one consideration will be whether to waive the inclusion of these plans in the determination of the second lowest cost silver plan – upon which the subsidies are based.

§ 1332 Waiver Requirements:

The four guardrails for § 1332 waivers are met for the proposal to encourage Medi-Cal plans to participate in Covered California:

- *Coverage*, and *Comprehensiveness*: there is no impact to these elements, and
- *Affordability* and *Deficit Neutrality*: if the Medi-Cal plans are included in the calculation of the second lowest cost silver plan this proposal could increase affordability of coverage through Covered California for consumers and decrease the federal subsidies.

Newly Qualified Immigrants Wrap

California law calls for moving Medi-Cal expansion adults (under age 65, not pregnant, not eligible for Medicare) who are subject to the 5-year bar to Covered California (immigrants who have less than 5 years in a "qualified immigration status" or do not meet an exception).[1] The Department of Health Care Services (DHCS) will pay their premium, minus the premium tax credits they are eligible for and DHCS will cover any cost sharing. All newly qualified immigrants will be enrolled in one special silver plan to allow for this. The newly qualified immigrants who do not enroll in Covered California will receive only restricted scope benefits. Current understanding is that once the program opens in 2017, those who enroll outside of Covered California's open enrollment will be in Medi-Cal until the next open enrollment. If they have a special enrollment qualifying event at the time of application, however, they will be required to enroll in Covered California.

As DHCS and Covered California are working on the business rules to set up this program, a number of challenges have been identified, including continuity of care issues as some newly qualified immigrants may be placed first in Medi-Cal fee for service, then moved to Medi-Cal managed care, and then moved into Covered California. When they reach the 5th year in a

[1] Cal. Welf. & Inst. Code § 14102.

qualified immigration status, they will be moved back to Medi-Cal fee for service, and then Medi-Cal managed care again. Other details have also not been worked out such as how beneficiaries, once enrolled in Covered California, will receive additional Medi-Cal services such as adult dental or in-home supportive services. Beneficiaries who report a pregnancy also have the potential to move to Medi-Cal and then back again, depending on where they are in the five years. Additionally, Medi-Cal children who become adults may also be moved to the NQI wrap for a short period of time until they reach their fifth year in qualified status. On top of all this, we know that newly qualified immigrants are largely limited English proficient, so communication about the complexities of the wrap program, the need to involve DHCS in tax reconciliation – even for those who are not otherwise required to file taxes, and navigating more than one managed care system will be challenging.

Instead of sending the Newly Qualified Immigrants to Covered California, why not bring the premium tax credits they are eligible for to DHCS to keep them in Medi-Cal? This avoids continuity of care issues, keeps them with the same coverage as other family members, and simplifies the delivery of other Medi-Cal services to this population. Reconciliation of the premium tax credits could be handled by DHCS after income redetermination because the beneficiaries would not be receiving the credits directly, which is far simpler than the current plan of having beneficiaries repay DHCS or DHCS reimburse beneficiaries. As this population is already eligible for and going to be enrolled in Covered California, there are no additional costs to the federal government. DHCS need only identify which Medi-Cal recipients are NQI eligible but would not otherwise need to move them.

§ 1332 Waiver Requirements

Sending the premium tax credits to DHCS in order to keep newly qualified immigrants in a state-only Medi-Cal program meets the four guardrails of the 1332 waiver:

- *Coverage*: this would cover the same number of newly qualified immigrants as without a waiver;
- *Affordability*: coverage via Medi-Cal is just as affordable as coverage through Covered California that is subsidized by DHCS;
- *Comprehensiveness* coverage under Medi-Cal is as comprehensive as coverage under Covered California with additional Medi-Cal benefits, and
- *Federal Deficit Neutrality*: DHCS would only be drawing the premium tax credits this population is otherwise eligible for under the Affordable Care Act and this population is currently required to apply for under Welf. & Inst. Code § 14102. This last requirement is further bolstered by the fact that under the current plan, should any individual refuse to enroll in the NQI wrap program through Covered California, the federal government would still be required to reimburse the state for any restricted-scope services received by this population.

Funding for Transition Bridge Month

State law requires DHCS and Covered California to work together to ensure that when a recipient for one program becomes eligible for the other, they are moved without a break in coverage or additional requests for information that one program already has.[2] Medi-Cal recipients who become eligible for Covered California due to increase in income or reduction in household size currently are not being moved seamlessly from Medi-Cal to Covered California and in most cases end up with a gap in coverage. Given current DHCS practices which require only 10 day notices of termination and Covered California special enrollment regulations that require someone losing coverage to enroll in a plan prior to the last day of coverage to have coverage in place the next month (see 10 CCR 6504(h)(3)), even under the best case scenario, that is very little time to notify and educate a Medi-Cal beneficiary as to what their choices are and how to enroll.

Instead, DHCS could hold these persons losing Medi-Cal in Medi-Cal for an additional month (either via its own § 1115 waiver or in a state-only program) and use a § 1332 waiver to collect the premium tax credits that person is eligible for rather than have those credits sent directly to a qualified health plan. That would give beneficiaries an extra month to change programs and avoid a gap in coverage. Should Medi-Cal beneficiaries decide to move to Covered California immediately, they can do that. But many Medi-Cal beneficiaries do not receive information about Covered California until the last days of the month and then need some time to figure out which plans they can use to keep their same providers or even get help in understanding how premium tax credits and cost-sharing reduction plans work.

1332 Waiver Requirements:

The 1332 waiver analysis is similar to that in the NQI wrap with regards to the 4 guardrails:

- *Coverage*: as this population is already entitled to premium tax credits (and cost-sharing reductions in many cases) without a waiver in the process of being sent to Covered California for plan selection, there is no change to the number of people covered;
- *Affordability*: coverage via Medi-Cal is more affordable than coverage through Covered California, thus meeting this requirement;
- *Comprehensiveness*: coverage under Medi-Cal is more comprehensive than coverage under Covered California, thus meeting this requirement, and
- *Deficit Neutrality*: this population is already entitled to premium tax credits and, in many cases, cost-sharing reductions, thus meeting the requirement that the waiver not increase the federal deficit.

Benefits Proposals

[2] Cal. Welf. & Inst Code 15926(h)

One of the waivable provisions in a § 1332 waiver are the Essential Health Benefits (EHB) requirements. Below are two proposals regarding benefit improvements that California can make with a § 1332 waiver.

I. Pediatric Services EHB category

A. Improve the EHB pediatric services category by supplementing it with Medi-Cal benefits.

A robust and comprehensive EHB is critically important for children. The health plans used as EHB benchmarks were developed for adults and without adequate consideration of children's health needs. The U.S. Department of Health and Human Services (HHS) established a special supplementing method for pediatric oral and vision care because many of the EHB benchmark plan options did not cover those services. Yet most EHB benchmark plans do not cover a category of benefits titled "pediatric services" in general. For example, California's EHB benchmark plan does not identify separate pediatric services, therefore children receive the same coverage that adults do, with the exception of oral and vision care.

Recommendation:

We recommend that Covered California request a waiver of the provisions at 45 C.F.R. § 156.100 and § 156.110 that set the EHB pediatric services standard based on the state's benchmark plan, and instead:

1) Supplement the entire pediatric services category with the health benefits received by children under the Medi-Cal program, including the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit standard.

In California, Medi-Cal benefits will be the standard for EHB pediatric dental services beginning in 2017, so this proposal expands that standard to other pediatric services as well. This change helps ensure children enrolled in Covered California receive the health care they need, and also helps ensure children transitioning from Medi-Cal to Covered California continue to receive the same benefits.

2) Supplement certain pediatric services with Medi-Cal benefits.

If the state determines that supplementing the entire pediatric services category is a long-term approach that it is not ready to undertake this year, then for 2017 it should supplement just certain pediatric services with Medi-Cal benefits. For example, California's EHB benchmark plan does not cover hearing aids or audiology services. These are areas where Covered California can make improvements for 2017 by diverging from the EHB benchmark approach and covering these benefits as they are covered under Medi-Cal.

By using the § 1332 waiver to supplement the pediatric services category with Medi-Cal benefits, the state is making these benefits part of the EHB, and is not creating a new benefit

mandate that would require the state to defray the cost.[3] The state is also supplementing pediatric services with Medi-Cal benefits, which is not an option through the EHB benchmark approach, and hence requires the waiver. In terms of the cost of adding a benefit like hearing aids to the benefits package, reports have shown that covering hearing aids has only a small impact on premiums.[4]

1332 Waiver Requirements:

- *Coverage:* There is no change in the number of people covered in these pediatric services proposals.
- *Affordability*: The proposals do not undercut any of the affordability protections in the ACA. APTCs, out-of-pocket limits, and cost-sharing reductions remain the same.
- *Comprehensiveness*: The proposals provide coverage that is more comprehensive than what is currently available without the waiver.
- *Deficit neutrality*: If there is an increase in premiums, there would be an increase in federal spending in APTCs. Yet, these pediatric services proposals will likely save federal funds, and therefore balance out any costs involved. By improving the pediatric services available to enrollees, children will be healthier by receiving the health care they need. This may lead to health care savings and savings in educational costs as well.

II. Adult Dental and Vision Services

A. Require coverage of adult dental and vision services as part of the state's EHB benchmark.

Pursuant to 45 C.F.R § 156.115, an issuer of a plan offering EHB may not include routine non-pediatric dental services nor routine non-pediatric eye exam services. Therefore even if the state's EHB benchmark plan covers adult dental and vision services, they must be excluded.

Recommendation:

[3] Assembly Bill 2004, was introduced by Assemblymember Bloom on February 16, 2016, mandating coverage by private health plans of hearing aids for all enrollees under 18 years old. Yet, per federal regulations, if a state requires a Qualified Health Plan to offer benefits in addition to those included in the EHB benchmark plan, the state has to defray the cost of covering the additional benefits if the mandate is enacted on or after January 1, 2012. So the state would have to defray the cost of this new mandate unless it is covered as a habilitative service (to help a child *gain* a new skill that he/she did not have before) versus a rehabilitative service (to help the child *regain* a skill that he/she had before but lost.) Yet hearing aids are considered an essential part of habilitative ***and*** rehabilitative care and should be covered for both purposes.

[4] James Highland et al., Compass Health Analytics, Inc., Actuarial Assessment of House Bill 52: An Act to Provide Access to Hearing Aids for Children (June 2012), *available at* http://chiamass.gov/assets/docs/r/pubs/12/mb-child-hearing-aids-actuarial.pdf. House Bill 52 (HB52), which was before the 2011-2012 session of the Massachusetts legislature, mandated insurance coverage for hearing aid devices and related services and supplies for minor children age 21 or younger. This report projected that adding hearing aid coverage would have a mid-level cost of $0.04 PMPM representing 0.008% of annual premium for five years for fully-insured plans that would be subject to the proposed mandate.

We recommend that Covered California request a waiver of 42 C.F.R. § 156.115(d), which excludes coverage of adult dental and vision services as part of the EHBs, and instead require coverage of these services. In fact, the benchmark selected for 2017 already covers some vision services including routine vision screenings that are preventive care services and eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglasses. Under this waiver proposal, the vision benefits that are already included in the state's EHB benchmark plan would be provided to adults. In terms of dental benefits for adults, ensuring preventive dental services are covered may lead to improved health outcomes and long-term cost-savings, therefore we recommend that these services be provided to adults as part of the EHB as well.

1332 Waiver Requirements:

- *Coverage*: This proposal does not impact the number of individuals receiving coverage.
- *Affordability*: This proposal does not undercut any of the affordability protections in the ACA. APTCs, out-of-pocket limits, and cost-sharing reductions remain the same.
- *Comprehensiveness*: This proposal provides coverage that is more comprehensive for adults than what is currently available without the waiver.
- *Deficit neutrality*: Adding adult dental and vision services may have an impact on the cost of premiums. If there is an increase in premiums, there would be an increase in federal spending in APTCs. Yet, covering adult dental and vision services is likely to save federal funds because state residents will be healthier. There are many studies that show that good oral health has a significant impact on overall health. There may also be savings in terms of productivity at work, and other areas where the federal savings will offset any costs.

Thank you for your consideration of our comments as California designs its § 1332 waiver.

Sincerely,

Jen Flory and Elizabeth Landsberg
Western Center on Law & Poverty

Kim Lewis and Michelle Lilienfeld
National Health Law Program

Trinh Phan, Legal Aid Society of San Mateo County

cc: Jennifer Kent, Director, Department of Health Care Services