

# The American Recovery and Reinvestment Act of 2009

## Maximizing Opportunities for Health

Prepared by Peter Harbage Consulting for The California Endowment

*Prepared by:*



---

## **Table of Contents**

Introduction .....	2
American Recovery and Reinvestment Act of 2009: Clinic Funding and California .....	3
American Recovery and Reinvestment Act of 2009: Cobra Continuation Health Coverage and California.....	5
American Recovery and Reinvestment Act of 2009: Primary Care and Public Health Workforce.....	7
American Recovery and Reinvestment Act of 2009: Prevention, Wellness and Comparative Effectiveness and California .....	9
Federal 2009 Omnibus Appropriations Bill: State Health Access Grants .....	11
American Recovery and Reinvestment Act of 2009: Chart Summary .....	13

## Introduction

The American Recovery and Reinvestment Act of 2009 (ARRA) is an unprecedented opportunity for California to invest in improving the health of its citizens. But to claim the billions of dollars available, California will need to take new actions and act decisively. To aid in this effort, The California Endowment with support from Harbage Consulting have developed the following series of short California-specific briefs on the opportunities present in the ARRA, specifically focusing on those that improve the social determinants of health and clinical prevention efforts. These briefs have focused on the key facts that policymakers need to know to begin the process of positively affecting change.

A summary of each brief follows.

- **Prevention and Wellness and Comparative Effectiveness Funds:** Through \$4 billion in funding for block grants to state and local public health departments and funding for comparative effectiveness research, we can reduce health care costs and improve the quality of life for many Americans. This funding will help support evidence-based disease prevention, reduce hospital infections, and fund immunization programs.
- **Training Primary Care Providers:** \$600 million to address shortages and prepare our country for universal health care by training primary health care providers, including doctors, dentists and nurses. The funds would also help pay medical school expenses for students who agree to practice in underserved communities through the National Health Service Corps. In addition, the Recovery Act includes other job training and development dollars that may be leveraged for health care workforce.
- **Community Health Centers:** \$1.5 billion, including \$500 million to increase the number of uninsured Americans who receive quality health care through clinics,

and \$1 billion to renovate clinics and make health information technology improvements.

- **COBRA Healthcare for the Unemployed:** \$30.3 billion to extend health insurance coverage to the unemployed, and extend the period of COBRA coverage for older and tenured workers beyond the 18 months provided under current law.
- **Indian Health Service Facilities:** \$550 million to modernize aging hospitals and health clinics, and make health care technology upgrades to improve health care for underserved rural populations.

## American Recovery and Reinvestment Act of 2009: Clinic Funding and California

As a critical part of the U.S. safety net, community clinics provide accessible, affordable primary care to low-income families, and medical homes to more than five million children.<sup>1</sup> These clinics also have also been shown to improve health outcomes and reduce costs. Communities with health centers have 10 percent lower infant mortality rates than communities without health centers, and low-income mothers served by health centers are less likely to have low birth weight babies.<sup>2</sup> In addition, community health centers have been shown to reduce pediatric emergency room use by 38 percent.<sup>3</sup> Community health centers have seen a growing level of support over the last several years through the President's Initiative, which has provided millions of dollars in grant funding since 2002.

### Goal and National Impact of the ARRA Provisions

The ARRA offers significant support to America's community health centers. While workforce and other supports are available, there are two major sources of funds to support infrastructure and service delivery efforts:

- \$500 million in grants were available to health centers that operate under section 330 of the Public Health Service Act ("PHS Act"):
  - o *New Access Point Grants* (\$155 million): The New Access Point Grants program had accepted applications from new clinics in December 2007, but none of those applications was awarded a grant due to lack of funds in the program. The ARRA funds were used to support this grant program, and provided grants to 126 new community health centers, which had submitted applications in December 2007. These grants are to be used either to open new service sites at existing

health centers, or to transform existing clinics and Federally Qualified Health Centers (FQHCs) look-alikes into section 330-funded health centers – qualifying them for additional federal funding.

- o *Increased Demand for Services (IDS) Grants* (\$338 million): In March, existing clinics were eligible to submit requests for grants to help them meet the increased demand for their services, particularly among the newly uninsured, due to the economic downturn. Unlike the first round of grants, which were for new health center sites, clinics can use these funds for operational needs such as staffing and extending hours of operation or existing services. The grant dollars were allocated to clinics based on a formula where every clinic receives a \$100,000 base allocation, plus \$6 for every patient plus an additional \$19 for every uninsured patient served, over a two-year period<sup>4</sup>. This is similar to the existing special population funding proportion.
- \$1.5 billion is still available as grants, "for construction, renovation and equipment, and for the acquisition of health information technology systems for health centers, including health center controlled networks receiving operating grants under section 330 of the PHS Act, notwithstanding the limitation in section 330(e)(3)."

Section 330 of the Public Health Service Act defines health centers as "not-for-profit organizations which provide preventative and primary care services to the uninsured and underserved populations, often in collaboration with other community organizations."

### Key California Questions and Impact

Of the \$2 billion available, the federal government has already made two sets of grant awards available.

	Grants for California	Percent of Total Federal Funding	Jobs Saved or Created	New Patients Served
New Access Point Grants	\$15.6 million (to 12 grantees)	10.1%	600	80,890
Increased Demand for Services Grants	\$48.1 million (to 117 grantees)	14.2%	896	303,474 (including 148,376 uninsured)

SOURCE: HHS Recovery website at [www.hhs.gov/recovery/](http://www.hhs.gov/recovery/).

The remaining funding available for California clinics will be a share of the \$1.5 billion for construction, equipment and health information technology. The Department of Health and Human Services (HHS) has indicated that these dollars may be allocated along the lines of the IDS grants where clinics will receive some funding based on a formula, but also be able to apply for competitive grants. If California continues to receive between 10 to 14 percent of the funding, this will mean between \$150 and \$210 million, which will protect or create thousands of jobs and help clinics serve hundreds of thousands of patients – including the more than 2.5 million children who rely on community clinics and community hospitals for their usual source of care.<sup>5</sup>

The final plan for how the remaining funds will be spent is due from HHS no later than 90 days from enactment, or no later than August of 2009.

#### Next Steps for California

California's foundations as well as state clinic associations could take the following steps to make sure that the state's clinics are competitive in future grant application cycles:

- Monitor the development of grant programs at the federal level, and provide timely and specific technical assistance to clinics on an on-going basis.
- Grants are likely to go to projects which are "shovel ready," and can demonstrate a significant impact in increasing patients served and in creating jobs. Foundations should help clinics identify those projects and begin work on gathering the type of information clinics need to develop strong grant applications.
- Retain grant writers to support clinics in developing grant applications.
- Convene leaders in the community health clinic community to create a strategic vision such that construction funds are not just being requested by individual clinics, but that they are being leveraged to develop systems of care for California's safety net, particularly for children.

Additional information on how these ARRA funds are being allocated will be available through the HHS recovery plan website at [www.hhs.gov/recovery/](http://www.hhs.gov/recovery/).

<sup>1</sup> National Association of Community Health Centers, "Health Centers and SCHIP: Improving Access to Care for Kids," June 2007.

<sup>2</sup> National Association of Community Health Centers, "America's Health Centers," August 2008.

<sup>3</sup> See for example: Gold, M. and Rosenberg, R., "Use of Emergency Room Services by the Population of a Neighborhood Health Center", *Health Services Reports* 89,1 (January-February 1974): 65-70; Hockheiser, L., Woodward, K., and Charney, E., "Effect of the Neighborhood Health Center on the use of Pediatric Emergency Departments in Rochester, New York," *285 New England Journal of Medicine* 148 (July 15, 1971): 148-152; Moore, G., Bonnano, R., and Bernstein, R., "Effect of a Neighborhood Health Center on Emergency Room Use", *Medical Care* 10,3 (May-June 1972): 240-247.

<sup>4</sup> Health Resources and Services Agency, "ARRA Briefing Update: Increased Demand for Services." Grantee Technical Assistance Conference Call, March 10 2009. [http://bphc.hrsa.gov/recovery/ARRABriefing\\_IDS.pdf](http://bphc.hrsa.gov/recovery/ARRABriefing_IDS.pdf)

<sup>5</sup> University of California Los Angeles, California Health Interview Survey, 2007.

## American Recovery and Reinvestment Act of 2009: COBRA Continuation Health Coverage and California

In January 2009, the rate of unemployment in California had reached 10.1 percent – 2.5 percentage points higher than the national unemployment rate.<sup>6</sup> According to the Bureau of Labor Statistics, more than 1.8 million Californians are without work. As nearly 50 percent of California children receive their health insurance through a family member's employer,<sup>7</sup> rising unemployment is likely leading to rising uninsurance among families. ARRA provisions will help many of the recently unemployed to be able to afford to keep their health coverage.

### Goal and National Impact of the ARRA Provisions

The American Recovery and Reinvestment Act (ARRA) provides federal subsidies to help the unemployed keep their health insurance. Under the 1985 Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), eligible employees are able to continue their employer-sponsored health insurance after losing their jobs. While the federal law exempted businesses with less than 20 employees from COBRA, California has a law which extends similar protections to former employees of businesses with 2 to 19 employees.

The original COBRA legislation requires former employees to pay the full premium costs of their coverage, plus a 2 percent administrative fee. For workers who have lost a job with a small firm covered by California's Cal-COBRA, the administrative fee is a full 10 percent of the premium costs.<sup>8</sup> With employer-sponsored coverage premium costs averaging \$4,036 for an individual and \$11,493 for a family in California in 2006,<sup>9</sup> COBRA coverage is too expensive for many unemployed Californians to afford.

ARRA includes a number of provisions designed to make it easier for families to purchase health coverage under COBRA, including \$24.7 billion

in premium subsidies. The key ARRA provisions on this issue are:

- *Subsidies for 65 Percent of COBRA Premium Costs:* Individuals and families will only have to pay 35 percent of the cost of their COBRA coverage for nine months of the 18-month COBRA eligibility period. Today, families in California pay an average of just 27 percent of their premium costs (16 percent for individuals) with employer-sponsored coverage, which means that while 35 percent is more than they would have paid while employed, the subsidy will provide immediate financial relief to those who are eligible. In an improvement on other health care subsidy programs, such as the Health Care Tax Credit, the federal government will reimburse employers or insurers for the amount of the subsidy, and families won't have to pay the full costs up front and wait for federal reimbursement.
- *New Choices Under COBRA:* ARRA also tries to make coverage more affordable by allowing employers to give families the option to switch from their current health plan to any other lower cost plan they currently offer.
- *Eligibility:* Only those whose employment has been involuntarily terminated since September 1, 2008, going forward through December 31, 2009 and who are also eligible for and elect COBRA or Cal-COBRA continuation coverage are eligible for the subsidy. As COBRA allows workers to purchase insurance through their former employer's plan, that plan must be in effect for unemployed workers to be COBRA eligible. If the company goes out of business or completely terminates their employee health coverage plan, COBRA no longer applies.
- *Income Guidelines:* The full 65 percent subsidy is available to individuals earning less than \$125,000, and families earning less than \$250,000. Individuals and families whose gross income for the whole

taxable year may exceed that amount are still eligible to receive the subsidy now when they may need it. If their incomes go back up during the year, the subsidy will be recouped as taxes, with the repayment phasing out for individuals earning up to \$145,000 and families earning up to \$290,000.

- *Extending the Take-Up Period:* Under the original COBRA language, workers had only 60 days to decide to purchase coverage. Recognizing that many of the already unemployed in this economic downturn may not have taken up COBRA due to the cost, this gives a number of families a second chance at health coverage. The take-up period extension applies to those individuals involuntarily terminated between September 1, 2008 and the enactment of ARRA on February 17, 2009. Families who take up COBRA coverage in this extension period will not be required to pay premiums back to the day they lost their coverage, as is the requirement under the original COBRA law. Instead, coverage generally begins in March 2009 [more precisely, it begins the first coverage period after February 17], and families are only responsible for paying their 35 percent share from March going forward. States have the option to similarly extend the take-up period under their continuation laws. California AB 23 would extend the take-up period for Cal-COBRA.

#### **Key California Questions and Impact**

The amount of COBRA subsidies dollars California will receive will depend on individuals and families electing coverage, and being able to afford their 35 percent premium contribution. Insurance plans are required to notify qualified beneficiaries, including those already laid-off, of their new COBRA rights under ARRA. The Secretary of Labor is required to lead federal outreach to employers, health plans and states to support those efforts.

Despite the 65 percent subsidy, there may be Californians who still cannot afford to pay for their COBRA coverage. Under ARRA, eligible individuals are not themselves required to pay their share of the premium. Massachusetts has already announced it will combine its existing program which uses state funds to help low- and middle-income families pay the costs of COBRA with the ARRA initiative to help further offset the costs.<sup>10</sup>

Most of the ARRA COBRA provisions automatically apply to those individuals covered by Cal-COBRA. The exception is the special election period for those who were involuntarily terminated from their jobs and became eligible for Cal-COBRA between September 1, 2008 and February 17, 2009, but did not take up that coverage. The California State Legislature is currently considering a bill which would extend the ARRA COBRA provisions to those individuals and families. The deadline for businesses to send notices to employees regarding their eligibility for the special election period was April 18, 2009.

#### **Next Steps for California**

California's foundations could support outreach efforts to help California families take advantage of the COBRA subsidy.

- *Supporting businesses:* The Department of Labor has developed many materials for businesses to use in notifying employees of their eligibility for premium assistance, as well as for the special election period. Small businesses which do not have access to human resources support could use help in understanding their responsibilities and how to notify employees. Foundations could fund or direct efforts to assist small businesses.
- *Supporting Cal COBRA:* If the California Legislature extends ARRA COBRA provisions to the small business employees covered by Cal-COBRA, there will be an even greater need for technical support for small businesses and in developing outreach materials.

- *Supporting families:* There are several ways foundations can help support California families at risk of losing their health coverage through unemployment:
  - *Outreach.* As the burden of taking up COBRA coverage falls on families, there is an opportunity for the foundations to lead a general outreach effort targeting Californians who may be eligible. This outreach effort could include a website and ad campaign educating consumers about their rights and where to go with questions.
  - *Further premium assistance.* For many unemployed families trying to make ends meet with reduced income due to unemployment, even paying just 35 percent of their COBRA premium may be too much. Foundations can encourage and support community organizations screening families for public programs or other types of medical assistance to see if they are COBRA eligible. Helping families pay their 35 percent premiums may be a more cost effective way of keeping Californians covered. Keeping families covered under one plan supports children’s health – when the whole family is covered children are more likely to access care when they need it.<sup>11</sup>

## American Recovery and Reinvestment Act of 2009: Primary Care and Public Health Workforce

The American Recovery and Reinvestment Act (ARRA) includes funding to address the health professions workforce shortage which California, like the nation, is experiencing particularly in primary health care providers such as pediatricians and dentists. Nationally, studies have suggested that there will be shortage of 124,000 physicians across the country by 2025, and 37 percent of that shortage is in primary care.<sup>12</sup> California already has a “barely adequate” supply of primary care physicians statewide, although geographic disparities have resulted in some counties already having shortages of both primary care and specialty physicians.<sup>13</sup>

### Goal and National Impact

ARRA invests \$500 million in addressing health care workforce shortages, including:

- The National Health Service Corps will receive \$75 million to continue to help primary care providers repay student loans in exchange for two years of service in an area with a high shortage of health professionals. The providers eligible for these grants and scholarships include primary care physicians such as pediatricians, nurse practitioners, primary care physician assistants, dentists, and mental health providers. Twenty percent of these funds must be used for field operations.
- The remaining \$425 million is to be used for programs authorized in the Public Health Services Act (PHS), including:

<sup>1</sup> Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics.

<sup>2</sup> University of California, Los Angeles, California Health Interview Survey, 2007.

<sup>3</sup> Kaiser Family Foundation, State Health Facts, 2007 data.

<sup>4</sup> Kaiser Family Foundation, State Health Facts, 2006 data.

<sup>5</sup> Cooney, Elizabeth, “Boost to health coverage planned,” Boston Globe, March 9, 2009.

<sup>6</sup> See for example, Lambrew, Jeanne, “Health Insurance: A Family Affair,” The Commonwealth Fund, May 2001.

- o *General*: Providing “scholarships, loan repayment, and grants to training programs for equipment as authorized in the PHS Act.”
- o *Telemedicine* (Section 330L): Grants to states to reduce the statutory and regulatory barriers to telemedicine, allowing doctors to treat patients remotely.
- o *Primary Care* (Section 747): Funds training for primary care physicians, including family physicians and general pediatricians, particularly those who provide care to the underserved.
- o *Public Health* (Section 767): Traineeships for students seeking graduate training in public health fields, particularly those fields with a workforce shortage.
- o *Public Health Dentistry* (Section 767): Funding to create training centers and provide financial assistance for students of public health dentistry.

It does not appear that there is funding to specifically address the nursing shortage, although some of the general funding may be used for that purpose. In addition to the ARRA funding outlined here, the President’s Budget included \$330 million for health care workforce training. The ARRA also included significant funding for general workforce training, including \$3.95 billion under the Workforce Investment Act, that while not specifically targeted for health care may be able to be used for health care workforce.

#### **Key California Questions and Impact**

The Department of Health and Human Services (HHS) has yet to release guidelines on exactly how the \$500 million in workforce development dollars will be dispersed. These forthcoming rules will determine the impact on California’s health professions workforce, as will whether

or not the organizations and individuals eligible for the grants seek to apply for them.

- *National Health Service Corps*: California has significant opportunities to benefit from the workforce development grants. Every county in California has Health Professional Shortage Areas (HPSA) which may receive health professionals participating in the National Health Service Corps for primary, dental or mental health care. Several California counties have a large number of HPSAs, including Los Angeles County with 43 and San Diego County with 24. Whether California will see an increase in health professionals in these areas will depend in large part on whether medical students choose to apply for the grants and relocate within the state. This program could increase availability of pediatricians and other pediatric primary care providers for California’s underserved children.
- *Telemedicine*: California has been moving forward to define and expand telemedicine in the state since the Telemedicine Development Act of 1996. Thus, California has already taken the first legal steps to encouraging the wide use of telemedicine in the state.<sup>14</sup> The Medical Board of California had previously sought to create a program to create a telemedicine registration program to allow physicians in other states to register in California without requiring full licensure, which would require action by the state legislature. This effort could be assisted with the increased PHS Act Section 330L funding.
- *Primary Care*: This program was authorized in 1963, and although it was not reauthorized in 2002, it was funded through 2008. The 2009 budget did not request funding for the program in order to focus funding directly on placing health care providers in areas that face shortages.<sup>15</sup> Although HHS may consider distributing funds through this program, it seems unlikely.

- *Public Health Dentistry*: California did not receive any funding through this program in 2008, although the University of California's School of Dentistry does have a Department of Dental Public Health and Hygiene – one of a limited number of programs in the country eligible for funding through this program.

### Next Steps for California

For most of the programs which may be funded by the workforce dollars in ARRA, California's foundations could play a key role in reaching out to the organizations across California to:

- Facilitate coordination among eligible entities and existing stakeholders to leverage funding, and to target those dollars to be most effective in addressing California's workforce needs.
- Publicize the availability of the grants, and provide technical assistance to those eligible in submitting grants.
- Reach out to stakeholders, which could be able to effectively use telemedicine grant dollars, such as the California Center for Connected Health, to establish an out-of-state physician registry system and facilitate that grant-writing process. Another use of funding could be to target telemedicine dollars towards expanding access to pediatric specialists.
- Investigate the possibility of using grant dollars to address the key causes of workforce shortages in California, including low Medi-Cal reimbursement rates and payment disparities in primary care.

## American Recovery and Reinvestment Act of 2009: Prevention, Wellness and Comparative Effectiveness and California

Children are increasingly at risk for developing chronic diseases. For example, the percent of children and youth who are overweight has tripled since 1980.<sup>16</sup> Coordinating investments in clinical and community-based prevention and wellness strategies with comparative effectiveness research can help children grow up healthier and improve the quality of care they receive if they do get sick.

### Goal and National Impact of ARRA Provisions

The American Recovery and Reinvestment Act (ARRA) makes a significant investment of \$2.1 billion to fund prevention and wellness activities, as well as comparative effectiveness research.

The ARRA appropriated \$1 billion for a "Prevention and Wellness Fund," including:

- *Immunizations*: The Centers for Disease Control and Prevention (CDC) will receive \$300 million for immunization programs authorized by section 317 of the Public Health Service Act (PHS Act).
- *Prevention of Chronic Disease*: The U.S. Department of Health and Human Services (HHS) will receive \$650 million to promote prevention and wellness strategies targeted at reducing chronic disease which are authorized by the PHS Act.
- *Healthcare Associated Infections*: State governments will receive \$50 million to reduce healthcare associated infections.

An additional \$1.1 billion for comparative effectiveness research (CER), to be distributed as follows:

<sup>12</sup> Dill, Michael J. and Edward S. Salsberg, "The Complexities of Physician Supply and Demand: Projections Through 2025," Center for Workforce Studies and the Association of American Medical Colleges, November 2008.

<sup>13</sup> Grumbach, Kevin, MD, Andrew Bindman, MD, and Arpita Chattopadhyay, PhD, "The California Physician Supply Re-Count: Fewer and More Specialized," University of California San Francisco for the California HealthCare Foundation and the University of California Program on Access to Care," October 2008. <http://www.chcf.org/documents/MPM-Sacto10-30-08Grumbach.pdf>

<sup>14</sup> <http://www.medbd.ca.gov/licensee/telemedicine.html>

<sup>15</sup> Health Resources and Services Administration, "Justification of Estimates for Appropriations Committees, Fiscal Year 2009," <ftp://ftp.hrsa.gov/about/budgetjustification09.pdf>.

<sup>16</sup> Partnership to Fight Chronic Disease, "An Unhealthy Truth: Rising Rates of Chronic Disease and the Future of Health in America," accessed April 5, 2009.

- *The Agency for Healthcare Research and Quality (AHRQ)* will receive \$300 million to build on its Effective Health Care program, which both conducts original research and synthesizes existing research on health care for patients, doctors and policymakers.
- *The National Institutes of Health (NIH)* will receive \$400 million for CER under section 301 and title IV of the PHS Act.
- *HHS* will also receive \$400 million for research comparing the “clinical outcomes, effectiveness and appropriateness” of medical treatments. The funds can also be used to encourage the development and use of medical technologies to help collect the outcomes data required for CER.

The Institute of Medicine will recommend research priorities for the agencies receiving CER funds, and guidance from a new Federal Coordinating Council for Comparative Effectiveness Research will also help coordinate efforts.

#### Key California Questions and Impact

More information is needed from the federal government on how these diverse funding streams will be disbursed, but there are likely to be numerous opportunities for California to receive grants.

- *Immunizations:* California is already slated to receive more than \$23.4 million in section 317 immunization grants, or 12 percent of the immunization funds directly dispersed to states.<sup>17</sup> The amount was determined by an established federal formula, and the funds will be used to provide vaccines to low-income children and adults who do not qualify for Medicaid vaccine programs. The 2009 President’s Budget called for California to receive \$54.3 million for the section 317 immunization program, which was approximately 12 percent of total section 317 grants that year. These funds will go directly towards improving health

outcomes for California’s children by expanding access to immunizations.

- *Clinical/Community-Based Prevention and Wellness Pilots:* The ARRA calls for investing in evidence-backed, community-based disease prevention programs and includes accountability measures to ensure the funding is being used to directly improve the health of Americans. Many of these efforts have been supported by private resources through the efforts of philanthropy, Kaiser Permanente and Safeway. A key question for the state is how the prevention and wellness grants could be used to support or expand these efforts.
- *Comparative Effectiveness Research:* California’s medical research centers make the state likely to benefit from the investment in CER funding. There is one “Evidence-based Practice Center” in California participating in the AHRQ Effective Health Care program: the Southern California Evidence-based Practice Center at RAND in Santa Monica.

#### Next Steps for California

The impact of prevention, wellness and research funding on California depends on the state’s ability to pull in money through successful grant applications. In addition:

- *California Grants Clearinghouse:* In the immediate term, California’s foundations, the research centers and government agencies should monitor and analyze government guidance as it is released on how these different categories of grants will be distributed. The state, the University of California or a foundation could proactively undertake this monitoring and establish a clearinghouse for grant opportunities available for California applicants. This clearinghouse could also provide help with grant writing or other technical assistance.

- *Prevention:* California foundations and/or the state could begin working on identifying prevention and wellness activities around chronic disease that may serve as the basis of a grant application. These should include both existing projects which need additional funding, and potential projects which could be kick-started by the federal grants. California foundations could convene state and local government representatives, community-based organizations and advocates for this purpose. Such a convening could also lay the groundwork for a coordinated effort to bring prevention grant dollars into the state.
- *Healthcare Associated Infections:* Foundations already conducting work around healthcare acquired infections should begin exploring how their efforts may be combined with state agency efforts in applying for, or making efficient use of, the state grants.
- *Comparative Effectiveness Research:* Foundations interested in leveraging the comparative effectiveness research grant dollars could fund a process to connect researchers at the “Evidence-based Practice Centers” with other interested researchers to identify projects and collaborative partnerships.

## Federal 2009 Omnibus Appropriations Bill: State Health Access Grants

Following the 2007 debate over comprehensive health reform, California policymakers and stakeholders have been seeking ways to expand coverage to the state’s uninsured populations, including 683,000 children and more than 1.2 million low-income adults.<sup>17</sup> The State Health Access Grants, authorized in the Federal 2009 Omnibus Appropriations Bill, offer an opportunity for California to receive federal dollars to provide some limited assistance for expanding coverage.

### Goal and National Impact

These grants will provide a limited amount of funds to support new state efforts to expand access to affordable health coverage for the uninsured. States can use the grants for programs which target specific populations, such as uninsured children, or for comprehensive expansion efforts. The grants can be used for a range of programs, including:

- Shared responsibility or “three share” reform plans which require contributions from the government, employers and the individual;
- Reinsurance to subsidize insurer losses;
- Subsidized high-risk insurance pools;
- Premium assistance for private coverage programs;
- State insurance “connectors” that provide access to affordable, portable coverage for small employers and workers not usually eligible for employer-sponsored coverage;
- Statewide or automated enrollment systems for public programs; and
- Strategies to insure low-income childless adults.

<sup>17</sup> U.S. Department of Health and Human Services, “American Recovery and Reinvestment Act, Section 317 Immunization Funding,” accessed April 13, 2009 at <http://transparency.cit.nih.gov/RecoveryGrants/grant.cfm?grant=vaccines>

<sup>18</sup> University of California, Los Angeles, California Health Interview Survey, 2007 Data. [www.chis.ucla.edu](http://www.chis.ucla.edu).

The total amount of grant funding available to a given state is limited. Grants for comprehensive coverage will provide states between \$7 and \$10 million per year, and grants for targeted population expansions will total between \$2 and \$4 million per year. The grants will be available over a five-year period, subject to state's meeting agreed-upon benchmarks. States must match 20 percent of the federal grant using public or private dollars unless they can prove financial hardship, and states must also show the programs will be sustainable once the grant period ends.

### Key California Questions and Impact

California is well-positioned to take advantage of these grants. Following the 2007 debate, policymakers have been actively working on how to expand coverage to targeted populations of uninsured in the state. Already, several California legislators have proposed a bill to provide all uninsured children in the state with access to affordable coverage by building on existing public coverage programs. State policy-makers and stakeholders are also exploring the possibility of seeking a Section 1115 Waiver to provide coverage to low-income childless adults through the state's Medicaid program, Medi-Cal. Either or both of these efforts would likely qualify for grant funding from the federal government.

Final rules on the grant application and process have not yet been released by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA). When those rules are released, California policy-makers are likely to have questions regarding how best to proceed.

### Next Steps for California

California's foundations have already been actively supporting efforts by policymakers, advocates and other stakeholders to build consensus and support around proposals to expand coverage to children and low-income childless adults. Steps should now be taken to:

- Identify the proposals which are most likely to receive wide support in the state, which

are sustainable for the state given the ongoing budget crisis, and which are likely to receive support from the federal State Health Access Grants program.

- Think creatively about how the limited funds available through the grant may best be leveraged to help expand coverage in California. For example, the grants could be used for subsidies to support enrollees in the high risk pool, or to develop an auto-enrollment mechanism to support a coverage expansion.
- Identify potential sources of matching funds in California, including state funds or private funds, given the state's ongoing budget difficulties.
- Convene stakeholders and the state, and providing technical support in writing the grant and managing the grant process.

### ARRA 2009 Summary Chart

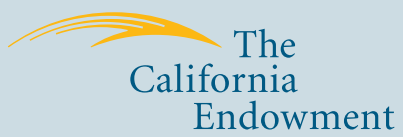
Issue Area	Agency Responsible for Disbursing Funds	Organizations Eligible for Funding	Timeline for Funding Release	Total Funding Available
<b>Prevention, Wellness and Comparative Effectiveness</b>				
Immunizations	CDC	PHS Act Section 317 Services	Disbursed	\$300 million – CA received \$23.4 million
Chronic Disease Prevention	HHS	Program authorized by PHS Act. More details to come from HHS.	To be determined.	\$650 million
Healthcare Acquired Infections	HHS	State governments	To be determined.	\$50 million
Comparative Effectiveness	AHRQ, NIH and HHS	Evidence-based Practice Centers - in California this is the Southern California Evidence-based Practice Center at RAND in Santa Monica.	To be determined.	\$1.1 billion in total. AHRQ, which operates the evidence-based practice center program, will receive \$300 million.
<b>Community Health Centers and Clinics</b>				
New Access Point Grants	HRSA	New Federally Qualified Health Centers	Disbursed	\$155 million – CA received \$15.6 million
Increased Demand for Services	HRSA	Existing Federally Qualified Health Centers	Disbursed	\$338 million – CA received \$48.1 million
Construction/ HIT Grants	HRSA	Federally Qualified Health Centers (public or non-profit health centers as defined by Section 330 of the PHS Act)	Information should be released by August 2009	\$1.5 billion
<b>Public Health Workforce</b>				
National Health Service Corps	HRSA	The following types of primary care providers working at an approved site in a Health Professional Shortage Area (two-year commitment): <ul style="list-style-type: none"> <li>• Primary care physicians: MD or DO in family practice, internal medicine, pediatrics, obstetrics-gynecology, psychiatry</li> </ul>	Applications to be available in coming months	\$75 million in total – each provider eligible to receive up to \$50,000 to help repay student loans.

ARRA 2009 Summary Chart (continued)

Issue Area	Agency Responsible for Disbursing Funds	Organizations Eligible for Funding	Timeline for Funding Release	Total Funding Available
<b>Public Health Workforce (continued)</b>				
		<ul style="list-style-type: none"> <li>• Primary care nurse practitioners</li> <li>• Certified nurse-midwives</li> <li>• Primary care physician assistants</li> <li>• Dentists: general or pediatric</li> <li>• Dental hygienists</li> <li>• Behavioral and mental health providers: health service psychologists, licensed clinical social workers, psychiatric nurse specialists, marriage and family therapists, and licensed professional counselors</li> </ul>		
Assorted PHS Programs	HHS	No details yet announced	No details yet announced	\$425 million
<b>COBRA</b>				
COBRA Subsidies	DOL	<p>Individuals who meet the following conditions:</p> <ul style="list-style-type: none"> <li>• Involuntarily lost their jobs since September 1, 2008;</li> <li>• Had health insurance through their employer, and whose employer continues to offer coverage to current employees;</li> <li>• Full subsidy available for individuals earning less than \$125,000 and families earning less than \$250,000. Subsidies phase out up to individuals earning \$145,000 and families earning \$290,000 per year.</li> </ul>	On-going	Up to 65% of COBRA premiums for a 9 month period.

ARRA 2009 Summary Chart (continued)

Issue Area	Agency Responsible for Disbursing Funds	Organizations Eligible for Funding	Timeline for Funding Release	Total Funding Available
<b>State Health Access Grants (not ARRA)</b>				
Grants to expand access to coverage for the uninsured	HRSA	States	Applications due June 16, 2009	Up to \$10 million per state



**The California Endowment**  
1000 North Alameda  
Los Angeles, CA 90012  
800.449.4149  
213.928.8801 (fax)  
[www.calendow.org](http://www.calendow.org)