THE AFFORDABLE CARE ACT COMES TO CALIFORNIA

Major provisions of the Affordable Care Act (ACA) have gone into effect, including the expansion of Medi-Cal (the state’s Medicaid program) and the provision of subsidized coverage through the state’s insurance marketplace, Covered California. Under the ACA, most people must have health insurance or pay a tax penalty. In addition, health insurance coverage is now guaranteed, regardless of health status. There are no longer annual limits on coverage, and variations in insurance costs face specified limits.

The challenges of connecting millions of people to new coverage options and facilitating simple, streamlined enrollment were witnessed throughout the state and the nation. Despite some initial difficulties, enrollment figures exceeded expectations, with an estimated 1.4 million people enrolling through Covered California and more than two million qualifying for Medi-Cal. Translating coverage into access to health services will pose a new set of policy challenges. The next several years will require considerable monitoring, oversight, and adjustment to manage cost pressures, maintain increased insurance coverage, and ensure that the state’s health care providers are able to adequately serve those seeking care.

FIRST-YEAR ENROLLMENT EXCEEDED EXPECTATIONS

MEDI-CAL EXPERIENCES RAPID GROWTH

Medi-Cal provides comprehensive health insurance to low-income people. The ACA brought about key changes to Medi-Cal’s eligibility requirements: low-income adults no longer need to have either a qualifying disability or a dependent child to qualify for coverage.
Medi-Cal is the state’s second-largest General Fund expenditure after K–12 education. In the 2014–15 budget, the Medi-Cal program will spend an estimated $90.5 billion—an increase of more than $20 billion from the previous year’s Medi-Cal appropriation. The vast majority of additional funds are coming from the federal government, although the cost to the state’s General Fund is estimated at $17.4 billion, which represents an increase of nearly 5 percent from the previous year’s Medi-Cal budget.

Medi-Cal will serve nearly one in three Californians. According to the current budget, an estimated 11.5 million Californians will be served by the Medi-Cal program—about 30 percent of the state’s total population. This represents an increase of nearly 2.4 million people, with about 825,000 previously eligible and 1.6 million made newly eligible by the ACA. This distinction is important because the newly eligible will be funded entirely by the federal government through 2016. After that, the state’s funding share will increase incrementally through 2020, when the state responsibility will be set at 10 percent. For those previously eligible, the state is required to pay its standard 50 percent match rate.

Enrollment in Medi-Cal managed care plans is expanding rapidly. Medi-Cal managed care is expanding rapidly, with most new enrollees being signed up for managed care plans. Through the first eight months of 2014, enrollment in these plans increased by nearly 250,000 people each month, on average. Increases also occurred in 2013, with the shift of children from the Healthy Families Program into Medi-Cal and the transition from fee-for-service to managed care in the state’s rural counties.

Services and coverage have also expanded for mental and behavioral health. Mental and behavioral health services are an essential benefit under the ACA. This requirement applies to all health plans and represents new services available to Medi-Cal beneficiaries. Given the higher prevalence of mental health conditions and substance-use disorders among lower-income populations, these expanded benefits could be salutary, particularly to some made newly eligible for Medi-Cal—including the homeless and those supervised by county corrections agencies. Making full use of these expansions will require policy initiatives that ensure quality care, better integrate physical and mental health services, and expand behavioral health provider networks.
MENTAL AND BEHAVIORAL HEALTH NEEDS HIGH AMONG POTENTIAL NEW MEDI-CAL ENROLLEES

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<thead>
<tr>
<th>Condition</th>
<th>Total adult population</th>
<th>Low-income adults (under 200% FPL)</th>
<th>Poor adults (under 100% FPL)</th>
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<tbody>
<tr>
<td>Severe mental illness, narrow definition</td>
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<tr>
<td>Severe mental illness, broad definition</td>
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<tr>
<td>Alcohol or drug diagnosis</td>
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NOTE: FPL refers to the Federal Poverty Level, which is set by the federal government each year and used to determine eligibility for a variety of safety net programs.

COVERED CALIFORNIA BEGINS ITS SECOND YEAR

California’s health insurance marketplace, Covered California, provides a place where individuals and small businesses can shop for, compare, and enroll in health plans. Individuals and certain small businesses can also access federal tax credits to offset the cost of insurance purchased through Covered California.

- **Successful first-year enrollment leads to higher targets for the second year.**
  
  At the end of Covered California’s first open enrollment period, reports indicated that about 1.4 million people enrolled in coverage; slightly more than 1.1 million had their coverage take effect by paying the first premium. Still, enrollment levels exceeded projected targets, particularly in some regions, such as the greater Bay Area, and among some racial/ethnic groups, such as Asian Americans. But other groups, including Latinos and young people ages 18–34, were underrepresented. In its second year of enrollment, Covered California is seeking to increase enrollment by 500,000 people and expand its reach to underrepresented groups.

- **Insurance premiums for the second-year enrollment period have increased modestly.**
  
  All of the same health plans will participate in Covered California and have negotiated relatively modest premium increases. Statewide, the average rate for coverage increased 4.2 percent, but federal subsidies should insulate most of those enrolled through Covered California from large price shocks. Premium changes differ across regions—from a decrease of 1.9 percent (San Joaquin Valley) to an increase of 6.6 percent (San Francisco).
**DESPITE INSURANCE EXPANSIONS, MILLIONS WILL REMAIN UNINSURED**

- **Even years after ACA implementation, millions of Californians are expected to remain uninsured.**
  While it is still too soon to know the number of Californians who have gained insurance coverage, millions will continue to be uninsured. More than 70 percent of uninsured Californians plan to obtain insurance coverage, according to PPIC surveys, but barriers will continue to exist for many. Others will choose not to purchase coverage despite the new insurance mandate. Despite subsidies and coverage expansions, affordable coverage may still prove elusive for some. Also, undocumented immigrants are prohibited from purchasing coverage through Covered California and are not currently eligible for full Medi-Cal coverage. But recent federal action on immigration could extend Medi-Cal to part of the state’s undocumented population.

- **Tax penalties for not having insurance will increase in future years.**
  The tax penalty for not having coverage in 2015 is $325 per adult. In 2016, the tax penalty will be either 2.5 percent of income or $695 per adult, whichever is greater. Penalties for children are half that of adults, with a maximum penalty amount per family. It is not clear, however, how many people will be subject to these tax penalties. Estimates suggest that the majority of Californians who remain uninsured will be exempt from penalties because of their low income level, lack of affordable coverage options, or immigration status.

- **Counties and safety net providers will continue to play a role in providing care to the uninsured.**
  Given the sizable increase in Medi-Cal enrollments, the number of low-income uninsured Californians served by counties through indigent care programs and other safety net providers will undoubtedly decline. Consequently, the state budget has reduced the funds it provides to counties for indigent care by $700 million, with larger declines expected in the future. And while counties should see a decline in their indigent care program costs, it will be important to monitor anticipated and actual county savings, with particular attention to counties operating public hospital systems.

**HEALTH OUTCOMES, ACCESS, AND QUALITY ARE UNEVEN 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 exist across socioeconomic, racial/ethnic, and regional groups. 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.

- **Regional health differences are significant.**
  Asthma is one example of broad, regional variation in health. Asthma symptoms and attacks have been linked with environmental factors, although in most instances, asthma can be managed with regular preventative health care, medication, and adherence to a recommended course of treatment. But many end up in the emergency department because of severe or poorly managed asthma. Several counties in California’s Central Valley, High Sierra, and Inland Empire regions have emergency department visit rates for asthma that are above recommended targets suggested by the federal government.
EMERGENCY DEPARTMENT VISIT RATES FOR ASTHMA VARY WIDELY BY REGION

Emergency department visit rates

- Below target range
- Within target range
- Above target range
- Data not available

SOURCE: California Office of Statewide Health Planning and Development emergency department data, accessed through the California Department of Public Health, California Environmental Health Tracking Program web query system.

NOTES: Visit rates are age adjusted and include all ages. To be within target range, the rate of emergency department visits for asthma should be 49.6 visits per 10,000 residents ages 5–64. This objective is set by Healthy People 2020, a federal program that provides national objectives for health promotion and disease prevention.

LOOKING AHEAD

- **Improve enrollment system integration and streamline renewals to maintain coverage gains.**

  California has implemented the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) to determine eligibility for federal subsidies and enroll people in plans through Covered California. CalHEERS also determines eligibility under the new income criteria for Medi-Cal, but counties continue to administer and process enrollment for the Medi-Cal program. The large initial influx of enrollees strained these systems, resulting in enrollment delays and a large backlog of Medi-Cal applications. Improvements are in progress, but it is imperative that the state’s enrollment systems be seamlessly integrated to prevent unnecessary delays. This effort is crucial if California is to sustain its insurance coverage gains.

- **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 and continued access to health care. A sufficient number of health care providers must participate 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 smaller provider networks to keep premium costs low. Existing state law requires all health plans to provide timely access to care and puts explicit limits on wait times for health care appointments. A new state law will strengthen these standards and provide increased oversight to Medi-Cal managed care plans. It will be important to continue 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 public hospital systems, primary care clinics, and comprehensive health centers, are an important source of care for low-income people who have gained coverage and for those who remain uninsured. Policymakers will need to monitor the capacity and financial conditions of the state’s safety net providers, particularly county-operated public hospital systems, to ensure they remain viable.

• **Pursue payment and delivery system reforms that will control costs and better coordinate care.**
  The ACA included incentives to promote cost efficiency. As the state moves forward with its expanded Medi-Cal program, it will be important to seek strategies that provide cost-effective care that can be expanded and sustained over time. Throughout the state and the nation, various reforms will be tested to align incentives to promote improvements in both health care delivery and health outcomes and to control costs.

• **Improve data systems.**
  Effective assessments of health care services, quality of care, and costs require better integrated and available data systems. To this end, some states have mandated the creation of a database that includes insurance claims information from all health insurers in the state. Efforts to create an “all payer claims database” in California are currently underway, but are voluntary and do not include all payers. In addition, philanthropic organizations have been working to increase the availability of health data. All of these efforts are needed to increase transparency and provide needed information for consumers, purchasers, health care providers, and policymakers.