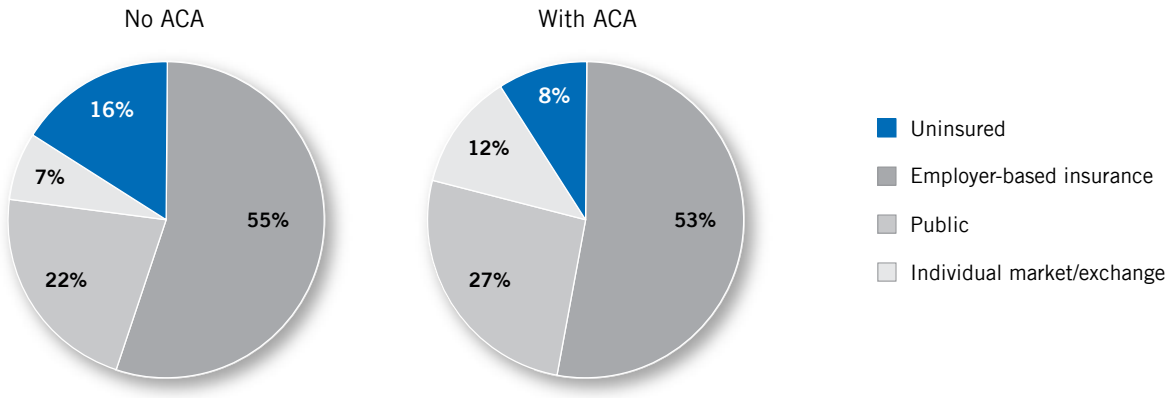
THE AFFORDABLE CARE ACT USHERS IN SWEEPING CHANGES IN CALIFORNIA

California is on the verge of historic changes to its health care system as the result of federal health care reform. The Affordable Care Act (ACA) represents sweeping policy changes intended to expand health care coverage, reform the financing and delivery of services, and advance prevention and wellness efforts. California has embraced reform, enacting state legislation to implement many key elements of the ACA—including creation of a state-based insurance marketplace, expansion of Medi-Cal (the state's Medicaid program), simplification of eligibility and enrollment systems, and reform of the insurance market.

Despite California's substantial progress and commitment, much remains uncertain about how these changes will reshape health care in the state. Some of this uncertainty stems from lack of federal guidance. But some of it relates to California itself—its size and diversity, its existing programs and capacity, and its implementation decisions. Connecting millions of previously uninsured Californians to available coverage options and facilitating simple, streamlined enrollment will undoubtedly come with challenges. Expanding health insurance to millions could also strain existing provider networks. The next several years will require considerable monitoring, oversight, and adjustments to fulfill the potential that federal health care reform offers.

THE ACA COULD CUT THE NUMBER OF UNINSURED CALIFORNIANS IN HALF BY 2019



SOURCE: UC Berkeley–UCLA CalSIM model, Version 1.8, enhanced scenario estimates.

MEDI-CAL IS EXPANDING

Medi-Cal provides health insurance to low-income people. To qualify for Medi-Cal, individuals were once required to earn a low income and to have either a dependent child or qualifying disability. As of January 2014, single adults with no dependent children are also eligible for the program. In addition, income eligibility has increased to 138 percent of the federal poverty level (about $16,000/year for an individual or $32,500/year for a family of four). As a result of these changes, an estimated 1.4 million Californians are expected to become eligible for the program.

- **Medi-Cal is the state's second-largest General Fund expenditure after K–12 education.**
  In the 2013–2014 budget, the Medi-Cal program will spend an estimated $69.5 billion, with $16.1 billion coming from the General Fund. These expenditures will provide services for more than 10 million Californians. The Medi-Cal expansion to single adults will be funded entirely by the federal government for the first three years—the current state budget assumes about $1.5 billion in federal funds to provide coverage to newly eligible enrollees.

- **Medi-Cal will be serving many more Californians.**
  Nearly 635,000 Californians made newly eligible for Medi-Cal by the ACA are expected to enroll during the first six months of 2014. Medi-Cal enrollment has also increased substantially as nearly 900,000 children have transitioned into Medi-Cal from California's Healthy Families Program, the state's version of the federal Children's Health Insurance Program.

- **Enrollment in Medi-Cal managed care plans is expanding across the state.**
  In 2012, slightly more than 60 percent of Medi-Cal beneficiaries received services through managed care health plans instead of fee-for-service payments—and this number is expected to increase substantially in the coming years. Specifically, managed care is expanding to 28 rural counties and also to many seniors and people with disabilities, including those who are eligible for both Medi-Cal and Medicare. This shift to managed care is intended to provide better, more coordinated care and to help control costs.

COVERED CALIFORNIA, CALIFORNIA'S NEW INSURANCE MARKETPLACE, OPENS FOR BUSINESS

New health insurance marketplaces where individuals and small businesses can shop for, compare, and enroll in health plans are a cornerstone of the ACA coverage expansions. California chose to establish a state-based marketplace, called Covered California, and is taking an active role in shaping the coverage options available. Individuals with incomes up to 400 percent of the federal poverty level ($92,200/year for a family of four) will be able to use federal tax credits to subsidize the cost of coverage purchased through Covered California. Certain small businesses will also be eligible for tax credits to offset insurance costs.

- **Enrollment efforts are ambitious.**
  Covered California is targeting enrollment efforts to more than 5 million Californians—primarily people who are uninsured and those who directly purchase coverage in the individual insurance market. Slightly more than half of these Californians could be eligible for federal subsidies, according to available estimates.

- **Several enrollment avenues are available.**
  Web-based portals, call centers, county health and human services offices, and a network of paid enrollment advisors will provide substantial enrollment assistance. Health care providers will also be a key resource.

- **Covered California will have an extended enrollment period in its first year of operation.**
  Open enrollment, the period during which people can enroll in health plans, will last from October 2013 through March 2014 in the first year of operation, but will be shorter in future years. People who do not enroll in coverage during open enrollment will not be able to do so until the following year, even if they become ill or need health services.

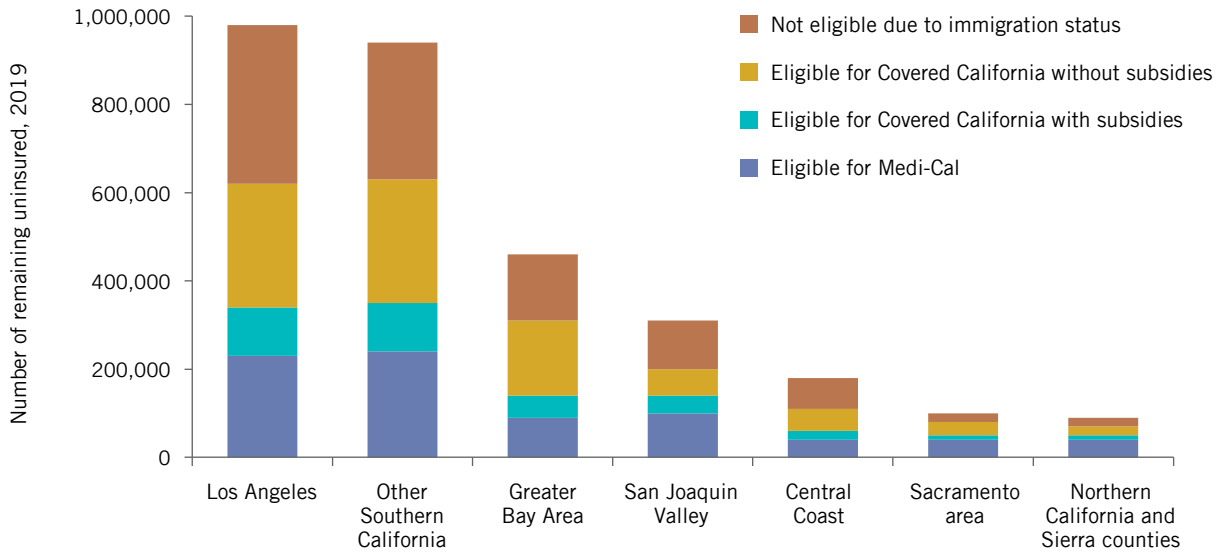
- **Multiple coverage options are available, but they share the same standard benefits.**
  In 2014, Covered California will offer health plans from 11 health insurance companies, with different pricing and plan choices available across 19 regions. Standard benefit packages and cost-sharing requirements are the same across all plans.

DESPITE INSURANCE EXPANSIONS MILLIONS WILL REMAIN WITHOUT COVERAGE

- **Even years after ACA implementation, millions of Californians are expected to remain uninsured.**
  Despite expanded insurance options, three to four million Californians are likely to lack insurance. Nearly four in ten of those projected to be uninsured in California in 2019 will be eligible for subsidized coverage through either Medi-Cal (25%) or Covered California (12%) but will not be enrolled. The rest will not be eligible for subsidized coverage because either their income is too high or they are offered affordable coverage through their employer (29%), or because of their immigration status (33%).

- **Most of those without insurance will be exempt from tax penalties.**
  Although the ACA requires people to have health insurance or pay a tax penalty, estimates suggest the majority of Californians who remain uninsured will be exempt from this penalty because of their low income level, lack of affordable coverage options, or immigration status. More than half of the remaining uninsured will have limited English skills and six in ten will live in Southern California.

PROJECTIONS SHOW A HIGH NUMBER OF UNINSURED WILL BE IN SOUTHERN CALIFORNIA BY 2019



SOURCE: UC Berkeley–UCLA CalSIM model, Version 1.8, enhanced scenario estimates.

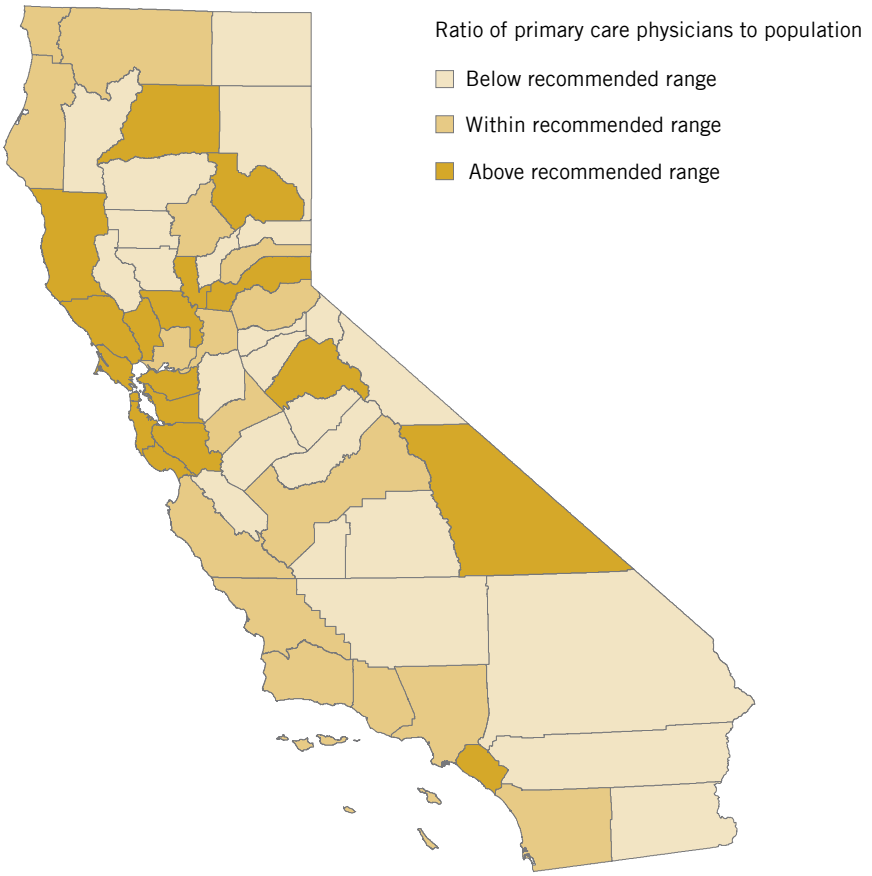
- **Counties and safety net providers will continue to play a role in providing care to the uninsured.**
  The 2013–2014 state budget reduced state funding for county health programs in anticipation of a decline in the number of uninsured Californians currently served by counties. But some counties, in particular those that operate public hospital systems, will continue to be responsible for the sizable population of those who remain uninsured. A quarter of those remaining uninsured statewide will be eligible for Medi-Cal—and they can enroll in the program when they receive health services. This allowance will potentially increase Medi-Cal enrollment and provide some financial protection for safety net providers.

HEALTH OUTCOMES, ACCESS, AND QUALITY ARE UNEVEN ACROSS ACROSS THE STATE

- **The health of Californians varies significantly across communities and populations.** Health can be measured in a number of ways, including outcomes, access to and quality of care, personal behaviors, and social and physical environments—and significant differences by socioeconomic status, race/ethnicity, and region exist. For example, compared to all Californians, those with a high school education or less have significantly lower life expectancies—as do African American men and women. Likewise, people living in certain regions of the state and in particular communities face greater obstacles to health. Many of these disparities are driven by potentially preventable diseases and causes of death.

- **Health care providers and safety net resources are not evenly distributed across California's regions.** The supply of primary care physicians varies substantially across California's counties. Counties in the Central Valley and Inland Empire have physician-to-population ratios that are below recommended levels and are also substantially lower than other counties in the state. While there is some uncertainty around what constitutes an adequate number of physicians—and questions about how changing delivery systems models could impact recommended ratios—there is currently a very poor geographic distribution of primary care physicians throughout California's regions. In addition, some counties have much less availability than others in terms of health clinics.

MANY COUNTIES HAVE RELATIVELY LOW LEVELS OF PRIMARY CARE PHYSICIANS



SOURCE: Primary care physician ratios are based on data from the 2011–2012 U.S. Health Resources and Services Administration Area Resource File and 2011 Census Population Estimates assembled and made available by the Robert Wood Johnson Foundation and University of Wisconsin County Health Rankings project.

NOTE: Recommended ranges are based on physician supply needs estimated by the Council on Graduate Medical Education. Below recommended range refers to fewer than 60 primary care physicians per 100,000 population; within recommended range refers to between 60 and 80 primary care physicians and above recommended range refers to more than 80 primary care physicians.

LOOKING AHEAD

- **Streamline and maximize enrollment in available coverage programs.**
  A new state system will be used to determine eligibility for federal subsidies and enroll people in plans available through Covered California. The same system will also determine eligibility under the new income criteria for Medi-Cal, but counties will continue to administer and process enrollment for the Medi-Cal program. The integration of these eligibility and enrollment systems will need to be closely monitored to ensure that those seeking insurance do not fall through the cracks. This ”no wrong door” approach to enrollment is required by the ACA and will be essential to ensure high levels of enrollment in available coverage options. Covered California will need to enroll a broad group of eligible Californians, particularly people who are young and healthy, to keep premiums low in future years. And counties will need to maximize Medi-Cal enrollment to limit their financial exposure to indigent care costs.

- **Monitor access to care under Medi-Cal and Covered California health plans.**
  Getting people connected to insurance coverage is just the first step; coverage needs to translate into meaningful access to health care. A sufficient number of health care providers need to participate both in the Medi-Cal program and in the provider networks of Covered California’s health plans. But reimbursement rates for Medi-Cal are low compared to other payers, which hinders provider participation. And many health plans offered under Covered California have limited provider networks to keep premium costs low. State law requires all health plans to provide timely access to care and puts explicit limits on wait times for health care appointments. It will be important to monitor and assess the ability of health plans to meet these regulations.

- **Support health care safety net providers.**
  The state’s safety net providers, including county hospital systems, primary care clinics, and comprehensive health centers, will be an important source of care for both low-income people who gain coverage and those who remain uninsured. Policymakers will need to encourage the meaningful participation of safety net providers, particularly county-operated public hospital systems, in the integrated delivery systems used by Medi-Cal and Covered California health plans. Health care safety net providers will also need financial support to continue care for the uninsured.

- **Promote a culture of health and wellness to improve health and reduce disparities.**
  Leaders from health care, public health, philanthropic, and community organizations will need to work collaboratively to bridge the gap between health coverage and community prevention. They should also identify opportunities for Medi-Cal and Covered California to incorporate health goals in their purchasing strategies and take advantage of ACA resources to invest in population health. This broad environmental approach is critical to improving health outcomes and health equity, reducing demands on the health system, and lowering costs associated with preventable disease and disability.

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