5 Years Into the Affordable Care Act:

California Leads the Way

March 2015
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About Health Access

Health Access California is the statewide health care consumer advocacy coalition, working for quality, affordable health care for *all* Californians. Founded in 1987, Health Access Foundation is an independent non-profit research and education organization.

Author

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Executive Summary

California has much to celebrate on the five-year anniversary of the Affordable Care Act (ACA). More than 4 million Californians have coverage through the new options of the ACA, and more than 60% of previously uninsured adults were covered as of July 2014. Thanks in part to our "active purchaser" exchange, Covered California, robust insurance market reforms, and more, the rate of growth in premium costs has also been cut in half.[i] This report highlights the state's achievements both in implementing the law and improving on it (Part I). Part II describes the results and priorities for communities that have the most to gain from the ACA. And Part III summarizes the work still left to do to bring the full promise of reform—not just coverage, but access to care and better health outcomes—to every man, woman, and child living in the Golden State.

Affordable Care Act: Real Results for California

The Affordable Care Act is working well for California and for millions of Californians…

- **Maximizing coverage** through early expansion of Medicaid for all under 138% of poverty, and affordable options in Covered California, as well as other provisions to bolster private coverage.
- **Security for those with coverage through consumer protections**, from no denials for pre-existing conditions to the annual limit on out-of-pocket costs of $6,600 for an individual/$12,700 for a family[ii]) to the guarantee of decent benefits.
- **Controlling cost and improving quality:** By embracing a number of ACA initiatives, California has started on the pathway to the "quadruple aim:" better care, lower costs, improved health outcomes, and health equity.

Implementing and Improving on the ACA

On key areas of reform where states have had considerable flexibility, California has been a leader among states, improving on the law and making it more inclusive (for example, including undocumented immigrants):

- Bargained for better value consumers with our "*active purchaser*" exchange (i.e. leveraging the exchange's bargaining power to promote value for the consumer). Covered California has negotiated average premiums that were literally $325 a

month for 2014[iii] rather than $450 per month as originally projected;[iv] and has made progress in standardizing plan choices for consumers.
- Kept insurers accountable and facilitated transparency on premium rates by requiring review of all rate hikes for individual and small employer coverage.
- Simplified eligibility and enrollment through enrollment vehicles like CalFRESH (California's largest food assistance program) express lane eligibility and hospital presumptive eligibility. Our early Medicaid expansion, the Low-Income Health Programs, which operated in most counties, were used as a base from which to enroll almost 650,000 low-income individuals served by county safety net programs.
- Strengthened the ACA's early ban on exclusion and improved affordability for children with pre-existing conditions.
- Included certain immigrants in public programs using state-funded Medi-Cal; and (at least in certain counties) providing safety net care and coverage options for the undocumented and remaining uninsured.
- Dedicated significant resources to targeting and making headway in enrolling groups with high rates of uninsurance, including communities of color and LGBT Californians.

Fulfilling the Promise of Reform

California has used the ACA as a jumping off point for reforms that go beyond the ACA, tackling issues of particular importance to California:

- **Coverage for the remaining uninsured.** There are 2.6 million undocumented immigrants living in California, more than the total population of four states. Some have access to coverage and care programs established in certain counties, but too many are left without access to primary care, preventive care, or desperately needed specialty care.
- **Improving health equity** not only by maximizing enrollment for communities of color but through prevention and population health initiatives and efforts to address the social determinants of health. Though California is a diverse state, too many parts of the health care delivery system are ill equipped to deliver care across cultural barriers or collect data to make sure that care is equitable.

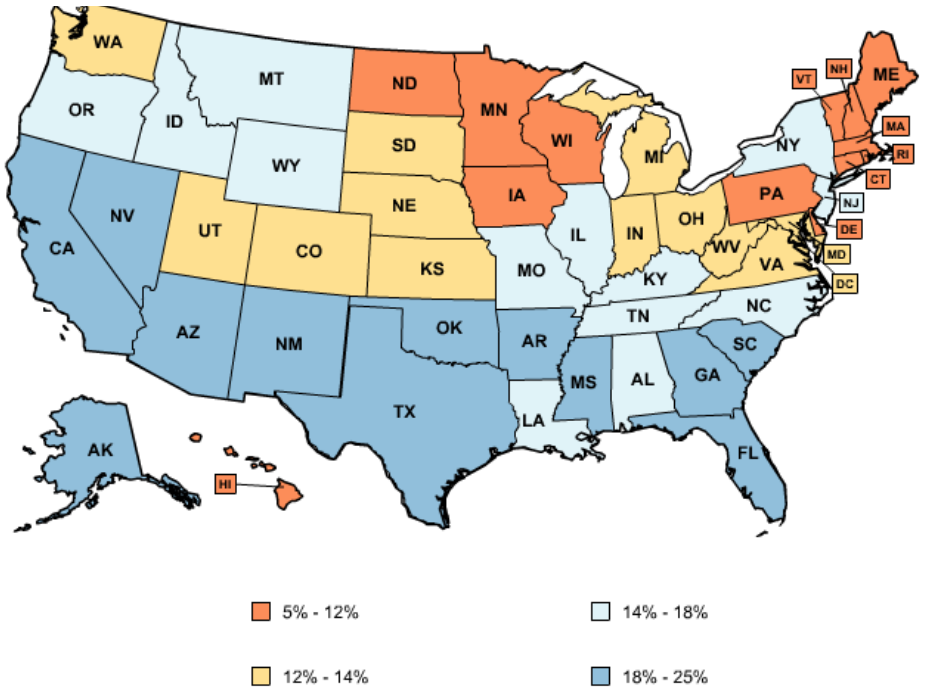
There's plenty more to do, but in most areas the state is moving in the right direction. As the nation awaits the Supreme Court's decision on King v. Burwell (about the status of subsidies in federally-facilitated exchanges), expected in June of 2015, California has an important story to bring forward in the national debate about the ACA and its future. Instead of 'repeal and replace' or questionable Medi-Cal waivers (Medicaid reforms), states should maximize the considerable flexibility in the ACA to pursue state priorities for reform that provide more care and coverage at lower costs while reducing health disparities. California offers a powerful model for all of this.

Part I Background

The Starting Point in 2010: A Chasm to Cross

When the ACA was enacted in 2010 California had the 7th highest uninsured rate in the nation, more in line with states stretching across the southern tier of the United States from Arizona, New Mexico and Texas to Florida and South Carolina. About 1 out of 5 Californians was uninsured. When the ACA was enacted, California had over seven million uninsured—more than Massachusetts had people.

State Uninsured Rates in 2010



Source: Kaiser Family Foundation, 2010.

The issue in California wasn't just the high proportion of uninsured, but the high rate of underinsurance, of consumers facing increasingly high out-of-pocket costs. High cost sharing reduces access to medically necessary and otherwise cost effective care.[v] Data from 2011-2012 showed that Californians with high deductible plans were more likely to put off medically necessary procedures compared to those without high-deductible plans (16.1% vs. 6.6%).[vi] For California's reform efforts, even pre-dating the ACA, affordability for those with coverage, both in terms of premiums and out-of-pocket costs, was just as important as coverage for the uninsured. The ACA provides a systemic approach to these challenges.

A Commitment to Robust Implementation

For California, the ACA was the next decisive chapter in a distinguished history of reforms at the state level. Prior to the ACA, California had undertaken numerous efforts to reform health care, from the successful enactment of HMO reform in the late 1990's to a failed effort to enact an employer mandate in 2003-04 and multiple stalled efforts for single-payer reform, followed by comprehensive and groundbreaking reform proposals by Democratic legislative leaders Fabian Nuñez and Don Perata and Republican Governor Arnold Schwarzenegger in 2007-08. While California, facing its own serious financial challenges and partisan divisions, was unable to enact reform in 2008, that effort served as a dress rehearsal for the Affordable Care Act in 2009-2010 and provided some of the substance for what happened nationally.[vii] When the ACA was finally signed into law in 2010, then Governor Schwarzenegger (R) committed to take full advantage of its benefits.[viii] That California was able to embrace the ACA and take it further is also a testament to the cohesiveness of the advocacy community and its longstanding dedication to public accountability and stakeholder engagement around reform.

California was the first state to enact enabling legislation for its state-based exchange in 2010-2011: AB 1602, John A. Pérez. California Health Benefit Exchange and SB 900, Elaine Alquist. California Health Benefit Exchange. The state received over $1 billion in federal grants to operate its exchange, "Covered California." From the beginning, California was committed to improving on the ACA. California went further than the ACA required on 30 of 55 ACA Exchange Provisions.[ix] California's SHOP (Small Business Health Options Program), too, went quite a bit further than required in the ACA, improving on 15 of 23 standard categories.[x] Most critically, the exchange was granted "active purchaser" authority, allowing it to negotiate premiums as well as numerous contract provisions with health plans, including the authority to standardize benefit designs.

Specifically, California's exchange is much more robust in terms of public governance, prohibitions on conflicts of interest for Board members and staff, open meetings provisions and other protections required of a public agency. The state maximized federal funding to launch Covered California, in part because of the statutory prohibition on using *any* state general fund dollars for the exchange.[xi] On benefit standards and insurance market policies California exceeds the ACA standard. The ACA includes the following insurance reforms:

- Guaranteed issue of coverage: insurers and plans may no longer deny coverage based on a pre-existing condition in the individual market. This in turn allows individual consumers to shop around for better deals or value –they are not locked in out of fear that they will be denied coverage if they go shopping.
- Premiums cannot vary based on health status.

- Modified community rating: premiums can only vary by age (and only at a 3:1 ratio required in federal law), and geographic regions (California has designated 19 regions for its 36 million people).
- Circumstances which justify a Special Enrollment Period (SEP) are the typical life transitions: marriage, divorce, birth of a child, losing a job.

California made modest improvements on key areas of reform as follows:

- No tobacco rating (so people who smoke don't get charged higher premiums and priced out of the coverage for treatments to stop smoking.). Only 9 states have done disallowed tobacco rating. This was out of a recognition that tobacco rating would functionally price smokers out of health insurance, when they need health coverage more than non-smokers. Also, such policies discriminate against people suffering from addiction, a medical condition.[xii]
- California added to the list of qualifying SEP events:
    - New domestic partnership
    - Individual/dependent loses minimum essential benefits as defined by federal standard
    - Individual gains or becomes a dependent through marriage, birth, adoption, or foster care placement.
    - Issuer substantially violated material provision of health coverage policy or contract
    - Individual or dependent gains access to new QHPs as result of a move
    - Individual demonstrates that failed to enroll during open enrollment because s/he was misinformed about having minimum essential benefits.
    - Individual released from incarceration.
- The essential health benefits built on the existing base in California law for most coverage which required coverage of medically necessary care without annual or lifetime limits and applied this standard to all coverage in the individual and small employer markets as well as adding prescription drug coverage and habilitative services.

While the ACA allows states to adopt a different "benchmark" benefit plan for newly eligible adults, California opted to have one benefit package for all adults. As a result of this decision, all Medi-Cal consumers enrolled in full-scope coverage have access to all medically necessary care. These broad based reforms of the ACA, and of California's implementation, were broadly felt in many specific communities. The next section details the impacts through the diverse communities that are benefiting from the ACA.

Part II Results by Group

The Uninsured

In August of 2012, the baseline year for this report, an estimated 6.9 million non-elderly Californians (21.3% of the population) were uninsured for all or part of the past year.[xiii] More than 1.7 million Californians had coverage in the individual market, though many were paying a high proportion of income for coverage that typically did not include comprehensive drug coverage or had other limits on benefits, such as hospital only coverage.

Since most of the coverage expansions did not start until 2014, most of the pre-ACA baseline data can be found in the California Health Interview Survey (CHIS) on 2011-2012 surveys. Among the many findings from the report, these stand out:

- In 2012, job-based coverage was the source of coverage for 49.1% of non-elderly adults and children.
- California Latina/os remained the group with the highest uninsured rate (28.4%) and the lowest rate of job-based coverage (33.9%).
- Medi-Cal and Healthy Families (California's Children's Health Insurance Program, which has been folded into Medi-Cal) insured one-fifth of non-elderly Californians.

Leslie Foster: *Glad to Have Peace of Mind Knowing I'm Covered*

After graduating with a degree in film production in 2006, Leslie found himself in an unstable situation, without a job, and without coverage for the first time. A plan through the private market was not feasible for him and he did not qualify for Medi-Cal. Passionate about social issues, Leslie closely followed the campaign to pass the ACA. By this time he was living in Los Angeles and pursuing his passion for documentary film making. Yet, the specter of being without coverage lingered in the back of his mind. When the ACA became law, he was eager to find out if he could benefit from it. In 2013, when Covered California opened for enrollment, he navigated to the website found the site quite comprehensive in nature and appreciated the Shop and Compare tools that enabled him to make an informed decision about his coverage. *"I fully support the ACA and am grateful to finally have the peace of mind of knowing I'm covered."*

For the uninsured with moderate incomes, Covered California offers new affordable coverage options:

- **Affordability credits** for coverage purchased in the Exchange for families earning up to 400% FPL ($97,000 for family of 4).
- The Exchange **bargaining power allows for a "group rate"** for individuals and small businesses, to get the best possible price.
- **Standardized products** that are easier to understand and compare.

In terms of enrollment, Medi-Cal and Covered California have exceeded most expectations. After just one year of open enrollment California has slashed the uninsured rate by more than half and slowed the growth in premium costs also by about half. For the second open enrollment period, Covered California just met its 500,000 target, for a total enrollment of around 1.4 million. Covered California has expanded the special enrollment period allowance provided by the federal government to allow Californians unaware of tax penalties for going without insurance a "special enrollment" opportunity through April 30, 2015.

High Proportion of Covered CA Enrollees Use Subsidies

	2014 Open Enrollment (%)	2015 Enrollment to date					
	Total	Renewal (As current on 2/26/2015*)		2015 New (Plan selections as of 2/22/2015)		Total	
	Column %	Count	Column %	Count	Column %	Count	Column %
Eligible for Subsidy	88%	834,587	91%	436,970	88%	1,271,542	90%
Unsubsidized	12%	78,718	9%	58,103	12%	136,820	10%
Total	**100%**	**913,305**	**100%**	**495,073**	**100%**	**1,408,362**	**100%**

* Note: Number is less than 944,000 total renewed due to regular monthly inflow and outflow of consumers who gain and lose other sources of coverage.

Source: Covered California, Executive Director's Report, March 5, 2015

California also compares well to the rest of the nation in the proportion of enrollees using a subsidy. Covered California reports that even though many Californians had been denied coverage based on health status pre-ACA, the mix of health status for the first year's enrollment was average, critical in keeping premiums low for future years. In addition, California has done a good job of enrolling young Californians, despite the insurer predictions that "young invincibles" would not take up coverage. The proportion of new enrollees who are young adults ages 18-34 increased from 29% to 34% from 2014 to 2015.

Age Mix of Covered CA Enrollees Improves 2014 to 2015

	Age			
	2014 Open Enrollment (Plan selections 10/1/13 – 3/31/14)		2015 New (Plan selections through 2/22/2015)	
	Count	Column %	Count	Column %
Age 17 or less	77,963	6%	26,726	5%
Age 18 to 25	161,762	12%	64,093	13%
Age 26 to 34	241,066	17%	101,895	21%
Age 35 to 44	238,801	17%	83,867	17%
Age 45 to 54	338,439	24%	113,730	23%
Age 55 to 64	336,525	24%	101,909	21%
Age 65 or more	1,373	<1%	2,853	1%
Total	**1,395,929**	**100%**	**495,073**	**100%**

Source: Covered California, Executive Director's Report, March 5, 2015

No Wrong Door: Maximizing Outreach & Enrollment Assistance

Covered California also maximized federal dollars available for outreach and education, receiving $88.7 million in 2013 and $130 million in 2014; and for year two a significant investment in a Navigator and In-Person Assistance Program.[xiv] The portion dedicated to targeted Medi-Cal enrollment assistance was matched by The California Endowment — another key to success. Finally, Covered California mounted an aggressive marketing campaign, which was configured to reach 39 million Californians where they "live, learn, work, worship, and play." Agents and brokers also played an important role, signing up 43% of new enrollments for 2015 coverage in Covered California plans.[xv] Other crucial assistance was provided by county workers, enrollment counselors, and Covered California call center staff. Aounty-based eligibility workers can also sign applicants up for Covered California coverage in addition to Medi-Cal and other social services programs.

THANK YOU *to Consumers Union for contributing to the above section.*

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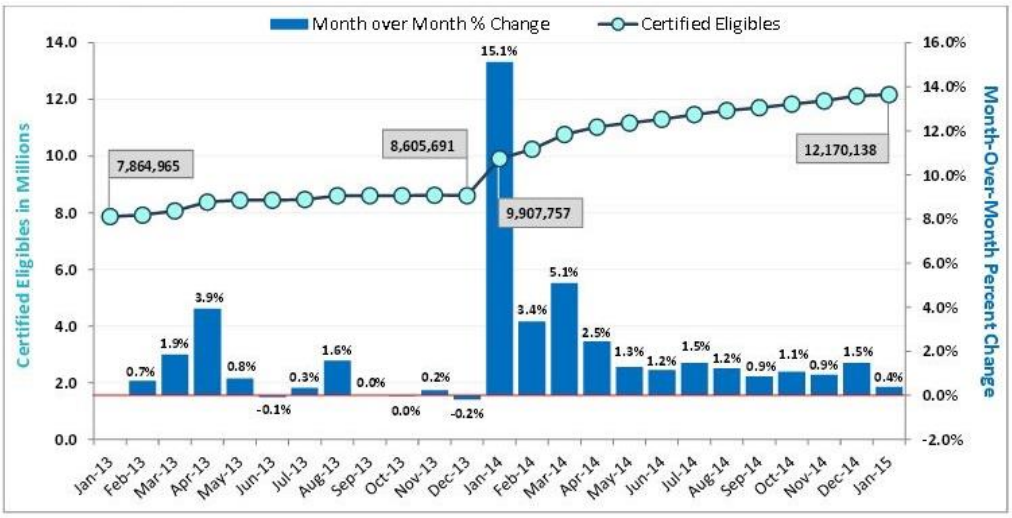
Medi-Cal for Low Income Californians

The Medi-Cal Expansion for Low-Income Adults

Prior to the first ACA open enrollment, an estimated one third (32.5%) of the 9.44 million low-income non-elderly Californians were uninsured.[xvi] Before California expanded Medi-Cal, only children, parents including caretakers and pregnant women, seniors, and people with disabilities who met certain income and asset thresholds were eligible for Medi-Cal. Adults who did not fall within these categories were excluded from Medi-Cal coverage, no matter how poor, even if they were destitute or homeless.

Medi-Cal Certified Eligibles and Monthly % Change, 2013-14

Source:



Research and Analytic Studies Division, Medi-Cal Eligibles 24-Month Trend at January 2015-Advance Counts. Medi-Cal Statistical Brief, California Department of Human Services.

Under the ACA, California chose to dramatically expand Medi-Cal to cover childless adults with incomes at or below 138% of the federal poverty level through the passage of AB x1 1 (Perez) and SBx1 1 (Hernandez/Steinberg). Enacted in 2013, these bills did several things:

- Expanded full scope Medi-Cal benefits to childless adults and enhanced the level of outpatient mental health and substance abuse treatment required under the ACA's mental health parity provisions. Specialty mental health treatment would still be provided by the counties.
- Expanded coverage for undocumented immigrants excluded by the ACA in 2 ways:
    - Expanded ICHIA (Immigrant Children's Health Improvement Act, an option for states under the Children's Health Insurance Program) for childless adults using state funds.

- Uses state-funding to expand Medi-Cal to those Permanently Residing Under Color of Law (PRUCOL[xvii]), including individuals who have been granted Deferred Action for Childhood Arrivals (DACA).

- Kept California's former foster youth who would have aged out of Medi-Cal at age 21 under prior rules on Medi-Cal beginning July 2013 until the ACA provision extending their coverage until age 26 took effect on January 1, 2014. This prevented former foster youth turning 21 years old from experiencing a gap in coverage.
- Provided comprehensive Medi-Cal benefits for pregnant women to keep them healthy during the pregnancy and so they won't have to buy additional health coverage with her Medi-Cal.
- Kept working parents on Medi-Cal by converting the working parent income deductions to the new, simplified income standard.
- Allowed Medi-Cal decisions to be made on predictable prorated income, helping seasonal workers such as farm workers if they show evidence of the pattern.
- Eliminated the requirement that most parents complete semi-annual status reports about changes to income and assets. This requirement was burdensome and resulted in some recipients dropping off the program mid-year because they did not send in the required paperwork, though their income or assets had not changed.

Richard J. "What would happen if I got in an accident?

Richard is a recent college graduate from Sacramento working in a part-time job without health insurance. When his university coverage ended, he looked at buying an insurance plan, but was put off by the high cost: *"$150 a month was too much for me."* Richard went uninsured for about a year and a half and worried about the risk of going without coverage: *"I am very lucky to be healthy, and I don't take any medications – but what would happen if I got in an accident?"* Come open enrollment, he applied for Covered California and found out he qualified for Medi-Cal at no cost. *"I work with a lot of people who are transitioning to new careers or changing careers. It's good to have options for coverage in those in-between times."*

When we talked to Richard shortly after he signed up, he hadn't used his coverage yet, and didn't expect to. But mid-year, he suffered a back injury and had to go to the emergency room. *"It worked ridiculously well - I asked how much it was going to cost, and they told me I was covered. Had this happened before I had insurance I probably wouldn't have gone to the ER, or even the doctor – I would've just gone without medical attention."*

Between December 2013 and January 2015 the eligible count increased by 41.4%. All told, the ACA Medicaid reforms, expansion, and outreach efforts provided health coverage for more than 3 million additional Californians, including both those previously eligible but not

enrolled as well as those who became newly eligible.[xviii] For the newly-eligible population, the federal government covers 100% of the costs for the first three years (2014-2016); the federal government's portion reduces slightly, bottoming out at 90% of cost by 2020.

Simplifying Eligibility and Streamlining Enrollment

As noted above, California's implementation of the Affordable Care Act was configured to ensure that "all doors led to coverage," whether someone applied through the new Covered California online portal, called Covered California for help, or applied directly to a county human services department via phone, mail, online or in person. Covered California and county human services agencies partnered to ensure that individuals calling with likely Medi-Cal eligibility could be handed off directly to a county eligibility worker to enroll in coverage. A majority of applicants, regardless of the application pathway they used, learned they were eligible for Medi-Cal rather than for Covered California subsidies.

The ACA includes a number of provisions to reduce paperwork and eligibility barriers.

- It removes the complicated "asset test" that is a barrier to enrollment and retention, and that prevents poor families from saving.
- It requires the use of a single application for all insurance affordability programs.
- It requires states to adopt a new annual renewal process that begins with an ex parte review of case information to see if recipients can be found eligible for continuing coverage, prior to requesting information from them.

It streamlines enrollment through enrollment channels like presumptive eligibility and express lane enrollment through CalFresh. An estimated 415,000 enrolled this way from Jan 1 2014 through September 2014.[xix]

California was already doing a lesser version of hospital presumptive eligibility, but the policy was strengthened as part of the effort to bring that policy into line with ACA regulations. While the ACA kept the Children's Health Insurance Program intact, California chose to move the separate Healthy Families program into the Medi-Cal program, shifting almost 900,000 children from Healthy Families to Medi-Cal.

Still to do: Medi-Cal Eligibility and Enrollment

One key pending bill (SB33 by Hernández) would improve Medi-Cal by limiting estate recovery. Many low-income Californians age 55 and older are reluctant to enroll in Medi-Cal because they are afraid the state will seek to 'recover' their costs by billing their estates when they die. The federal government requires states to recover against Medi-Cal beneficiaries age 55 and older for long term care services such as nursing home care, but

California is one of only 10 states that collects for *all* medical care, including the total premiums paid to a health plan.

In terms of maximizing enrollment, there is still plenty of work to do.

- **Streamline enrollment for kids**. 9% of kids eligible for Medi-Cal or Healthy Families were still uninsured as of 2012. Research is needed to determine whether issues that existed prior to the ACA, such as lack of information, concerns about immigration status, and churning due to program requirements not being met, continue or if new reasons can be identified for this under-enrollment.
- **Add missing programming to CalHEERS**, the state's new computer system for Covered California and ACA Medi-Cal enrollment.
    - There are still vital Medi-Cal programs for pregnant women and former foster youth that are not programmed into CalHEERS almost a year and a half after the system launched (*see more under Children and Youth, below*).
    - The Medi-Cal Access Program (formerly Access for Infants and Mothers or AIM) provides services for pregnant mid-income pregnant women (213-322% FPL) and is more affordable than Covered California options. The Access Program is required by law to be included in CalHEERS but was left out altogether when the system launched in October 2013.

The Leadership of the Counties & County Eligibility Workers

Low Income Health Program as a Base for Early Enrollment

To prepare for Medi-Cal expansion, most counties chose to participate in the Low Income Health Program (LIHP) demonstration project to provide health coverage for eligible low-income childless adults a full year prior to Medi-Cal expansion. Part of the state's "Bridge to Reform" Medicaid waiver (transformation initiative) demonstration, the LIHPs provided health care coverage to low-income Californians from July 2011 through December 2013. By September 2014, 662,445 individuals were automatically enrolled in the state's Medi-Cal expansion January 2014 [xx] A small fraction of the 650,000 LIHP enrollees, just under 40,000 Californians, had higher incomes and were encouraged to apply for subsidies through Covered California.

During the LIHP or pre-Medi-Cal expansion phase, the counties could use a portion of savings from reduced utilization of uncompensated care to provide care and something close to coverage for the remaining uninsured. This was a win-win for the counties that chose to participate they could draw down federal resources and cover more people in their indigent care systems. These new dollars coming into the counties were shown to have an economic multiplier effect.[xxi] Given the counties' success and leadership role on so many

issues,[xxii] it will be important to build on what's working by keeping them well funded in the next waiver renewal and extending their role.

Elisa Miller, Program Specialist, San Bernardino County Transitional Assistance Department

"Having started as a Medi-Cal Eligibility Worker over 30 years ago, and during that time seeing many customers who did not qualify for any health coverage, it is very satisfying to see the availability of coverage for all, and staff so dedicated to ensuring that coverage for customers. They each felt a personal role in ensuring a customer's application was successfully completed and the customer would have access to much needed coverage." Elisa oversees a task force of eligibility workers who have been working with thousands of customers to obtain verifications required to complete their Medi-Cal/Covered California applications.

County Eligibility Workers

California's progress was dependent on the work of the counties, including the approximately 15,000 county-based eligibility workers' role in enrollment. During the Great Recession they stepped up and enrolled millions of Californians in Medi-Cal. Counties then enrolled more than 650,000 LIHP patients in the early Medi-Cal expansion, followed by the millions of new enrollees in the run-up to full ACA implementation and beyond. For the County Welfare Directors Association of California, which represents county human services agencies in all 58 counties, there is no turning back from the "monumental shift" that has taken place since passage of the ACA and that extends from front line workers to executive leadership. Over this period county human service agencies have used the ACA as a touchstone to look at how they serve clients and what they can do to effectively promote coverage and access to vital human services for all eligible people. As one county's brochure said, "Now we can say YES."[xxiii] In terms of maximizing enrollment, the counties have been ready to partner with Covered California. For example, during the first open enrollment, applicants calling the Service Center were experiencing excessive wait times. Here again, the counties positioned themselves to accept a warm handoff from Covered California during busy times. Here again the counties stepped up and agreed to take additional calls, in addition to the calls they were already taking.

People Living with Pre-Existing Conditions

Spike Dolomite Ward: *Things are Good, Thanks to the ACA*

"I was one of the early beneficiaries of the law. When I was diagnosed with an aggressive form of breast cancer back in 2011, I had no health insurance and this meant my treatment options were very limited. I was uninsured not because I'm a lazy, freeloading deadbeat but because my husband and I are self-employed. We had been purchasing insurance on the individual market. But after exhausting all of our resources trying to keep up with premiums of $1,500 a month, we had no choice but to cancel it.

Looking back on those years, I can say that not having insurance amplifies cancer stress. After the diagnosis, instead of focusing all of my energy on getting well, I was panicked about how we were going to pay for everything. I felt guilty and embarrassed about not being insured."

Shortly after my diagnosis, the Pre-existing Condition Insurance Plan kicked in, and it made it possible for me to purchase insurance at least until 2014 when the whole concept of pre-existing conditions could finally disappear into the history books. Today my husband and I and our 12 year old daughter are all covered by Covered California. I'm getting checked every 3 months by the same oncologist who treated me in 2012. Things are good! I can tell you that "Obamacare" — at least the part I've participated in — works.

An estimated 16 million Californians, including over 2.2 million children, were living with some sort of pre-existing condition. Before the ACA, many of these individuals were considered "uninsurable" and denied individual coverage or asked to pay premiums far higher than others of the same age and region. For this reason, many simply went uninsured.

All around the nation insurers also used different tricks, some of them misleading, to discriminate against people with pre-existing conditions. These included elimination riders (a provision in an insurance policy that allows the insurer to permanently exclude coverage for a pre-existing condition disclosed at the time of application); look back periods (how far back an insurer could look into an applicant's medical history to determine premiums or insurability); and exclusion periods (the number of months a person could be excluded from coverage.

The ACA changed all of this: No longer could insurance companies make money by denying coverage based on health status. Instead, if they wanted to compete in the new "community rated" marketplaces, the theory was that insurers would need to learn how to help people manage their medical conditions (or keep people healthy). This was a 180-degree shift, and

what insurers lost from disruptions to the old business model (denying coverage based on health status) they would ostensibly gain in volume—more covered lives. In this respect, the interests of insurers and advocates for the uninsured have been aligned.

Prior to the ACA California had a number of insurance market reforms benefiting people with pre-existing conditions already on the books. For example:

- Elimination riders were prohibited in California and 12 other states.[xxiv]
- The look-back period was limited to 12 months in California and 12 other states. Fourteen states had a better standard than California.
- The maximum exclusion period was 12 months in California and 23 other states. Four states exceeded this standard.[xxv]

It would take the ACA and the "modified community rating" policy built into it (where individuals and small businesses pool or share risk with the community) to make the very concept of pre-existing conditions a thing of the past.

THANK YOU *to Western Center on Law and Poverty and to the County Welfare Directors Association of California for contributing to the above section.*

WESTERN CENTER ON LAW & POVERTY

HEALTH ACCESS

Children, Youth, and Young Invincibles

Maria Burgos, Aged 22

I entered the foster care system when I was 11 months old. Throughout my childhood, I saw instances of kids' health needs not being met, and situations that could have been avoided. When I turned 18, my social worker told me I wouldn't qualify for Medi-Cal anymore. But during my junior year of college I got pneumonia that left me with bad asthma. I used my scholarship money to pay for an inhaler — money that I usually used to pay for books and flights home. While I was visiting my foster parents in Los Angeles, I almost got stuck without enough money to fly back to school on the east coast. I'll graduate from college in May and I plan to attend medical school the following fall. It's a relief to know that I'll be covered while I'm applying to programs. My experiences with health care have driven me to want to study medicine. Covering foster care youth until they are 26 is a step in the right direction.

The ACA includes many provisions benefiting children and youth through expansions, insurance reforms, simplified enrollment, and improvements in the quality of care. Following are the major provisions with estimates of how many California children, youth and young invincibles (ages 18-34) have been helped to date (*next page*):

ACA Provision	Kids/Youth Benefiting
Cover more kids through more streamlined eligibility processes	700,000 children eligible but not enrolled
No more discrimination based on pre-existing conditions.	2.2 million children
Youth can stay on parents' coverage through age 26. As one result, job-based dependent coverage rose from 13.6% in 2009 to 16.7% in 2012. Other groups saw a decline in this category.[xxvi]	435,000 children[xxvii]
Young adults took advantage of expanded coverage options and enrolled in Medi-Cal and Covered California.	400,000 in 2014 680,000 in Medi-Cal 166,000 in 2015 (Covered California only)
Youth exiting foster care at age 18 or older in any state qualify for Medi-Cal coverage until age 26 regardless of income. Prior law had the age limit at 21.	Estimated 39,000 former foster youth eligible.[xxviii] About 6,682 enrolled in Medi-Cal for former foster youth[xxix]
Free preventive care for children	1.6 million children
End to lifetime or annual dollar limits on coverage[xxx]	3.2 million children
125,000 youth who received DACA eligible for Medi-Cal	125,000 young adults[xxxi]
Investments in school-based health care	$14 million to 35 school-based health centers

Source, unless otherwise noted: http://www.100percentcampaign.org

Areas for Improvement: California Children

- **Invest in children's health care and coverage.** Over half of California's children are enrolled in Medi-Cal, yet access to care is threatened because California ranks nearly last (47th) in spending per enrollee. Congress needs to swiftly re-authorize and fully fund the Children's Health Insurance Program;
- **Improve monitoring and reporting on quality of care** for children in Medi-Cal.
- Certain children may need **specialized pediatric providers**, but because children represent only a fraction (< 10%) of Covered California enrollees, it is important to ensure that their needs are not overlooked by the marketplace.
- **Improve dental care for kids.** In light of the recent audit detailing problems with the Denti-Cal program and the new embedded dental benefit for children in Covered

California, the state must monitor access and address the under-utilization of dental care for children in Denti-Cal and Covered California.

- **Ensure continuous coverage.** Because circumstances can change rapidly and unexpectedly for families with children and family members may have different types of coverage, it is critical to ensure continuous coverage for children and youth.

Riana King (age 23) of the Young Invincibles

Riana King was 20 when she learned she could stay on her parent's plan through the ACA. At age 23, Riana is working full time at Young Invincibles, a nonprofit. Riana was diagnosed with Crohn's disease when she was 10 years old. A few years ago Riana developed severe constant pain in her stomach and ended up in the emergency room. She was told she needed emergency surgery. Had she been uninsured, that bill coupled with her 2 week stay in the hospital would have cost close to $400,000. On top of that her monthly medicines would cost thousands of dollars and routine procedures even more. *"The reason I am still on my dad's insurance is because I have a chronic condition and his plan covers everything at zero cost to me. With my condition, as a young women at an entry level position this gives me peace of mind that I do not have to pay a lot to stay healthy." "If I had to constantly worry, my condition would flare up."*

Areas for Improvement: Former Foster Youth & Other Young Adults

- Former foster youth are eligible for full-scope Medi-Cal until age 26 regardless of income. However, CalHEERS is not currently programmed to determine eligibility for Medi-Cal based on former foster youth status, resulting in former foster youth receiving incorrect eligibility determinations. All are asked about their income, and some are placed into the wrong Medi-Cal program, or told they are eligible only for a Covered California program with a monthly premium. The state should prioritize and implement needed programming fixes to enable these vulnerable young adults to receive the health care to which they are entitled and provide information to counties on those who have been enrolled erroneously into Covered California programs or the incorrect Medi-Cal program.
- Per California law and policy, youth exiting foster care at age 18 or older after January 1, 2014, are to be automatically enrolled in the Medi-Cal program for former foster youth upon leaving care, with no break in coverage and no new application needed. However, some former foster youth have been inappropriately dropped from Medi-Cal, raising concerns that the automatic enrollment process is not going as smoothly as it should. Moving forward, the automatic enrollment

process should be closely monitored and any systemic or individual problems identified should be promptly addressed.

- Millennials are the most diverse generation in US history. In order to truly understand the health disparities experienced by this generation, we need to see Covered California and DHCS report more data on age, gender identity and sexual orientation, and disaggregated race/ethnicity data (particularly for the API communities).
- Young adults are most likely to be buying health insurance for the first time, so targeted and culturally appropriate outreach and education are particularly important to ensuring young Californians make good health coverage decisions by educating first time policy holders on how to take advantage of all the benefits their health plans offer.
- Young adults experience life changes such as marriage, graduation, child birth, and job changes extremely frequently, making young people eligible for Special Enrollment Periods throughout the year. Education and outreach efforts should not end at Open Enrollment but continue to proactively educate and enroll young people throughout the year.
- While over 125,000 young adults who received Deferred Action for Childhood Arrivals (DACA) status were eligible for full-scope Medi-Cal, CalHEERS programming problems and confusion on eligibility due to delayed instructions to counties resulted in many young people being denied or erroneously given limited-scope coverage. CalHEERS programming must be corrected to ensure that all eligible immigrants, including undocumented young Californians and their families can accurately access coverage.

THANK YOU *to Children Now and the Young Invincibles for contributing to the above section.*

CH1LDREN NOW

YOUNG INVINCIBLES
TOGETHER, INVINCIBLE.

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Workers and Employment-Based Coverage

Declines in Job-Based Coverage

By 2012, many Californians returned to work, but those jobs were less likely to include an offer of coverage. Four in ten of the non-elderly uninsured were living in households with at least one full time worker in 2009, compared to half in 2012.[xxxii] Job-based coverage declined for both full and part-time workers. For workers losing coverage, the ACA could

not come soon enough. The question was: how many would find their way into subsidized coverage through Covered California?

Since passage, the ACA's admittedly weak large employer responsibility requirement has been weakened even further in implementation in part because of the loophole in the ACA that allows large employers to offer junk plans while still satisfying the employer requirement. Sadly, an employee who accepts such junk insurance is ineligible for subsidies through Covered California. Employers are also shifting more of the cost of health care onto workers by offering high deductible plans, cutting benefits and narrowing networks.

California has improved on the ACA for large employers that want to provide high-quality, affordable health care coverage to workers. The Governor signed into law legislation to increase transparency for large purchasers to enable them to contain health care costs and implement value-based benefit designs to improve workers' health outcomes. Reducing the cost of health coverage allows large employers to continue to offer coverage and remain competitive with employers that do not.

Central to the ACA is the idea of shared responsibility between individuals, employers and the government. The ACA built on our existing employer-sponsored insurance system and depends on employers continuing to provide coverage and a revenue stream to fund reform. While the ACA contains mechanisms to preserve coverage, more is needed to shore up and improve job-based coverage and to ensure that workers can enroll in subsidized coverage if they do not have an offer of affordable coverage, including:

- Continuing to secure the fair share contribution of employers into the health care system. The ACA imposes an employer responsibility penalty that requires employers to provide affordable coverage or pay a penalty to help offset the cost of subsidies in the Exchange. More needs to be done to prevent employers from evading their responsibilities by using part-time, seasonal or temporary workers.
- Protecting tax payers from subsidizing the cost of healthcare for low-wage workers whose employers pay so little that they are eligible for Medi-Cal.
- Increasing transparency on cost and quality data so that large purchasers can control health care costs and continue to provide affordable, high-quality health care to employees.
- Closing the loophole that allows employers to offer substandard, bare bones coverage to workers in order to evade the employer responsibility penalty. Federal and state law sets a floor for benefits for individuals and small employers, but no equivalent laws apply to large employers with over 50 employees. Workers who accept substandard coverage are barred from subsidies in the Exchange and face exorbitant medical bills if they face illness or injury. Workers deserve the same protections as individuals and employees at small businesses as to the quality of the coverage they're offered.

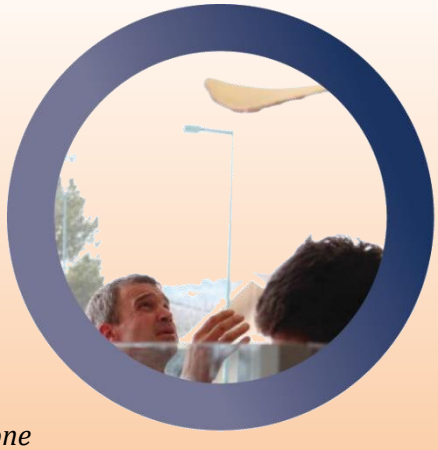
THANK YOU *to the California Labor Federation for contributing to the above section.*

California LABOR Federation

HEALTH ACCESS

Small Businesses and Their Employees

Julie & Robert Pancoast (Pancoast Pizza)



My husband and I were about to renew our insurance from Kaiser, but then we learned that our premiums were going way up and for thinner benefits. We decided it was time to explore options for our business, Pancoast Pizza—not just for us but for our uninsured employees. Fortunately, we met the criteria for California's SHOP [Small Business Health Options Program] exchange. Thanks to SHOP and the small business tax credits which reduce the employees' portion by 50%, we are now providing decent, affordable insurance. We chose to offer a Gold level plan, which covers one employee's seizure medications. Everyone is hiring now, so we need to have something special we can offer our employees so we stand out. Having coverage in place creates a more secure environment for us as employers and for employees.

Since the mid-1990s, small businesses in California had many of the insurance market reforms required under the ACA. Prior to full implementation of the ACA, small business owners often offered insurance so that the owner who was uninsurable as an individual could obtain coverage for him or herself. California had its own small business purchasing pool, which failed due to *adverse selection* (where the pool attracts older and sicker people, thus increasing premiums and undermining the viability of that market). Given the failed experiments with small business purchasing pools here in California and elsewhere, there were serious questions about the viability of a small business exchange.

Despite all of those doubts, Covered California forged ahead with its SHOP exchange—and, unlike the federal marketplaces, did not delay implementation, not even by a year.

In the design of its SHOP California Improved on the ACA in several ways:

- Again, California recognizes the seasonal labor force by redefining full time employee to a person who works an average of 30 hours a week.
- California applies the prohibition on pre-existing conditions exclusions to grandfathered (plans in place before the ACA that were allowed to continue) and non-grandfathered plans alike.
- Issuers may not require applicants or dependents to fill out a health questionnaire—the rationale being that you never know how this information might be used.

The hope was that with more robust SHOP standards somehow the state's SHOP would exceed the dismal expectations. Despite all those improvements on the law, few were surprised when few small businesses enrolled, and even fewer took advantage of the unbelievably cumbersome small business tax credits.

The SHOP online enrollment portal was initially delayed a few months and then when it finally launched, it proved to be unworkable for employees, employers and insurance agents alike. After two months of operation, the website was pulled down in February 2014 and has not been replaced. SHOP customers experienced other delays and administrative challenges due to the IT system that Covered California had selected. A new IT system has since been put in place which has helped to reduce the number of problems. In the fall of 2014, Covered California expanded SHOP's "employee choice" feature which now allows for an employer to select two contiguous tiers of coverage (i.e. silver and gold) and employees can select any plan in those two tiers.

Going forward a more concerted effort is needed to help small businesses make sense of the many choices they have under the Affordable Care Act.

- Educate small businesses about the coming changes to the small group market.[xxxiii] By the end of 2015, all small businesses offering health coverage will be required to purchase an ACA-compliant plan. Small businesses should be educated about why this change is happening, the new benefits they are now entitled to and how SHOP may be a beneficial choice for their business.
- Conduct outreach and marketing to small businesses with 50 to 100 employees who become new eligible for the small group market and SHOP in January 2016. This presents an opportunity for SHOP to pick up some market share.
- Launch an improved SHOP online enrollment portal. Currently, brokers and small business owners can only enroll in SHOP via mail and fax. Most every other state now has an online enrollment system for SHOP.

- SHOP should pay insurance agents in a more timely manner. Commissions have been delayed up to 12 months. This discourages agents from enrolling in SHOP which is a problem since agents are the de-facto sales team for SHOP.
- SHOP should consider increasing the number of carriers that participate in SHOP. Currently, one major insurer is not selling in SHOP which puts the SHOP at a competitive disadvantage in many rating regions dominated by that carrier.

People of Color and Immigrants

People of Color

Though they make up 63% of the state's population, people of color represented 75% of California's uninsured population in December 2013.[xxxiv] For this reason, communities of color and the estimated 7.5 million Californians with limited English proficiency (LEP) have had a great deal at stake in the ACA, starting with the coverage provisions.

In 2012, recognizing that nearly half of Medi-Cal beneficiaries spoke languages other than English at home,[xxxv] and that 40% of the projected Covered California subsidy-eligible population were LEP, efforts got under way to ensure linguistically appropriate outreach and education to maximize enrollment.

One study from the California Pan-Ethnic Health Network, UC Berkeley Center for Labor Research and Education, and UCLA Center for Health Policy Research estimated that an additional 110,000 LEP Californians could be enrolled using a targeted approach. This project identified the following priorities (presented with initial results below).[xxxvi]

In response, Covered California invested resources in targeted outreach, marketing and enrollment assistance to communities of color including targeted ads to California's diverse communities, translated outreach materials and the availability of dedicated 800 numbers in California's 12 threshold languages. These efforts are starting to pay off, as reflected in the distribution of 2015 enrollments by race/ethnicity.

Distribution of Covered CA Enrollment by Race/Ethnicity, 2014 & 2015

	CalSIM 1.91 (%)	Race & Ethnicity - SUBSIDY ELIGIBLE *RESPONDENTS* ONLY -			
	Total	2014 Open Enrollment (Plan selections 10/1/13 – 3/31/14)		2015 New (Plan selections through 2/22/2015)	
		Count	Column %	Count	Column %
Asian	21%	208,357	23%	53,076	18%
Native Hawaiian or Pacific Islander		2,237	<1%	895	<1%
Black or African American	5%	26,038	3%	10,359	4%
Latino	38%	280,025	31%	105,553	37%
White	34%	317,311	35%	99,512	34%
American Indian or Alaskan Native	4%	2,496	<1%	1,289	<1%
Other		26,305	3%	9,708	3%
Multiple Races		50,101	5%	9,163	3%
Total	**100%**	**912,870**	**100%**	**289,555**	**100%**

Note: Excludes individuals who did not respond to the race or ethnicity questions: 195,144 (23%) for 2014 and 147,415 (34%) for 2015.

For the Latino and African American community enrollment in 2015 is much closer to the Cal SIM 1.91 estimates. Moving forward, disaggregated data on the race, ethnicity and primary language of Covered California enrollees for each of Covered California's 19 different rating regions is important in order to more fully understand enrollment trends of California's diverse subpopulations. Additionally, as more Californians become covered, the state must transition from a culture of coverage to one that is focused on promoting health equity and quality care.

What's Left

- **Continue to invest in culturally appropriate marketing and outreach**, including in California's Navigator
- **Protect and expand access to health coverage for the remaining uninsured** through an expanded Medi-Cal program, access to Covered California and county safety-net supports.
- **Ensure quality and equity in health care coverage** by using patient data to identify and reduce health disparities while ensuring delivery system reforms and payment incentive programs promote health equity.
- **Promote cultural and linguistic access to coverage and care by ensuring** standardized written translations of marketing and outreach materials including the

Summary of Benefits and Coverage and the uniform glossary of insurance terms in the languages spoken by California's consumers[ii] as well as the availability of up to date provider directory information on languages spoken by doctors and their staff.

- **Invest in primary care and workforce diversity in underserved areas** so consumers can receive culturally and linguistically appropriate care.
- **Invest state dollars towards improving the social and environmental factors that impact health,** including better utilization of community health workers and policies to prevent chronic conditions.

Qualified Immigrants

California has a long history of expanding coverage to lawfully residing qualified immigrants. In this area in particular, California has gone beyond the ACA. For example, California offers state-funded coverage for these populations. For example, "qualified" immigrants do not have to wait five years before they can be eligible for Medi-Cal and the state also covers immigrants Permanently Residing under Color of Law (PRUCOL), as noted above. Starting in 2014, this policy was extended to childless adults, which includes immigrants who are Permanently Residing under Color of Law (PRUCOL), as noted above.

Deferred Action for Childhood Arrivals & Undocumented Immigrants

Individuals who have been granted Deferred Action for Childhood Arrivals (DACA) and are income eligible qualify for Medi-Cal. This means that DACA recipients are eligible for state-funded full scope Medi-Cal because deferred action is an eligibility category under PRUCOL. However there are 1.4- 1.5 million undocumented Californians who will remain uninsured because of their immigration status. The Affordable Care Act specifically excludes undocumented immigrants from enrolling in health plans through Covered California and receiving full-scope Medi-Cal. Because of this exclusion, undocumented Californians often delay care until conditions become more extreme, resulting in expensive trips to emergency rooms, or foregoing care altogether.

What's Left

See priorities under Part III, Remaining Uninsured.

Wei Lee: *We are already paying into the system*

I came to California and settled in San Francisco with my family at age 16 to flee persecution and reunite with the rest of my family—though we'd be undocumented. As a healthy teenager, I didn't really know about health insurance—or what it means to go without. Then, at the age of 24, it hit me all at once when I got jumped and mugged on the way home one night. Though I was beaten to the ground and left hemorrhaging, I said no when the police asked me if I wanted to go to the hospital. Later, on my friends urging, I agreed to go to SF General but with the premise that my friends would help me enroll in Healthy San Francisco (HSF) before I left the hospital. After undergoing tests to rule out concussion, and getting shots, I was able to enroll in HSF and sent home. Thanks to Healthy SF, instead of paying $1,000 for my hospital bill, I only had to pay $15.

I know what it's like to live without insurance, and this is why I'm dedicating a lot of my time, with other ASPIRE members, to the campaign for #Health4All and SB4. As hard working immigrants, we are paying taxes, contributing to the economy as a whole. We are already paying into system but not able to get anything in return—this is not right.

Thank you to the California Pan-Ethnic Health Network and to the California Immigrant Policy Center for contributing to the above section.

Lesbian, Gay, Bisexual, & Transgender Communities

California's sizeable lesbian, gay, bisexual, transgender, queer, and questioning community faces significant disparities in health[xxxvii] and health coverage, and thus they, too, have had much to gain from the ACA. Across the U.S. the LGBT community is more likely to be uninsured than their non-LGBT counterparts (17.6% vs. 13.2%)[xxxviii] In CA, 23.9% of subsidy-eligible (between 139%-400% of federal poverty level) straight people were uninsured, but 28.2% of subsidy-eligible LGBT people were uninsured. The discrepancy is even more pronounced in certain areas of the state. For example, in the Central Valley, 20.4% of subsidy-eligible straight people were uninsured while 27.9% of subsidy-eligible LGBT

people were uninsured. And in southern CA, 26.2% of subsidy-eligible straight people were uninsured while 35.5% of subsidy-eligible LGBT people were uninsured.[xxxix]

The law itself and the regulatory framework around it include a number of initiatives designed to close the coverage gap and improve the health status of the LGBT community, including:

- The coverage expansions (*described above*) disproportionately benefit communities like LGBT with high uninsured rates.
- The ACA bans discrimination based on sexual orientation and gender identity and funding allocated for LGBT enrollment assistance. Section 1557 of the ACA explicitly prohibits discrimination based on sex, which is defined as including gender identity. Subsequent federal regulations barred discrimination based on sexual orientation.
- The ACA calls for LGBT inclusion in routine data collection and surveillance on disparities. If they have not already, most national health surveys are working to include questions and data points relevant to LGBT inclusion.

Policy developments outside the ACA itself also have important implications for efforts to close the coverage gap or address LGBT health disparities, in particular the legalization of marriage in 37 states—with this issue likely to be decide favorably for the rest this summer and the Supreme Court's 2013 ruling on DOMA (Defense of Marriage Act), which opens the gateway to spousal benefits for married LGBT couples—even in the eyes of the IRS.[xl] This has taken some time to fully implement. Since 2010 the state has come a long way in terms of maximizing these opportunities, though it has a long way still to go.

Successes to Date

In addition to changes (i.e. coverage expansions) noted in other sections of this report that significantly benefit LGBT people and families, these stand out:

- California law and thus Covered California treat domestic partners the same as married couples (except for federal tax subsidies).
- The Brown Administration has committed to including demographic questions about sexual orientation and gender identity on Covered California's streamlined application and other state surveys, but this is not yet accomplished.
- Insurance plans now have to cover necessary medical care for transgender patients.
- Covered California's Outreach and Education Grant and Navigator Program includes grantees specifically reaching out to LGBT communities.
- Covered California's background check policy was modified to prevent unintentional discrimination against LGBT individuals.
- The application for coverage through Covered California includes the ability to indicate family that includes same-sex partners.[xli]

Unfinished Business for LGBT Communities

Looking at various sources, we can pinpoint the following priorities moving forward:

- Better data collection: the Covered California application is only a start. Many databases, including electronic health records, clinical surveys, and most government forms still do not collect LGBT data. As the state moves toward a comprehensive All Payer Database, it will be important to close the gaps in LGBT data collection in both the public and private sector.[xlii]
- Ensure access to LGBT-friendly and trans-competent providers across the state.
- Provide health care for undocumented LGBT people.

Thank you *to the California LGBT Health and Human Services Network for contributing to the above section.*

LGBT HEALTH California LGBT Health & Human Services Network

HEALTH ACCESS

Seniors and People with Disabilities

The ACA includes a number of initiatives designed to help seniors directly (for example closing the donut hole or free preventive care and an annual wellness visit) or to stabilize Medicare funding and improve quality of care. The latter, by their very nature, will take time to pan out, though positive results can already be demonstrated.

- In 2013 alone, 358,862 California seniors stuck in the prescription drug 'donut hole' saved over $333 million on prescription drugs, saving an average of $931 per beneficiary. By 2020 the 'Donut Hole' will be completely closed.
- More than 3.5 million California seniors used one or more free preventive services. These benefits are available for all 4.8 million seniors on Medicare.

Low-Income Seniors and People with Disabilities ("Dual Eligibles")

The ACA provides states with incentives and resources to limit growth in spending and improve care coordination and aging in place for the "dual eligibles:" seniors and people with disabilities who are, by virtue of their low income, eligible for both Medicare and Medicaid. An important context for Dual Eligible pilot demonstration projects and waiver initiatives targeting the "duals" is the hard fact that this relatively small number of individuals accounts for such a large portion of spending. In 2012 when California decided to implement this option, one-sixth of the state's elderly (17% or 1.1 million seniors and people with disabilities) were dual eligible. In an effort to improve care and rein in spending on this group, officials originally decided to implement the pilot program in 8 counties to managed care.[xliii] However, the roll out was delayed by nearly two years, and the scope narrowed to 5 counties. The state expects to have 7 counties participating by July of 2015.

Aside from early challenges related to plan readiness (e.g. in Alameda and Orange Counties), there have been several documented cases of confusion related to notices which have hampered the start of the demonstration, and providers and beneficiaries have been reluctant to make the change. By November 2014, 69% of the eligible participants had opted out of the program. The initial plan had been to expand the duals demonstration to the rest of the state, with the goal to limit cost growth and improve care and outcomes for this, the most expensive segment of the population. One of the California requirements for the duals demonstration, however, is for the pilot to demonstrate cost-effectiveness. Should the duals demonstration not meet that threshold, it would cease. As of 2015, the duals demonstration has relied on the managed care organization tax to meet this threshold. Over the course of the years ahead, the Administration and interested stakeholders will look to increase participation in the pilot, contain costs, and extend the managed care organization tax in order to continue the demonstration.

It bears noting that Medicare costs and the overall burden of caring for a rapidly aging population will get some relief by having better, more affordable coverage in place for older pre-Medicare adults ages 50-64. With that coverage, they will do better managing chronic conditions, which means they should not cost as much once they become eligible for Medicare.[xliv]

Part III Lots More To Do!

Maximizing and Expanding Coverage

Enrolling hard to reach populations and the eligible but uninsured

Even with millions of Californians newly covered, we have many still to enroll. We know who they are in terms of race/ethnicity, gender, age, sources of coverage without the ACA, income, language proficiency, and other factors, thanks to modeling from the Cal SIM (California Simulation of Insurance Markets, UCLA School of Public Health and UC Berkeley Labor Center). Of those eligible for subsidies in 2015 40% have limited English proficiency, for example. 37.5% are Latino, 5.1% are African American, and 12% are Asian or Pacific Islanders.[xlv]

Covered California and DHCS should continue using these data to more precisely target outreach both during the current special enrollment period and in year 3 of open enrollment. Enrollment entities should focus on communities of color as well as groups like young adults, who are more likely to experience a life event (changing jobs, moving, getting married, having children, turning 26, or leaving prison, etc.).[xlvi]

California's success with enrollment and slowing the growth in premium costs notwithstanding, the enrollment process does not work as well as it. While some issues can be explained as the glitches that come from the first few years of any venture, or the need to ramp up to the scale sufficient to California's size, other barriers require thoughtful re-examination of the enrollment process itself. These challenges and goals include:

- Real-time communication and improved notices for consumers, so they know the status of their Medi-Cal or Covered California application and are not left in the dark—at one point up to 900,000 Californians were left hanging on their Medi-Cal applications during the backlog).[xlvii]
- Ongoing funding streams for enrollment assisters, which are needed to help enrollees learn how to use their benefits or, where there may be challenges, to file and track complaints.
- A more concerted campaign to educate and enroll harder-to-reach populations, including Latino and low-English proficient communities.
- Better auto-enrollment systems to help people transition between types of coverage, minimizing disruptions due to "churn "and maximizing enrollment in a multi-payer system, especially during "special enrollment" opportunities.
- Improved computer systems so it is easier to disenroll when appropriate. It's been said that nobody can check out of "Hotel California."[xlviii] There may, in fact, be legitimate reasons to disenroll: for example, the enrollees may have been offered insurance through a new job. It is important also for planning and evaluation purposes to have an

accurate enrollment numbers.

Cover the Remaining Uninsured and Undocumented Immigrants

Undocumented immigrants are explicitly excluded from the ACA as they have been from many other federal health programs. This means they cannot enroll in a Covered California health plan, receive tax credits and subsidies or use Covered California to purchase health coverage—even if they want to pay full price. While California has taken some steps to correct this injustice, much more needs to be done.

Javier & Luz: Their conditions were preventable

Javier and Luz and their two children live with relatives in California, and are undocumented (names have been changed at their request). They survive off low wage seasonal employment that does not offer health benefits. Javier is diabetic but rarely visited a doctor due to the cost. The local community health center helped him with insulin, but even the cost of discounted care was too much. This meant he went without. One day, he lost his sight. Like anyone in that situation, he was terrified and went to the E.R., who referred him to an ophthalmologist. The diagnosis: glaucoma and diabetic retinopathy. Since his diagnosis, a local vision center and an ophthalmologist have offered him free and discounted care, including exams, laser treatments, and two surgeries. The local Lion's club pitched in to help as well. Unfortunately, none of this was enough to cover the total cost of care, pushing him and his family into severe, irreconcilable debt. Luz worries about the debt daily, and has opted to forgo health care in all but the most extreme conditions. Most recently, she suffered an ear infection for several weeks hoping it would go away without treatment. After one particularly painful night, she saw a provider for care. By that time, her face was terribly swollen on one side and she was in great pain. Had she come sooner, she could have been treated quickly and easily, but adding $40 to their existing debt seemed insurmountable. For people like Javier and Luz, Health for All would change their lives. Javier's condition was preventable. Luz's condition was easily treated. But in both cases, there was unnecessary pain, suffering and hardship. We can fix that with Health For All.

While many California counties serve the undocumented in their safety-net, too many counties do not. County systems should reconsider covering the remaining uninsured, including the undocumented, and state funding formulas and waiver negotiations should aim to advance that goal.

Some—but not all—of these Californians will soon be covered if the President's executive order on immigration is upheld by the courts. Senate Bill 4 (Lara) seeks a statewide solution to providing health coverage to the undocumented starting with an expansion of state-funded Medi-Cal. An estimated 1 million undocumented Californians are not eligible for any ACA health plans or state-funded full-scope Medi-Cal due to their immigration status. On November 20, 2014, President Obama took administrative action to grant temporary relief from deportation and eligibility for work permits for millions of undocumented immigrants across the nation. The announcement expands the current DACA program to individuals who were "aged out" and also creates a Deferred Action for Parents of Americans and Lawful Permanent Residents ("DAPA") program for undocumented parents of U.S. Citizens and Lawful Permanent Residents. While these programs have been temporarily delayed, once they are available and granted, individuals with expanded DACA or DAPA status should be eligible for full-scope Medi-Cal, *if* they meet all other requirements.

Benefit Design and Affordability

Improved Standardization

One concern in 2014 was that many of those below 250% FPL who were eligible for cost sharing reduction help that reduced copays, deductibles and out of pocket maximums did not take advantage of that opportunity and instead purchased bronze products with high cost sharing but lower premiums. For 2015, the problem persists, but those with the lowest incomes were the least likely to pick bronze, suggesting that many consumers were correctly making the trade-off between premiums and cost sharing.[xlix] Covered California is committed to educating consumers about the availability of cost sharing reduction products and the help they can provide.

Covered California Enrollment by Metal Tier, 2014 & 2015

	Metal Tier - SUBSIDIZED only			
	2014 Open Enrollment (Plan selections 10/1/13 – 3/31/14)		2015 New (Plan selections through 2/22/2015)	
	Count	Column %	Count	Column %
Minimum Coverage	6,534	1%	2,902	1%
Bronze	297,448	24%	128,342	29%
Silver	809,085	66%	274,351	63%
Gold	61,507	5%	17,866	4%
Platinum	47,746	4%	13,509	3%
Total	**1,222,320**	**100%**	**436,970**	**100%**

Despite all that California has done to standardize benefit designs, the unaffordable cost sharing inherent in the lower actuarial value tiers creates challenges for consumers as well as for advocates attempting to propose standardized benefit designs that can readily be understood by consumers. Problematic benefit design elements include:

- **Coinsurance**—this type of cost sharing should be limited or eliminated, or at least better labeled to explain the risks. Consumers cannot know what the cost of a given service will be when it is expressed as 20% of an unknown.
- **Deductibles**: the 2016 benefit designs assure that deductibles are applied consistently within actuarial value tiers but for many consumers, the concept of a deductible is very confusing. The very high deductibles required for the lower actuarial value tiers remain barriers to necessary care.
- **Market place choices** should be easier to understand and data needs to be available and intelligible at the point of sale to make meaningful choices.

Affordability

Affordability of coverage and care remain challenges: some will remain uninsured, others will face high costs for coverage or care while living in some of the highest cost regions in the country. While the ACA provided significant subsidies to millions of consumers, four specific populations need more help:

- Many undocumented immigrants are explicitly excluded from federal health programs. As stated above, state and county safety-net programs are needed to provide care and coverage for the remaining uninsured.
- The ACA allows workers whose out-of-pocket premium costs are more than 8% of income to be able to get subsidies in a state marketplace. But a federal interpretation of the law states that if worker coverage is less than 8% but family coverage is more than 8% then subsidies are unavailable for the family—leaving some spouses and children without an affordable offer of coverage. This **"family glitch"** can and should be remedied at the federal level legislatively. Until the federal government corrects the family glitch, California should explore providing some help as well.
- The ACA states that all who spend more than 8% of their income on coverage are exempt from the requirement to have coverage; moreover, it provides protection that they won't have to pay more than 9.5% percent of income for a "silver" plan. But subsidies are only available up to 400% of the poverty level. There are consumers, mostly ages 50-64 in high-cost health care areas who are just above the 400% threshold and therefore face premiums higher than 9.5% of income. For a single woman living in Los Angeles on $50,000 a year, expecting her to pay more than $4,250 for insurance is asking a lot—in fact, the second lowest cost silver plan for a 55 year old in Los Angeles (90210) costs $5,436 in 2015. It means that health insurance is one of the biggest costs in her budget, probably second only to housing. Federally, or perhaps statewide for a high cost-of-living state like California, it would be good to provide modest **relief for those having to spend more than 10% or 12% of income, regardless of their FPL**. It would make the ACA's affordability guarantee truly universal.

- For those below 400% of poverty, the question is whether the financial help provided is actually enough. Even with lots of sign-ups, and the influx of subsidies valued at hundreds or thousands of dollars for many low-income families, some families are simply not able to afford the premium required, or the cost-sharing. Technically, they are not subject to the mandate—but this is not much solace if they are left with nothing. States like Massachusetts and Vermont have supplemented the federal subsidies, in order to help families make ends meet.

Shore Up Job-Based Coverage

California should continue to secure the fair share contribution of employers into our health system, to better secure and expand coverage for working families, to protect taxpayers and ensure the sustainability of our health system for the long-term, and to promote fairness and a level playing field for employers who offer health benefits but compete against those who don't or who cut back their benefits.

Consumer Protections: First Coverage, then Care

As more Californians find their way to coverage, they will need new consumer protections:

- **Timely access to care in adequate networks of providers**, which has been a longstanding issue, but now it is more urgent with so many more gaining coverage. California can help alleviate these concerns, through additional oversight, legislation, regulation, investigation, litigation, and contract negotiation. California already has strong consumer protections that require that managed care plans networks are adequate to provide needed care in-network in a given geographic region in a timely manner—no more than 10 business days—and in the languages spoken by consumers. Those who can't get a doctor in-network should be allowed out-of-network with in-network cost-sharing.
- **Standardized and accurate provider directories**, to ensure patients can select the right plans and make the right choices. These directories should include information on the languages spoken by providers and their staff.
- **An end to discriminatory formularies and pricing for specialty medications**. In November 2014, the federal government issued guidance stating that placing all or most drugs that treat a specific condition on the fourth tier or prohibiting coverage of a single tablet regimen is discriminatory. A legislative and regulatory effort is underway to bring state law into compliance with federal guidance on this issue.
- For those in Medi-Cal, especially those in fee-for-service outside a managed care plan, a legitimate issue is **reimbursement rates**, which are some of the lowest in the nation. But we should pursue rate increases, contingent on meeting certain access parameters, or take a more focused approach to rate increases that prioritize delivery system reform goals, for example by starting with primary care rates. There are several ways to **invest**

more in Medi-Cal: through a new Medicaid waiver, provider fees, and new revenues—but **with accountability** on Medi-Cal plans to maximize the benefits for Medi-Cal beneficiaries.

- **Better oversight of Medi-Cal plans** in general, especially those that take care of the most vulnerable; and monitor the transitions of populations into Medi-Cal managed care, to ensure seniors, people with disabilities, and others get the care that they need, and that DHCS is providing the needed oversight.
- **Improved consumer assistance hotlines** as more Californians are covered and many experience coverage for the first time. California has built on pre-ACA or existing consumer assistance programs in addressing the ACA requirement to help consumers who are having problems with accessing care or with grievance and appeals processes.

Cost and Quality

The ACA's various cost containment elements have helped get the nation the slowest growth of health care costs in 40 years. The increased review of insurer rates has resulted in hundreds of millions of dollars in rate retractions, reductions, and rebates. Covered California has been an active purchaser, driving down premiums below projected levels and cutting in half the rate of premium growth in the individual market. While not enough, these are promising signs that some elements of the reform are starting to work. The ACA provides new tools for additional work in the area of cost, quality, and public health, and California should engage these opportunities. As the state looks for further solutions to bring down system-wide health care costs the following priorities should be considered:

- Increase transparency in our health system, so we can "follow the money" at the insurer, provider, drug company, and doctor level. Some bills are pending that would advance **greater transparency on cost and quality**, for example through an all-payer database.
- Push for consumers to get the **right care and the right time**, in a health system that pays for value not volume, pay for performance rather than per person or per procedure.
- Improve **administrative efficiency** in the health system, from medical loss ratios to other efforts to reduced overhead.
- Maintain aggressive oversight over health insurance rates.
- Support **patient safety** efforts to reduce hospital infections and other costly mistakes.
- For self-pay patients, advance policies that protect against overcharging, abuse, and other practices that leave health consumers financially insecure, or in debt, from "junk" insurance and underinsurance, unfair pricing and billing by providers.
- Even those with coverage need **consumer protections against "surprise bills,"** balance billing, and other unfair practices. Patients who have health coverage shouldn't get surprise bills from physicians when the patient's health plan refuses to pay, or when they went to an in-network hospital but got seen by an out-of-network doctor.

Part IV Conclusion

Thanks to the Affordable Care Act and to California's improvement on the law, millions of Californians are benefiting from new coverage, access, and financial help to afford coverage. California provides a bright example of what can be done at the state level to achieve the law's best intentions. But reform is never done—and no matter what our results, there will be improvements and fine tuning over the coming years, if not in perpetuity.

The ACA sets the foundation for near universal coverage with parameters and guardrails around what that coverage must include. Beyond that, the ACA is a study in federalism, giving states considerable flexibility on insurance market reforms, benefit designs, affordability, enrollment systems, and more. Against that background, California is leading, using the ACA as a jumping off point for robust reforms that make sense for California and go further than the ACA. The elements of the state's success include:

- Must have leadership and support from the highest level, even from a Republican governor or a fiscally conservative Democratic Governor.
- Just as important as expanding coverage is streamlining eligibility and making it easy to enroll and renew coverage. Though still a work in progress, collaboration across the traditional silos of government and with the counties and enrollment assisters has created a "continuum of support" for consumers.[l] The key will be to apply this continuum to the rest: Using coverage to stay healthy or to make meaningful choices when it's time to re-enroll.
- Robust reform requires upfront investments. Both federal funding and foundation efforts have been critical to success here in California.
- Transparency around the process and public accountability at every level. One reason given for the state's willingness to embrace a progressive reform agenda culminating in an embrace of the ACA is the power of coalitions, specifically to the ability of advocates to coalesce around a coherent agenda for reform.[li]

A lingering problem is too many Californians are locked out of this new system. By maximizing federal dollars set aside for the ACA coverage expansions, California is saving an estimated $1.9 billion dollars in uncompensated care costs.[lii] A portion of these funds is already spoken for—but not all. Given the long list of accomplishments over the last five years, our goal is that within the *next* five years or less the state's ongoing reform process will result in quality, affordable, health care coverage for every man, woman, and child living in the Golden State—and that coverage and care will help all Californians, no matter what language they speak or where they came from, enjoy longer healthier lives.

Appendix A Legislative Priorities for 2015-2016

Patient Protection Legislation to Limit Out of Pocket Costs

While many more Californians are now covered under the Affordable Care Act, many premium-paying patients who are covered still struggle with out-of-pocket costs. Some practices by providers and insurers unfairly burden patients with unmanageable cost-sharing, interfering with access to care people need. Health Access California is sponsoring a package of bill that protect covered patients from unfair charges.

SB137 ***(E. Hernández)*** **Accurate Provider Directories:** Standardizes provider directories and has more oversight on accuracy so people know whether their doctor and hospital are in network when they shop for coverage, when they change, or when they try to use their coverage to get care. *Co-sponsored with Consumers Union and CPEHN.*

AB248 ***(R. Hernández)*** **Minimum Value Coverage***:* Prohibits sale of subminimum coverage by insurers to large employers. Such plans put workers in a double bind: with unmanageable costs for uncovered care; and because they took up that coverage, they are automatically ineligible for premium subsidies through Covered California.

AB339 ***(Gordon)*** **Prescription Drug Cost Sharing**: Requires insurers to cover medically necessary prescription drugs, including those for which there is no therapeutic equivalent; Prohibits placing most or all of the drugs to treat a condition on the highest cost tiers of a formulary; requires formularies to be based on clinical guidelines and peer-reviewed scientific evidence; and more.

AB533 *(Bonta)* **SURPRISE BILLS**: Protects patients from "surprise" bills from out-of-network doctors when they did the right thing by going to an in-network hospital or imaging center or other facility. The bill would ensure that such a consumer only has to pay the in-network cost sharing.

AB1305 *(Bonta)* **LIMITATIONS ON COST SHARING IN FAMILY COVERAGE***:* Ensures that an individual patient faces the ACA-set individual out-of-pocket maximum (now $6350), even if they are in a family plan (which has an overall family out-of-pocket max of $12,700). If it's just one person in the family that got sick, they shouldn't be penalized for being in a family plan rather than an individual one.

Other High Priority Bills

SB4 (Lara) **#HEALTH4ALL** would allow Californians otherwise excluded because of immigration status to buy coverage through an exchange like Covered California—but using their own money and without subsidies and expand Medi-Cal to those remaining undocumented under 138%FPL for adults and 261%FPL for kids. *Sponsored by the author and the top priority for Health Access and many others.*

SB33 (E. Hernández) **ESTATE RECOVERY**: would limit estate recovery in Medi-Cal to the federally required minimum of long-term care services. Would also eliminate recovery from the estate of a surviving spouse of a deceased Medi-Cal beneficiary, and require DHCS to provide claims detail information free of charge to Medi-Cal beneficiaries.

SB26 (E. Hernández): **ALL PAYER DATABASE:** establishes an all payer claims database system to provide valid, timely, and comprehensive health care performance information that is publicly available and can be used to improve the safety, appropriateness, and medical effectiveness of health care, and to provide care that is safe, medically effective, patient-centered, timely, affordable, and equitable.

AB463 (D. Chiu) **PHARMACEUTICAL COST TRANSPARENCY ACT OF 2015:** Requires each manufacturer of a prescription drug sold in California with an acquisition cost of >$10,000 annually or per course of treatment to file a report by May 1 of each year with OSHPD on the costs for each drug.

Appendix B Legislation on ACA Implementation (2010-2014)

The passage of the Affordable Care Act at the federal level was not the end but the beginning of legislative activity to reform California's health care system and to make it more responsive to the needs of all Californians. Since passage of the ACA, California has enacted over three dozen pieces of legislation. Here is a selection of these bills:

ACCESS FOR CALIFORNIANS WITH PRE-EXISTING CONDITIONS

AB1887 (Villines)/SB227 (Alquist), 2010

FEDERAL FUNDING FOR A HIGH-RISK POOL: Authorizes MRMIB to apply for federal funding for, and to create, a new "high-risk" Pre-Existing Condition Insurance Program (PCIP) to provide coverage to people denied for pre-existing conditions.

AB2244 (Feuer), 2010

ACCESS AND AFFORDABILITY FOR CHILDREN WITH PRE-EXISTING CONDITIONS: Requires guaranteed issue, eliminates all pre-existing condition exclusions, and limits premium increases based on health status, phasing in modified community rating for children under age 19 in the individual market. Improving on federal reform: Rating rules of 2 to 1 in open enrollment.

AB151 (Monning), 2011

GUARANTEED ISSUE FOR SENIORS: Assures that those who previously covered by Medicare Advantage plans have guaranteed issue for Medi-Gap coverage.

AB1x2 (Pan); SB1x2 (Hernández), 2013

BAN ON PRE-EXISTING CONDITIONS AND OTHER INDIVIDUAL INSURANCE MARKET REFORMS: Prevents insurers from denying or discriminating for pre-existing conditions, and institutes other market rules/consumer protections for those who purchase health coverage on their own. Limits different premiums on age to 3:1.

NEW OVERSIGHT ON INSURER PREMIUMS

SB1163 (Leno), 2010

PROVIDING TRANSPARENCY ON RATES: Requires 60 days public notice of rate hikes and requires health plans to provide to the public information about their rate methodology. Improving on federal reform: Requires review of all rate hikes in individual and small group market, rather than just "unreasonable" increases. Also, collects additional information on underlying cost increases.

SB51 (Alquist), 2011

REQUIRING PREMIUM DOLLARS TO BE SPENT ON HEALTH CARE: Allows state regulators to enforce the Medical Loss Ratio provision of the Affordable Care Act that requires insurers in the large group market to spend 85% of premium dollars on health care and insurers in the small group and individual markets to spend 80% of health care dollars on actually providing health care rather than for administration or profit.

AB1083 (Monning), 2012

REFORMING THE SMALL GROUP MARKET: Conforms new insurance market reforms for small businesses to prior state law as well as the Affordable Care Act, particularly so small employers don't get additional premium spikes based on the health of their workers.

BETTER BENEFITS AND CONSUMER PROTECTIONS

AB2345 (De La Torre), 2010

COVERING PREVENTIVE SERVICES: Requires insurers to eliminate cost-sharing for some preventive services such as pap smears, mammograms, other cancer screenings, and immunizations. Conforms to federal reform.

SB222 (Evans/Alquist) & AB210 (Hernández), 2011

GUARANTEEING MATERNITY COVERAGE: Requires that health plans sold in the individual and small group markets, respectively, stop discriminating against women and provide as a basic benefit, maternity care and maternity-related care. Ensures Californians get needed care, preventing them from falling onto taxpayer-funded programs. Improving on federal law: Starts in July 2012, eighteen months earlier than the maternity requirement as part of the federal essential benefits package in 2014, allowing for a smoother phase-in.

SB 951 (Hernández) & AB1453 (Monning), 2012

ESSENTIAL HEALTH BENEFITS: Protects consumers from underinsurance and junk insurance by requiring that health plans and insurers cover a minimum set of essential health benefits, including ten categories of benefits defined in the ACA. The bill sets the minimum floor for benefits to be equivalent to the Kaiser small group HMO.

SB 964 (E. Hernández), 2014

OVERSIGHT OF HEALTH PLAN NETWORK ADEQUACY: Requires the Department of Managed Health Care (DMHC) to do annual reviews of all health plans for timely access and network adequacy and that reviews be done separately for Medi-Cal managed care and the individual market so that consumers in Medi-Cal managed care and Covered California get timely access to necessary care.

SB 1052 (Torres), 2014

HEALTH PLAN FORMULARIES: standardize plan formularies so that consumers know which plans cover which drugs at what costs. This measure applies to the individual and employer coverage markets.

SECURITY TO STAY ON COVERAGE

AB2470 (De La Torre), 2010

REGULATING RESCISSIONS AND MEDICAL UNDERWRITING: Sets standards for rescission, the insurance industry's practice of terminating coverage as if the coverage had never been issued. Improves on federal reform by continuing coverage pending determination of rescission, and providing more notice.

SB1088 (Price), 2010

ALLOWING YOUNG ADULTS TO STAY ON THEIR PARENTS' COVERAGE: Requires group health, dental, and vision plans to allow dependent children to continue on their parents' coverage through age 26.

AB36 (Perea), 2011

ALIGNING TAX CODE FOR YOUNG ADULTS STAYING ON PARENTAL COVERAGE: Aligns state tax code to conform to federal law related to parents covering young adult children.

MEDI-CAL EXPANSIONS AND RELATED MEASURES

AB342 (Perez), 2010

MEDI-CAL WAIVER: EARLY EXPANSIONS FOR LOW-INCOME ADULTS: Expands county-based "coverage initiatives" using federal matching funds to provide better access for low-income Californians, as a bridge to full expanded Medicaid under health reform in 2014. Improving on federal reform: Allows hundreds of thousands of Californians to get coverage prior to 2014, and to be ready for full Medi-Cal coverage on day one.

SB208 (Steinberg), 2010

MEDI-CAL WAIVER: SYSTEM CHANGES: Implements a new Medicaid waiver with the federal government, in order to draw down new federal funds, to encourage better coordinated care, including shifting seniors and people with disabilities to mandatory managed care, with certain consumer protections.

1296 (Bonilla), 2011

STREAMLINING ELIGIBILITY AND ENROLLMENT: Requires the California Health and Human Services Agency establish a standardized single application form and related renewal procedures for Medi-Cal, Healthy Families, the Exchange, and county programs. Sets a framework so that millions of Californians gain meaningful and easy access to coverage under the ACA. (Modified by Assemblywoman Bonilla's AB1580 in 2012).

AB1x1 (Speaker Perez); SB1x1 (Hernández /Pres. Pro Tem Steinberg

MEDI-CAL EXPANSION AND STREAMLINING: Expands Medi-Cal to all legal residents up to 133% of the poverty level, including over one million adults without children at home. Puts in place eligibility and enrollment reforms to make it easier to get on and stay on Medi-Cal coverage.

AB1x3 (Hernández)

BRIDGE PLAN OPTION: Allows those in Medi-Cal to stay in the Medicaid managed care plan as their incomes fluctuate and qualify them for Covered California. Conceptual goal is to improve continuity of care, affordability for lower-income families, and more stability for safety-net health providers.

NEW SYSTEMS TO ASSIST CONSUMERS IN 2014 AND BEYOND

AB1602 (Speaker Perez), 2010

CREATING A NEW EXCHANGE: Establishes the operations of the California Health Benefit Exchange which would be an independent state agency tasked in negotiating for the best prices and values for consumers and providing information regarding health benefit products. Improving on federal reform: The California Exchange will be an active purchaser, with protections against adverse selection.

SB900 (Alquist/Steinberg), 2010

RUNNING A NEW EXCHANGE: Establishes the governance of the Exchange by a 5 member board appointed by the Governor Schwarzenegger and Legislature. The board will serve the individuals and small businesses seeking health care coverage through the Exchange. Improving on federal reform: Creates independent state agency with conflict of interest protections.

AB922 (Monning), 2011

IMPROVING CONSUMER ASSISTANCE: Improves the Office of Patient Advocate to provide better assistance to California health care consumers by providing a central, enhanced center to handle consumer questions and complaints, and for them to be triaged to the appropriate agencies, whether regulatory or administrative, state or federal, etc. The bill also transfers the Office of Patient Advocate, and the Department of Managed Health Care, to the Health and Human Services Agency.

AB174 (Monning), 2012

SYSTEMS INTEGRATION: Establishes funding for Office of Systems Integration to establish information-sharing between the Franchise Tax Board and the Employment Development Department to specified health care agencies and county departments to verify applicant eligibility for state health care programs as well as claims data information.

AB792 (Bonilla), 2012

NOTICE OF COVERAGE OPTIONS DURING LIFE CHANGES: Requires insurers to provide information to consumers who are dropping off group coverage about their coverage options including at Covered California. Also provides notice at family court, when adoption, divorce, and other life changes are key moments when consumers should seek coverage options.

AB1761 (Speaker Perez), 2012

DECEPTIVE MARKETING: Prohibits any individual or entity from falsely representing themselves as the Exchange, Covered California.

SB18 (Leno), 2014

FOUNDATION & FEDERAL FUNDS FOR MEDI-CAL RENEWAL: provides $6 million to the State from the California Endowment to fund Medi-Cal renewal assistance and draws down the same amount in federal funds.

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