
# ADVOCATES' GUIDE TO HEALTH CARE REFORM IMPLEMENTATION IN CALIFORNIA

APRIL 2011

## ADVOCATES FOR HEALTH JUSTICE

The Asian & Pacific Islander American Health Forum (APIAHF) is a health justice non-profit organization dedicated to improving the health and well-being of more than 17 million Asian Americans, Native Hawaiians, and Pacific Islanders living in the United States and its jurisdictions. We believe that all persons have the right to be healthy, the right to live in a thriving community, and the right to quality, affordable, and accessible health care. For the past 25 years, APIAHF has worked with community advocates, public health leaders, and policymakers to generate policies, programs, and systems changes to improve the health of Asian American, Native Hawaiian, and Pacific Islander communities.

Through our policy and advocacy efforts, APIAHF was instrumental in the creation of the White House Initiative on Asian Americans and Pacific Islanders, fought for the passage of the Patient Protection and Affordable Care Act, and continues to demand the inclusion of Asian Americans, Native Hawaiians, and Pacific Islanders in the collection and reporting of local, state, and national health data.

Among our many successful partnerships, APIAHF is proud to direct the largest ever investment in Asian American, Native Hawaiian, and Pacific Islander communities through a $16.5 million grant by the W.K. Kellogg Foundation.

Our work derives from three core values:

**RESPECT** because we affirm the identity, rights, and dignity of all people.

**FAIRNESS** in how people are treated by others and by institutions, including who participates in decision making processes.

**EQUITY** in power, opportunities, and resources to address obstacles hindering vulnerable communities and groups from living the healthiest lives.

## MISSION

APIAHF influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of Asian Americans, Native Hawaiians, and Pacific Islanders.

25 1986-2011 APIAHF ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

# OVERVIEW

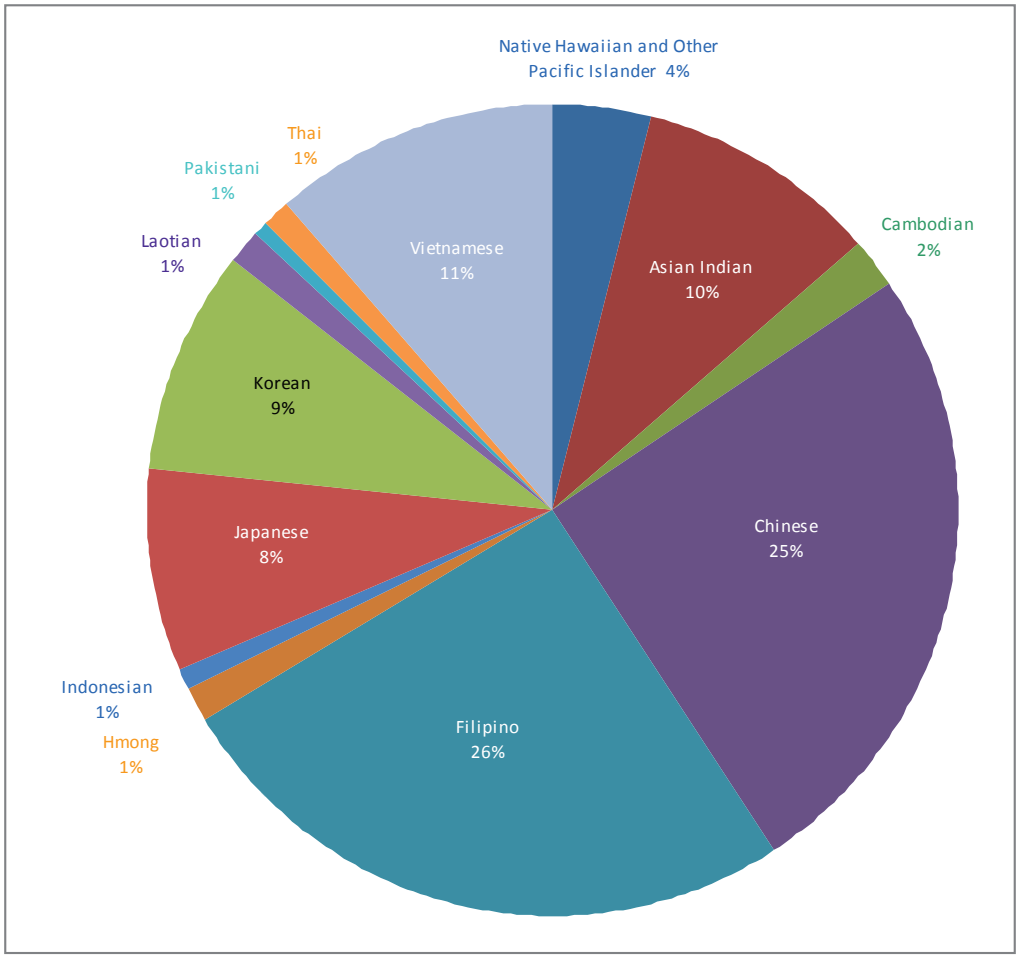
The national health care reform law, the Patient Protection and Affordable Care Act (PPACA), will be implemented in different ways by each state, territory and U.S.- associated jurisdiction between now and the year 2014. This is because the national health care reform law builds upon existing federal and state health insurance programs including Medicaid and the Children's Health Insurance Program, which currently have different rules and requirements in every state and jurisdiction.

This guide describes the current public and private health insurance rules and requirements in your state and summarizes the actions that your state has taken to implement national health care reform.[1] The guide also describes some of the important policy issues and provides questions that Asian American, Native Hawaiian, and Pacific Islander community advocates should consider and ask about implementation of national health care reform in your state.

# DEMOGRAPHICS

This section gives you some general background data on Asian Americans, Native Hawaiians, and Pacific Islanders in California.

**FIGURE 1. CALIFORNIA ASIAN AMERICAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER POPULATIONS**




Source: American Community Survey 2007-2009 Three-Year Estimate. All groups are alone and in combination.

[1] We have tried to include the most accurate and updated information available in this community guide. As federal and state laws, regulations, and budgets are implemented, the information in this community guide will need to be updated. Please let us know about any changes and updates you learn about and we will make the appropriate changes.

## ETHNIC COMPOSITION

There are more than 5 million Asian Americans, Native Hawaiians and Pacific Islanders (AA and NHPI) in California, equal to about 14% of the state's population. The AA and NHPI population in California is projected to grow to 18% in 2025.

Currently, Filipinos are the largest Asian ethnic subgroup, with about one fourth of Asian Americans being Filipino. Chinese are second, but are also almost one fourth of the population. Vietnamese is the third largest subgroup making up a little more than one tenth of Asian Americans in California.

## TABLE 1. LIMITED ENGLISH PROFICIENCY

| | Limited English Proficiency |
|---|---|
| **CA Total** | 19.9% |
| | |
| **Asian Inclusive** | 35.2% |
| **Asian Indian** | 23.7% |
| **Cambodian** | 46.1% |
| **Chinese except Taiwanese** | 43.7% |
| **Filipino** | 20.0% |
| **Hmong** | 49.2% |
| **Indonesian** | 32.2% |
| **Japanese** | 20.0% |
| **Korean** | 49.3% |
| **Laotian** | 43.1% |
| **Pakistani** | 25.2% |
| **Taiwanese** | 45.4% |
| **Thai** | 42.4% |
| **Vietnamese** | 52.6% |
| | |
| **Native Hawaiian/Pacific Islander Inclusive** | 10.4% |
| **Guamanian/Chamorro** | 6.5% |
| **Native Hawaiian** | 2.1% |
| **Samoan** | 11.9% |
| **Tongan** | 21.8% |
| | |
| **Non-Hispanic White** | 3.2% |
| **Black or African American** | 2.2% |
| **American Indian/Alaska Native** | 8.0% |
| **Hispanic or Latino (of any race)** | 38.8% |

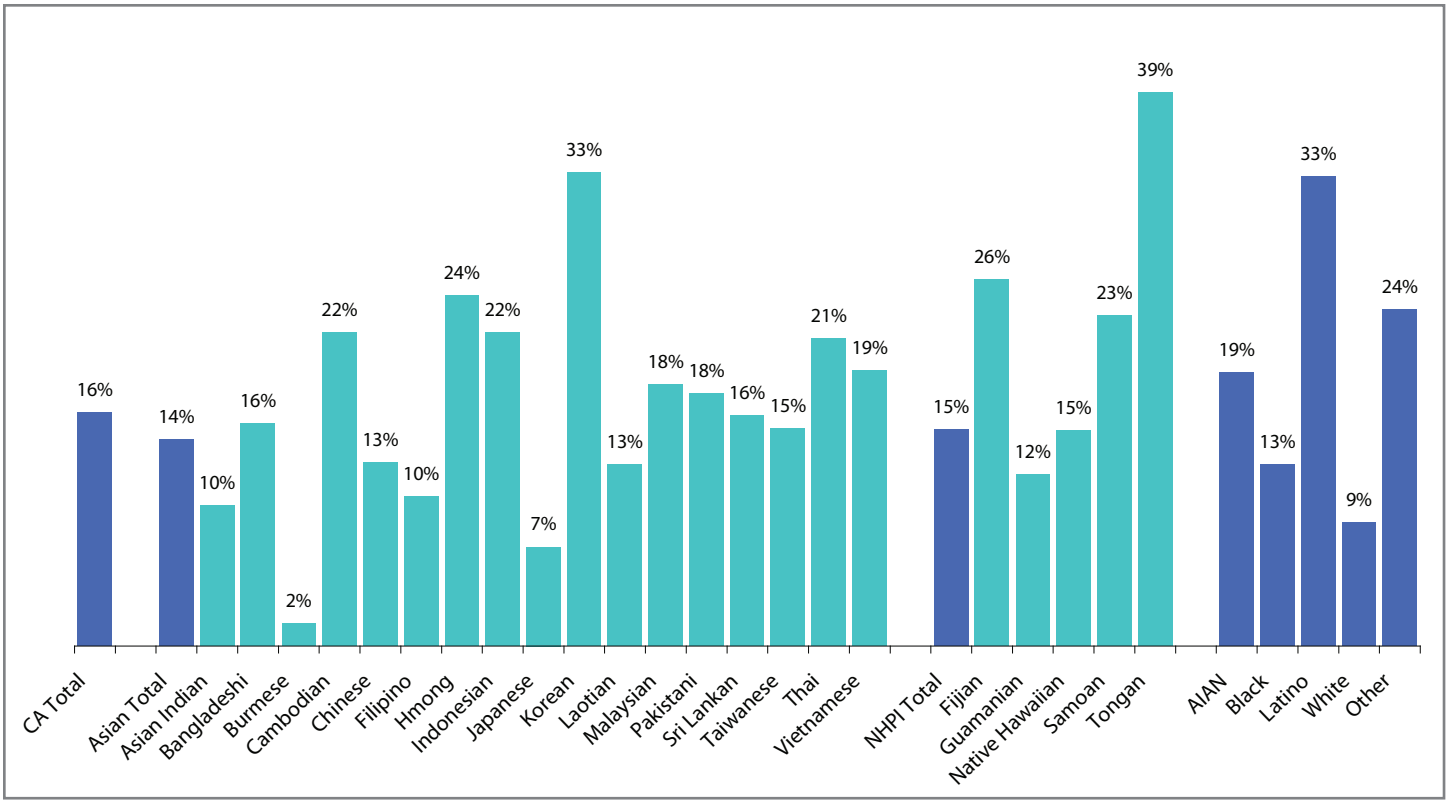
Source: American CommunitySurvey, 2007-2009 Three-Year Estimate.

## LIMITED ENGLISH PROFICIENCY

More Asian Americans (35%) have limited English proficiency (LEP) than the state average (20%) and most other racial/ethnic groups except for Latinos (38%). Vietnamese (52%) have the highest proportion of LEP, followed by Koreans (49%), Hmong (48%) and Taiwanese (47%). NHPIs also have high proportions of LEP (10%) compared to other racial/ethnic groups. Among Native Hawaiian and Pacific Islander subgroups, Fijians (23.3%) have the highest proportion of LEP.

## FIGURE 2. UNINSURED RATES BY RACE/ETHNICITY IN CALIFORNIA

Currently Not Covered by Health Insurance, Age 18 and Older




Source: Adult California Health Interview Survey, 2001, 2003, 2005, 2007

## HEALTH COVERAGE

Asian Americans (14%) and Native Hawaiians and Pacific Islanders (15%) reported slightly lower rates of being currently uninsured compared to the California average (16%), and much higher uninsured rates than Whites (9%) (see Figure 2). Among AA subgroups, Koreans (33%) reported the highest currently uninsured rates, followed by Hmong (24%), Cambodians (22%), and Indonesians (22%), all substantially higher than the state average, while Burmese (2%) and Japanese (7%) reported the lowest rates of uninsured, the lowest rates across all racial/ethnic groups. By NHPI subgroups, Tongans (39%) reported the highest currently uninsured rates, the highest across all racial/ethnic groups, followed by Fijians (26%), while Guamanians (12%) reported the lowest currently uninsured rates among NHPIs.

# MEDICAID, CHILDREN'S HEALTH INSURANCE PROGRAM, AND OTHER PUBLICLY FUNDED HEALTH INSURANCE PROGRAMS IN CALIFORNIA

Determining who is eligible for Medicaid, the Children's Health Insurance Program (CHIP), and your state (and county) publicly funded health insurance programs can be a very complicated process. These programs take into account family relationships (parents and children), age of children, and family income (based on the "Federal Poverty Level"). Federal law requires that all states provide Medicaid to pregnant women and to children at or below 133% of the Federal Poverty Level. States may choose to provide Medicaid to families at higher income levels. The Children's Health Insurance Program allows states to provide health insurance coverage to children and their parents who are above the Medicaid income requirements for that state, either through an expansion of the state Medicaid program or through a separate program. Fortunately, many states offer Medicaid and CHIP to children and their parents with higher family incomes. Some states combine these two programs to make it simpler for families. Other states have complex rules that may mean that some members of the family are in one program and other members of the same family are in another program.

**Who is Eligible for Medicaid in California (called "Medi-Cal")?**

Children under age 1 ≤200% of the Federal Poverty Level
Children ages 1-5 ≤133% of the Federal Poverty Level
Children ages 6-19 ≤100% of the Federal Poverty Level
Pregnant women ≤200% of the Federal Poverty Level
Electronic enrollment available

**Who is Eligible for Children's Health Insurance Program in California (called "Healthy Families")?**

Children under age 1 ≤250% of the Federal Poverty Level
Children ages 1-5 ≤250% of the Federal Poverty Level
Children ages 6-19 ≤250% of the Federal Poverty Level
Parents of Medicaid eligible children ≤106% of the Federal Poverty Level
Electronic enrollment available

**Who is Eligible for Other Publicly Funded Health Insurance Programs in California?**

County programs for low-income adults
www.itup.org/Reports/Health%20Reform/County_Health_and_Reform_11152010.pdf

County programs for low-income children (Children's Health Initiatives)
www.cchi4kids.org/local_cchi.cfm

## POLICY ISSUES

- By 2014, eligibility for Medicaid will be expanded in all states to include all adults (with or without dependent children) up to 133% of the Federal Poverty Level. However, states have the option of implementing the expansion now (beginning in 2010) and getting federal funding for the expansion.
- States must ensure that applicants for health insurance policies offered through the state health insurance exchanges are first screened for eligibility for Medicaid and CHIP.
- Nationally, both the Medicaid and Children's Health Insurance Program are under-enrolled, meaning that there are millions of eligible families and individuals who are not currently enrolled or covered. There is a need for effective and continuous community education and outreach to reach eligible families and individuals, and more streamlined enrollment and other procedures to make sure they stay covered by these publicly funded programs.

## QUESTIONS TO ASK

- When will the expansion of eligibility for Medicaid be implemented in your state?
- Is there language access in your current state Medicaid program (translated forms, interpreter services, enrollment website in multiple languages)?
- What community education and outreach is planned to explain these changes and enroll newly eligible individuals and families in your expanded state Medicaid program?
- Will this community education and outreach be linguistically and culturally appropriate?
- Will disaggregated, granular ethnicity data be collected and made publicly available about the race, ethnicity and language needs of applicants and those successfully enrolled in your expanded state Medicaid program?

# COMMERCIAL HEALTH INSURANCE IN CALIFORNIA

## THE PROBLEM

Most individuals and families get health insurance coverage through their employers. When employers purchase health insurance coverage for their employees, health insurance companies agree to provide health insurance to all the employees, knowing that the majority of employees will seldom need health care, or will only use relatively inexpensive services like preventive screenings, while a small number may use a lot of health care services. However, since employers may not cover dependent family members or may not offer affordable choices for their employees and their families, many employees and their families remain uninsured. Small businesses find it especially challenging to offer affordable health insurance to their employees and families.

As a result, many of the uninsured are considered by health insurance companies to be "high risk", meaning that they may need a lot of health care once they do get health insurance (because they probably have not had consistent health care in the past, including preventive services that may have diagnosed or prevented more serious conditions earlier). Almost all health insurance companies screen individual applicants who are not part of an employer-based plan and deny coverage for "pre-existing conditions." Since health insurance companies often deny these individuals coverage, their "risk" keeps going up, making it harder and harder to get them insured.

## THE SOLUTION

The national health care reform law solves this challenge of covering the uninsured by doing two things simultaneously: first, beginning in 2014, it requires most employers (with at least 50 employees) to provide health insurance to their employees, or pay fines that will help support publicly funded health insurance programs. This "employer responsibility requirement" will expand the numbers of individuals covered through our current employer-based commercial health insurance market.

Second, beginning at the same time in 2014, the health reform law requires all individuals to have or buy health insurance coverage. This "individual mandate" means that the relatively "healthy" uninsured individuals (mainly young adults) also become new customers in the health insurance market, with relatively lower costs to the health insurance companies. This will balance out the costs of the difficult to insure, "high risk" individuals.

The national health care reform law also requires states to create state "health insurance exchanges" known as the American Health Benefits Exchange (for individuals and families) and the Small Business Health Options Program (for small business owners and workers) to offer standardized health insurance policies beginning in 2014. The law also will provide tax credits to individuals and families with incomes up to 400% of the Federal Poverty Level to help offset the costs of buying health insurance through these state health insurance exchanges. If a state decides not to create its own state health insurance exchange, a national health insurance exchange will be created for residents of those states.

With the employer responsibility requirement, individual mandate and state health insurance exchanges all operating by 2014, the national health care reform law then prohibits denials of health insurance coverage for pre-existing conditions and terminations of coverage due to annual or lifetime limits of use. Meanwhile, until 2014, the law creates some temporary programs to offer health insurance coverage for high risk individuals and individuals with pre-existing conditions. Each state may operate its own programs (with some federal funding) or use new federal programs that have been created.

Finally, the national health care reform law requires each state to establish a health insurance consumer assistance office or "ombudsperson" to assist consumers with complaints about health insurance companies. Many states already had such an agency. The law also offers states funding to be more assertive in monitoring and regulating the health insurance companies operating in their state by reviewing and requiring approval for health insurance premiums charged and something called the "medical loss ratio", the percentage of premiums spent on direct medical care compared to administrative costs (and profits).

California operates a high risk insurance pool, called the Major Risk Medical Insurance Program (MRMIP): 7,036 are enrolled, or 0.3% of the state's individual health insurance market.

California operates its own temporary health insurance program for individuals with pre-existing conditions (rather than participating in the federal Pre-existing Condition Insurance Plan).

California has enacted state legislation to create its state health insurance exchange.

California has an Office of Patient Advocate.

California regulates its commercial health insurance market through its Department of Insurance and its Department of Managed Health Care.

California received a federal grant to monitor its commercial health insurance market.

## POLICY ISSUES

- The federal Department of Health and Human Services and state insurance commissioners are working together on regulations and rules for the state health insurance exchanges. A key issue will be determining what "essential benefits" must be included in the standardized health insurance policies to be offered through the state health insurance exchanges.
- The national health reform law gives states flexibility to provide alternative coverage models in their health insurance exchanges, such as multi-state health insurance policies and non-profit consumer operated and oriented plans ("co-ops"). These alternative coverage models must be created before 2014.
- With approximately 44 million new "customers" expected to buy health insurance through these state health insurance exchanges, commercial health plans and health insurance companies are preparing to expand their business to offer health insurance policies through the state health insurance exchanges.
- States have different levels of authority (and interest) in monitoring and regulating the commercial health insurance market in their state.

## QUESTIONS TO ASK

- Who regulates commercial health insurance in your state? Are state agency staff aware of issues of language access, cultural competency and disparities?
- Will your state offer non-profit co-op or multi-state plans in your health insurance exchange?
- Who is the health insurance consumer assistance office or ombudsperson in your state? How do they handle complaints about language access, cultural competency and discrimination?
- Is there language access assistance for enrollment in your state's high risk insurance pool and pre-existing condition program (translated forms, interpreter services, enrollment website in multiple languages)?
- What community education and outreach is being conducted to explain these plans and enroll eligible individuals and families? Is this community education and outreach linguistically and culturally appropriate?
- Will disaggregated, granular ethnicity data be collected and made publicly available about the race, ethnicity and language needs of applicants and those successfully enrolled in these new health insurance pools and plans?
- What are the current language access and cultural competency policies and practices of health plans and health insurance companies in your state? Are there key staff persons responsible for these functions that you know, or should get to know?

# HEALTH INSURANCE ELIGIBILITY ISSUES FOR IMMIGRANTS

The health reform law did not make any changes to existing eligibility rules for immigrants. Under federal law, most lawfully present immigrants are not eligible for federal health insurance programs such as Medicaid and the Children's Health Insurance Program (CHIP) for five years. Fortunately, the Children's Health Insurance Program Reauthorization Act of 2009 gave states the option of providing Medicaid and CHIP for immigrant children and pregnant women during that five-year waiting period, using a combination of federal and state funds.

Lawfully present immigrants—even those subject to the five-year waiting period—are eligible to purchase health insurance in the state health insurance exchanges. Low and moderate-income immigrants and families in this category are also eligible for federal tax credits and cost-sharing assistance.

Undocumented immigrants are not eligible for almost all federal health programs, with some very limited exceptions (such as the emergency health services and general public prevention programs). However, states can use state funding to provide health insurance programs for undocumented immigrants.

> California provides Medicaid to lawfully residing immigrant children and pregnant women.
>
> Prenatal care, breast and cervical cancer treatment, and certain other medical services are available to all persons residing in California, regardless of immigration status.
>
> California uses the Social Security Administration to verify citizenship status for Medicaid (but not for the Children's Health Insurance Program).

## POLICY ISSUES

- Many immigrant families have individual family members with different immigration statuses. This becomes confusing since some family members may be eligible for Medicaid and the Children's Health Insurance Program while others are not eligible because of the five-year waiting period.
- Undocumented immigrants are among those who will be exempted from the "individual mandate" beginning in 2014 to obtain health insurance coverage. However, it is not yet clear how undocumented immigrants will get this exemption without having to reveal their undocumented status.
- All state programs that receive federal funding must follow federal non-discrimination laws and rules that limit the number and types of questions that states may ask applicants about their national origin and immigration status.

## QUESTIONS TO ASK

- What role will consumer assistance programs and patient navigators have in helping to facilitate the application and enrollment process for immigrants who want to buy health insurance through your state health insurance exchange?
- How will immigration status be verified through your state health insurance exchange?
- How will your state health insurance exchange assist low-income immigrants buy health insurance through the exchange and get the federal tax credits?

California enacted SB 900 and AB 1602 to establish a state health insurance exchange.

California enacted SB 1088 to extend coverage to dependents up to age 26.

California enacted AB 2244 to prohibit denial of coverage to children for pre-existing conditions.

California enacted AB 1187 to establish a state temporary high risk pool.

California enacted AB 2345 to require new health insurance policies to comply with PPACA on preventive services.

Other bills implementing the national health care reform law are pending.

Governor created Health Reform Task Force.

California is not participating in any of the lawsuits against the national health care reform law.

## CALIFORNIA ACTIVITIES TO IMPLEMENT NATIONAL HEALTH CARE REFORM TO DATE

While some states have filed lawsuits against the national health care reform law (challenging the individual mandate and the expansion of Medicaid), all of them have taken steps to prepare to implement the law, especially all the changes that will become effective beginning in 2014.

### POLICY ISSUES

- The national health care reform law requires that state health insurance exchanges provide culturally and linguistically appropriate consumer assistance in enrollment and appeals.

### QUESTIONS TO ASK

- How will your state health insurance exchange be implemented?
- Who will be the designated consumer representative on the governing board of your state health insurance exchange?
- What opportunities will there be for public comment and community input into the policy decisions to be made by your state health insurance exchange (for example, what income requirements for subsidies, what specific services included in the new health insurance policies – especially oral and mental health services, whether language assistance services will be available)?
- How can community advocates be involved in public comment opportunities?
- Will there be language access for enrollment into the new health insurance policies offered by your health insurance exchange (translated forms, interpreter services, enrollment website in multiple languages)?
- What community education and outreach is planned to explain and enroll eligible individuals and families in the new health insurance policies offered by your state health insurance exchange?
- Will this community education and outreach be linguistically and culturally appropriate?
- Will there be funding for community based organizations to conduct education and outreach?
- Will disaggregated, granular data be collected and made publicly available about the race, ethnicity and language needs of applicants and those successfully enrolled in these new health insurance policies offered by your state health insurance exchange?

# CITATIONS AND REFERENCES


**National Conference of State Legislatures**

http://www.ncsl.org/default.aspx?tabid=20044 (Medicaid and Children's Health Insurance Program eligibility)

http://www.ncsl.org/?tabid=14329#2010_Pools (high risk insurance pools)

http://www.ncsl.org/?tabid=14329 (insurance plans for individuals with pre-existing conditions)

http://www.ncsl.org/?tabid=18906#AG_suits (state legal actions challenging PPACA)

http://www.ncsl.org/default.aspx?tabid=20231#Legislative (state legislative and administrative actions to implement PPACA)

**Kaiser Commission on Medicaid and the Uninsured**

http://www.kff.org/medicaid/upload/8130.pdf

**National Immigration Law Center**

http://www.nilc.org/pubs/guideupdates/med-services-for-imms-in-states-2010-07-28.pdf (state medical assistance programs for immigrants)

http://www.nilc.org/immspbs/health/immigrant-inclusion-in-HR3590-2010-04-19.pdf (immigrant eligibility under PPACA)

**Federal Poverty Level (FPL)**

https://www.cms.gov/MedicaidEligibility/Downloads/POV10Combo.pdf

**U.S. Census Bureau American Community Survey**

http://factfinder.census.gov/home/saff/main.html?_lang=en

**HealthCare.gov Implementation Center**

http://www.healthcare.gov/center

**Ethnic Health Assessment For Asian Americans, Native Hawaiians, and Pacific Islanders in California**

http://www.apiahf.org/images/stories/Documents/publications_database/policy_ca_ehap_aanhpi.pdf

**California Pan-Ethnic Health Network**

http://www.cpehn.org/pdfs/Implementing%20Reform.pdf

**California Senate and Assembly Legislation**

http://www.leginfo.ca.gov/bilinfo.html

**California Office of Patient Advocate**

http://www.opa.ca.gov/

**California Department of Health Services (Medicaid agency)**

http://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx

**California Managed Risk Medical Insurance Board (Children's Health Insurance Program)**

http://www.healthyfamilies.ca.gov/Home/default.aspx

**California Major Risk Medical Insurance Program**

http://www.mrmib.ca.gov/MRMIB/MRMIP.shtml

**California Pre-Existing Condition Insurance Program**

http://www.pcip.ca.gov/Home/default.aspx

**California Department of Insurance**

http://www.insurance.ca.gov/0100-consumers/0070-health-issues/index.cfm

**California Department of Managed Health Care**

http://www.dmhc.ca.gov/aboutthedmhc/gen/ann/gen_ann_hcr.aspx

**California State Health Insurance Exchange**

http://www.healthcare.ca.gov/Priorities/HealthBenefitExchange.aspx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