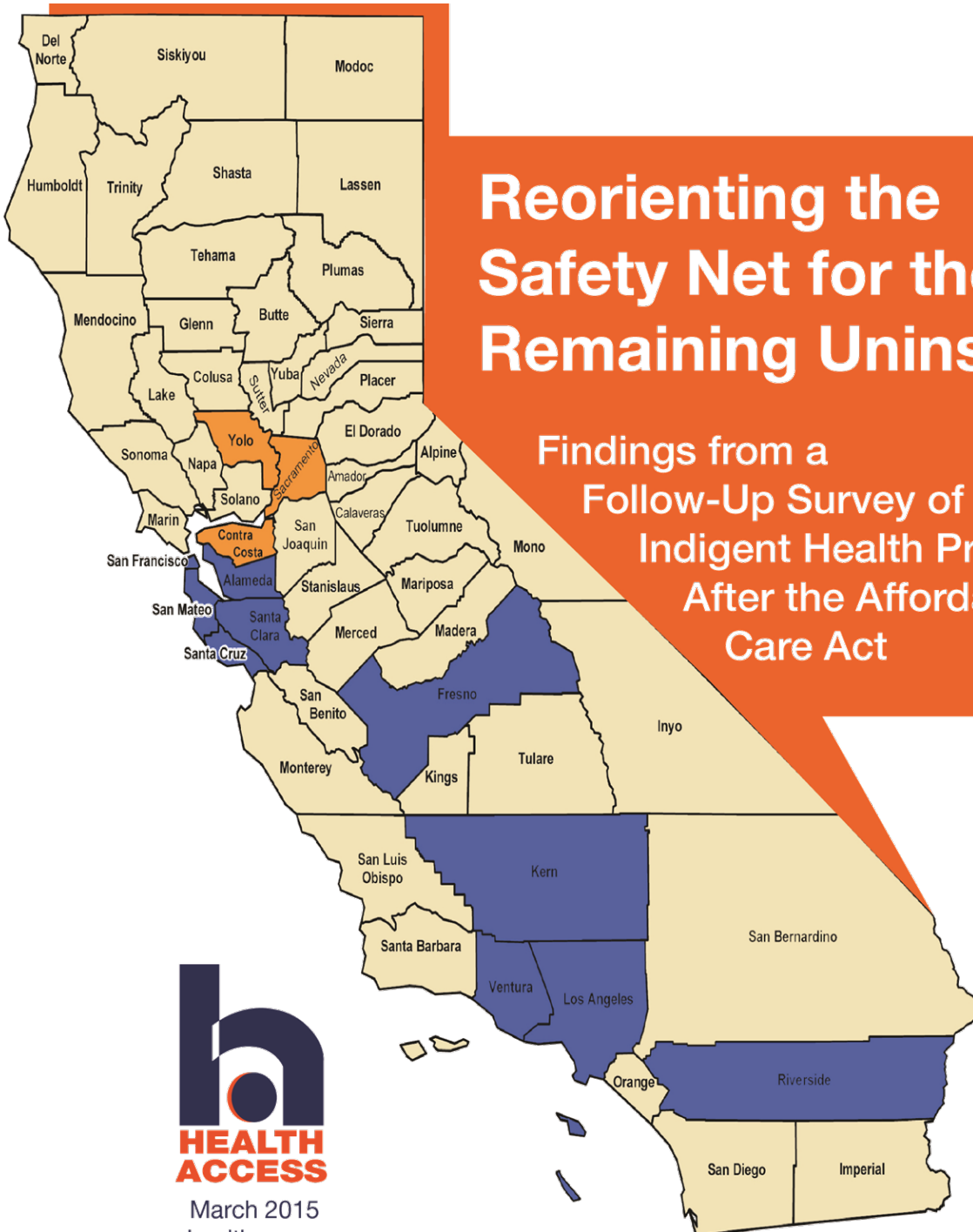


Reorienting the Safety Net for the Remaining Uninsured

Findings from a
Follow-Up Survey of County
Indigent Health Programs
After the Affordable
Care Act



March 2015
www.health-access.org



About Health Access

Health Access California is the statewide health care consumer advocacy coalition, working for quality, affordable health care for *all* Californians. Founded in 1987, Health Access Foundation is an independent non-profit research and education organization.

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Executive Summary

The historic expansion of health coverage under the Affordable Care Act provides the opportunity to ask how the county safety-net should be re-oriented to address the needs of the remaining uninsured. In late fall of 2014, Health Access conducted a survey of California county health departments, asking about eligibility and enrollment in programs for the medically indigent.

This was a follow up to a survey in 2013 of the 58 counties' approach to care or coverage for the remaining uninsured, to examine any major changes after implementation of the Affordable Care Act. The survey found that:

County safety net programs can better serve the remaining uninsured.

- California counties continue to be dramatically different in how they care for the “medically indigent,” both in term of how they provide care, who is eligible due to income and immigration status, and other factors.
- The 2014 implementation of the Affordable Care Act significantly reduced the number of Californians on county indigent care programs, as counties successfully enroll their patients in Medi-Cal and Covered California.
- Counties with broad eligibility requirements are seeing strong continued need for their safety-net programs, with tens of thousands people enrolled in some counties. Some are adapting and augmenting their programs to be more comprehensive, focusing on primary and preventive care.
- Counties with restrictive eligibility requirements, especially those that exclude the undocumented, are finding few if anyone left in their indigent care programs—but not because there is not need.
- While some counties adjusted benefits, counties generally did not change eligibility for their programs in the last two years, opting for a “wait and see” approach after both the ACA implementation and the state’s reallocation of some safety-net funds. Now some counties and advocates are looking to refocus and reform their programs to better meet community needs.

Based on this survey, our recommendations urge counties to re-orient their programs to better serve the remaining uninsured, as many counties are starting to plan their 2015-16 budgets. California’s health system is stronger when everyone, regardless of immigration status, has access to affordable care.



Background

California's County Safety Net and the New Context of the Affordable Care Act

Counties are obligated to provide care and coverage to low-income Californians who are uninsured, particularly to “medically indigent adults” that do not qualify for Medi-Cal or other state or federal programs. This is often referred to as counties’ “17000” obligation, named after the Welfare and Institutions Code (WIC) section of the state law. The broad language of WIC 17000, however, has resulted in counties interpreting and responding to the requirement differently, reflecting each county’s specific circumstances, demographics, politics, and resources.

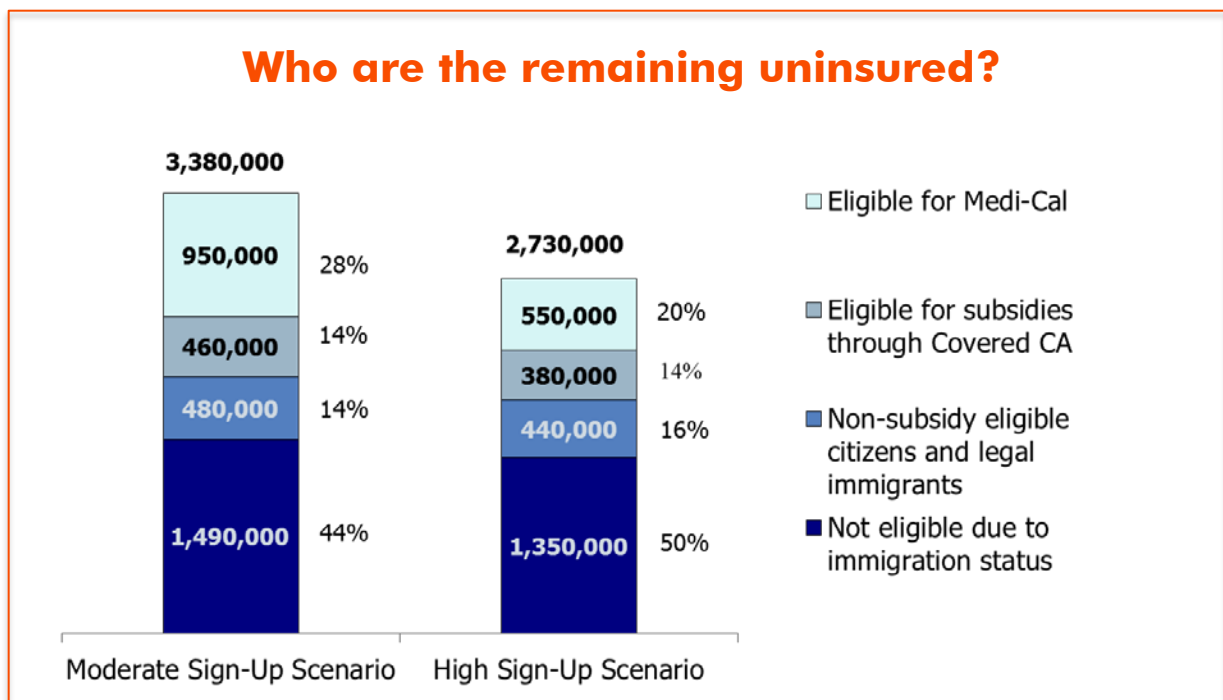
The challenge of providing care to medically indigent adults has changed in recent years, with the historic expansion of coverage under the Affordable Care Act resulting in new and more affordable coverage options for millions of Californians. Estimates suggest that after just the first enrollment period, California has reduced the number of uninsured by half. Approximately 1.4 million people are enrolled in coverage through Covered California, the state’s health exchange; and around 3 million have new coverage through Medi-Cal, the state’s Medicaid program.

In anticipation of the reduction in the number of uninsured Californians, Governor Jerry Brown signed AB 85 (Chapter 24, Statutes of 2013) to reallocate some funding from the county safety-net. Counties had traditionally received money from the state vehicle license fee to support county-based public health programs and indigent care services. These funds recently totaled about \$1.4 billion, and under AB 85, the state sought to reclaim as much as \$900 million from counties either through a set amount reallocated (a “60-40” split), or, as most counties chose, a more complicated “formula” that takes into account county’s costs and revenues. The reallocation is intended to leave resources for continued county responsibilities on public health and indigent care.

While many more people now have health care coverage, a significant segment of the population remains uninsured—about 3 million Californians are estimated by University of California researchers to remain uninsured even after several years of outreach and enrollment efforts. A majority of the remaining uninsured are citizens or lawfully present residents and disproportionately are Latino, African American and Asian-Pacific Islanders—but a significant percentage are undocumented immigrants.

These remaining three million people will face the health and financial consequences of being uninsured. They typically delay and are sometimes denied care because of lack of insurance. Paying medical bills out-of-pocket can get expensive quickly, especially for those without much resources to begin with. While some uninsured go to hospital emergency rooms (ER) as safety net, hospitals are only required to stabilize a patient in an emergency situation. So while an ER will treat a heart attack or gunshot wound, a hospital has the ability to turn away a patient with cancer or diabetes. Without insurance, a severe asthma attack will be treated, but care to manage asthma is not necessarily provided. Also, in emergency situations, hospitals bill uninsured patients, and these charges quickly run in the thousands of dollars even if the patient is not admitted.

While community clinics and hospital “charity care” provide some patchwork of services, counties remain the safety net of last resort. Otherwise, uninsured individuals will show up for care—sometimes too late—in their emergency rooms, which drives up costs and makes the health care delivery system less efficient for everyone else.



Most of the remaining uninsured are those under 133% of the federal poverty level and eligible for Medi-Cal, but not enrolled.

- Of these, some could be citizens who lack awareness of the program or their eligibility or have had trouble with the enrollment process.

- Another segment of the remaining uninsured under 133% of the federal poverty level are undocumented and therefore are explicitly excluded from federally-funded health coverage under the ACA.

For those over 133% of the federal poverty level, in addition to undocumented immigrants, there are other Californians who remain uninsured and are unable to get subsidized coverage. For those who may be eligible for subsidized coverage in Covered California (those over 133% of the federal poverty level), there may still be barriers of affordability. About a fifth to a quarter of the remaining uninsured are exempt from the individual mandate because the current options are still not affordable for them—this could be because of the cost of living in their area or other financial circumstances. In addition:

- Some of the remaining uninsured are (or will be) family members of workers with job-based coverage, but who do not qualify for family coverage or Exchange subsidies (also known as the “family glitch” problem).
- Some will fail to enroll on time because of the confusion surrounding open enrollment periods or difficulties with the enrollment.
- Even with special enrollment periods, some will drop off coverage during transitions in life and work, and fail to enroll in new coverage. They, too, will need care before the next open enrollment period.

For the remaining uninsured population, California needs a county safety-net that survives and thrives—but it needs to adapt to a new context. The combination of the Affordable Care Act, the AB 85 state-county funding reallocation, and now the President’s executive actions on immigration (discussed in our recommendations) creates a new focus and new set of opportunities for the county safety-net. Counties will be making decisions this spring, as they decide their 2015-16 budgets, as to whether to address these needs and opportunities.

In order to provide context for these discussions, Health Access worked to update its November 2013 report, “California’s Uneven Safety Net,” which is available on our website. Over the course of fall 2014, Health Access contacted county officials throughout California with a set of questions asking about changes in eligibility and enrollment. The enrollment numbers provided were point-in-time, with some answers coming to us over the span of many weeks. While the exact numbers are not directly comparable and have likely changed, some trends and conclusions are nonetheless clear.



Findings

Assessing California's County Safety-Net

The 2014 Health Access county survey shows that counties have a vital role to play in providing safety-net care and/or coverage to the remaining uninsured—with striking differences in approach from county to county. Our most recent survey found the following:

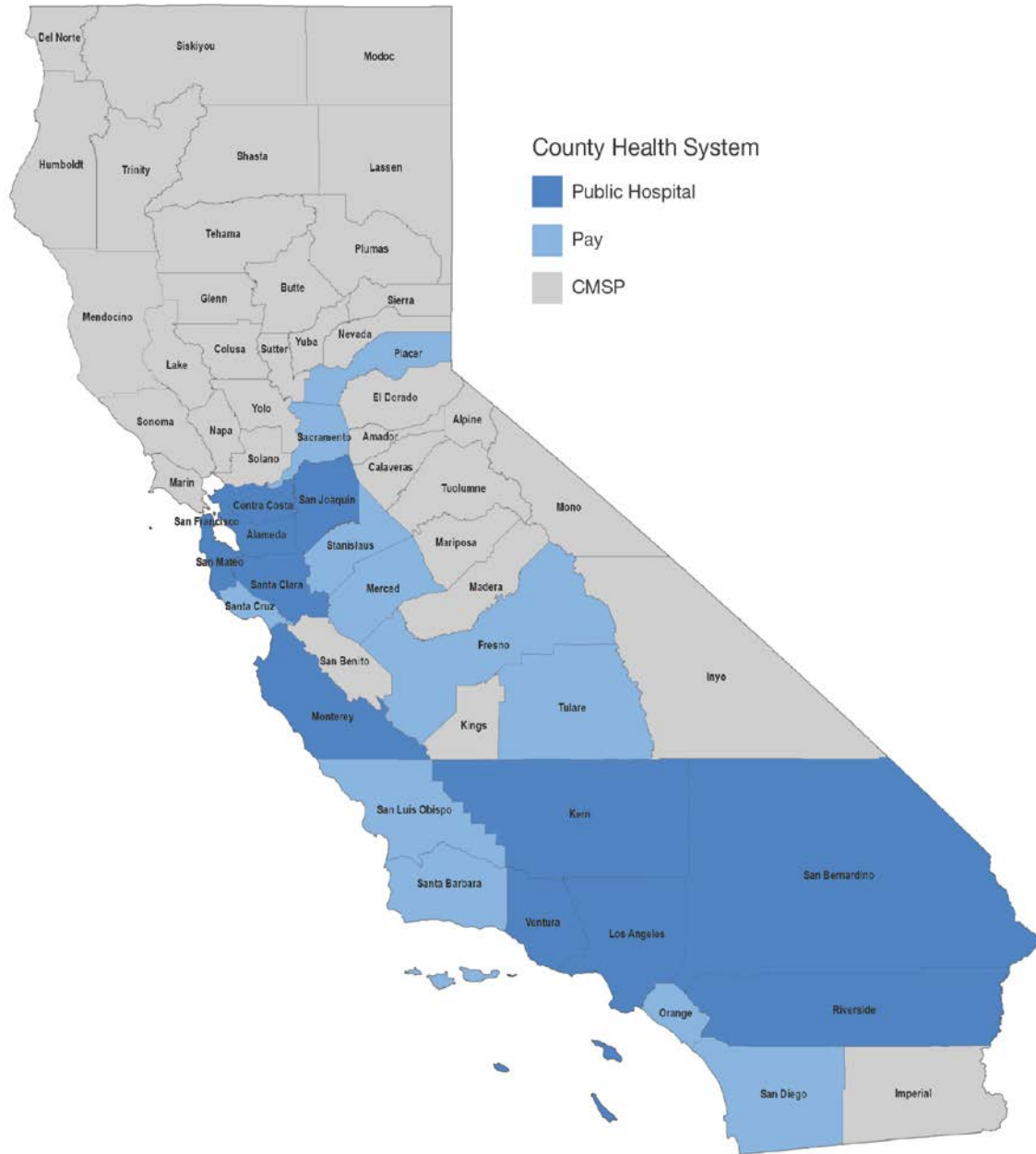
Counties safety-net services continue to be wildly disparate.

While California counties have the responsibility to provide care for the medically indigent, California's 58 counties continue to meet this mandate in widely and wildly different ways, both in term of what services they provide and how they provide them, and with regard to who qualifies based on income and immigration status. The differences between counties are as stark as ever from the 2013 survey, if not more so given the new context of the ACA.

How Care Is Provided: Unchanged from the 2013 report is the way that counties provide such care to the medically indigent. Twelve counties run public hospital systems, in most cases accompanied by a network of county clinics. These typically large and urban counties provide a range of services, from an emergency room to primary and preventative services. They include Alameda, Contra Costa, Kern, Los Angeles, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura counties

Another twelve counties are known as “payer” counties or “Article 13” counties, which run clinics and/or contract with a private health care providers, like clinics and community hospitals, to fulfill their indigent care obligation. These counties are Fresno, Merced, Orange, Placer, Sacramento, San Diego, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, and until recently, Yolo. Finally, the remaining 35 small, often rural, counties belong to the County Medical Service Program (CMSP) consortium, which offers basic enrollment-based coverage for those who qualify. Yolo County recently joined CMSP.

County Health Systems (Types)



Income and Immigration Status: As our 2013 county survey report also indicated a wide variation on the income-based eligibility requirements for free- or reduced cost care. Virtually all counties provide care to eligible Californians under the federal poverty level (\$11,770/year for an individual and \$24,250/year for a family of four). Some specifics:

- Eligibility is set at 200% of the federal poverty level (\$23,540/year for an individual, \$56,820 for a family of four in 2015) in 43 counties (all the CMSP counties plus eight others).
- Six counties set their income limits below 200%FPL (Fresno, Los Angeles, Merced, Placer, San Bernardino, and Santa Cruz).
- Appropriately for a high cost-of-living state, nine counties go above 200%FPL. They vary significantly in terms of co-payments or share of cost required of patients, which in some counties start at 62% of the poverty level, but are more prevalent as county programs go up the income scale.

Only 10 counties provide services beyond emergency care to undocumented immigrants: The counties of Alameda, Los Angeles, Riverside San Francisco, San Mateo, Santa Clara, Santa Cruz, Kern and Ventura serve patients without regard to immigration status. Fresno County has served the undocumented in the past, and is looking to continue to do so under a reformulated program (see the description later in this report). Three additional counties served the undocumented until the financial crisis in 2009, which led Sacramento, Yolo, and Contra Costa counties to cut those services from their budget. (Contra Costa continues to serve undocumented children but not adults.). The other counties limit services to emergency services and in some cases to community clinics or charity care programs.

Many Factors Affecting Access to County Indigent Care Programs: No one factor determines how restrictive or broad-based a county's indigent care program is. Even among counties that serve the undocumented, or those that have public hospitals, the survey shows major variance in terms of income eligibility requirements, with some counties setting their limit at or just above the federal poverty level (Los Angeles, Santa Cruz), while others (San Francisco, Santa Clara) serving patients at several times the federal poverty level.

The chart (*next page*) shows just some of the variability, based on income and immigration status. There are also major differences between counties in eligibility (such as asset tests or direct medical need), in duration of being enrolled, in the share-of-cost, and in the services provided.



California's Uneven Safety Net: County Indigent Care Programs After the ACA

	Enrolled 2013 Pre-ACA	Served Now (Late 2014)	Income Limit:%FPL	Ages Served	Name of Indigent Care Program	Type/AB85 Formula
Alameda*	90,603	37,000	200%	19-64	HealthPAC	Public Hospital
Contra Costa	11,212	0	300%	19+	Basic Health Care	Public Hospital
Fresno*	18,841	616	114%	21-65	MISP	Payor - Formula
Kern*	9,121	30	200%	19-64	MIP	Public Hospital
Los Angeles*	282,026	81,000***	138%	6+	My Health LA	Public Hospital
Merced	14,000	0	100%	21-64	MAP	Payor - Formula
Monterey	1292	15	200%	18-64	MAP	Public Hospital
Orange	54,278	58	200%	19-64	MSN	Payor - Formula
Placer	3,426	0	100%	19-64		Payor - 60/40
Riverside*	37,000	6,942	200%	21-65	MISP	Public Hospital
Sacramento	26,320	109	None**	19-64		Payor - 60/40
San Bernardino	32,637	511	133%	21-64	CMSP	Public Hospital
San Diego	41,664	310	350%	21-64	CMS	Payor - Formula
San Francisco*	56,048	22,000	500%	18-64	Healthy SF	Public Hospital
San Joaquin	7,428	250	200%	18-64	MAP	Public Hospital
San Luis Obispo	3,200	6	250%	19-64	CMSP	Payor - Formula
San Mateo*	31,090	20,000	200%	19+	ACE	Public Hospital
Santa Barbara	985	0	200%	21-64		Payor - 60/40
Santa Clara*	39,176	6,832	350%	19-64	Ability-to-Pay	Public Hospital
Santa Cruz*	2,560	180	100%	19-64	MediCruz Classic	Payor - Formula
Stanislaus	5,554	10	279%	21-65		Payor - 60/40
Tulare	4030	0	275%	21-65	TCMS	Payor - Formula
Ventura*	11726	0	700%	19+	Self-Pay Discount	Public Hospital
Yolo	1945	(in CMSP)	200%	21-64		CMSP - 60/40
CMSP	72,571	665	200%	21-64		CMSP - 60/40

White rows indicate those counties that cover the remaining uninsured; shaded rows indicate counties that do not.

Source: From the March 2015 Health Access Report, "Reorienting the Safety-Net for the Remaining Uninsured."

*Denotes counties that provide health services (beyond ER care) to undocumented adults. (Contra Costa has program for children regardless of immigration status.)

Enrolled Pre-ACA: From November 2013 report; estimate includes both LIHP and indigent care program.

Served Now: Survey conducted in Fall 2014, for a point-in-time estimate; Changes likely since then.

(***Los Angeles' My Health LA launched in September 2014, has since grown to 81,000)

Income Limit: Percent of Federal Poverty Level; Counties may have other eligibility rules (assets test, etc.).

(**Sacramento has no income limit; share-of-cost starting at \$600/month (62% FPL)

Ages Served: Some counties also have "Healthy Kids" children's coverage programs.

Name of Indigent Care Program: Medically Indigent Services Program, Medical Assistance Program, Medical Safety-Net Program, Access and Care for Everyone, etc.

Type of County: Public Hospital system, "Article 13" Payor or CMSP, County Medical Services Program

AB85 Decision: CMSP and 5 counties chose a set 60/40 reallocation; the rest took a cost-based formula

Some counties provide programs with a range of benefits over the course of months or even a year; others provide specific point-in-time episodic care at a clinic or hospital, but not a program that one can “enroll” in for on-going care.

A final conclusion is that for uninsured Californians, whether they have access to care is dependent on who they are and what county they live in.

Some counties adjusted benefits but largely not eligibility

Since Health Access’ previous report in 2013, most counties did not make significant changes to their safety-net programs, preferring a “wait and see” approach to the prevailing concerns about how ACA enrollment would fare, and how the state would reallocate funds for indigent care services under AB 85. The one county, Fresno, that contemplated a major rollback of eligibility seems to have found another solution.

Following full implementation of the ACA, some counties made benefit changes to their safety-net programs. For example, Orange County considered limiting services that could be provided through other county programs. Other counties such as Monterey, Sacramento, San Bernardino, San Mateo, Santa Clara and the CMSP counties explored or went ahead with dropping services such as mental health, vision care, and/or dental. In some cases, counties were reverting to previous benefit designs that were augmented when receiving a federal match through their Low-Income Health Program, the early expansion of Medicaid under the ACA.

Some counties adjusted enrollment criteria, but in different directions. For example, both Orange and San Luis Obispo counties implemented an asset test and/or medical necessity requirement to become eligible for benefits while other counties such as CMSP counties decreased the term of eligibility for enrollees to receive benefits. Other counties such as Placer, Santa Clara, and Los Angeles counties found ways to ease eligibility standards, such as removing asset tests, eliminating medical necessity standards, and lengthening the term of eligibility.

In terms of eligibility changes, the biggest debate was around the **Fresno County Medically Indigent Services Program**. In late 2013 and into 2014, Fresno County successfully sued (despite opposition from health and low-income advocates and contrary to preliminary court rulings) to get out from a longstanding legal injunction that required the county to serve undocumented residents in its medically indigent program. Concerned about the impact of the ACA and particularly AB 85 fund reallocation, the Board of Supervisors voted to end its medically indigent program and cancel its longstanding contract to give the local Community Hospital a set amount of money each year to care for the county’s

remaining uninsured. Due in part to a vibrant community response in Fresno and statewide, the Board of Supervisors put a temporary stay on the scaling back of eligibility, pending some assurances that the AB 85 formula would ultimately reimburse the county for indigent care services, and the passage of state legislation (AB 2731(Perea)) to provide the county more budget flexibility (related to the county's transportation fund) to deal with cash flow until the AB 85 reimbursement is made. The county is currently renegotiating a renewed indigent care program that will focus on specialty care, the gap the County has identified between the primary care provided by federally qualified health centers, and the hospital services provided by emergency Medi-Cal. As of this writing, the worst fears that access to health care was being curtailed appears to have been averted.

While counties largely kept their eligibility criteria stable, their enrollment patterns were decidedly not.

Many uninsured Californians moved from county-based indigent care programs into ACA coverage.

One immediate finding is that the Affordable Care Act was successful in covering many of California's uninsured, including many who were relying on county medically indigent programs.

In every county, enrollment in county-based health care programs went down dramatically. The comparison in the chart between enrollment reported in the November 2013 Health Access report (which includes both the county's Low-Income Health Plan and the counties' continuing indigent care program) and in this survey a year later shows significant reductions.

The county enrollment in late 2013 was at a historic high, given that 53 of 58 counties were running Low Income Health Programs, a federally-matched early expansion of Medicaid under the ACA—in which around 650,000 enrolled were then transferred to full Medi-Cal in January 2014. Under the new Medi-Cal expansion under the ACA, counties also worked to aggressively enroll both those in their indigent care programs, and new applicants in federal-funded programs (like Medi-Cal and Covered California) first—both for the benefit of the patient, as well as in the financial interest of the county.

While this outcome was expected, it provides further evidence that the ACA enrollment efforts worked—that people who were relying on the safety net are now getting comprehensive coverage and care. However, there is continued need for a safety net that survives and thrives..

Key counties see need for a stronger and smarter safety net

Counties with broad eligibility requirements are finding that even with the dramatic expansion of coverage under the ACA, there continues to be a huge need for safety-net services for the remaining uninsured.

Counties with broad eligibility requirements on income and immigration status, such as Alameda, Los Angeles, Riverside, San Francisco, San Mateo, and Santa Clara counties, report thousands (if not tens of thousands) of Californians are still getting care in their indigent care programs, demonstrating continued need for these services.

In addition, some counties are looking at providing safety-net services in a smarter way, typically through a medical home approach to preventive and primary care, rather than episodic and emergency care.

For example, Los Angeles started **My Health LA**, a “coverage-like” program has, since its September 2014 launch, enrolled over 81,000 Angelenos, perhaps the largest program in the nation that includes undocumented immigrants. My Health LA enrolls and assigns patients to a specific community clinic, which provides primary and preventive care for a capitated rate. The county hospital system continues to provide specialty care and hospitalization services. While not full coverage—for example, patients will not be covered when getting care at an out-of-county emergency room or outside of the network of their assigned clinic and county providers, My Health LA does provide a medical home and a range of services in an efficient and effective manner. The program is initially budgeted and expected to enroll nearly 150,000 Angelenos by July 2015.

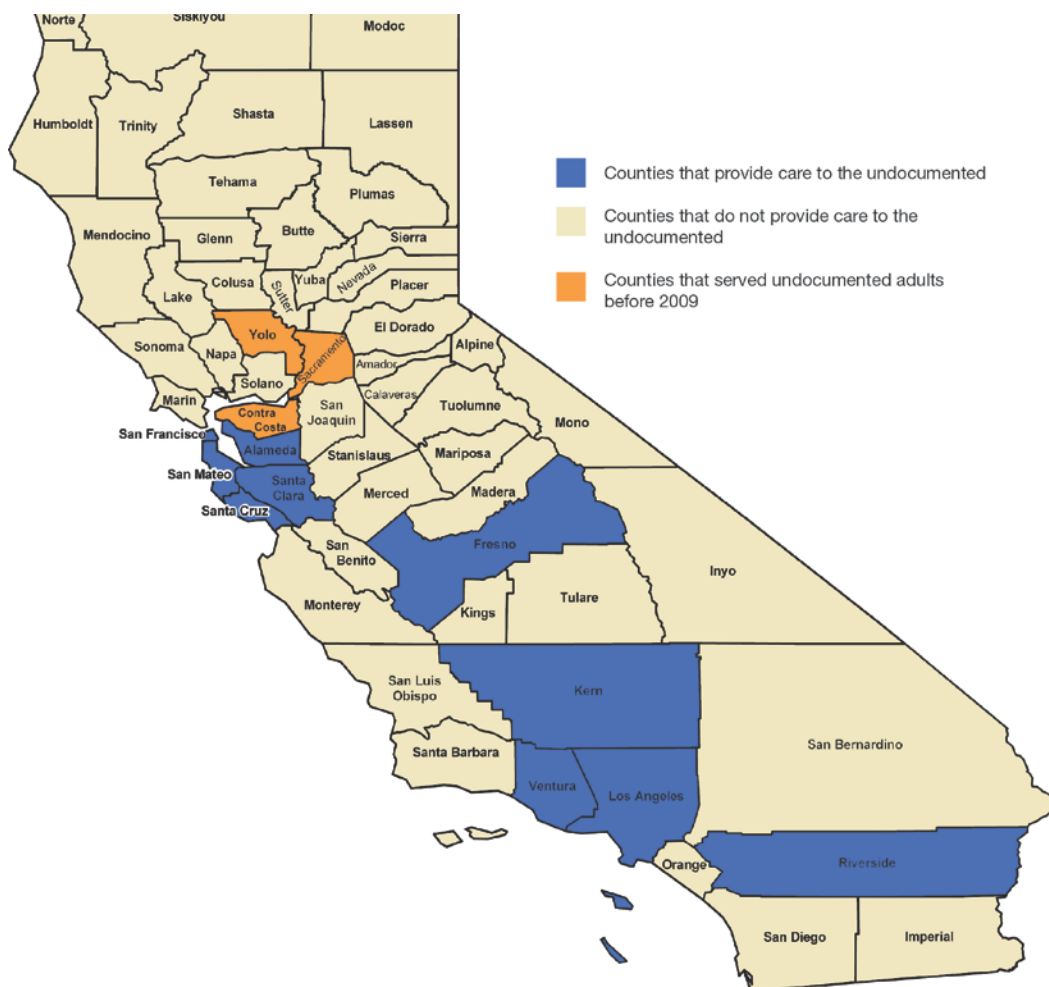
Community groups in counties like Santa Clara and Santa Cruz are also investigating how to go beyond episodic care to a coverage-like medical home, similar to how their Healthy Kids or Low-Income Health Programs worked.

Other counties that previously had groundbreaking “coverage-like” programs, such as Healthy San Francisco and HealthPAC in Alameda County, are figuring out how to adapt their program to align with the Affordable Care Act—even when their safety-net programs may have been more generous in certain ways. In particular, the counties wanted to encourage county residents to take advantage of the (federally funded) coverage offered under the ACA, but still offer key safety-net services for those who cannot or do not sign up for ACA coverage. San Mateo County, for example, increased cost-sharing for certain services to align with cost-sharing in Covered California in order to preserve equity between programs. Counties have

also explored having the county programs serve as a bridge to the next Covered California enrollment period for those who qualify, and to actively serve as a facilitator of coverage. Among the options a few high cost-of-living counties are researching involve providing additional financial help to those enrolling in Covered California (similar to Massachusetts and Vermont who had pre-ACA health reforms).

Even counties with strong safety nets recognize their value and the need for investment, sometimes including their own resources. For example, Alameda County voters approved Measure AA in June 2014 to reauthorize a half-cent sales tax to fund essential health services. (See Health Access’s upcoming report and analysis on Measure AA on our website.)

Care for the Uninsured: Variation by County



Restricted county programs with few patients left need to refocus on the remaining uninsured

In contrast, many counties surveyed, particularly those counties with restrictive eligibility with regard to income and immigration status, reported zero or just a few hundred enrollees in their indigent care programs—a dramatic change from thousands or tens of thousands enrollees just a few years ago. In these counties, consumers previously in the indigent care programs are now enrolled in Medi-Cal or Covered California thanks to the ACA. The eligibility rules for these county programs, however, have not been updated to address the needs of the remaining uninsured population.

The 2014 county survey reveals a stark contrast in enrollment figures between counties that served undocumented immigrants such as Alameda, San Francisco and Los Angeles counties and the counties that do not serve this population

Counties that do not serve undocumented immigrants in their indigent care plan had enrollments from the low hundreds to barely any at all. Some counties reported zero enrollees. The specific number may not be precise: some of these numbers have likely fluctuated since the survey, and some programs provide only point-of-time care and thus do not have ongoing enrollment that can be tracked by a survey. All these counties, including Merced, Monterey, Orange, Placer, Sacramento, San Bernardino, San Diego, San Joaquin, San Luis Obispo, Santa Barbara, Stanislaus, Tulare, and the CMSP counties, reported minimal use of their indigent care program, largely because there are not many residents left that fit their eligibility criteria. For those counties that do not go above 138% of the federal poverty level and do not cover undocumented immigrants, there should theoretically be no one eligible who is not better served in full-scope Medi-Cal. The fact that some programs may have a few dozen enrollees suggests there are continued technological, administrative, or policy issues in Medi-Cal enrollment that may be resolved in time.

The significant drop in enrollment in indigent care programs is not due to the fact that there are no people without insurance needing care and coverage in those counties—it is because county safety-net programs have not adapted to meet the needs of the remaining uninsured post-ACA implementation, where many individuals who were previously covered by these programs now have coverage through Medi-Cal or through Covered California.

Many counties are having discussions with stakeholders about re-orienting their safety-net services in light of the ACA and getting a new sense of who the remaining uninsured are:

- Sacramento County, at the direction of key County Supervisors, is convening a workshop on March 18th to explore what a program might look like, including to revisit the 2009 decision to cut services for undocumented residents.
- Contra Costa County has initiated a task force of key stakeholders including local hospitals and community clinics looking at various options. The task force is expected to publicly report its recommendations soon.
- CMSP has embarked on a strategic planning process to consider “the future of CMSP in light of the ACA,” to discuss “eligibility rules, benefit coverage, provider network, and identifying options for improvement.”
- Community groups have expressed interest in reforming the indigent care programs in Yolo, Monterey, San Bernardino, and other counties.

Many counties are finding surpluses and savings from their indigent care programs to make the needed investments in reforming their health system. While a realignment of county safety-net dollars (under AB 85) did allow the state to recoup much of that savings, some funding is left at the county level. Counties might also find savings spurred by the ACA in other areas (such as behavioral health and corrections programs) and locate additional offsets and resources to meet these ongoing needs.

Finally, the new Medicaid waiver being discussed this year might provide new opportunities for counties, both in providing more flexibility with safety-net care pool dollars, and in linkages between health and human services programs.

Counties have more experience to set-up or continue safety-net programs, given their recent experience with Low-Income Health Programs (LIHP) and the county-based early expansion of Medicaid under the ACA. But without federal funds and the restrictions that usually come with federal funding, counties have more flexibility to meet their financial and programmatic needs. Ultimately, the new, post-ACA context provides new opportunities for counties to redesign safety-net programs.



Recommendations

President's Immigration Order Will Further Change Composition of Remaining Uninsured

The President's executive order on immigration further changes the composition of the remaining uninsured population. It also calls the question about whether safety-net programs need to be reoriented and shapes our recommendations.

President Obama's executive order offers administrative relief from deportation to potentially over a million Californians. While these individuals are excluded from federally funded health programs, California has a history and policy of covering certain immigrant populations excluded by the federal government. As a result of the expanded "deferred action" status, more Californians living under 138% of the federal poverty level will be eligible for state-funded Medi-Cal coverage. Currently, DREAM Act students, or those under the "Deferred Action for Childhood Arrivals" designation, are already eligible for such coverage. The Governor's budget acknowledges this potential, and, while not providing a specific number in the budget, it also does not propose to change the eligibility rules that allow these Californians to receive coverage.

Counties that provide care for the undocumented will find more, but not all, of this population will be covered by state Medi-Cal. Counties that do not serve the undocumented, and have income eligibility that goes above 138% of the federal poverty level, will have new entrants for their county-based indigent programs. When the federal government issues deferred action status, these individuals will likely qualify for county indigent care programs. While the state will cover those under 138% of the federal poverty line, those above that threshold will qualify for a county program, depending on how high the income eligibility is in that county.

The fiscal impact on counties may be minimal—the AB 85 formula that most counties chose was designed to take into account both new costs and new revenues for a county's health care safety-net. To the extent that a county now has additional costs in covering a population that has emerged under existing eligibility rules, those costs are available to be reimbursed by the state.

Ultimately, the President's order provides a platform to finish the job of providing some form of care and coverage to all county residents..

Recommendations

Key decisions will be made by counties throughout the state in the next couple of months and in the next year, on both whether they are maximizing the opportunities in the law to enroll Californians in federally-funded coverage, and what kind of safety-net will exist for the remaining uninsured. This survey provides a quick snapshot of what counties are doing now, what they are thinking about doing in the future, and recommendations for action at both the county and state level. Based on our survey and our advocacy work, Health Access offers the following recommendations:

Counties should continue to take advantage of opportunities to enroll people into federally funded coverage available under the ACA, including Medi-Cal and Covered California. Counties have been on the front line of this work, which benefits consumers, communities, counties, and the health care system as a whole.

- Encouraging Californians to enroll in federally-funded coverage should not be done by eliminating safety-net services and options. Despite all efforts to enroll people into federally-funded coverage, there will undoubtedly be individuals who are left without coverage for a variety of reasons, including individuals who miss open enrollment, and individuals experiencing a life-changing event, such as the loss of a job or divorce.

Counties should maintain strong safety-nets through coverage-like programs that provide primary and preventive care, learning the best lessons from the Low-Income Health Programs that facilitated early expansion of Medi-Cal.

- **Counties that do not serve the undocumented should reconsider this policy, and focus their indigent care programs on the remaining uninsured population** that actually has the most need for a safety-net after implementation of the Affordable Care Act.
- **All counties should offer a safety-net in a smarter way, providing more comprehensive services including a medical home** that provides primary and preventive care, access to specialty care and hospitalization services, similar to Healthy San Francisco or My Health LA.

Just as the Low-Income Health Programs were a “bridge to health reform,” **the new county-based programs should be a “bridge to a statewide solution,”** solutions like SB 4 (Lara), that would extend affordable coverage to all Californians, regardless of immigration status.