



Implementation of the Affordable Care Act in California: A Window of Opportunity for State Policy Makers

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Executive Summary

Health care reform, as enacted in the federal Affordable Care Act (ACA), establishes the framework for sweeping changes to the nation's health care delivery systems and financing mechanisms. California's policy makers have a historic opportunity to make significant strides in expanding access, reforming care delivery, improving affordability, and advancing improved health outcomes and reducing health disparities.

Windows of opportunity open infrequently for far-reaching, meaningful public policy change. The ACA has opened a window; it is up to the states to implement many of reform's most significant changes. Our state has an opportunity to push the window wide open and, in so doing, advance long overdue improvements in the health care delivery system, in affordability, and, most importantly, in the health of the people of California.

The ACA creates the opportunity for California to make significant advances in eight principal policy areas:

- 1. A 21st Century Enrollment Experience: Simplifying and streamlining eligibility and enrollment systems to facilitate coverage.**
- 2. A Culture of Coverage: Advancing the goal of near-universal coverage through community norm change.**
- 3. A New Marketplace for Insurance: Establishing an "active purchaser" Exchange to improve the affordability of coverage.**
- 4. Delivery System Reform: Increasing collaboration of health care purchasers to improve the delivery system, improve health outcomes, and lower costs.**
- 5. Health Care Work Force Development and Care Delivery Processes: Expanding the health care work force and rethinking care delivery to assure access to health care services.**
- 6. Leveling the Playing Field for Health Plans: Simplifying the market for consumers and health plans through greater uniformity of health insurance regulation.**
- 7. Prevention and Wellness: Investing in community transformation to improve the health status of the population.**
- 8. Governance and Financing Review: Reconsidering the organization and funding of state programs, state department and regulatory functions, and state-county relationships in a post-ACA context to improve the effectiveness and efficiency of government.**

While many of the most significant changes called for by the ACA will not take effect until 2014, planning, preparing, and taking action has begun and must be sustained. This challenge comes at a time of continued state fiscal distress and state and federal political transition. The groundwork laid by state policy makers in 2010 provides an important foundation upon which the broader 2014 reforms can be built. Much of the work required to successfully implement in 2014 requires advance planning, legislative authority, regulatory development, procurements, system builds and testing. Given the numerous deadlines that must be met, the State has no time to waste. In many respects, 2014 is tomorrow.

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I. OVERVIEW

Health care reform, as enacted in the federal Affordable Care Act (ACA), establishes the framework for sweeping changes to the nation's health care delivery systems and financing mechanisms.¹

The ACA is designed to achieve near-universal coverage while transforming how care is paid for and provided. It is designed to extend health care coverage to an estimated 32 million uninsured individuals and make coverage more affordable for many more. Data from UCLA's Center for Health Policy Research indicates that 8.2 million Californians (nearly one-quarter of the non-elderly population) lacked health insurance for all or part of the year in 2009.² This is a sharp increase from the 6.4 million estimate for 2007 and reflects declines in coverage resulting from the ongoing recession and increase in the unemployment rate.

Among its many provisions, the ACA creates a requirement for most U.S. residents to obtain health insurance and provides for health benefit exchanges through which individuals and families will receive federal subsidies to reduce the cost of purchasing health coverage. The new law expands eligibility for Medicaid, slows the growth in Medicare spending, and contains numerous provisions designed to test delivery system reforms and promote prevention and wellness.

The UC Berkeley, Center for Labor Research and Education estimates that two million low-income Californians will qualify for Medi-Cal under the ACA, and an additional 2.4 million will be eligible for subsidies in the California Health Benefit Exchange (Exchange). Realizing the goal of expanded coverage will require more than requiring people to purchase coverage and offering coverage at an affordable price. It will require state policy makers and program administrators to have simplified and streamlined eligibility and enrollment systems and processes in place by mid-2013 to accommodate millions of Californians newly eligible for coverage in 2014.

The ACA is predicated on the principle of shared responsibility. Effective implementation requires responsibility and action from every sector of society:

- *Health plans and insurers* are required to provide access to insurance to individuals, regardless of their health status, age or occupation;

¹ On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148). The following week, on March 30, 2010, the President signed the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152), which amended numerous health care and revenue provisions in PPACA. The two bills are commonly referred to as the Affordable Care Act or "the ACA."

² Issue Brief: Number of Uninsured Jumped to More Than Eight Million from 2007 to 2009, UCLA Center for Health Policy Research, March 2010.

- *Government* will set the rules for the insurance marketplace and financially support access to affordable coverage for lower income residents;
- *Larger businesses* are required to contribute to the coverage of their employees who receive government-financed premium subsidies;
- *Providers* are required to collaborate and coordinate in the delivery of care in new ways; and
- *Individuals and families* are required to purchase and maintain insurance coverage for themselves and their children and, as individuals and members of the broader community, to take greater responsibility for managing their own health and being more involved in their health care decisions.

The ACA has opened a policy window for advancing significant policy reform; it is now up to California policy makers and program administrators to translate policy to practice. If California is thoughtful and strategic in its implementation; if key sectors and stakeholders can work collaboratively and maintain a comprehensive approach premised on shared responsibility; if plans, providers, regulators can innovate and adapt; and, if California can build a strong social consensus in support of reform and what it requires of all of us, our State has an opportunity to push the window wide open and, in so doing, advance long overdue improvements in the health care delivery system, in affordability, and, most importantly, in the health of the people of California.

II. OPPORTUNITIES TO ADVANCE POLICY GOALS

The structure of federal reform is not perfect, but offers considerable promise in advancing state coverage, affordability and health outcome goals. For California, the ACA will bring a significant infusion of federal funds in 2014 to expand coverage through the State’s Medicaid program (Medi-Cal) and provide subsidies in the form of federal tax credits to millions of state residents to offset the costs of coverage. Most immediately, additional federal support is available to support the State’s Pre-existing Condition Insurance Plan (PCIP, which will provide access to more affordable coverage for people with pre-existing medical conditions. The ACA also supports myriad delivery system and payment reforms through Medicare and Medicaid and invests significant federal grant funds in public health and health care work force development.

Many of the policy outcomes that can result from implementation have been sought by health advocates and policy makers for decades. How California chooses to implement the ACA will influence the viability and achievability of these opportunities. State policy and practice will determine the success of reform and the progress made in advancing long-sought policy goals of expanded coverage, improved affordability, better health outcomes and reduced health disparities. Each of these opportunities is described below.

1. A 21st Century Enrollment Experience: Simplifying and streamlining eligibility and enrollment systems to facilitate coverage.

The ACA requires states to simplify and streamline the rules by which persons are determined eligible for public programs, the processes used to determine and verify eligibility, and the means by which individuals are enrolled in coverage. These simplifications are essential to making progress on the ACA goal of achieving near-universal coverage.

The ACA requires California to:

- Utilize a single, streamlined application for Medi-Cal, Healthy Families (California's Children's Health Insurance Program (CHIP)), the Exchange, and other state programs.
- Establish a website that permits individuals to apply, enroll, and renew enrollment in Medi-Cal and to use an electronic signature for enrollment or re-enrollment as well as an internet portal through which individuals can apply for publicly-sponsored health care programs.
- Establish outreach mechanisms for enrollment of vulnerable populations.

To complement federal streamlined enrollment requirements, federal law creates an eligibility standard (often referred to as a "bright line") of Medi-Cal eligibility at 133 percent of the federal poverty level (FPL) for all legally present persons, simplifies income rules and waives the asset test.³

Maximizing federal funding for system development should inform any decision for meeting ACA requirements. There are multiple sources of federal funding available to support a more modern, streamlined and consumer-friendly eligibility and enrollment system, including Exchange planning and implementation grants that will provide 100 percent federal funding. The State's share of Medi-Cal related information technology (IT) costs is anticipated to fall from 50 percent to a 10 percent state match in 2011, under draft federal regulations currently available for public comment. Any approach/solution needs to be designed to maximize this new enhanced federal funding for both development and ongoing costs.

Meeting these requirements will require significant investment of attention and resources. Today, eligibility determination and renewal for Medi-Cal are decentralized processes administered by California's 58 counties and supported by three separate IT systems operated by three county-run consortia; eligibility determination and renewal for Healthy Families is a centralized process administered by the Managed Risk Medical Insurance Board. The newly authorized Exchange will establish its eligibility determination and enrollment processes. Important policy and information technology systems issues will need to be carefully considered, including how the Exchange's eligibility and enrollment functions will interact with Medi-Cal, Healthy Families and other public programs. California can use implementation of the ACA as an opportunity to significantly improve the applicant experience, develop a more

³ Average household size in California is 2.93 persons; 133 percent of FPL in 2010 for a family of three is \$24,352/year.

efficient system, and facilitate coverage for the estimated four million Californians who will become newly eligible for coverage in 2014.

2. Culture of Coverage: Advancing the goal of near-universal coverage through community norm change.

The changes to eligibility rules and enrollment processes called for in the ACA support one of the underlying tenets of federal reform – establishing a “culture of coverage” in which coverage is available and affordable, the processes and rules of enrolling and maintaining enrollment in publicly-funded or subsidized coverage are simple and efficient, and everyone accepts the responsibility to obtain and maintain coverage.

A culture of coverage is essential to realizing the potential of the ACA to advance long-sought goals of health coverage expansion and delivery system improvement. In addition, a culture of coverage will minimize the number of free-riders (those who only participate when they have a health care need) and reinforce the principle of individual and shared responsibility that undergirds the federal reforms.

California has numerous opportunities to advance a culture of coverage. Enrollment systems can be designed to be accessible and consumer-friendly; strategies for automatic enrollment and simplified renewal can be adopted; and the legal requirement to obtain and maintain coverage can be enforced. One of the challenges to achieving a culture of coverage is the unknown impact of the federal tax penalties associated with non-compliance with the mandate to purchase and maintain coverage. Many observers believe the penalties are too low to reinforce broad participation by those disinclined to participate in coverage. State policy makers could consider various approaches to strengthening the mandate, including cooperating in its enforcement, adding a state penalty, or implementing public information campaigns to increase awareness of the penalties.

A culture of coverage means not only enrolling people, but also facilitating continued enrollment during times of transition. Some potential avenues for the State to consider include:

- Assisting families proactively. If individuals are about to change insurance status due to a change in life circumstances such as a marriage, income or geographic relocation, the system could proactively reach out to them and determine if coverage can be continued or if a new type of coverage is required.
- Automating payments. The State could embrace practices and policies that make insurance easier to keep, including offering automated payments where appropriate to keep people enrolled during transition periods that might result in loss of coverage.

How coverage programs are branded and marketed will also influence the culture of coverage. Policy makers can use the bully pulpit, social media and third party partners to give voice to the benefits of shared responsibility and universal coverage. Public messaging can communicate

the ease of enrolling in coverage. Most important, the public needs to hear the message that participation is the key to assuring the overall success of health care reform.

3. A New Marketplace for Insurance: Establishing an “active purchaser” Exchange to improve the affordability of coverage.

One of the centerpieces of the ACA is the establishment of health benefit exchanges designed to improve the affordability of coverage and the organization and transparency of the insurance marketplace. The ACA provides federal tax credits to low to moderate income people who do not receive employer provided health benefits. Individuals are eligible for tax credits *if* they purchase coverage through the Exchange. As a result, California’s Exchange has an estimated guaranteed market of two to three million people. People not eligible for tax credits may also purchase coverage through the Exchange. The UC Berkeley, Center for Labor Research and Education estimates that California’s Exchange could grow to four to five million people.

The ACA provides a broad outline regarding Exchange requirements and leaves important discretion to the states. California law establishes the Exchange as an independent public entity and provides the Exchange with the authority to select and contract with health plans for participation. This selective contracting authority reflects policy makers’ intent that California’s Exchange be an “active purchaser” of coverage – seeking to maximize the value of coverage available through the Exchange. The authority of the Exchange to selectively contract with health plans is consistent with Medi-Cal’s and Healthy Families’ purchasing authority and provides the State with a tool to improve the affordability of coverage while advancing delivery system improvement goals.

4. Delivery System Reform: Increasing collaboration of health care purchasers to improve the delivery system, improve health outcomes, and lower costs.

The ACA provides opportunities for purchaser collaboration, including the Exchange, Medi-Cal, Healthy Families and CalPERS, to advance the goals of improved care, improved quality and lower costs. Such collaborations could focus on delivery system improvement such as reducing infections in inpatient facilities or health status improvements such as better birth outcomes or diabetes prevention. Implementation of the Exchange offers a new opportunity for the State to exhibit leadership in cross purchaser collaboration intended to drive delivery system change and improve health outcomes.

“Improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care.”⁴ Significant opportunity exists for the Exchange to collaborate with other purchasers to advance these aims. Aligning purchasing strategies among the Exchange, Medi-Cal, Healthy Families and CalPERS could allow the programs to jointly address provider

⁴ “Triple Aim” of delivery system reform as characterized by Don Berwick, Administrator of the federal Centers for Medicare and Medicaid Services (CMS).

participation and access issues in a way that does not require them to compete with each other. Aligning purchasing strategies could also allow the State to pursue the same quality standards, encounter data reporting requirements, and value-based payment methods for plans participating in all three programs.

The ACA contains a variety of opportunities for states to drive value in the health care delivery system through reducing unnecessary costs and improving clinical outcomes. California will have the opportunity to participate in these Medicaid options and move toward more coordinated, outcome-focused systems of care. A number of pilots and demonstration projects to test and disseminate new care and payment models are focused on the Medi-Cal and Medicare populations. Over 1.1 million Californians are dually eligible for both Medi-Cal and Medicare – these low income seniors and persons with disabilities represent the highest cost eligible group in the Medi-Cal program. Significant improvements in health outcomes and cost containment are anticipated if the two programs engage in collaborative efforts to coordinate the care and support the health of dual eligibles.

5. Health Care Work Force Development and Care Delivery Processes: Expanding the health care work force and rethinking care delivery to assure access to health care services.

Approximately four million uninsured Californians will be eligible for coverage as a result of the provisions of the ACA. Assuring that adequate access to services and providers exists for all Californians requires the State to take steps to promote the adequacy of the number, type, distribution, and cultural competence of health care professionals and allied health workers. Most analysts agree that California will face shortages in the required primary care work force. The opportunity created by this challenge is to develop innovative approaches to the training, licensure and practice patterns of health care professionals and allied health workers. Such approaches may include accelerated training programs, expanded scope of licensure, increased use of technology, including telehealth and telemedicine, and changes in the processes through which care is provided. A multi-pronged approach that is reflective of the relatively long lead time required for most work force development strategies is essential to addressing this looming challenge. While the ACA does not contain any requirements for states with regard to work force development, significant grant opportunities are provided to encourage state action to expand the health care work force. Increasing and accelerating the training pipeline is necessary but insufficient in meeting anticipated work force needs across the provider continuum. Failure to develop strategies to increase and expand the health care work force will result in the long-term failure of reform.

6. Leveling the Playing Field for Health Plans: Simplifying the market for consumers and health plans through greater uniformity of health insurance regulation.

The ACA establishes federal standards for the individual and small group insurance markets. States are charged with monitoring and enforcing the new standards. Some of the standards apply to self-insured plans which have historically been exempt from state oversight. These new federal standards are phased in between 2010 and 2014 and address aspects of coverage

including consumer protections, premium review, risk adjustment, product design, essential benefits, and provider network development. Many of the new federal standards will require conforming changes to state law and new administrative processes. For example, federal law provides for establishment of a risk adjustment mechanism administered by the State to correct for the distribution of health risk of enrollees between health plans. This is a new function for state government, as are new federal requirements regarding enforcement of medical loss ratios (MLRs)⁵.

The introduction of national standards in many areas of health insurer and health plan regulation will result in less variation in the product design and regulation of plans licensed by the California Department of Insurance and the Department of Managed Health Care. This should have the benefit of simplifying the marketplace for both health plans and consumers. It also creates an opportunity for policy makers to revisit whether California consumers are best served by the current two-department regulatory structure. California is the only state in the nation with two regulatory agencies for the health insurance/health plan industry.

7. Prevention and Wellness: Investing in community transformation to improve the health status of the population.

The ACA embraces a vision of health and wellness that extends beyond insurance coverage and reform. The ACA properly recognizes the role that coverage of preventive services plays in improving access and wellness, but also acknowledges that a comprehensive approach to prevention is required, one that recognizes the role the environment plays in supporting and optimizing health improvement and addressing health disparities.

In support of this broader vision, the ACA includes strong prevention and public health components to improve the health of Americans. These components make disease prevention and public health cornerstones of health care reform and, when fully implemented, will improve health and quality of life while lowering health care costs. The ACA calls for development of a national prevention strategy and provides a sustained public health funding stream and evidence-based programs for improving health outcomes.

Strategic investments in disease prevention can result in significant savings in a short time – reducing health care costs, increasing the productivity of the nation's work force, and helping people lead healthier lives. According to the U.S. Centers for Disease Control and Prevention, a vast majority of chronic diseases could be prevented through lifestyle and environmental changes.

One of the key prevention opportunities in the ACA is establishment of Community Transformation Grants under the Creating Healthier Communities program to support

⁵ The MLR is the percentage of premium dollars a plan spends on claims for medical services as opposed to administrative costs. The federal health care reform law establishes minimum MLR standards. The federal minimum MLR is 80 percent for small group and individual products, and 85 percent for large group products.

community-based disease prevention. Programs to promote physical activity, create smoke-free environments, and make nutritious food more affordable and available are examples of the types of initiatives that may be funded. The initiatives are intended to support community prevention efforts and environments which make healthy choices easier choices for more Americans. These competitive grants will be awarded to state and local governmental agencies and community-based organizations for preventive health activities to reduce chronic disease rates, address health disparities, and develop a stronger evidence-base of effective prevention programs.

This federal initiative is consistent with and complementary to California's long-standing leadership in public health in areas such as tobacco cessation. It is also consistent with philanthropic efforts to encourage healthy eating and active living. California's successes with tobacco control as well as these federal and philanthropic efforts offer the State a chance to innovate and partner across sectors to improve the health status of the population.

8. Governance and Financing Review: Reconsidering state programs, state departments and regulatory functions, and state-county relationships in a post-ACA context to improve the effectiveness and efficiency of government.

The significant changes to the financing and delivery of health care envisioned under the ACA provide an opportunity for California to rethink and redefine how programs, departments and regulatory functions at the state and county level are organized and how they might be better aligned to achieve policy goals.

- State programs: The ACA will expand comprehensive health coverage on a near-universal basis. This creates the opportunity for the State to evaluate the efficacy of the current configuration of disease- or condition-specific programs (such as the AIDS Drug Assistance Program or the Every Woman Counts breast cancer screening program), benefit-specific programs (such as Family Planning, Access, Care and Treatment), and programs serving special populations (such as the Medi-Cal Medically Needy Program or the Major Risk Medical Insurance Program). State funds currently spent on these programs may be able to be redirected to other priorities.
- State departments and regulators: The ACA moves the State toward greater uniformity of income counting and family size rules across the Medi-Cal, Healthy Families and Exchange programs. A similar move toward uniformity occurs for the State's two health insurance regulatory entities. This increase in uniformity calls into question whether interests of the state's residents are best served by having a multiplicity of administrative and/or regulatory entities with similar functions. Similarly, consideration will need to be given to the ongoing roles and responsibilities and organization and structure of state entities that oversee the purchasing of publicly funded health care, such as the Department of Health Care Services and the Managed Risk Medical Insurance Board. A reorganization of government may result in cost savings to the State through elimination of redundant functions.

- State-county relationships: Today over 1 million medically-indigent Californians receive health care services from their county of residence. Welfare and Institutions (W&I) Section 17000 designates the counties as “providers of last resort.” (Note: undocumented immigrants are not included in county responsibilities pursuant to Section 17000). Under the provisions of the ACA many of the medically indigent will likely be eligible for Medi-Cal. A review of state-local financing arrangements can inform policy makers’ consideration of whether counties should help support the costs of new Medi-Cal eligibles or whether the funds should be retained at the local level to support the safety net.

III. SUCCESS FACTORS

Successful implementation of the ACA in California will hinge on a number of success factors, the most critical being strong leadership from the Administration and Legislature to assure the following:

- A commitment to collaboration. Just as the federal government must work in partnership with the states to implement health care reform, so too must the State work in partnership with stakeholders, community partners and others to broaden access, promote quality, reduce costs, and improve health outcomes. In turn, changing the delivery system to one that is oriented toward and rewards care coordination will require a new and significant level of collaboration within the provider community and with health plans. Strong stakeholder engagement and collaboration is essential.
- Strengthened internal capacity within government. Implementation of federal health care reform falls to California at a time of considerable fiscal distress. Such fiscal challenges have contributed to the erosion of the State’s internal capacity and resources required to effectively implement the reforms called for by the ACA. Focused attention is needed to ensure a responsible alignment between the complexity and consequence of responsibilities of state ACA implementation and the internal capacity of the executive branch to responsibly and effectively execute. Federal resources, such as planning grant funding for the Exchange, will provide much needed support to the state. The State’s health philanthropies have also provided important support for the State’s initial implementation activities, though exclusive reliance on philanthropic resources is not a sustainable or responsible state strategy.
- Social consensus. A large part of the success of federal health care reform will depend upon the extent to which the public supports and complies with the new responsibilities required of them. There is much work to be done in this area, as indicated by many public opinion surveys. On the one hand, the public has been told that federal reform has the potential to transform our health care system into one that covers nearly all Americans and delivers better quality care at lower cost. At the same time,

notwithstanding that potential, health care costs will continue to rise, the uninsured will continue to increase, and quality will remain uneven. Building and sustaining social consensus in support of reform in this context is challenging and necessary; it will require not only leadership by our state's elected officials but by the broad diversity of California business, community and philanthropic leaders.

State policy makers and program administrators will need to consider how policy and program design decisions influence individual and employer behavior:

- Individual behavior. The ACA provides that, beginning in 2014, everyone must obtain and maintain coverage that provides for coverage of “essential health benefits,” be granted an exemption, or pay a tax penalty.⁶ It is uncertain how individuals will respond to the requirement to obtain and maintain coverage. Congress adopted the insurance mandate to address two policy goals. First, the mandate is intended to reduce the “hidden tax” associated with the shifting of roughly \$43 billion worth of care received nationally by people who do not have health insurance and who do not pay for it to employers, insurers, health care providers, and the government. In addition to discouraging this cost shift, the ACA is intended to encourage individual responsibility – a core principle of the ACA. Some may find it financially advantageous to pay the penalty and wait to enroll in coverage when they have a costly medical need. A sustained and multi-faceted effort to build a cultural norm in which insurance coverage is valued, expected and accessible will mitigate the need for penalties to promote coverage. At the same time, state policy makers may look to additional penalties to reinforce the requirement that individuals purchase coverage.
- Employer behavior. In addition to the requirement on individuals to maintain coverage, the ACA requires employers who have more than 50 full-time equivalent (FTE) employees to offer coverage. Employer behavior (and subsequent individual behavior) in response to the ACA is unknown and is likely to include:
 - Some employers may choose to no longer offer coverage because their employees would be substantially subsidized in the Exchange (and those offered affordable insurance cannot take advantage of the Exchange); some analysts believe this will be particularly attractive to small employer groups and their employees.
 - Individuals may be newly offered coverage by their employer; this is likely to occur in larger firms that do not now offer coverage but which under the ACA will be penalized for not offering coverage.
 - Individuals currently insured by their employer may drop that coverage if employers react to the new law by raising employee contributions.

⁶ Exemptions to the mandate will be granted for American Indians, those with religious objections, those without coverage for less than three months, undocumented immigrants, incarcerated persons, those for whom the lowest cost option exceeds 8 percent of income, and those with incomes below the tax filing thresholds (in 2009 these levels were \$9,350 for an individual and \$18,700 for a couple).

- Individuals who today decline their employer's insurance may respond to the individual mandate by enrolling in their employer's plan.
- Youths under age 26 may gain coverage through a parent's employer-sponsored plan under the ACA provisions for coverage of dependents of this age group.

IV. ENVIRONMENTAL FACTORS

Three key environmental factors will impact California's ability to successfully implement the ACA. These are the state fiscal condition, the national political context and pending legal challenges.

- State fiscal context. State policy makers will be challenged by the continuing recession, high unemployment, and a \$25.4 billion deficit over the next 18 months. While the ACA provides California with a significant infusion of federal funds it also requires investment of state funds to achieve its multiple goals. Prioritizing resources for these purposes will be a challenge for the foreseeable future. Most significant among the needed investments in the short-term are the infrastructure costs associated with modernizing Medi-Cal's eligibility and enrollment systems. The ACA requires significant changes in the processes for eligibility determination, changes unlikely to be supported by the State's current infrastructure. The infrastructure costs for the new Exchange are to be funded 100 percent by the federal government (after 2014, the Exchange will be funded via assessments on participating health plans); infrastructure costs associated with improvements to Medi-Cal eligibility and enrollment systems will be funded at 90 percent federal sharing ratios.

The ACA provides 100 percent federal funding for new groups of Medi-Cal eligibles between 2014 to 2016. In the long-term, State Medi-Cal spending on low-income adults will rise for two reasons. First, the ACA will increase enrollment among individuals who currently qualify but are not yet enrolled. California will pay the standard 50 percent share of Medicaid expenses for these eligibles. Second, the ACA requires states to cover all adults with incomes at or below 133 percent of FPL in their Medicaid programs. While the federal government will pay 100 percent of all health care costs for newly eligible adults during 2014 to 2016, California will begin paying some of these costs in 2017, with the state share gradually rising to 10 percent in 2020. Savings in existing state expenditures are possible in a number of areas, such as eliminating optional Medicaid coverage for adults over 133 percent of FPL and shifting these eligibles to the federally-funded subsidies in the Exchange and scaling back or eliminating "state-only" programs that support specific populations and/or benefits with state dollars and enrolling such beneficiaries in comprehensive coverage options in 2014.

- National political context. Many of the newly elected members of Congress campaigned on a promise to "repeal and replace" the health care reform law. While most analysts

believe a full-scale repeal would be nearly impossible to achieve, members of Congress have a number of tools that could influence the timing, progress and success of ACA implementation, including withholding funding, modifying regulations or conducting oversight hearings.

- Legal challenges to the ACA. Numerous suits have been filed across the country challenging the constitutionality of the ACA, including a multi-state suit by sixteen state attorneys general and four state governors on behalf of twenty-one states, joining two private citizens and the National Federation of Independent Businesses. In this multi-state suit, the Court allowed for two causes of action to proceed: (1) a challenge to the imposition of the individual mandate under the Commerce Clause; and (2) a challenge to the Medicaid expansion under the conditional spending authority of Congress.

On December 13, 2010, in a stand-alone challenge to the individual mandate brought by Virginia's attorney general in light of the subsequently enacted Virginia Health Care Freedom Act, the U.S. District Court for the Eastern District of Virginia ruled that the individual mandate is an unconstitutional exercise of Congressional authority.

On November 30th, the U.S. District Court for the Western District of Virginia dismissed a private suit brought by Liberty University challenging various components of the ACA on numerous constitutional counts. The court ruled that the imposition of the individual mandate and the shared employer responsibility requirements were valid exercises of congressional authority under the Commerce Clause. The court also dismissed Liberty University's contentions that ACA funding would be impermissibly directed toward abortion services, or that the University would somehow be entangled with the promotion or acceptance of the performance of abortion services within the health care sector.

On October 7th, in the first ruling supporting the law's constitutionality, a federal court rejected a private suit filed in Michigan alleging that Congress lacked the authority under the Commerce Clause to compel the private purchase of health insurance. The U.S. District Court rejected the claims, ruling that Congress had the power to pass the law because it affected interstate commerce and was part of a broader regulatory scheme.

V. Process

Immediately following enactment of the ACA, Governor Arnold Schwarzenegger called for the creation of an administration-wide Health Reform Implementation Task Force (Task Force). Convened in April 2010 by Kim Belshé, Secretary of the California Health and Human Services Agency, the Task Force included leaders of state agencies and departments with expertise in insurance regulation, Medi-Cal, health coverage purchasing, public health, financing, health information technology and health care work force issues.

The Task Force held bi-weekly leadership meetings organized around seven content areas essential to the State's implementation of the ACA. These focal areas are: the pre-existing condition insurance plan; eligibility and enrollment; the health benefit exchange; insurance market; public program expansion and delivery system reform; prevention and wellness; and work force planning and development. In addition to the Task Force meetings a series of workgroup meetings were held in each of the content areas. Approximately 100 staff from across state government participated in the work groups. The policy over-arching policy opportunities identified in this document are the result of the Task Force and work group discussions. The work group process was managed by the consulting team from Leading Resources Inc. with financial support from the California Health Care Foundation and the Blue Shield of California Foundation.

In addition, the Task Force initiated and oversaw three core activities essential to laying the groundwork for successful implementation of the ACA.

1. *Tracking of and responding to grants and guidance from the federal government:* The Task Force established a tracking system for ACA-related federal grants, looking at impacted departments, due dates, status, and disposition. It has also been tracking and responding, where appropriate, to ACA-related federal guidance.
2. *Establishing and maintaining a centralized website:* The Task Force developed a website that provides access to documents and developments related to California's implementation of the ACA and serves as one element of stakeholder outreach efforts. The site is available at www.healthcare.ca.gov.
3. *Supporting key legislation needed for early implementation efforts:* The Task Force focused on a number of pieces of legislation necessary for early implementation of federal reform. The following bills were signed by Governor Arnold Schwarzenegger during the 2010 legislative session in response to the ACA:

AB 1602 (Perez) and SB 900 (Alquist): California Health Benefit Exchange (Exchange)

- Creates the California Health Benefit Exchange; establishes the five-member governing board and describes the basic responsibilities and authorities of the Exchange.

SB 1163 (Leno): Health care coverage; denials; premium rates

- Requires all premium filings to be reviewed and certified by an independent actuary to ensure premium costs are accurately calculated and all proposed rate increases to be posted on insurer and regulatory websites making costs transparent. These consumer protections exceed what federal law requires under federal health care reform.

SB 1088 (Price): Health care coverage: dependents

- Prohibits health plans and health insurers from setting the limiting age for dependent children covered by their parents' health insurance policy at less than 26 years of age.

AB 2244 (Feuer): Health care coverage for children

- Prohibits insurers that sell individual market policies in California from refusing to sell or renew coverage to kids with pre-existing conditions.

AB 2345 (De La Torre): Health care coverage; preventive services

- Requires health care services plan contracts to cover certain preventive services with no cost-sharing.

AB 2470 (De La Torre): Health care coverage; cancellation; rescission

- Prohibits health plans or health insurers from canceling insurance unless there is a demonstration of fraud or intentional misrepresentation of material fact.

SB 227 (Alquist) and AB 1887 (Villines): Pre-existing Condition Insurance Plan (PCIP)

- Creates the Federal Temporary High Risk Health Insurance Fund to receive \$761 million in federal funding. Establishes PCIP within the Managed Risk Medical Insurance Board.

VI. CONCLUSION

The ACA provides states with an extraordinary opportunity to advance long-sought goals regarding coverage expansion, affordability, and health status improvements. How California policy makers and program administrators move forward with implementation will determine federal reform's impact on California. While many of the most significant changes called for by the ACA will not take effect until 2014, the Schwarzenegger Administration has undertaken significant planning and preparation activity and worked with the State Legislature to establish a foundation upon which the broader reforms of 2014 can be built. The imperative to move forward comes at a time of continued state fiscal distress and state and federal political transition. Much of the work required to successfully implement in 2014 requires advance planning, legislative authority, regulatory development, procurements, system builds and testing. Given the numerous deadlines that must be met, the State has no time to waste. In many respects, 2014 is tomorrow.