



California's Health Care Environment and Health Reform Efforts

EXECUTIVE SUMMARY

California is the nation's most populous state, home to over 37 million residents in 2011. California also has the largest number of uninsured at 7.3 million people or 20% of the state's population. This represents 15% of the total uninsured across the country. Therefore, California's actions to expand coverage through the Medicaid expansion and health insurance marketplaces under the Affordable Care Act (ACA) have implications, not only for health coverage and access within the state, but also for national goals of reducing the number of uninsured. As California develops its infrastructure to expand coverage through the ACA, it may prove to be a model for other states. However, a number of factors combine to make California a unique health care environment.

A Portrait of California

California is a highly diverse state with 60% of the state population identifying as a race other than White. California is also home to more than 10 million immigrants, including 5 million non-citizens which represent 14% of the state's population and 24% of non-citizens nationally. Twenty-four percent of Californians were living in poverty in 2011 and the unemployment rate in November 2012 was 10%, the third highest rate in the nation. Disparities in health exist across measures of health access and health status for California's racial and ethnic minorities and for individuals living in poor rural counties.

California's counties have a history of financing, and in some instances delivering, health care to low-income, underserved, and uninsured individuals. Medi-Cal, the state's Medicaid program, covers 7.1 million low-income Californians. In 2011, the state spent an estimated \$12.5 billion in General Funds on the program. With respect to expenditures, California spends an average of \$3,527 per Medicaid enrollee, the lowest amount in the nation. California has a concentrated private insurance market, with six insurers accounting for three-quarters of the market in 2011.

California's Budgetary Environment

After nearly a decade of recurring budget deficits, Governor Brown's revised 2013-2014 budget proposal projects a budget surplus of \$1.1 billion. To balance the budget, Governor Brown made significant cuts to health care and education funding, shifting authority from the state to the local level for a variety of services, including mental health and substance abuse treatment services in 2011, and developing a new tax and spending reduction initiative in 2012, which included

the movement of children from Healthy Families to Medi-Cal and the movement of dual eligible beneficiaries from fee-for-service to managed care through the Cal MediConnect Demonstration Project. Both program changes are anticipated to produce significant state savings.

California's Section 1115 Medicaid Demonstration Waiver: "Bridge to Reform"

On November 2, 2010, the federal government approved California's five-year "Bridge to Reform" Section 1115 Medicaid Demonstration Waiver, designed to assist the state in preparing for the Medi-Cal expansion in 2014 under the ACA. At least \$8 billion in federal matching funds have been made available to counties to expand coverage to low-income uninsured adults through the creation of the Low-Income Health Program (LIHP), to invest in and improve county and UC hospitals through a Delivery System Reform Incentive Pool (DSRIP), and to move seniors and persons with disabilities (SPDs) (excluding dual eligible beneficiaries) into managed care arrangements. Nearly 569,000 adults have been enrolled in the LIHP program across 52 counties and approximately 240,000 SPDs have been transitioned to Medi-Cal managed care.

Health Reform Implementation

California's adoption of the Affordable Care Act (ACA) Medicaid expansion will extend Medi-Cal coverage to all citizens with incomes up to 138% of the Federal Poverty Level (FPL) (\$15,856 for an individual or \$26,951 for family of three in 2013). It is estimated that between 990,000 – 1.4 million Californians will have enrolled in Medi-Cal under the expansion by 2019. In 2019, this will cost an estimated \$3.8 -5.3 billion, with the federal government paying at least 85% of the cost. An additional 2.9 million people will be eligible for premium tax credits, around 2 million of whom are expected to enroll in Qualified Health Plans (QHP) through the state's health insurance exchange marketplace, called Covered California, by 2019.

Effective outreach and enrollment will be important to the success of both the Medi-Cal expansion and the Covered California marketplace. In May 2013, the California Endowment, a private grant-making foundation, committed \$26.5 million for outreach and enrollment activities, for which the state can apply for federal matching funds for a total of \$53 million. California was awarded a second federal Consumer Assistance Program Grant for \$4.6 million to help inform consumers about their rights and benefits for health coverage through Covered California. In addition, Covered California announced the award of \$37 million in federal Outreach and Education Grants for 48 community organizations to engage the state's uninsured population and increase awareness and understanding of health coverage options.

Looking Ahead

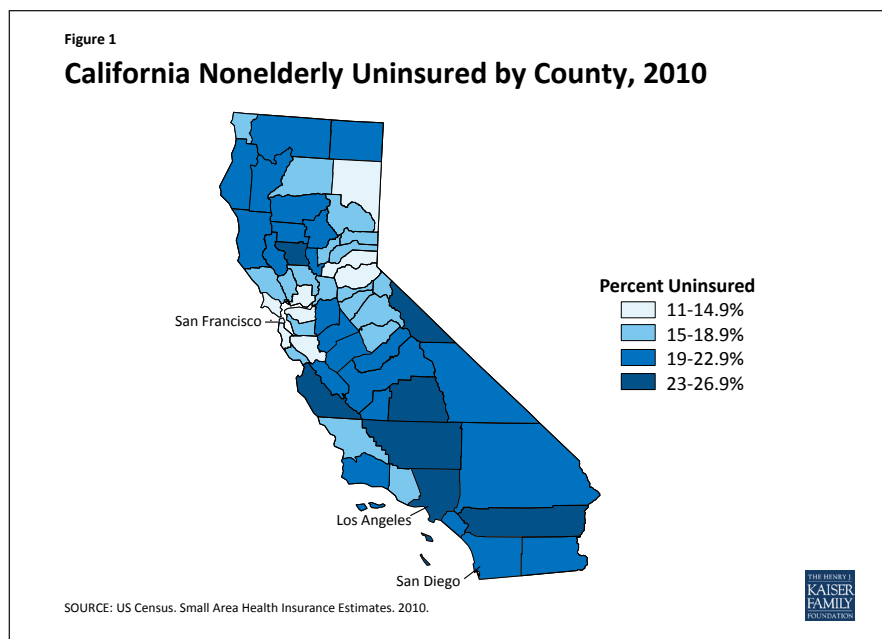
California has implemented its Medicaid waiver and is in the midst of planning and preparing for the coverage expansions under health reform. However, despite its progress, California will likely face a number of challenges to expanding coverage and reforming its health care system. California's cultural and ethnic diversity will pose outreach and enrollment challenges. Individuals enrolled in the county-based LIHP program will need to be seamlessly transitioned to new state-based coverage options available under the ACA, and the state's dual eligible beneficiaries will be transitioned to managed care. Ensuring sufficient Medi-Cal provider capacity for new coverage groups will also be challenging should the 10% provider rate cut go into effect, and given the fact that the 2013-2014 ACA primary care rate increase has not yet been implemented. Despite these and other challenges, many throughout California agree that the state and its residents will benefit from the successful implementation of health reform. Over the next five months, many new developments can be anticipated as our country's most populous state prepares for one of the largest coverage expansion in its history.

With an eye toward 2014, this brief provides an update on California's budget, Section 1115 waiver implementation, and health reform preparations, as well as future coverage and health care challenges and considerations.

INTRODUCTION

A main goal of the Affordable Care Act (ACA) is to reduce the number of uninsured through an expansion of Medicaid and the creation of new health insurance marketplaces. Beginning in 2014, most uninsured individuals up to 138% of FPL (\$15,856 for an individual or \$26,951 for family of three in 2013) will become eligible to enroll in Medicaid in states that move forward with the Medicaid expansion. In addition, many individuals between 100% - 400% FPL will qualify for subsidies to purchase health coverage in the insurance marketplace. These two provisions, along with new employer requirements and an individual responsibility requirement, have the potential to reduce the nearly 49 million uninsured by up to 48%.¹

While uninsured individuals reside across the U.S., some states have a greater share of uninsured. California, the nation's most populous state, was home to over 37 million residents in 2011. California also has the largest number of uninsured of any state across the country. In 2011, 20% of the state's population was uninsured, or about 7.3 million people, which is 15% of the uninsured across the country.² The number of uninsured individuals in California alone is greater than the total state populations of 8 states and DC.³ However, the uninsured are not equally distributed across



California's 58 counties (Figure 1). Los Angeles County, which has a population the size of Michigan, has the same number of uninsured as the entire state population of Nebraska.⁴ Therefore, California's actions to expand coverage through the Medicaid expansion and health insurance marketplace have implications, not only for health coverage and access within the state, but also for national goals of reducing the total number of uninsured.

As California develops its infrastructure to expand coverage through the ACA, it may prove to be a model for other states. However, a number of factors combine to make California a unique health care environment.

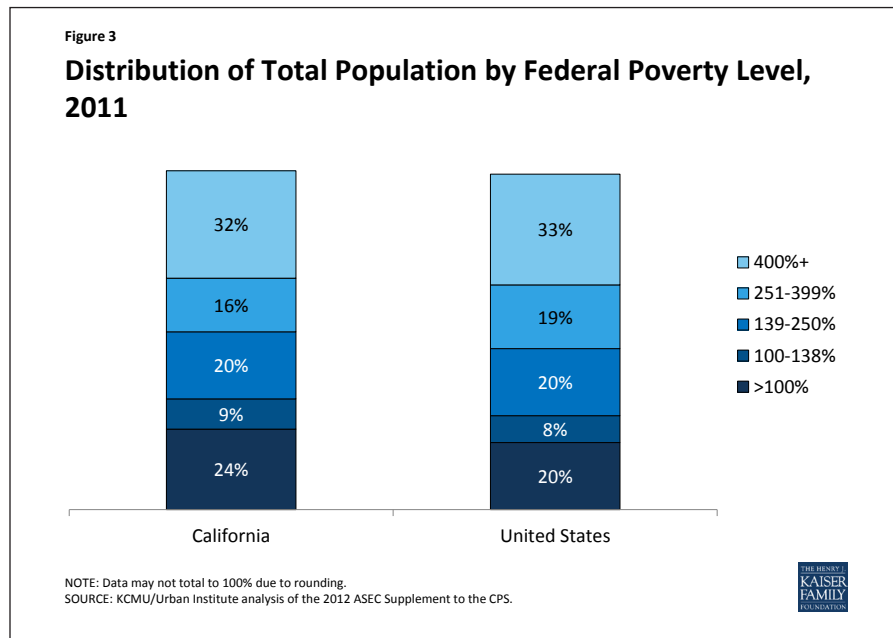
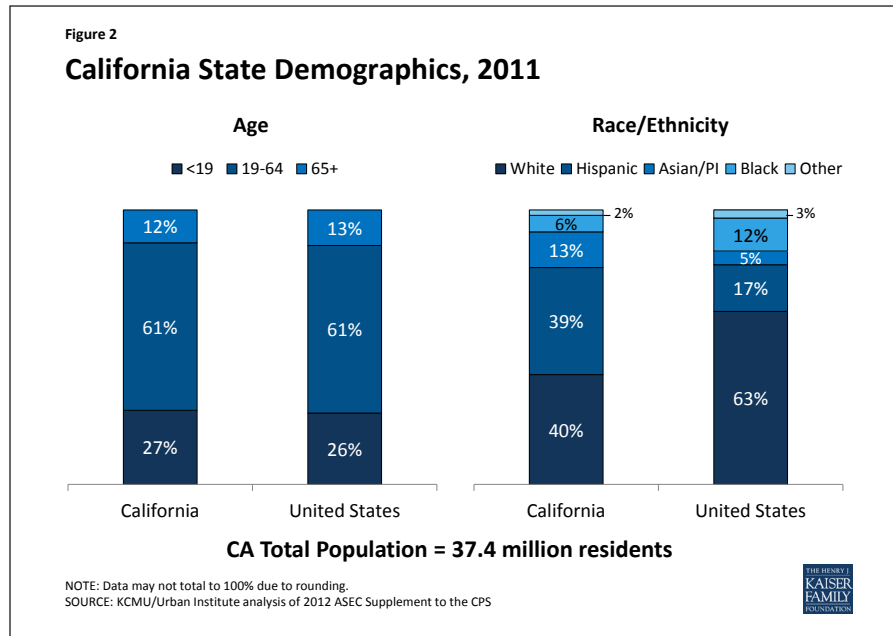
A PORTRAIT OF CALIFORNIA

California is a highly diverse state. In 2011, 40% of the state's population identified as White, 39% as Hispanic, 13% as Asian/Pacific Islander, and 6% as Black (Figure 2).⁵ California is also home to more immigrants than any other state at more than 10 million people, including 5 million non-citizens which represent 14% of the state's population and 24% of non-citizens nationally.^{6,7}

California has poverty and unemployment rates that are higher than national averages. As of 2011, 24% of the state's population, or nearly 9 million people, were living in poverty, compared to a national poverty rate of 20% (Figure 3).⁸ As of November 2012, California's unemployment rate was just under 10%, the third highest rate in the country.⁹

Disparities in health exist among California's racial and ethnic minorities. In 2011, 18% of White nonelderly adults in California had no regular health care provider, compared to 23% of Blacks and 42% of Hispanics. Nearly 30% of Hispanics and 21% of Blacks reported being in fair or poor health, compared to 12% of Whites.¹⁰ Population health also varies across California's 58 counties, with poor rural counties, especially those in the Central Valley, faring worse than urban ones.¹¹

California has a history of county-delivered health care services. California's counties have traditionally had broad authority over the provision of health-related services. California relies on its counties to provide or administer medical care, public and environmental health services, and behavioral health and substance abuse treatment services for its low-income, underserved, and uninsured populations.¹² County programs are funded by a complicated mix of local, state, and federal funds.



One-sixth of the country’s uninsured reside in California. Over 7 million people, or 20% of the state’s residents, were uninsured in 2011. The number of uninsured in California accounts for 15% of the uninsured across the U.S. As a percent of the state’s population, California’s uninsured rate is the fourth highest in the nation and it exceeds the U.S. average uninsured rate of 16% (Figure 4).¹³

Medi-Cal is a large program with low-reimbursement rates.

California’s Medicaid program, known as Medi-Cal, covers 7.1 million low-income Californians, for whom the state spent 14% of its general revenue funds, an estimated \$12.5 billion, in SFY2011.^{14,15,16} In 2012, Medi-Cal payment rates to physicians for primary care services were 43% of Medicare rates, compared to a national average of 59%.¹⁷ California’s Medicaid spending per enrollee is the lowest in the nation at \$3,527, compared to a national average of \$5,527.¹⁸

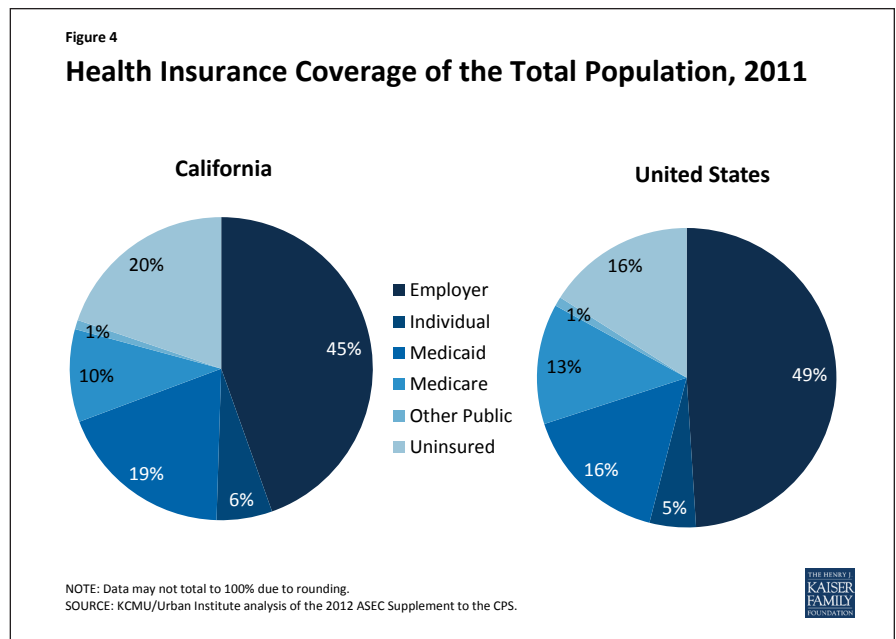
California has a concentrated private insurance market and higher than average premiums. Five health insurance carriers accounted for three-quarters of business in California’s \$111 billion health insurance industry in 2011.¹⁹ As of 2012, premiums for both single and family coverage in the state continued to be higher than the national average; however, the average employer contribution was also significantly higher. Workers in California are more likely to be covered by health maintenance organizations (HMOs) (55%), such as Kaiser Permanente, than workers nationally (16%).²⁰

CALIFORNIA’S BUDGETARY ENVIRONMENT

California will have a budget surplus for the first time in many years. After nearly a decade of recurring budget deficits, Governor Brown’s revised 2013-2014 budget proposal projects a budget surplus of \$1.1 billion.^{21,22} This fiscal projection is supported by Budget Bill (AB 110), which passed the legislature on June 15, 2013.²³ When Governor Brown took office in 2011, California faced a \$25.4 billion budget deficit.²⁴ Over the following two years, Governor Brown enacted two new agendas to control costs and raise revenues.

In 2011, the Governor introduced a realignment strategy that shifted authority from the state to the local level in a variety of areas, including public safety, mental health and substance abuse treatment services, and child welfare and adult protective services. The realignment took effect in October 2011 and was among many actions in the adopted 2011-2012 budget that reduce state General Fund spending by \$16 billion. Also included in the budget was a 10% Medi-Cal provider rate cut that passed the state legislature in 2011 and was recently upheld by the 9th Circuit Court of Appeals in May 2013.^{25,26,27}

Facing a potentially large shortfall again, the Governor’s 2012-2013 budget put forward an initiative to raise new, temporary taxes and reduce state spending by \$8.1 billion, including a \$1.2 billion reduction to Medi-Cal.²⁸ The tax initiative, known as Proposition 30, which raises personal income tax rates on very-high income Californians



for seven years and increases the sales tax rate by one percent for four years, was approved by California voters in November 2012.²⁹ The Governor's budget also made significant changes to the state's social safety net programs, including consolidation of Healthy Families into the Medi-Cal program and movement of dual eligible beneficiaries to managed care plans.

Beginning in January 1, 2013, 875,000 children enrolled in the Healthy Families program (California's Children's Health Insurance Program) began transitioning to Medi-Cal through four phases over the course of the year.³⁰ Goals of the transition include simplifying eligibility and coverage rules, improving coverage, and eliminating premiums for lower-income beneficiaries. As a result of this transition, the Budget projects a General Fund savings of \$13.1 million in 2012-13, \$58.4 million in 2013-14, and \$72.9 million ongoing.³¹ As of March 14, 2013, the first phase was complete, transitioning 178,000 children to Medi-Cal.³²

The Governor's budget also included a provision to move dual eligible beneficiaries, or beneficiaries eligible for both Medi-Cal and Medicare, and Medi-Cal only beneficiaries who rely on long-term services and supports (LTSS) into managed care plans through a new Coordinated Care Initiative (CCI).^{33,34} The goals of the CCI are to streamline both payment and delivery of services to provide better, more cost-effective care to beneficiaries.³⁵ California submitted a proposal for the movement of their dual eligibles through a program called "Cal MediConnect" to the Centers for Medicare & Medicaid Services (CMS) on May 31, 2012 and signed a Memorandum of Understanding (MOU) with CMS on March 27, 2013 for a three year demonstration in eight counties.^{36,37,38} An anticipated 456,000 beneficiaries will be eligible for the demonstration. The Governor's 2012-13 budget reported a General Fund savings of \$611.5 million and his May 2013 revised budget projects General Fund savings of \$119.6 million in 2013-2014.³⁹ Although enrollment was previously scheduled to begin in October 2013, the Department of Health Care Services (DHCS) has delayed implementation until January 2014.⁴⁰ In response to constituent concerns about state readiness for the transition, 14 Members of Congress sent a letter to CMS on June 4, 2013 to request further delay of the transition.⁴¹

CALIFORNIA'S SECTION 1115 MEDICAID DEMONSTRATION WAIVER: "BRIDGE TO REFORM"

California received a waiver to help prepare for health reform in 2014. On November 2, 2010, the federal government approved California's five-year "Bridge to Reform" Section 1115 Medicaid Demonstration Waiver designed to assist the state in preparing for the Medi-Cal expansion in 2014 under the Affordable Care Act (ACA).⁴² Under the waiver, at least \$8 billion in federal matching funds have been made available to expand coverage to low-income uninsured adults, invest in and improve county and UC hospitals, and move seniors and persons with disabilities (excluding dual eligible beneficiaries) into managed care arrangements.⁴³ To do this, the waiver permits the creation of a Low-Income Health Program (LIHP) and a Delivery System Reform Incentive Pool (DSRIP), and gives flexibility to the state for a managed care expansion for seniors and persons with disabilities (SPDs). The non-Federal share of the waiver program is principally financed by counties and there are little state General Funds.⁴⁴

Low-Income Health Program (LIHP)

Under California's waiver, counties can receive federal matching funds to expand coverage to low-income adults who are not otherwise eligible for Medi-Cal, through LIHP. LIHP consists of two programs: the Medicaid Coverage Expansion (MCE) for non-elderly, non-pregnant adults with family incomes at or below 133% of the Federal Poverty Level (FPL) (or a lower threshold set by the county) and the Health Care Coverage Initiative (HCCI) for non-elderly, non-pregnant adults with family incomes between 133-200% of the FPL (or a lower threshold set by the county).⁴⁵ Counties that elect to participate in the LIHP program can choose whether to cover only MCE or both MCE and HCCI adults. An unlimited amount of matching funds are available to counties for MCE adults and up to \$630 million

in federal matching funds are available to counties for HCCI adults, both at a 50% federal matching rate.^{46,47} As of February 2013, just under 569,000 adults were enrolled in LIHP programs across 52 counties.^{48,49}

As part of the Bridge to Reform waiver, the state plans to seamlessly transition LIHP enrollees to coverage options available under the ACA. In August 2012, the Department of Health Care Services (DHCS) submitted their Initial LIHP Transition Plan to CMS with the intention of beginning the transition on July 1, 2013.⁵⁰ The Medicaid expansion bill ABX1-1/SBX1-1, which recently passed both houses of the legislature, would allow LIHP enrollees to continue care with their current providers during and after the transition, if they choose.⁵¹

Delivery System Reform Incentive Pool (DSRIP)

Through this new pool, public hospitals are able to access up to \$3.3 billion in federal matching funds over five years to improve the quality of care and as part of larger delivery system reforms envisioned in the ACA. Federal funding is available for four CMS priority areas: (1) infrastructure development, including investments in technology, tools, and human resources; (2) innovation and redesign, including investments in new and innovative care delivery models; (3) population-focused improvement, including enhancing care delivery for the five-to-ten highest-burden conditions facing low-income people who use public hospitals; and (4) urgent improvement in care, which refers to hospital-specific interventions that are achievable and measurable in the improvement of care within five years.⁵² California's 12 major county hospitals and five UC hospital systems are participating in DSRIP.⁵³ Within the first year of implementation, all participating hospitals met their infrastructure benchmarks and received \$600 million in federal funds.^{54,55} Participating hospitals and health systems continue to make improvements across the priority areas and greater coordination has been reported between clinics and both emergency departments and specialists, which are reported in their semi-annual reports.⁵⁶

In June 2012, CMS approved a waiver amendment to establish additional DSRIP projects to support the transition of LIHP enrollees with HIV and an additional waiver amendment to create a DSRIP program for Non-Designated Public Hospitals (NDPH) is still pending with CMS.⁵⁷

Managed Care Expansion for Seniors and Persons with Disabilities (SPDs)

California's waiver allows counties to mandate enrollment of seniors and persons with disabilities (SPDs) who qualify for Medi-Cal (other than dual eligible beneficiaries) into managed care arrangements that meet specified plan readiness requirements.^{58,59} From June 2011 to May 2012, approximately 240,000 SPDs in 16 counties were transitioned from fee-for-service to managed care.⁶⁰ Goals of the transition were to improve access to and coordination of care for this high-need population. Preliminary findings of a beneficiary survey conducted by researchers at the University of California at Berkeley School of Public Health and the California HealthCare Foundation found that, in most domains, approximately two-thirds of SPD beneficiaries did not report significant problems with the transition, while one-third did. Some key issues were identified in the (1) notification and distribution of materials to beneficiaries, which led to confusion about the mandatory nature of the transition and about which plan would best meet their needs; (2) continuity of care and plan navigation, including confusion about how to make appointments with specialists; and (3) higher out-of-pocket costs due to changes in prescription drug coverage and longer or more complicated commutes to appointments. In addition, a subset of beneficiaries reported that their mental health care services had been negatively impacted.⁶¹ The state and advocates are looking at the experiences from this transition to inform and help prepare for future transitions of care for high need beneficiaries, including the upcoming transition of dual eligible beneficiaries to managed care, mentioned above.

HEALTH REFORM IMPLEMENTATION

Health reform has the potential to significantly expand coverage in California. Under the Affordable Care Act (ACA), California will extend Medi-Cal coverage to nearly all citizens with incomes up to 138% of the Federal Poverty Level (FPL) (\$15,856 for an individual or \$26,951 for family of three in 2013). It is estimated that between 990,000 – 1.4 million Californians will have enrolled in Medi-Cal under the expansion by 2019. In 2019, this will cost an estimated \$3.8 -5.3 billion, with the federal government paying at least 85% of the cost.⁶² An additional 2.9 million people will be eligible for premium tax credits, around 2 million of whom are expected to enroll in Qualified Health Plans (QHP) through the state’s health insurance exchange marketplace by 2019.⁶³

Medi-Cal Expansion

Governor Brown has been supportive of expanding the Medi-Cal program under health reform. His 2013-2014 budget includes plans to simplify Medi-Cal eligibility for currently eligible beneficiaries (referred to as the “mandatory expansion” group by the Governor’s office) and to extend coverage to childless adults and uninsured parents (referred to as the “optional expansion” group by the Governor’s office).⁶⁴ The budget includes \$350 million from the state General Fund to begin paying for the “mandatory expansion” in 2014. While the Governor’s proposed budget, released in January 2013, outlined two possible methods for expanding coverage to the “optional expansion” group, either a state-based expansion or a county-based expansion, the May 2013 revision calls for a state-based Medi-Cal expansion. The revised budget also proposes an incremental reduction to the state’s current allocation of about \$1.4 billion to counties for health coverage of the uninsured, assuming a reduced need for uncompensated care funding after health coverage is expanded under the ACA.⁶⁵ The Medi-Cal expansion has also received support from the California Legislature with expansion bill ABX1-1/SBX1-1 passing both houses on June 15, 2013.⁶⁶

Health Insurance Exchange Marketplace

California became the first state in the country to pass legislation to create a Health Benefit Exchange, now known as Covered California, on September 30, 2010. Covered California has an appointed five-member governing board and operates as an independent public agency (quasi-governmental). The Covered California Board holds monthly meetings that are open to the public either in-person or via webcast. All documents and transcripts, as well as Covered California solicitations and news updates, are available on their website (www.healthexchange.ca.gov).

On July 10, 2012, Governor Brown sent a letter to HHS announcing California’s intention to run a state-based health insurance exchange marketplace, for which CMS granted conditional approval on January 3, 2013.^{67,68} In February, Covered California launched its new consumer website (www.coveredca.com) which will provide consumers with information about the coverage opportunities available. The website is available in English and Spanish and numerous fact sheets have been translated into 11 other languages.⁶⁹

To fund planning and operations, the Covered California has actively pursued federal exchange grant funds and has been awarded an Exchange Planning Grant, as well as Level 1 and Level 2 Exchange Establishment Grants. Covered California is currently being funded by a \$674 million Level 2 Establishment Grant that runs through December 2014. Through its grant awards, California has drawn down over \$910 million in federal grant money. This is the most funds awarded to any state across the country.⁷⁰ In addition, Covered California legislation creates the California Health Trust Fund within the State Treasury, which will be continuously appropriated and used to manage the finances of the marketplace in the future.⁷¹

Although much work remains, California has been moving forward with the marketplace’s technology infrastructure and health plan application, design, and benefits that will be available to consumers. In June 2012, Covered California, the Department of Health Care Services, and the Managed Risk Medical Insurance Board, awarded a

contract to Accenture for the development and operations of a new Eligibility, Enrollment and Retention System (CalHEERS), which will serve as the technology infrastructure for all three agencies. The infrastructure has been designed and the interface continues to be built and the technology tested.⁷²

California passed a law in October 2011 requiring that a single, statewide application be available on paper and electronically for all entities accepting and processing applications under health reform. It also requires simplified citizenship and identity verification at application and renewal and increased coordination with other public programs.⁷³ In September 2012, the Board approved using the eValue8 tool, which measures and evaluates health plan performance, as part of the QHP solicitation to support a quality rating system.⁷⁴

On May 23, 2013, Covered California announced the 13 commercial health plans that will participate in the health insurance marketplace and their premium rates for individual policies.⁷⁵ Covered California divided the state into 19 geographic regions for setting insurance rates. Each region has an average of five insurers offering coverage, while rural regions will have two-to-three health plans to choose from.⁷⁶ Health policies will be offered at four different metal tiers, reflecting the level of coverage offered: platinum plans will offer 90% coverage, gold plans will offer 80% coverage, silver plans will offer 70% coverage and bronze plans will offer 60% coverage. Health coverage at all levels will include ten Essential Health Benefits and plan contracts include beneficiary protections, such as a maximum annual out-of-pocket costs of \$6,350.⁷⁷

Outreach and Enrollment

Effective outreach and enrollment will be important to the success of both the Medi-Cal expansion and the Covered California marketplace. In response to concern that the state would not fund Medi-Cal expansion outreach and enrollment efforts, the California Endowment, a private grant-making foundation, committed \$26.5 million for outreach and enrollment activities in May 2013. The state will be able to apply for federal matching funds, for a total of \$53 million. These funds will be used for the state's Community Based Organization Grants Program for Medi-Cal outreach and enrollment, which targets vulnerable populations and will assist individuals with successfully completing Medi-Cal applications.⁷⁸

Supporting efforts to inform consumers about their rights and benefits for health coverage through Covered California, the state applied for and was awarded a second federal Consumer Assistance Program Grant of \$4.6 million.⁷⁹ Funds from this grant are being used to develop and promote a consumer-friendly insurance exchange website and corresponding toll-free number for consumers to call, to conduct a statewide media campaign to educate consumers about their rights and responsibilities, to provide assistance with enrollment into coverage, to evaluate the effectiveness of initiatives, and to collect and track consumer problems.⁸⁰

In addition, Covered California is using federal funding for an Outreach and Education Grant Program for organizations and entities to engage the state's uninsured population and increase awareness and understanding of health coverage options.⁸¹ This program will complement the state's broader marketing strategy and help build capacity for their Assister Program, which includes In-Person Assisters (IPAs) and Navigators.⁸² On January 21, 2013, Covered California released a Request for Applications for the Outreach and Education Grant Program.⁸³ The program will distribute \$37 million in grants to community organizations, \$40 million to entities targeting individuals, and \$3 million to entities targeting small businesses eligible to purchase coverage through the Small Business Health Options Program (SHOP) Exchange. And on May 14, 2013, Covered California announced the 48 community organizations receiving Outreach and Education grants.⁸⁴

Primary Care Payment Rate Increase

To help ensure that access in Medicaid expands to meet anticipated higher demand for care, the ACA requires states to pay certain physicians Medicaid fees that are at least equal to Medicare rates for a list of 146 primary care services in 2013 and 2014. The idea is to attract new physicians to Medicaid and provide greater support for physicians who already participate. As a result, Medicaid fees paid to certain physicians for primary care services will increase by an unprecedented 73%, on average, in 2013.⁸⁵ However, for primary care providers in California, Medi-Cal physician fees will increase by 136%, to comply with the requirement to pay qualified physicians at least Medicare rates for ACA primary care services.⁸⁶ Although the primary care physician rate went into effect on January 1, 2013 and runs through December 31, 2014, California has not yet begun increasing provider payment rates. According to the Department of Health Care Services website, they expect to implement the rate increase during the summer of 2013, making it retroactive to all Medi-Cal primary care services that have been provided since January 1, 2013.⁸⁷

LOOKING AHEAD

California has been making steady progress in its preparations for health reform in 2014. With nearly all counties participating in its LIHP program, hospitals and health systems continuing to reform their delivery systems through DSRIP, and the state having completed its transition of SPDs to managed care, California's implementation of its Medicaid waiver is well underway. In addition, Covered California has been actively preparing for the ACA coverage expansion through the launch of its consumer website, the development of its CalHEERS technology, the selection of the 13 commercial health plans that will participate in the marketplace, and the granting of funds to 48 community organizations that will assist with outreach and education efforts. In addition, both the state and Covered California have maximized federal and private funding opportunities to support health reform activities.

However, despite its progress, California will likely face a number of challenges to expanding coverage and reforming its health care system. California's cultural and ethnic diversity will pose outreach and enrollment challenges.⁸⁸ Enrollment assisters, such as community health workers and patient navigators, who are familiar with and have relationships within different racial and ethnic communities, will play an important role in health reform expansion efforts. However, ensuring that these individuals are appropriately trained to effectively convey health messages to members of the community and making sure they are well integrated into the health system so that they complement other health center staff will be a challenge.

Even with effective outreach and enrollment efforts, an estimated 3 to 4 million Californians, or about 10% of the state's population, could remain uninsured after health care reform is fully implemented. About one-quarter of these individuals will be undocumented immigrants and three-quarters will be U.S. citizens or lawfully present immigrants. Half of these individuals will likely be eligible for Medi-Cal but not enrolled, some will qualify for subsidized health coverage through Covered California but will be unable to afford it, while some will be ineligible for coverage due to their immigration status. Two-thirds of the remaining uninsured will be Latino and about 60% will have limited English proficiency.⁸⁹ All of these individuals will likely rely on California's health care safety-net, but the proposed reductions to safety-net funding in Governor Brown's May 2013 revised budget may challenge safety-net providers' financial ability to maintain access at current levels.

In addition, not all of California's counties will be equally affected by health reform. A January 2011 Health Affairs article predicts that about half of the reduction in the uninsured will be in Los Angeles County and the largest percentage reduction in uninsured will be in San Diego County. The two counties expected to have the largest proportional reduction in the uninsured, San Diego and Riverside, are also the two counties with the fewest number of individuals who will be exempt from the individual mandate.⁹⁰ As a result, the overall impact of the ACA will vary by county.

The state's Section 1115 Demonstration waiver will expire in 2015 and individuals and organizations on the ground are challenged to figure out how to most effectively use waiver authority and funds to expand coverage in a way that can be sustained after the waiver's expiration. The Governor announced in his May 2013 budget revision that the state will be pursuing a state-based Medi-Cal expansion. However, developing an infrastructure at the state level to maintain coverage for low-income adults as they transition from the county-run LIHP program to the state-based Medi-Cal expansion and health insurance marketplace in 2014 is continuing to evolve.

The state's plan to transition dual eligible beneficiaries to Medi-Cal managed care through the Cal MediConnect demonstration project is proceeding. However, challenges encountered during the recent transition of SPDs to managed care offer insights regarding the scope of the demonstration project, the definition of consumer protections, important elements of the health assessment tool, and the benefit package to be offered.⁹¹

Despite already having the lowest Medi-Cal provider reimbursement rates in the country, providers may face an additional 10% rate cut. How to maintain sufficient Medi-Cal providers should the rate cuts go into effect is a challenging issue. Bills repealing the provider reimbursement rate cut have been approved by unanimous vote in both the State Assembly (AB 900) and Senate (SB 640) and are making their way through their respective chambers. However, Governor Brown has threatened a possible veto of the bills should they pass both houses.^{92,93} Absent further action, the 10% provider rate cut could be implemented this summer, which could counteract any anticipated increases in payments to primary care providers, as a result of the primary care rate increase under the ACA.

Despite logistical, delivery system capacity, and funding challenges, many throughout California agree that the state and its residents will benefit from the successful implementation of health reform. The Affordable Care Act provides an opportunity to simplify the current very complicated public health insurance system, in addition to simplifying plan enrollment and application procedures.⁹⁴ Many individuals will obtain access to affordable coverage options and will be able to make preventive health care a priority. Enrolling uninsured people in coverage should help to reduce cost shifting for uncompensated care that benefits both privately insured individuals and state and local agencies.⁹⁵ Over the next five months, many new developments can be anticipated as our country's most populous state prepares for one of the largest coverage expansion in its history.

This brief was prepared by Rachel Arguello of the Kaiser Commission on Medicaid and the Uninsured.

Endnotes

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