ITUP
INSURE THE UNINSURED PROJECT

Thoughts On Financing Care And Coverage For Those Who Are Uninsured and Ineligible for Covered California and Full Scope Medi-Cal Due To Their Immigration Status (Updated March 17, 2016)

SB 10 (Lara) poses the necessary question: what should California do to finance care and coverage for those who are uninsured due to their immigration status?

At least half of California's undocumented residents are uninsured, while the others are covered -- primarily through their employers, and to a lesser degree, through state limited benefit programs.[1] The undocumented uninsured are ineligible for Covered California, and eligible only for limited scope Medi-Cal that covers genuine emergencies and maternity care.

For the most part, the undocumented are young, healthy, low-wage workers living in the shadows.[2] They work in agriculture, in restaurants and hotels, in residential construction, in car washes, in janitorial and cleaning services, and in domestic labor.[3] They are the backbone of many low-wage industries.

Many live in mixed-status families, where a household is comprised of members with different immigration statuses (legal permanent residents, U.S. citizens, undocumented). There are an estimated 1.5 million uninsured undocumented California residents.[4] Of whom, an estimated 170,000 to 250,00 are uninsured undocumented children who will become eligible for full scope Medi-Cal effective May 1, 2016.[5] Due to the changing economy and tighter immigration enforcement, many more are long-term California residents rather than seasonal migrants, and their numbers are declining.[6]

This population seeks care both at safety net institutions and with local community doctors.[7] Their per capita costs are quite low due to low health service utilization rates.[8] This is a function of their undocumented status, combined with their youth and good health status. They pay sales, income, and social security taxes, yet cannot use many public services other than public education for their children and emergency care through Medi-Cal.[9]

Many of the safety net funding streams for the uninsured are being or will be substantially reduced or terminated: realignment, LIHP, SNCP, FQHC §330 grants, and DSH.[10] While these reductions are not inappropriate given the large increase in federal funds to cover the newly insured,[11] these cumulative cuts will disproportionately impact institutions that primarily care for the remaining uninsured low-income populations.

The challenge for California is to assure care and coverage to an undocumented working population that is not evenly distributed throughout the state, but rather most heavily concentrated in the Central Valley, the Central Coast, and Southern California counties.[12] There are several approaches to financing care and coverage for the undocumented. First, their care could be covered by California's county safety nets. Second, they could be covered by the state of California. Third, they could be covered by their employers or by private individually purchased coverage. Fourth, their care could be partially funded by the federal government. Lastly, we could consider hybrid programs and shared responsibility.

1. Local

While each California County has a safety net to provide care for the undocumented, they are very different in funding, coverage, and care delivery. Counties with public facilities typically pay for care for their undocumented residents in their own facilities.[13] Most counties with private safety nets do not pay for full scope care to the undocumented.[14] However a growing number are paying for limited coverage, such as primary care, and one or more are paying for specialty care.[15] Some counties with public safety nets only pay for care delivered in their own public facilities and not in private safety net institutions.[16] Other counties with public safety nets (like Los Angeles and Alameda) pay for care in their own facilities, and in private safety net community clinics.[17] In some counties, local private physicians play a large role in care for the low-income uninsured, while in others the county and community clinics play that role.[18]

Local safety nets rely on a mix of federal, state, and county funds that can fund care for the undocumented. The largest sources of funds are emergency Medi-Cal and DSH;[19] the second largest are county health realignment, tobacco litigation settlement, and county match;[20] a few counties such as Los Angeles and

Alameda passed local taxes which help fund their care to the uninsured regardless of immigration status, and lastly, there is a mix of state limited benefit or niche programs, such as Breast Cancer Screening and Treatment and Prostate Cancer Treatment, CHDP, CCS state only, GHPP, ADAP, and Family PACT.[21] Counties with county hospitals self-fund the match for programs like the Safety Net Care Pool (SNCP), DSH, and DSRIP (now PRIME and GPP); counties without county hospitals do not have this option.[22] The federal government's §1115 waiver funding to public hospital counties under the Global Payment Program (GPP) can be used for a full complement of care and services to the uninsured undocumented.[23] Federally Qualified Health Centers (FQHC clinics) receive federal grant funds to offset some clinic costs of care to the uninsured, regardless of their immigration status.[24] Most clinics also rely heavily on self-pay and some on Family PACT to pay for care to the uninsured. In Los Angeles, over a third of community clinic visits are to the uninsured, and the county pays for about 1/3rd of those. Outside of Alameda and Los Angeles, the county is not a large contributor to clinics' financial balance sheets for their care to the uninsured.[25]

Private safety net providers in those counties that do not pay for care for the undocumented rely on the same mix of program dollars but typically without the county funds – i.e. no county realignment, tobacco litigation settlement, or county match – to help pay for care to the undocumented uninsured. Many of these counties are reconfiguring their county indigent health programs to fill in the ACA's coverage gaps. Examples include eliminating any coverage that overlaps with the ACA's coverage expansions, developing interim or bridge coverage between Covered California's open enrollment periods, and providing limited primary care or specialty care to the undocumented.[26]

The courts have not, as yet, interpreted Welfare and Institutions Code §17000 as requiring county care, or financing of care or coverage of the undocumented.[27] If the state legislature were to require counties to cover or care for the undocumented, California's laws on state mandates would require the state to reimburse the counties for 100% of these costs.[28] On the other hand, the legislature could set a condition on the state's funding of county health programs[29] that the local programs care for uninsured county residents regardless of their immigration status. If care to the undocumented uninsured is to be primarily delivered at the county/local level, steps ought to be taken to standardize the level of care and coverage available throughout the state, rather than the patchwork of policies that currently prevail.

Alternatively, instead of going through the county government to fund the local safety nets, state and/or federal governments can bypass county government infrastructure entirely and directly fund the local safety net; this approach avoids the variants in local political responsiveness to the needs of the remaining uninsured. Examples of this approach are community clinics' state EAPC (Early Access to Primary Care) and federal §330 programs, the SB 12 (Maddy) state/county program for private physicians, and the DSH (Disproportionate Share Hospital) programs for public and private hospitals.[30] However, such a program would need to be consolidated and integrated to coordinate medical care across different provider settings and populations, rather than the siloed and fragmented systems we have today. In our view, those who benefit from these allocations should work closely together and be part of a coordinated and integrated delivery system for the remaining uninsured; the costs would be less and the care more efficient and effective for the patients.

2. State

California state government pays for a limited and defined set of services to the undocumented through emergency or limited scope Medi-Cal, DSH, ADAP (AIDS Drug Assistance Program), AIM (Access for Infants and Mothers), Breast Screening and Treatment and Prostate Cancer Treatment, CHDP (Child Health Disability Prevention), CCS (California Children's Services) state only, GHPP (Genetically Handicapped Persons), and Family PACT (Family Planning, Access, Care and Treatment).[31] To make some programmatic sense of this disconnected alphabet soup, this coverage includes genuine emergency care and deliveries, limited prevention services (family planning, prenatal care, well child visits, immunizations, and screening for breast cancer and AIDS), and specific treatment for a very limited set of rare diseases. Most other primary care and most specialty care services are excluded.

Limited-scope Medi-Cal and these disease-specific programs account for the bulk of the most costly services for the undocumented.[32] The Lara bill (SB 10) would build on the state infrastructure of programs, expand Medi-Cal to full scope, and create a parallel Exchange without premium assistance for the

undocumented. The Senate fiscal analysis projected costs may be as low as $280 million or in excess of $740 million state General Funds.[33].

In order to help fund care and coverage for the undocumented, the state could also redirect, repatriate, and consolidate program funding. For example, the state could repatriate some additional realignment funding from public hospital counties who will benefit from this coverage expansion. AB 85 of 2013 gave counties a choice between two different formulas to reduce their health realignment: a 60/40 split with the state, or an 80/20 split of the county health "savings" from ACA implementation (a formula more attractive to the public hospital counties that still anticipated caring for the undocumented). Moving all counties to the 60/40 match would allow the state to "claw back" the additional savings from provider counties associated with coverage expansions of the Lara bills. The state could seek an additional amendment to its new federal waiver to consolidate private sector DSH like and supplemental hospital funds to pay for private sector care to the remaining uninsured comparable to the Global Payment Program for public hospitals.[34] In recognition of the ACA's impacts in reducing uncompensated care to the uninsured, the federal government proposes to reduce federal DSH funds by 50% in 2017; the deadline for this reduction has been extended to 2018.[35] California already uses a hospital fee to upgrade Medi-Cal reimbursements to Medicare levels – the maximum permitted under federal law. It is time for California to repurpose all of its remaining funds to emphasize care for the remaining uninsured in both inpatient and outpatient venues in public and private delivery systems. The state could consolidate existing programs and funding streams that help pay for care to the undocumented into a simple, cohesive program, and give local safety nets the needed flexibility to fill in the gaps.[36]

3. Federal

As already discussed, the federal government finances some care to the undocumented uninsured. Examples include the Medicaid match for emergency (limited scope) Medi-Cal and hospital uncompensated care through DSH. It helps quite significantly to reimburse certain clinics (non-profit FQHCs) for their costs of uncompensated care to the uninsured. Federal law unfortunately, precludes federal Medicaid funds from being used for non-emergency care to the undocumented.[37] And the ACA prohibits the Exchanges (Covered California) from covering or financing care to the undocumented.[38] The new federal §1115 waiver helps county hospitals with their costs of care for the uninsured.[39] This leaves very few sources of affordable care for the undocumented uninsured, other than through their employers or the limited numbers of remaining county hospitals.

The most important step forward for the federal government is to pass immigration reform that will allow a path to legal residency, and ultimately citizenship, for undocumented workers living in the shadows.[40] While the path to citizenship under the Senate bill is long, it does provide a timeframe and horizon for the reform process.[41]

The federal, state, and local governments have begun to use the new §1115 waiver to improve the performance of safety net care, slow the projected growth in program spending, and consolidate the federal funding silos; the federal government could allow the state or local safety nets to further consolidate existing federal programs and federal funding.[42]

4. Employers and private health insurance

Up to half of the undocumented workers may be covered through employment-based coverage.[43] The ACA will not do too much to improve that, but it may be of some help, as we discuss in this section. The ACA requires large and medium sized employers to offer coverage to full time employees or pay a penalty if their employees use premium assistance in the Exchanges.[44] The effective date of this requirement was delayed until 2015 for large employers (over 100) and 2016 for medium sized (50-100 employees).[45] Since most large and medium sized employers already offer coverage, the employer mandate has only a small effect.[46] It is possible that some large agribusinesses, light manufacturing and large restaurants will now begin to offer coverage to their workers regardless of immigration status.

There are no requirements for large or medium sized employers to cover their part time, temporary or seasonal employees.[47] There is as yet no evidence that employers have shifted their full time employees to part time or seasonal status to escape the mandate.[48]

There is no requirement for small employers to offer coverage for their employees although many already do so, and there is a short-term tax credit targeted at small low wage workers, which could have some benefit if the time frames were extended, and it became more widely known and used.[49] The employer mandate will have a modest impact in increasing the offer of employer coverage to low wage workforces counter balanced by a very small shift towards the Exchange.[50] To the extent that employers opt to pay a penalty rather than offer coverage, those workers who are US citizens and legal permanent residents can qualify for coverage through Medi-Cal and Covered California, but not those employees who are undocumented and uninsured.

Healthy San Francisco provides a much better framework for financing care to the undocumented uninsured. The San Francisco ordinance[51] requiring employers to offer coverage or pay into a pool has an important variation on the federal requirements. First it applies to employers with as few as 20 employees, and second it applies to part time and other flex workers on a pro rata basis.[52] As the ACA now offers coverage for all citizens and legal permanent residents, the future evolution of the San Francisco ordinance is important as a model for other counties. It is now being used to help pay for premium and cost sharing assistance in Covered California and to defray the county's cost of care to the undocumented workforce.[53] California might want to explore a §1332 waiver and state legislation that would mirror the Healthy San Francisco model.[54]

Some Los Angeles high-end restaurants are adding a surcharge to customer's bills to pay for coverage of their full workforce.[55] This provides coverage for both the higher wage wait staff and the lower wage kitchen staff. There is some consideration to phasing out tipping and replacing it with a service fee to fund better wages and benefits for all restaurant staff.[56]

At the other end of the spectrum, Wal-Mart is discontinuing health benefits for part-time workers with less than 30 hours per week.[57] Since the ACA has no mandate for employers to offer coverage to flex workers, the company will shift these costs to the federal government, which pays for the Exchanges and Medicaid expansions. Target and Home Depot have adopted similar policies. This may prove advantageous and offer more affordable and extensive coverage for low- and moderate-income flex workforces. Since the undocumented part-time workers are ineligible for full scope Medi-Cal or the Exchanges, this will cause hardship unless the state begins to better design coverage for flex workers as it could do with a §1332 waiver.[58]

Many of the undocumented work in agriculture and related fields. Large agribusinesses are exploring two issues: the first is arranging for onsite primary care in partnership with community clinics; the second is a redesign of benefit packages. The ACA requires large employers to offer minimum benefits equal in value to but not in the design of the lowest cost bronze plan; the employer must offer to pay 60% of the cost of the plan. Some agribusiness plans have offered coverage with low annual caps combined with low copays and deductibles and low contributions from the low wage employees; it is the other end of the spectrum from catastrophic coverage and gives ready access to coverage of basic care but little protection from very expensive care.

Employment-based coverage is a possible building block for coverage of many undocumented uninsured workers. One difficulty with this approach, however, is that under federal laws,[59] employers are not permitted to hire undocumented workers. Thus many undocumented workers are paid cash for their services and others work using false identification and/or false Social Security Numbers. Because many of the undocumented live in mixed-status families, dependent coverage through employment is also likely to be an important source of coverage for undocumented spouses and children.

As discussed earlier, the undocumented can purchase individual coverage, but not on the Exchanges and not with federal premium assistance. The option to buy coverage in Covered California or a parallel state Exchange without state premium assistance is proposed by SB 10. The estimated cost of using this approach with premium and cost sharing assistance is at least $200 million in General Funds.[60] The premiums for this type of individual coverage would need to be the same as those offered on the individual market. Using Covered California, there is no pricing advantage and there may be deterrence due to fears of enrolling in public coverage;[61] in fact, there is a pricing *disadvantage* for this model

because premiums would reflect the higher costs of care for US citizens and legal permanent residents, rather the typically low utilization and costs associated with young immigrants and their families.[62]

In addition, to make the parallel Exchange product financially solvent, coverage for the undocumented may need to be paired an individual mandate. Currently, the undocumented are exempt from the individual mandate because they are not eligible to participate in the federal Exchanges, federal premium assistance, or full scope Medi-Cal.[63] Opening a complementary state Exchange with or without state premium assistance may require a mandate to avoid adverse selection, where individuals only purchase coverage when they need it.[64]

5. Hybrids and other recommendations

As a starting point, immigration reform is the most vital building block as it allows the undocumented workforce to emerge from the shadows. If immigration reform passes, undocumented individuals should contribute towards the costs of their own care through premiums and co-payments and should be required to enroll in coverage if affordable, just as U.S. citizens and legal permanent residents must.[65] The primary building block should be employment-based coverage, as the undocumented have a very high rate of workforce participation.[66] As discussed a §1332 waiver using the Healthy San Francisco model holds substantial promise.

Because the undocumented have very low incomes, Medi-Cal managed care is the right fallback safety net program for those without an offer of employment-based coverage.[67] There should be a sliding scale premium option like Covered California for those few with incomes above the poverty levels.[68] The covered benefits package for the undocumented could be streamlined to reflect the available funds and affordability for the low wageworker.[69]

Financing of coverage should be built on the federal, state, and county funds already in the system that pay for care to the undocumented.[70] Coverage should be consolidated so that the multiple, unfamiliar, and disconnected programs become a single understandable program of care for the undocumented.[71]

An amendment to the new §1115 waiver should be sought to allow consolidation of federal, state, and local programs and funding streams.[72] The "coverage dividends"[73] (i.e. savings in state and local programs for the uninsured) at the state and local program levels could and should be redirected to pay for their care and to strengthen reimbursement rates for Medi-Cal providers.[74]

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[1] The California Health Interview Survey (CHIS) does not ask if their survey respondents are undocumented, but rather arrives at its estimates of the undocumented by excluding all of the above, i.e. not US Citizen, not Legal Permanent Resident, therefore undocumented. This has produced over the years a very consistent figure of 1 million undocumented uninsured. For example, the CalSIM (California Simulation of Insurance Markets) estimates in 2012 found that there are 1 million uninsured undocumented Californians. They projected that the undocumented uninsured would be one third of the remaining uninsured. See Lucia, Jacobs, Dietz, Graham Squire, Pourat and Roby, After Millions of Californians Gain Health Coverage Under the Affordable Care Act, who will Remain Uninsured (UC Berkeley Center for Labor Research and UCLA Center for Health Policy Research, September 2012) at www.healthpolicy.ucla.edu
The more recent CalSIM estimates project that for 2015-19 there will be 1.5 million uninsured undocumented Californians. See CalSIM Version 1.91 Statewide Data Book 2015-2019 (UC Berkeley Center for Labor Research and UCLA Center for Health Policy Research, May 2014) at www.healthpolicy.ucla.edu. There has been no increase in illegal immigration, nor any changes in employment based coverage that would explain changes of this magnitude. The difference in these estimates is making an assumption that the 850,000 undocumented with emergency Medi-Cal coverage were erroneously counted in the past as having full scope Medi-Cal coverage, as opposed to limited scope or Emergency Medi-Cal coverage (i.e. uninsured). See Lucia, Jacobs, Watson, Graham Squire, Pourat, Roby and Kominski, A Little Investment Goes a Long Way (UC Berkeley Center for Labor Research and UCLA Center for Health Policy Research, May 2014) at www.healthpolicy.edu The new projection is that the undocumented uninsured will be half of the remaining uninsured. If California continues to pursue an enhanced enrollment strategy, twenty percent will be Medi-Cal eligible but not enrolled and thirty percent will be Covered California eligible but not enrolled. We

may have already reached and enrolled nearly all the Medi-Cal eligible as Medi-Cal enrollment has far exceeded CalSIM projections. Of the Covered California eligible but not enrolled half will be eligible for premium assistance and the other half will not. A surprisingly small six percent of the remaining uninsured will have incomes in excess of 400% of the federal poverty level.

[2] See Howland, Peganny, Coleman and Connolly, Remaining Uninsured: A Population Profile (ITUP, February 2014) at www.itup.org. It is important to remember that the eligibility rules for immigration status differ between Covered California and Medi-Cal so that those individuals with DACA status are Medi-Cal eligible, but not Covered California eligible. We use the phrase undocumented inartfully to refer to all those who cannot qualify for full scope Medi-Cal or for Covered California. In fact, there are subgroups that may qualify or not depending on California and federal law. See NILC, Immigrants and the Affordable Care Act (National Immigration Law Center, January 2014) at www.nilc.org/immigrantshcr.html for a summary of federal requirements. California does not apply the 5-year waiting period for new legal immigrants who need and otherwise qualify for Medi-Cal.

[3] Ibid. See also Wulsin, Covering 800,000 Uninsured Undocumented Workers (Insure the Uninsured Project, September 5, 2007) and Watson, California's Agricultural Workers (ITUP, July, 2010) at www.itup.org See Pastor and Marcelli, What's at Stake for the State: Undocumented Californians, Immigration Reform and Our Future Together (Center for the Study of immigrant Immigration, Univ. of Southern, CA, 2013) www.dornsife.usc.edu/csii/undocumentedca/

[4] See n. 1

[5] Senate Floor Analysis of SB 4 (Lara) at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0001-0050/sb_4_cfa_20150911_210035_sen_floor.html

[6] For example, when the Los Angeles Healthy Kids program began, it enrolled 5,000 children (primarily undocumented) under the age of 5; it now has about 400 in that age category.

[7] CHIS reports that among Latinos uninsured for a full year with incomes below 200% of poverty, 44% have no usual source of care, 40% use the clinics, and 13% use private doctors. See www.askchis.ucla.edu By contrast for full year insured Latinos with incomes below 200% of FPL, 41% use private doctors, 42% use clinics and 15% have no usual source of care.

[8] See Lucia, et al, A Little Investment Goes a Long Way and Pourat, Wallace, Hadley and Ponce, Assessing Health Care Services Used by California's Undocumented Immigrant Population in 2010, *Health Affairs*, vol. 33, no. 5 840-847 (May 2014) The study finds that the cost of full scope Medi-Cal Coverage for Undocumented Adults is $236 per member per month, of which $142 per member per month is already in the system through the emergency Medi-Cal program that pays for genuine emergencies, prenatal care and deliveries. They estimate that the incremental costs of full scope coverage would be $360 million in 2015, growing to about $430 million in 2019.

[9] See, Institute for Taxation and Economic Policy, Undocumented Immigrant's State and Local Tax Contributions (July, 2013) at www.itep.org California's undocumented pay over $2 billion in state and local taxes. Standard and Poor's reported that the undocumented pay over $7 billion in Social Security Taxes for benefits they are ineligible to receive. See Goldman et al, Immigrants and the Cost of Health Care, Health Affairs (November/December 2006) at www.healthaffairs.org and Congressional Budget Office, The Impacts of Unauthorized Immigrants on the Budgets of State and Local Governments. www.cbo.gov

[10] For example county health realignment funds were being cut by over $700 million under AB 85; LIHP funds ended on December 31, 2013; SNCP funds ended November, 2015; clinics' FQHC augmentations will end in 2017, and hospitals' DSH funds will be cut by 50% in 2018. Counties have an option of an 80/20 split of the revenue impacts of the ACA coverage expansions on their delivery system's bottom lines that has mitigated the realignment reductions.

[11] For example in the Proposed Governor's Budget, May Revise 2014, there is a projected increase of $7.5 billion in Medicaid (Medi-Cal) spending for the newly eligible of which $6.7 billion is an increase in federal reimbursements due to the ACA. The total annual benefit of the ACA to Californians is now close to $20 billion, including both Covered California and increased Medi-Cal spending. The Medi-Cal costs of the expansion eligibles are projected to be $14 billion, of which $0.74 billion is state General Fund. See ITUP Summary of the Governor's Proposed State Budget for 2016-17 (January 11, 2016) at www.itup.org

[12] See Wulsin, Covering Uninsured Undocumented Workers (ITUP, 2007). Most counties do not pay for a full scope of care to the undocumented uninsured, other than those counties with large public hospitals. However, a growing number of small and some medium sized counties are offering primary care and a few are offering specialty care services. See Wulsin et al, Care Coverage and Financing for California's Remaining Uninsured (ITUP, June 2015) at www.itup.org; and Acosta, Perkins and Wulsin, Delivery Systems and Financing Care for the Remaining Uninsured in Imperial, Tulare, Kern, Merced and Stanislaus Counties (ITUP, September 10, 2015) at www.itup.org

[13] California HealthCare Foundation, California Indigent Care Profiles, 2009 at www.chcf.org and Health Access Foundation, California's Uneven Safety Net, A Survey of County Health Care (November 2013) at www.health-access.org County hospitals bill their patients according to an ability to pay schedule. Each county sets its own income and residency rules.

[14] Ibid. Fresno is seeking to terminate its contract with Community Regional Medical Center for care to the county's indigent in light of the ACA's coverage expansions. The Superior Court ruled in April 2014 that the county may

proceed with its efforts to terminate the contract. The county in 2015 initiated a small program to help pay for physician specialty care for the undocumented.

[15] See Health Access. County Map of Care for the Undocumented (October 2015) at http://www.health-access.org/ The map does not reflect that San Bernardino, San Joaquin and Kern deliver care to the undocumented in their county hospital systems, and Tulare, Stanislaus and Santa Barbara provide care to the undocumented in their county clinics.

[16] Riverside with a strong county clinic infrastructure for example might be less willing to pay community clinics than San Bernardino, and Contra Costa could be less willing to pay community clinics than Alameda. Under existing law, each county makes it own decisions on whom to care for or cover, for what benefits, and in what network.

[17] Los Angeles has instituted a new program, My Health LA (to replace its Healthy Way LA Unmatched program) with about 130,000 participants. Alameda voters approved Measure AA – a half-cent sales tax dedicated to care for the uninsured through the year 2034 with a 75% share of the vote.

[18] In the Inland Empire, 47% of the low income uninsured report that private physicians are their usual source of care; whereas in Los Angeles County only 11% of the low income uninsured report that private doctors are their usual source of care. CHIS, Usual Sources of Care for Los Angeles' Uninsured, 2011-12 California Health Interview Survey at www.chis.ucla.edu and CHIS, Usual Sources of Care for Inland Empire Counties' Uninsured, 2011-12 California Health Interview Survey at www.chis.ucla.edu

[19] Emergency Medi-Cal pays only for genuine emergency care and for prenatal care and deliveries for the undocumented. It has an enrollment of over 850,000 and spending of about $142 per member per month for adults and $138 per member per month for children. The state and federal governments pay for the program. This program has been in existence since the mid-80s when it was enacted and signed by then President Ronald Reagan and is available in every state's Medicaid program.

The Ryan White program pays for care to persons with HIV or AIDS regardless of immigration status.

DSH pays for public hospital care to the uninsured and DSH lite pays for private hospital care to the uninsured. These programs can pay for care to the undocumented; however it is in the discretion of each hospital as to how to allot these funds. DSH has been in place since the late 80s and was established during the presidencies of President Reagan and the first President Bush. States such as Massachusetts and Tennessee converted their DSH hospital subsidy programs into premium assistance for coverage expansion under the auspices of a §1115 waiver. DSH funds will be cut by 50% in 2018 in light of the expected enrollment of the uninsured in the ACA's coverage expansions. California might wish to expand its recently approved Global Payment Program under the §1115 waiver to pay for care for the remaining uninsured receiving both inpatient and outpatient care from private sector safety net institutions.

[20] Realignment dollars are a share of the state sales and vehicle license fees allocated to county health, mental health and social services. Health realignment pays for both public health and indigent health. These funds were based on funding formulas from the early 80s and late 70's and are completely out of touch with the population growth and socio-economic shifts. It was cut by about $725 million for the 2014-15 fiscal year, reflecting the state takeover of care to the MIAs from the counties with 100% federal matching funds; the reductions may increase over time as the ACA tales over an increasing amount of county responsibilities. Tobacco litigation settlement funds are the amounts reimbursed to the counties for their share of care to county indigents whose care was precipitated by smoking related illnesses and conditions. Counties are not required to devote these funds to county indigent health care although many do so. County match (i.e. county General Fund) is required to receive the state realignment funds; the match is frozen to the levels of county contributions in the late 80's and early 90's; some counties like Alameda, Los Angeles and San Francisco have increased their match and enacted new local revenue sources.

[21] CHDP and CCS are programs of limited benefits for children. CHDP (state funded) pays for well child visits and CCS (state only) pays for specialty and hospital care for designated conditions; CCS state only is funded half by counties and half by the state for children with no other source of coverage. GHPP is for uninsured adults with comparable highly costly and specialized conditions and is akin to CCS. It has been funded by state General Funds and federal matching funds from the Safety Net Care Pools; most participants will be moved into Covered California and Medi-Cal. Family PACT pays for family planning for the uninsured with a 90/10 match; spending has declined dramatically as Medi-Cal and Covered California enrollment has grown, but the program is still available for the remaining uninsured regardless of immigration status. California also pays for Breast and Cervical Cancer Screening and Treatment as well as for prostate cancer treatments. See Acosta and Kho, 2015 Health Care Financing Report: Public Programs (ITUP, July 2015) at www.itup.org for changes in funding, the General and Special Fund contributions, and patient participation in many of these programs.

[22] LIHP was a bridge program for the uninsured US citizens and legal permanent residents (up to 200% of FPL) who would otherwise be eligible for Medi-Cal or Covered California under the ACA's coverage expansions. The federal match for that program ended December 31, 2013 when the subscribers were seamlessly transitioned into Medi-Cal managed care. The Safety Net Care Pool paid for uncompensated care to the uninsured; it excluded non-emergency care to the undocumented consistent with the requirements of federal law. Rather than requiring assessment of citizenship and legal permanent residency status for every individual safety net patient, it discounted the federal match by roughly 12% to adjust for any non-emergency care to undocumented patients. That program paid for all types of care to the uninsured with US citizen and legal permanent residency status. It has now been subsumed with

DSH into the new Global Payment Program. See Acosta, §1115 Waiver Summary, Part 5 (ITUP, February 2, 2016) at http://itup.org/wp-content/uploads/2016/02/ITUP-1115-Waiver-Summary-Part-51.pdf DSRIP (Delivery System Incentive Pool) is a subpart of the Safety Net Care Pool and was designed to improve the quality and cost efficiency of county public hospitals and public clinics in particular; it was not available to the non-profit community clinics or to the private hospitals. UC hospitals were treated as public hospitals although they do not share the same uninsured and Medi-Cal patient profiles of the county hospitals. DSRIP was transformed into PRIME in the new waiver to help the safety net writ larger (i.e. District Hospitals are included) participate far more effectively and efficiently in providing quality care through Medi-Cal managed care. See Acosta, §1115 Waiver Renewal Analysis – PRIME (ITUP, February 4, 2016) at http://itup.org/legislation-policy/2016/02/04/%C2%A71115-waiver-renewal-analysis-prime/ This should have spillover effects in conjunction with the GPP program in improving the over-all quality of the safety net delivery system to the remaining uninsured to the extent that the local safety nets collaborate in providing care to both populations.

[23] See Acosta, §1115 Waiver Renewal Analysis of the Global Payment Program (ITUP, February 4, 2016) that combines county DSH and SNCP into a unified program financing a full complement of services to the remaining uninsured regardless of immigration status at http://itup.org/legislation-policy/2016/02/04/%C2%A71115-waiver-renewal-analysis-global-payment-program-gpp/. OBRA of 1986 established the requirement that every state's Medi-Cal program must pay for genuine emergency care and deliveries (limited scope) to the undocumented. OBRA applies to all Medicaid eligibility categories. 42 USC 1396b(v); 42 CFR 435.406 California decided to cover prenatal care for the mother and child for which it receives full federal participation due to the child's status. In 1995 Congress clarified that new legal permanent residents (LPRs) are only eligible for a federal match for limited scope benefits. California decided to cover full scope for all new legal permanent residents although the federal match is only available for emergency and maternity care – about two thirds of the program's costs for these eligibles. Lucia, et al, A Little Investment Goes a Long Way

[24] In Southern California, federal grants and contracts comprised 16% of FQHC clinic revenues in 2012. OSHPD, Clinic Financial Reports (2012)

[25] OSHPD, Community Clinic Data 2012. In 2014, uninsured visits comprised 28% of clinic visits. Federal grants and contracts were 13% of clinics' revenues. County reimbursements comprised only 2% of clinic's patient revenues. Acosta, Compilation of OSHPD Community Clinic Data 2014 (ITUP, October, 5, 2015) at http://itup.org/blog/2015/10/05/preview-of-regional-primary-care-clinic-stats-from-preliminary-oshpd-data/

[26] In general, Section 17,000 requires county care only for those not eligible for other programs like Medi-Cal, Medicare, private insurance or Covered California. Orange and San Diego have bridge programs to provide some medical assistance in the interim periods between Covered California's open enrollment periods. Medi-Cal eligibility is open at any time with up to three months of retroactivity prior to the actual application for coverage.

[27] W and I Code §17000 requires counties to "support all incompetent, poor and indigent persons and those incapacitated by age, disease or accident, lawfully resident therein". Counties not offering indigent care to the undocumented maintain that they are not lawfully resident therein. The Supreme Court in Rodriguez v. San Antonio School District 411 US 1 (1973) held that financing inequities in education did not violate the equal protection clause. The Supreme Court of California in Serrano v. Priest found that the California Constitution, which has a strong constitutional guarantee of a free public education, prohibited wide financing inequities in public education. In Plyler v Doe, 457 US 202 (1982) the Supreme Court held that the undocumented children could not be denied public funding for K-12 public education. In Memorial Hospital v Maricopa County 415 US 250 (1974) the Supreme Court held that medical care was one of the basic necessities of life and struck down the county's durational residency rules that conditioned access to county health care on a one year residency in the state of Arizona; this case involved the constitutional interstate travel rights of US citizens. The constitutional and statutory questions a court might be called upon to consider are whether counties, using primarily state and federal funds, can make distinctions in financing care for the uninsured indigent based on their immigration status.

[28] See California Commission on State Mandates, Guide to the State Mandate Process (State Controller's Office, 2003) at www.sco.ca.gov/ard_mancost.html

[29] In general, county health obligations are set forth in the Welfare and Institutions Code §§16800 et seq. 16900 et seq., 17000 et seq. and 17600 et seq. A county's health realignment funds can certainly be conditioned on a county's reporting and on its performance of its responsibilities towards its residents.

[30] EAPC was funded by Prop 99 and distributed to clinics based on their OSHPD reports on uncompensated care to the uninsured; it was discontinued during the Great Recession. DSH and DSH lite have been distributed based on hospital's inpatient bed days to the uninsured and Medi-Cal populations as reported through OSHPD. Public hospital DSH is now based solely on their care to the uninsured, regardless of site of care, and it will be performance-based and can be redistributed based on a county hospital's performance in caring for the local remaining uninsured. County hospital counties and UC hospitals fund the DSH match. The match for DSH lite in private hospitals is funded by the state. Federal §330 funds help pay for FQHC community clinics care to the uninsured with performance based grant funding. SB 12 (Maddy) funds are a bad debt/charity care pool for private physicians and hospitals financed by Prop 99 and by moving violation traffic fines; reimbursement is based on submitted claims. The uninsured patient's immigration status is irrelevant. The state could redirect the Prop 99 tobacco tax savings from state limited benefit

programs such as MRMIP and AIM to fund EAPC or SB 12 (Maddy) – i.e. community clinics and private doctors; or it could use them to help fund SB 10 (Lara). About $200 million in Prop 99 funds by the terms of the Tobacco Tax Initiative must be spent on care to the uninsured.

[31] AIM pays for full scope benefits for pregnant women and infants with incomes up to 300% of the federal poverty level. Premiums are calculated at 1.5% of the family income. ADAP pays for the high costs of life sustaining medications for persons with HIV or AIDS. These programs will need to be coordinated with the Covered California and Medi-Cal expansions. ADAP now pays for "premium assistance" to assure participation in Covered California. AIM has not yet done so, but may in the future. California and its counties also have programs for immunizations, communicable diseases, tuberculosis and kidney dialysis that treat uninsured persons regardless of their immigration status.

[32] See n. 8.

[33] The Senate fiscal committee analysis of the Lara bill projects annual costs of $280 to $740 million without the benefits of DACA and DAPA which is held up in the courts or $175 to $455 million with the benefits of DACA and DAPA. http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0001-0050/sb_4_cfa_20150504_111259_sen_comm.html

[34] The purpose of DSH is to pay for uncompensated care to the uninsured and underpayments for Medi-Cal. Massachusetts and Tennessee were examples of states that shifted their DSH funds to help pay for care to the uninsured under a §1115 waiver. The state could make changes without a federal waiver by simply redirecting DSH funds so that they follow care to the uninsured patients in hospital inpatient and outpatient settings.

[35] ITUP, Congratulations Congress! (April 15, 2015) at http://itup.org/blog/2015/04/15/congratulations-congress/

[36] See Howland, Peganny, Connolly and Coleman, California's Remaining Uninsured (ITUP, February 2014) at itup.org/delivery-systems/2014/02/04/californias-remaining uninsured. This issue brief recommends that California consolidate all existing state programs for the remaining uninsured into a coherent whole rather than parceling them into individual silos and permit local safety nets collaboratively to fill in the gaps with their existing programs and financing.

[37] See n. 23

[38] ACA §1401 and 5000A. Although the undocumented pay taxes, they are excluded from the tax credits under the Affordable Care Act and the individual mandate.

[39] The new waiver combines DSH and SNCP into the Global Payment Program for the uninsured, regardless of site of care or immigration status. Acosta, §1115 Waiver Renewal Analysis of the Global Payment Program (ITUP, February 4, 2016)

[40] See Coleman, What Are the Health Implications of Comprehensive Immigration Reform (ITUP, July 10, 2013) at itup.org/blog/2013/07/10-what-are-the-health-implications-of-comprehensive-immigration-refrom

[41] Ibid.

[42] See Acosta, §1115 Waiver Renewal Analysis – PRIME and Global Payment Program (ITUP, February 4, 2016). Rhode Island, Vermont and Massachusetts all secured global budget waivers to reform their Medicaid programs and New York secured an important DSRIP waiver to enhance the performance of their Medicaid managed care programs and transform local safety nets. See Vermont waiver documents at www.medicaid.gov/Medicaid and www.medicaidwaiver.org/state/vermont and Rhode Island Waiver at www.ohhs.ri.gov/Medicaid/ and the Lewin Group, An Independent Evaluation of Rhode Island's Global Waiver (December 6, 2011) at www.lewin.com/publications/201112060458. See New York's new DSRIP waiver at https://www.health.ny.gov/health-care/medicaid/redesign See Waiver Approval Letter from Marilyn Tavenner, CMS Administrator to Judy Bigby Sec'y of Mass Health and Human Services (December 2011) and Governor Patrick announces $26.75 Billion Medicaid Waiver Agreement (December 21, 2011) at www.mass.gov/governor/pressoffice/pressrealeases/2011/111221-medicaid-waiver-agreement-announced

[43] CalSIM Version 1.91 Statewide Data Book 2015-2019

[44] ACA §1513

[45] Wulsin, Understanding the ACA's Employer Responsibilities and the Impacts of the Delay in Employer Penalties (ITUP, July 5, 2013) at www.itup.org

[46] California HealthCare Foundation, California Employer Health Care Benefits (April, 2015) at http://www.chcf.org/publications/2015/04/employer-health-benefits

[47] Wulsin, ITUP's Analysis of Employment Based Coverage Under the Affordable Care Act (ITUP, August 30, 2013) at www.itup.org

[48] Kaiser Family Foundation, Employer Health Benefits Survey (September 22, 2015) at http://kff.org/report-section/ehbs-2015-summary-of-findings/

[49] Wulsin, Understanding the Affordable Care Act's Implementation in California – A Small Business Perspective (ITUP, October 14, 2013) at www.itup.org

[50] CalSIM Version 1.91 Statewide Data Book 2015-2019 shows employment based coverage at 17.5 million insured Californians in 2015 and 17.4 million with employment based coverage in 2019

[51] The recent amendments to the San Francisco Ordinance require large employers (over 100) to spend at least $2.48 per hour for health insurance for their employees in 2015, $1.65 per hour for medium (20-99) employees. The

ordinance applies to employees who work at least 8 hours per week and have worked more than 90 days. San Francisco Health Care Security Ordinance (June 17, 2014) at www.sfgsa.org/index.aspx?page=418
[52] Ibid.
[53] This appears to be the current direction of Healthy San Francisco that will help pay Covered California premiums and help defray out of pocket responsibilities. See Healthy San Francisco at www.healthysanfrancisco.org. See Wulsin, ITUP Draft Recommendations for the San Francisco Universal Health Council (ITUP, December 13, 2013) at www.itup.org and Wulsin, Healthy San Francisco, the Spirit of the Pioneers, (July 30, 2015) at http://itup.org/blog/2015/07/30/san-francisco-the-spirit-of-the-pioneers-taking-steps-to-improve-both-healthy-san-francisco-and-the-aca/
[54] See Connelly and Wulsin, Opportunities for California Under Section 1332 of the Affordable Care Act (ITUP, February 16, 2106) at http://itup.org/itup-latest-news/2016/02/16/opportunities-for-california-under-section-1332-of-the-affordable-care-act-2/
[55] Shan Li, LA Area Restaurants Adding Surcharge to Cover their Workers, Los Angeles Times, October 6, 2014, http://www.latimes.com/business/la-fi-restaurant-healthcare-surcharge-20141007-story.html#page=1
[56] See discussion at http://ny.eater.com/2015/10/14/9517747/danny-meyer-no-tipping-restaurants.
[57] Dudley and Giammona, Wal-Mart Cutting Health Benefits to Some Part time Workers, Bloomberg News, October 7, 2014, http://www.bloomberg.com/news/2014-10-07/wal-mart-will-cut-health-benefits-to-some-part-time-employees.html
[58] See Connelly and Wulsin, Opportunities for California Under Section 1332 of the Affordable Care Act (ITUP, February 16, 2106) http://itup.org/itup-latest-news/2016/02/16/opportunities-for-california-under-section-1332-of-the-affordable-care-act-2/
[59] See discussion at Dyson, The Legal Pitfalls of Hiring Undocumented Immigrants (NOLO) at www.nolo.com/legal-encyclopedia/legal-pitfalls-hiring-undocumented-immigrants
[60] The Senate fiscal committee analysis of the Lara bill projected General Fund costs of $200 to $400 million for a parallel exchange for the undocumented with comparable premium and cost sharing assistance to the ACA. http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_1001-1050/sb_1005_cfa_20140519_082601_sen_comm.html
[61] Levitt, Health Coverage and Affordability in California and the US (Kaiser Family Foundation, February 23, 2016at http://hbex.coveredca.com/stakeholders/Covered%20California%201332%20Waiver/February%2023,%202016%201332%20State%20Innovation%20Waiver%20Public%20Meeting/levitt_coveredca_1332_february_2015.pdf
[62] See Lucia, et al, A Little Investment Goes a Long Way and Pourat, et al, Assessing Health Care Services Used by California's Undocumented Immigrant Population in 2010,
[63] ACA §1501
[64] This is the prime reason for the individual mandate much reviled by the ACA's opponents. See Wulsin, Thoughts on An Individual Mandate (ITUP, Sept. 4, 2007) at www.itup.org and Wulsin and Dougherty, Individual Mandate: a Background Report (California Research Bureau, April 2009) at www.library.ca.gov/crb It is like something out of Alice in Wonderland to imagine the application of an individual mandate to individuals living in the shadows, but a mandate could be more readily applied if immigration reform provides a path towards registration and legalization.
[65] See ACA §1501
[66] See Howland et al, Remaining Uninsured: a Population Profile (ITUP, February 2014) at www.itup.org
[67] Ibid.
[68] Most have very low wages and incomes. Ibid.
[69] The undocumented are young, healthy and low users of services even when insured. Ponce, Assessing Health Care Services Used by California's Undocumented Immigrant Population in 2010. However, some report that immigrant farm workers are becoming an aging population, beginning to exhibit the chronic illnesses associated with age and the accumulated injuries of decades of hard manual labor. ITUP Regional Workgroup, Fresno, June 3, 2014 at http://itup.org/wp-content/uploads/2011/04/Central-Valley-Executive-Summary-2014.pdf.
[70] See earlier discussions of these revenues, there are several types; they include institutional subsidies and individual specific limited benefit programs.
[71] See Howland et al, Remaining Uninsured: Programs, Funding and Reforms (ITUP, February 2014) at www.itup.org
[72] See n. 36.
[73] Coverage dividends occur at the county, state and provider levels. For example the state repatriated the county health realignment funds but did not re-invest these funds into improving the Medi-Cal program. The savings in state General Fund funding for state limited benefit programs for the uninsured could be reallocated. Proposition 99 initiative funds must be spent on the uninsured, and could be redirected to such a program. Furthermore non-profit and public hospitals and clinics' burdens of charity care and bad debt are being reduced as the ACA's coverage expansions take meaningful effect, their community benefit requirements and other obligations to care for the uninsured could be updated to reflect current realities.
[74] Ibid.