CALIFORNIA HEALTH CARE

PPIC PUBLIC POLICY INSTITUTE OF CALIFORNIA

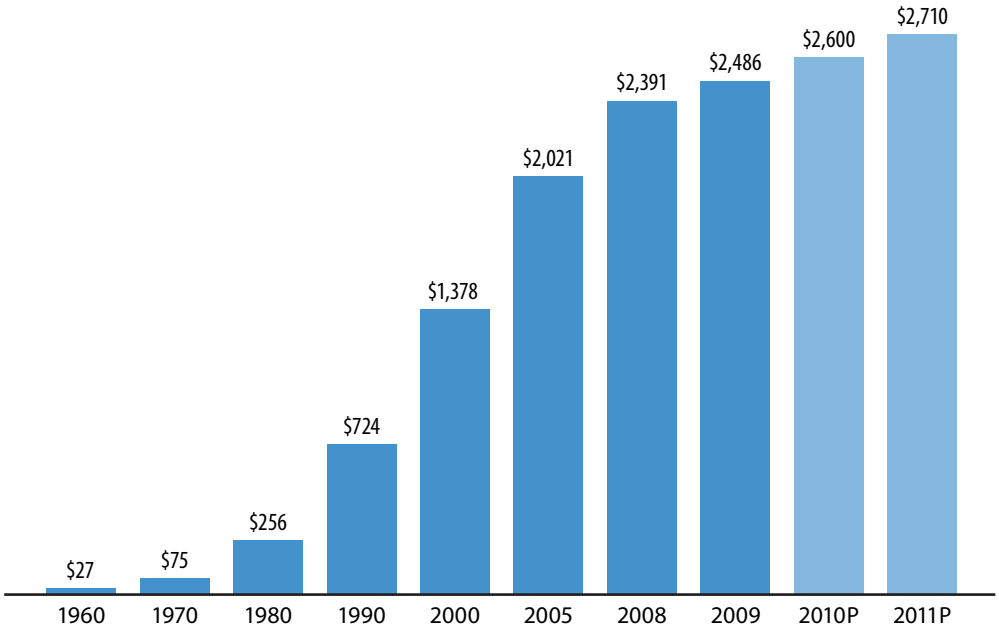
CALIFORNIA IS PREPARING FOR HEALTH CARE REFORM AMID BUDGET CONSTRAINTS AND GROWING NEED

California faces myriad health care challenges. The state currently has 7.1 million uninsured residents. Health care costs continue to increase and outpace economic growth, threatening economic competitiveness and state fiscal solvency. And health care quality remains uneven.

Government plays an important role in the financing and delivery of health care services. Federal, state, and county governments finance public programs and services for millions of Californians who are older, disabled, low-income, or uninsured. The growth in health care costs across government programs represents an increasing demand on scarce public dollars and squeezes the availability of funding for other state priorities.

The federal Affordable Care Act (ACA) represents sweeping policy change intended to achieve near-universal health care coverage, contain health care costs, advance quality, and improve health outcomes. The ACA provides a clear federal framework but allows states significant flexibility in implementation. But policymakers don't have much time: Even though the ACA's major provisions don't take effect until January 2014, required implementation tasks are numerous, varied, and complex.

NATIONAL HEALTH CARE SPENDING HAS INCREASED DRAMATICALLY SINCE 1960



SOURCE: *Health Care Costs 101*, California HealthCare Foundation, May 2011. Used with permission.
NOTE: Selected rather than continuous years of data shown prior to 2008. Years 2010 forward are CMS projections (September 2010 data release).

THE PROBLEM OF THE UNINSURED IS SIGNIFICANT AND GROWING

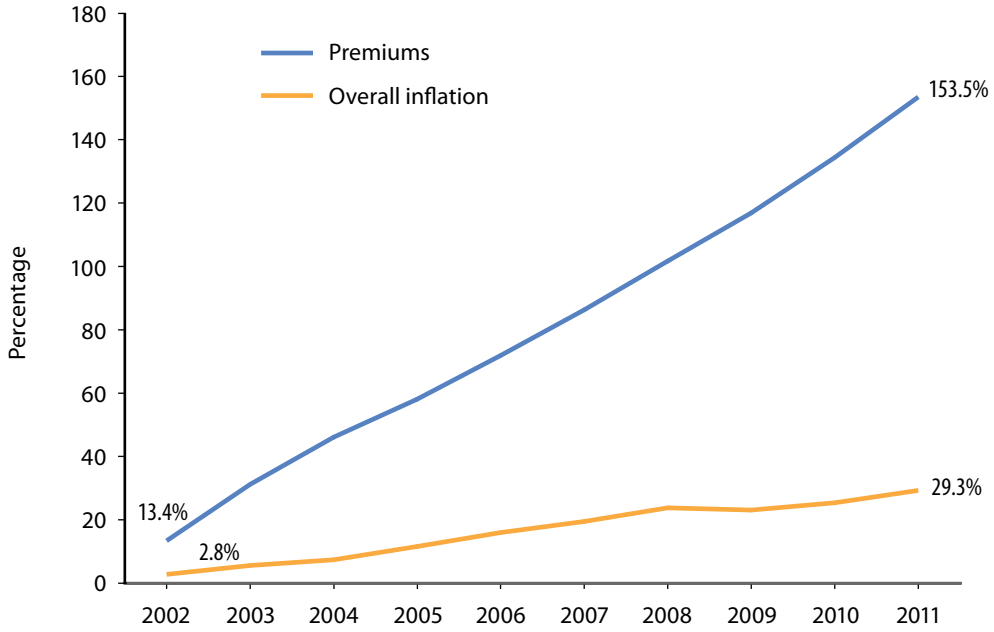
- **A large and growing number of Californians are uninsured.**
  In 2010, 7.1 million Californians lacked health insurance coverage, up from 5.26 million in 2007. Lack of insurance is associated with poor access to and quality of care. Uninsured individuals forgo needed care, pay significant out-of-pocket costs, and rely on hospital emergency rooms for basic medical needs. Latinos comprise nearly 60 percent of uninsured residents.

- **Employer-based coverage has fallen steadily over the last decade.**
  Coverage through employers declined from 61.9 percent in 2000 to 53 percent in 2010, declines that have not been offset by expansions in Medi-Cal and individual coverage. Nearly 70 percent of the uninsured work full- or part-time, while 90 percent of the uninsured live in a household with a full-time worker.

HEALTH CARE COSTS CONTINUE TO GROW AT A RATE THAT SURPASSES ECONOMIC GROWTH AND INFLATION

Health care spending can be measured a number of ways—as a percentage of gross domestic product, total state government spending, employee compensation, or household expenditures. Regardless of measure, spending on health care presents a significant and growing investment.

PREMIUMS FOR FAMILY COVERAGE HAVE RAPIDLY OUTPACED INFLATION



SOURCE: *California Employer Health Benefits Survey*, California HealthCare Foundation, December 2011. Used with permission.

- **Medi-Cal is the state's second-largest general fund expenditure.**
  In the current budget year, Medi-Cal (the state's Medicaid program) will spend an estimated $15.4 billion general fund and provide comprehensive services for 7.7 million Californians. Medi-Cal serves low-income families, seniors, and people with disabilities, including 1.2 million individuals eligible for both Medi-Cal and the federal Medicare program. This "dual eligible" population comprises 11 percent of Medi-Cal's total caseload, and 41 percent of program costs.

- **Workers are paying more for employer-sponsored family coverage.**
  Increases in health insurance premiums have moderated in recent years, but growth in employer-sponsored family coverage continues to far exceed the inflation rate. Over the past decade, worker contributions for family coverage have soared by 113 percent.

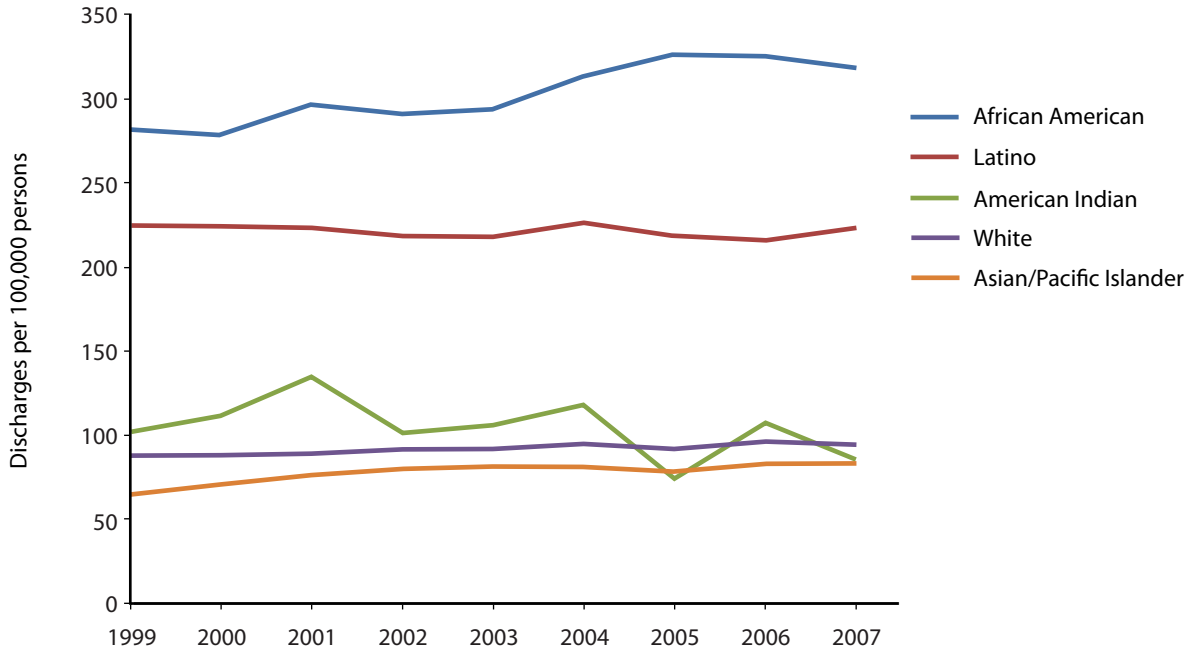
- **A number of factors are driving the growth in health care spending.**
  New or increased use of medical technology represents upwards of two-thirds of cost growth. Other significant factors include the aging population and personal health behaviors, including tobacco use, physical inactivity, and overconsumption of food.

DESPITE SIGNIFICANT AND GROWING SPENDING, QUALITY IS UNEVEN AND HEALTH DISPARITIES ARE WIDENING

- **California's health care quality is slightly lower than average.**
  Health care quality can be measured across a number of domains, including coverage, access to services, the patient experience, utilization, and outcomes. In relation to other states, California ranks 29th according to federal rankings of states for overall health care quality.

- **Across California there is significant variation in health care access, quality, and outcomes.**
  Certain populations—such as those without insurance and those with limited incomes—are at higher risk of poor health and poor outcomes. In particular, communities of color consistently face higher levels of disease, disability, and mortality than non-Hispanic whites. Improvement in key health indicators—including infant and maternal mortality, obesity, and diabetes management—is especially urgent.

AFRICAN AMERICANS AND LATINOS ARE ESPECIALLY VULNERABLE TO COMPLICATIONS FROM DIABETES

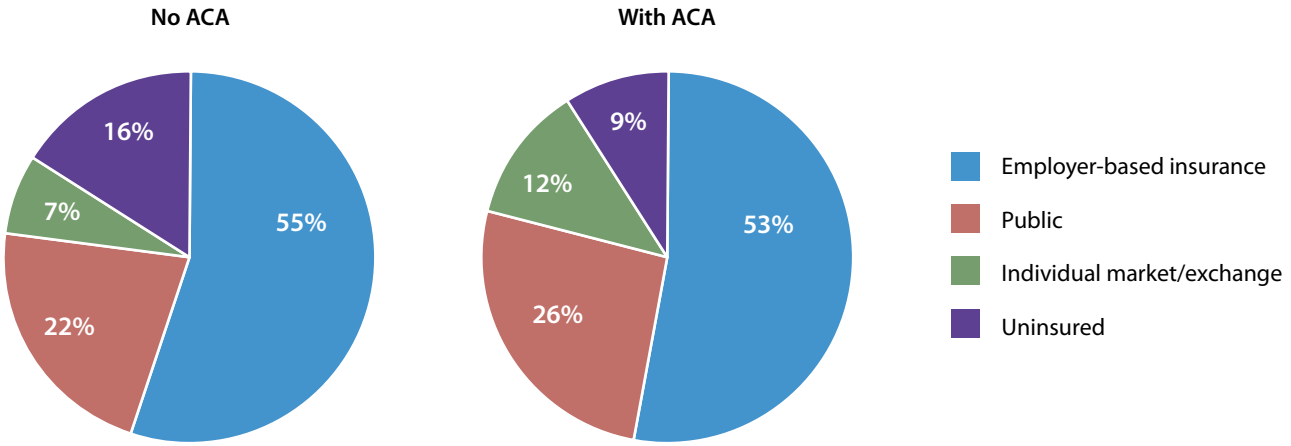


SOURCE: *Racial and Ethnic Disparities in Healthcare in California*, Office of Statewide Health Planning and Development, Winter 2010.
NOTES: This graph measures hospitalization rates for long-term diabetes complications. "Latino" consists of people who identify as Hispanic. "American Indian" includes Eskimo and Aleut and may be under-reported. "Asian/Pacific Islander" combines various populations that may have different overall health characteristics.

THE FEDERAL AFFORDABLE CARE ACT CALLS FOR SWEEPING CHANGES

Implementation of the ACA will result in major shifts in the way health care is financed and delivered. Beginning January 1, 2014, health insurers will be required to provide coverage to all individuals, regardless of their health status, pre-existing condition, or age.

THE ACA IS PROJECTED TO CUT THE NUMBER OF UNINSURED SUBSTANTIALLY BY 2019



SOURCE: California Simulation of Insurance Markets, UC Berkeley Labor Center, March 2012.

- **Californians are concerned about the minimum coverage requirement.**
  Most Americans will be required to have minimum coverage for themselves and their children or pay a penalty, a policy that seeks to achieve a broad mix of both healthy and less healthy enrollees. This "individual mandate" represents the most controversial element of the ACA and was at the center of legal challenges decided by the U.S. Supreme Court in June 2012. The PPIC Statewide Survey has found that 63 percent of Californians oppose requiring all Americans to have health insurance or pay a fine. But 69 percent support the requirement if the government provides financial help for those who can't afford insurance.

- **Medi-Cal will be expanded.**
  To promote affordability and increase compliance with the mandate, Medi-Cal will be expanded. Beginning in January 2014, eligibility for parents with children will increase from roughly 100 percent of the federal poverty level ($29,900 for a family of four) to 138 percent ($31,809 for a family of four). For the first time, Medi-Cal will cover single adults in this same income category. The Supreme Court decision allows states to opt out of Medicaid expansion without incurring a penalty, but California has already begun early implementation efforts to extend coverage to more single adults.

- **An online health care marketplace will be created.**
  A new California Health Benefit Exchange will provide an online marketplace for individuals and employees of small businesses to shop for, compare, and purchase plans. Individuals with incomes up to 400 percent of the federal poverty level ($92,200, for a family of four) will be able to use tax credits to purchase coverage through the exchange. Certain small businesses will be eligible for tax credits to offset insurance costs.

- **Larger businesses will be required to contribute to employee coverage.**
  Slightly more than half of Californians are insured through their employers. Under the ACA, employers with more than 50 employees will be required to contribute to the cost of coverage for their employees or pay a fee.

- **Coverage will expand considerably, but a significant number of Californians will remain uninsured.** Estimates indicate that roughly two million uninsured Californians will enroll in coverage under the Medi-Cal expansion. An additional two million individuals will enroll through the Health Benefit Exchange with subsidies. Still, an estimated three million Californians are expected to remain uninsured, more than a million of whom are undocumented immigrants.

- **The ACA also provides new ways to improve health care services and public health.** Beyond coverage, the ACA establishes new incentives and requirements for insurers and health plans to promote coordinated care, achieve better quality, and lower costs. The ACA also includes new resources to pursue health promotion and wellness activities, improve public health infrastructure, and increase community prevention—the Community Transformation Grant program is one good example.

LOOKING AHEAD

With the Supreme Court decision to uphold the ACA, attention now shifts to the states. The California context for ACA implementation is challenging, given the state's fiscal distress, the November election, and worsening coverage, cost, and quality problems. In 2010, California took early action on the health policy front, enacting legislation to implement many key elements of the ACA. Still, California policymakers have much work to do and relatively little time—decisions made in the next 12 to 18 months will determine the success of reform. Key steps include:

Redesigning Medi-Cal to strengthen the foundation of reform. Medi-Cal is the foundation upon which federal ACA reforms will be built. Yet, as the second largest general fund expenditure, Medi-Cal will continue to be subject to near-term budget reductions and proposals that could compromise its strength. Policymakers will need to leverage ACA payment and care delivery tools to improve Medi-Cal affordability and quality goals, particularly for high-cost, high-need populations.

Simplifying eligibility determination and enrollment to facilitate coverage. State eligibility determination and enrollment processes will need to accommodate an estimated four million Californians expected to enroll in Medi-Cal and Health Benefit Exchange coverage. The state will need to recreate long-standing labor- and paper-intensive processes by simplifying eligibility rules and offering multiple pathways to coverage, including self-service, online systems.

Expanding the health care workforce to assure access. The ACA's coverage expansion will place significant demands on the state's health care workforce—which is already struggling to meet the needs of California's growing, aging, and increasingly diverse population. A comprehensive strategy should include expanded training of primary care providers, greater use of allied health professionals, broader use of telehealth and telemedicine, and increased use of team-based care models that capitalize on existing medical personnel.

Creating a new insurance marketplace to improve affordability and quality. The new Health Benefit Exchange is a gateway to subsidized coverage for millions of Californians—and it can help organize a more competitive insurance marketplace. As a purchaser on behalf of an estimated three to five million Californians, the exchange can structure competition based on price and quality—and stimulate changes in the way care is paid for and delivered.

Reforming care delivery to improve value. State policymakers will need to take steps to improve value—such as creating greater transparency on provider costs, quality, and outcomes. In addition, they can help promote insurance designs that encourage the use of high-value providers and services. Through Medi-Cal, the Health Benefit Exchange, and CalPERS (for state employees), the state is well-positioned to catalyze a variety of new approaches.

Promoting a culture of health and wellness to improve health, 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, identify opportunities for Medi-Cal and the Health Benefit Exchange 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.

Reconsidering state and local responsibilities to promote accountability. The ACA will require the state to assume some responsibilities currently borne by county government. Many medically indigent adults served by counties today will become newly eligible for Medi-Cal or the Health Benefit Exchange in 2014. Additionally, many individuals now eligible for service- or disease-specific state programs will also gain access to comprehensive coverage. As these examples suggest, policymakers will want to pay particular attention to state and county roles in and responsibilities for low-income health care.

We invite you to dig deeper at ppic.org. Related PPIC resources include:

Expanding Medi-Cal: Profiles of Potential New Users
PPIC Statewide Survey: Californians and Healthy Communities
Emergency Department Care in California: Who Uses It and Why?
Pay-or-Play Health Insurance Mandates: Lessons from California

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