Covered California and the Medi-Cal Expansion:
Information to Help Patients and Physicians Understand Coverage Options
Prepared by ACCMA Staff

Starting in 2014, millions of currently uninsured Californians are expected to obtain health insurance. Most of these patients will receive coverage through either the Medi-Cal program, which will be expanding eligibility to an additional 1.4 million Californians who do not currently qualify, or through Covered California, an online marketplace where patients can compare commercial plans and qualify for income-based federal subsidies to help cover the costs. As efforts to enroll patients in these programs have begun in earnest, there has been some confusion among patients about which coverage options are best for them. Recognizing that many patients may be looking to their physicians for assistance and guidance, the Alameda-Contra Costa Medical Association (ACCMA) has prepared the following article to give physicians an overview of the new coverage options available for patients, with links to resources where patients can be referred for more information or for assistance enrolling. The article also provides an update on issues that physicians should be concerned about as it relates to their participation in Medi-Cal and Covered California.

Penalties for No Coverage
At the beginning of the year, most adults will be required to demonstrate that they have health insurance or else will pay a fine. The fine becomes more costly over a three-year period. In 2014, the fine will be the greater of either 1 percent of annual income or $95 per adult, with additional fines imposed on adults with children who are not covered. By 2016, the fine will increase to the greater of either 2.5 percent of income or $695 for an individual and $2,085 for a family. Employers with 50 or more full-time employees that either do not offer coverage, or whose coverage does not meet minimum federal requirements mandated by the ACA, will be penalized starting in 2015.

New Rules for Health Plans
Starting in 2014, the Affordable Care Act (ACA) precludes commercial health plans from denying coverage for pre-existing conditions, setting premiums based on health status, and capping lifetime benefits. The ACA also requires all commercial plans (even those offered outside the exchange) to provide essential health benefits that include the following: ambulatory patient care; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services (including behavioral health treatment); prescription drugs; rehabilitation and habilitation services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care). Additionally, insurance plans must cover preventive care and medical screenings without charging copayments, coinsurance or deductibles for such services.

Patients who have questions or concerns should check with their carrier to see how these provisions of the ACA will affect coverage. Some provisions will apply uniformly to all plans while others may be more specific to a type of plan. For instance, nearly all plans are required to extend dependent coverage to children under the age of 26 (already in effect), while in contrast several plan types are exempt from the requirement to cover essential health benefits (for example grandfathered plans, large group plans, self-funded plans, retiree-only plans, and plans that provide limited benefits).

Physicians should also be aware that some patients have reported receiving notices of cancellations, while others have reported significant increases in the cost of premiums. This is largely attributable to changes that plans have to make to meet ACA requirements, either by expanding covered benefits (at an increased cost to insureds), or by canceling coverage that does not meet federal requirements.

Covered California – California’s Health Exchange
On October 1st, Covered California, the state’s health benefit exchange, began enrolling individuals and small businesses with 1 to 50 eligible employees for health coverage. The exchange is an online purchasing portal that is intended to promote competition among health plans. 12 commercial plans have been selected statewide, with five offered locally: Anthem Blue Cross, Blue Shield of California, and Kaiser Permanente will be offered in both Alameda and Contra Costa Counties, plus Contra Costa Health Plan and Health Net in Contra Costa.

The health exchange establishes four tiers of coverage: bronze, silver, gold, and platinum. All categories offer the same set of essential health benefits, but differ according to the patient’s share of costs. Bronze plans have the lowest monthly premiums and higher out-of-pocket costs, while platinum...
plans have the highest monthly premiums and lower out-of-pocket costs (see table below). The percentages of care that plans are expected to cover through premiums (as opposed to out-of-pocket costs) are, on average: 60% (bronze), 70% (silver), 80% (gold), and 90% (platinum). The health exchange also establishes a fifth plan will also be available entitled “catastrophic,” which will be available to those who are under 30 years old or can provide a certification that they are without affordable coverage or are experiencing hardship. Deductibles for the catastrophic plan will be equal to the amounts specified as out-of-pocket limits for HAS-qualified high deductible health plans; prevention benefits and 3 primary care visits are excluded from the deductible. See Table 1 above for an illustrative example of pricing and premiums.

Individuals earning between 138 and 400 percent of the federal poverty level may qualify for federal subsidies to offset premium costs for plans purchased through the exchange. Eligibility for premium assistance is calculated on a sliding scale based on family income and the number of people in the family. Individuals with incomes up to $45,960 and a family of four with an income up to $94,200 may be eligible for premium assistance. Those earning below 250 percent of the federal poverty level may also qualify for additional cost-sharing reductions for co-pays and deductibles.

Federal premium assistance is only available when enrolled in a health plan through Covered California, and it is paid directly to the health plan in which the patient is enrolled. Premium assistance will be adjusted at the end of the benefit year to reflect any change in the patient’s income level for the following year.
year based on the patient’s actual income. A patient may be held accountable for any excess subsidies received when filing that year’s taxes. For this reason, patients should immediately report any changes to Covered California that impact their subsidies, such as changing jobs, losing a job or receiving a promotion.

Small employers in California with up to 50 employees will also be able to purchase coverage through the Small Business Health Options Program (SHOP). In 2016, eligibility will expand to employers with 100 or fewer employees, and in 2017 California will have the option to expand the SHOP program to all employers.

**Medi-Cal Expansion**

Effective January 2014, the ACA expands Medi-Cal eligibility to all adults and families earning up to 138% of poverty level ($15,856), expanding from the current 106% threshold. Significantly, the expanded coverage applies to all people within that income criteria, not just individuals with dependents or with a disability. In addition, there will no longer be dependent or disability requirements to qualify, and childless adults between the ages of 19 and 64 meeting the income requirements will be eligible for Medi-Cal for the first time. Children will continue to be eligible for Medi-Cal as long as their family income is 250% of the poverty line or below ($48,825 for a family of three in 2013).

Open enrollment for Medi-Cal coverage began on October 1, 2013, and continues through the end of the year for coverage beginning on January 1, 2014. Approximately 1.4 million Californians under age 65 are expected to be newly eligible for Medi-Cal in 2014 under the program expansion. As with current Medi-Cal requirements, legal immigrants who have been in the country for five years or less and immigrants who are not lawfully in the country are not eligible.

Also, starting in 2014, Medi-Cal will begin covering a range of mental health and substance abuse services. These include psychotherapy, psychological testing and evaluation, outpatient drug monitoring, and a wide range of alcohol and narcotics abuse treatment services.

**Medi-Cal Expansion Bridge**

Under a 2010 agreement with the federal government, California created temporary, county-based Low Income Health Programs (LIHP) to provide coverage for individuals likely to qualify for Medi-Cal under the expansion in 2014. The program provides health care coverage through December 31, 2013 to many low-income adults aged 19 to 64, and more than 527,000 Californians were enrolled in LIHP during the first quarter of 2012-13. In 2014, most LIHP enrollees will be eligible to transfer to Medi-Cal when the program expansion takes effect, while others may qualify for subsidized coverage under the exchange. It is unclear what coverage options are available for the remaining LIHP insured patients who are not covered under Medi-Cal or through the exchange. For example, in Alameda County, it is estimated that 44,000 patients will remain in the LIHP program, and efforts are being made to secure funding to continue some level of service to the patients next year.

**How Patients Can Enroll in Medi-Cal**

Patients are not required to reapply to Medi-Cal if they already receive Medi-Cal benefits; their benefits will continue until the next regularly scheduled annual redetermination date; however, individuals who do not receive Medi-Cal and would like to apply for coverage, or would like to check their eligibility for Medi-Cal may do so through the following:

**Apply in-person or call their county’s social services office** – Patients may apply for Medi-Cal in person or mail-in an application to their county’s social services office. Applications can be downloaded online at www.dhcs.ca.gov/services/medi-cal/Pages/MediCalApplications.aspx. Patients in Alameda County may contact the Alameda County Social Services Agency at (510) 268-3787; patients in Contra Costa County may contact the Contra Costa County Employment and Human Services Department at (925) 313-7987.

**Call a Health Insurance Technician (HIT) (Alameda County)** – Patients in Alameda County may contact the Health Insurance Enrollment Assistance department at 800-422-9495 to be pre-screened for Medi-Cal in Alameda County. The HIT provides information and referrals for application assistance for Medi-Cal as well as CalFresh, Cash Aid, and Kaiser Child Health Plan. HIT’s can schedule in-person enrollment assistance appointments to complete new and renewal applications. Enrollment assistance is available by appointment only.

**Call an Eligibility Specialist (Contra Costa County)** – Patients in Contra Costa County may contact the Healthcare Access Center at 800-709-8348 to speak with an eligibility specialist for assistance on determining eligibility and to apply for Medi-Cal. The Healthcare Access Center is a department within the Contra Costa County Employment and Human Services Department.

**Apply online at www.benefitscal.org** – This site connects patients to applications for Medi-Cal, County Medical Services Program (CMSP), CalFresh (formerly known as Food Stamps) and California Work Opportunity and Responsibility to Kids (CalWORKs) benefits in California. Patients can apply online by picking their county of residence. It also provides ongoing access to secure and private benefit information.

**Apply online at www.CoveredCA.com** – Patients can also apply for Medi-Cal through the Covered California website. The process is the same as applying for exchange plans. The online portal launched on October 1, 2013, allowing individuals to pre-enroll in the Covered California health plans and Medi-Cal prior to January 1, 2014.

**What Should Physicians Be Concerned About?**

Both provider and patient advocates have been eager to know which providers are being included in the exchange network. Providers’ interest has been stoked by the general ambiguity with which some health plans have conducted their provider contracting, such as failing to identify products as exchange products and using “all products” or “all affiliates” clauses to include physicians in an exchange network.

At this point, the ACCMA is aware of the following regarding how physicians are being included in the “Covered California” Exchange plans offered by Blue Shield and Blue Cross:

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Covered California
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Blue Shield – Over a year ago Blue Shield issued new contracts to participating physicians that included an addendum to participate in additional plans at discounted payment rates of 10, 20, or 30% below Blue Shield’s standard fee schedule. The plans were not identified as Exchange plans. Blue Shield indicates that physicians who completed the re-contracting process and did not opt out of those plans will be included in the panel of physicians for their Exchange plans. Additionally, Blue Shield recently auto-enrolled approximately 1400 into an “Exclusive PPO Network” that will be used in their PPO Exchange plans. Letters were sent to physicians informing them of this auto-enrollment. Because the notice of this auto-enrollment was made more than 45 days before it takes effect (on January 1st), this auto-enrollment complies with California law requiring that health plans notify physicians of any material change in their contract. It is therefore contractually enforceable unless the physician opts to resign from the underlying contract through which they participate in all Blue Shield plans.

Blue Cross – For Blue Cross HMO Exchange plans, they are utilizing the existing contracts they have with delegated medical groups. For their PPO Exchange plans, last year physicians in Blue Cross’ PPO Select plan were notified that they would be part of the Blue Cross PPO Exchange plans unless the physician proactively opted out of that contract by December 31st, 2012. While the ACCMA does not recommend whether physicians should or should not participate in Exchange plans, it is recommended that physicians fully understand the contractual terms under which they are to provide care through health plans and determine whether those terms are acceptable.

Checking Contractual Status with Covered California Plans
Covered California briefly launched the long-awaited online provider search function in October, only to take it down shortly thereafter, due to inaccuracies and slow performance. The provider search function has recently been active again; however, the California Medical Association (CMA) has noticed that some information on languages spoken and participation status on some physicians remain inaccurate.

The search function allows patients to determine if a particular physician is contracted with any of the participating health plans. Though aimed at patients, physicians can also use the search to determine which plans list them on their exchange provider directories. CMA encourages physicians to review their status with plans offered in their area to determine whether they are showing as participating or non-participating. If you find that you are being identified as contracted with an exchange plan but did not intend to do so, contact the appropriate provider relations representative at the health plan and CMA’s Center for Economic Services at economicservices@cmanet.org or (800) 786-4262.

The provider search is available through Covered California’s “Preview Plans” tool. To access the search:

2. Next, select the “Preview Plans” tab at the top of the next screen.
3. The user will then be directed to provide some general demographic information and click “See My Results” at the bottom right.
4. Click “Preview Plans” again on the next page, then select the “Find Your Doctor or Hospital” bar in the middle of the screen, which opens a dropdown box with both “Find Your Doctor” and “Find Your Hospital” options.
5. Select the “Find Your Doctor” option, and input the physician’s name and location. If the desired physician is contracted with a participating Covered California health plan, his or her name should appear in the subsequent provider list.
6. Select the desired name from the list and choose the “Add to My Providers List” option. If you would like to search for another physician, click “Find Your Doctor” again and repeat the process. Once your list is complete, select “Choose a Plan.” The plans in which the chosen physician(s) participate will show a green checkmark in the “My Doctors” row within the summary at the lower half of the page. A red minus-sign box indicates that the physician does participate in the plan.

For more guidance on contracting issues with the exchange plans see CMA guidebook “CMA’s Got You Covered: A physicians guide to Covered California, the state’s health benefit exchange” at www.cmanet.org/issues-and-advocacy/cmas-top-issues/aca/exchange-resources/

Inadequate Medi-Cal Reimbursement Rates
Under the ACA, rates for primary care services will rise to Medicare levels in 2013 (retroactive to January 1st) and 2014 for eligible physicians who completed an attestation process earlier this fall. Eligibility was limited to physicians who are board certified in family medicine, internal medicine, pediatrics and related subspecialties, or who bill 60 percent or more of Medi-Cal services for the evaluation and management (E/M) and vaccine administration codes. While this is welcome news and a much needed increase in reimbursement rates, it unfortunately does not apply to all physicians or all services. In addition, reckless Medi-Cal cuts by the California Legislature have undermined the benefit of the primary care increase by slashing reimbursement rates 10% across the board. To make matters even worse, the state recently announced plans to begin recouping 10 percent cuts retroactive to 2011, which will be withheld prospectively from Medi-Cal reimbursements starting in January 2014. These cuts will have a major
impact on the Medi-Cal system, forcing physicians out of the program at a time when millions of new patients will be diverted into the Medi-Cal system as a result of the ACA expansion. CMA has fought on multiple fronts to stop the 10 percent Medi-Cal cuts. CMA was successful in stopping the cuts in federal court, but the Ninth District Court of Appeals reversed the ruling and allowed the state to retroactively recoup cuts approved by the Legislature since 2011. California already ranks among the bottom three states in the nation in Medi-Cal reimbursement rates even before the cuts.

**Grace Period Necessitates Constant Verification of Patient Eligibility**

State regulators have addressed an ambiguity in federal law that would have forced contracted physicians to provide services without any guarantee of payment to patients who are delinquent on their premiums. The Department of Managed Health Care (DMHC) has clarified that health plans offering individual coverage through the exchange must follow current state law, which requires plans to “suspend” coverage after 30 days, with reinstatement rights if the enrollee pays premiums by the end of the grace period. Once an enrollee’s coverage is suspended, physicians are no longer obligated under their contract to provide covered services, and patients are financially responsible for the cost of services unless their coverage is reinstated before the end of the grace period.

The ACA requires a 90 day “grace period” and instructs plans to provide coverage during the first month of delinquency, with the option to “pend” claims in months two and three. This provision has caused significant concern because it implies that physicians would still be required to provide services under the terms of their contracts without any guarantee of reimbursement.

While DMHC’s determination is promising, it still requires physician practices to routinely check eligibility patients at the time of service to determine coverage status. Physicians also continue to have a legal and ethical duty to ensure for continuity of care irrespective of a change in patient’s insurance status.

**Resources for Physicians**

*“Health Care Reform Update: California Health Exchange Gets Ready to Launch”*

This resource article available through the ACCMA Resource Library, provides the most recent updates on the new health care requirements, and what physicians should be concerned about. To obtain a copy of this article visit www.accma.org/PracticeTools/ResourceLibrary.aspx, or call (510) 654-5383.

**CMA Exchange Website**

CMA has developed an online resource on the California exchange for physicians at www.cmanet.org/issues-and-advocacy/cmas-top-issues/aca/exchange-resources. The website provides several resources such as “On-Call” documents on contracting with the exchange, fact sheets on the exchange and essential health benefits, and “CMA’s Got You Covered: A Physician’s Guide to Covered California, the state’s health benefit exchange,” to help educate physicians on the exchange and ensure that they are aware of important issues related to exchange plan contracting.

**CMA On-Call #7450 “Health Benefit Exchange”**

This “On-Call” document from CMA’s online health law library (document #7450) includes a discussion on network adequacy, potential administrative burdens associated with exchange plans, the grace period issue, concerns that physicians unknowingly may be contracted with exchange plans, what to look for in the mail on exchange plan contracting, and examples of termination provisions in current exchange contracts. To download this document visit CMA’s Exchange Resources page at www.cmanet.org/issues-and-advocacy/cmas-top-issues/aca/exchange-resources.

**CMA Reform Essentials**

CMA Reform Essentials is a regular publication covering issues related to California’s implementation of federal health care reform, including network adequacy, model contract development and reporting requirements. To access the current or past issues of the CMA Reform Essentials visit www.cmanet.org/cma-reform-essentials.

**CMA Practice Resources**

CMA Practice Resources (CPR) is a free monthly newsletter from CMA’s practice management experts that focuses on critical payor and health care industry issues, including contracting with health plans in the exchange, and how these issues directly impact the business of a physician practice. To access the current or past issues of CPR, visit www.cmanet.org/cpr.

**CMA Guide to Contract Amendments**

For more information on options available to physicians when a plan makes a material change to a contract, see CMA’s “Contract Amendments: An action guide for physicians,” available free to members on the CMA website at www.cmanet.org. To learn more about critical issues related to exchange plan contracting, visit CMA’s exchange resource page at www.cmanet.org/exchange.

**Kaiser Family Foundation Health Reform Website**

The Kaiser Family Foundation provides a website on health reform, which includes several research, journalism and communications materials for physicians and consumers on the impacts health reform will have on the uninsured. Some resources include a health insurance subsidy calculator, coverage gap estimates, and how Medicaid Disproportionate Share Hospital (DSH) Payments change under the ACA. To access the Kaiser Family Foundation website on health reform, visit kff.org/health-reform.