CALIFORNIA HEALTHCARE FOUNDATION

Tracking ACA Implementation in California

This guide tracks the California implementation of the Affordable Care Act (ACA), whose provisions touch on most aspects of the health care system, including cost, quality, and access. It describes the law's requirements for public and private coverage and breaks each into implementation objectives — some complete, others underway, and some not yet begun.

The law requires, with few exceptions, that people obtain health insurance, and it provides new structures and supports to help them do so. Today about 1 in 5 nonelderly Californians is uninsured. This ratio is expected to fall to 1 in 10 by 2016 because of the ACA. Those who obtain health insurance should gain not only financial security, but also improved access to care, and through it, better health outcomes.

This guide is organized by these broad ACA goals and implementation objectives:

Goal 1: Expand coverage in public programs. The law expands Medi-Cal coverage to low-income adults and children. This should improve access to care for the neediest Californians.

- Objective 1: Execute required, and assess optional, Medi-Cal eligibility changes
- Objective 2: Determine coverage options for low-income individuals
- Objective 3: Use financial incentives to improve access and quality

Goal 2: Simplify and streamline eligibility and enrollment. States must provide a means by which people can quickly learn if they are eligible for state-funded programs or subsidized private health plans, apply, and enroll.

- Objective 1: Improve the consumer experience
- Objective 2: Promote and support enrollment

Goal 3: Protect health insurance consumers. The law prohibits insurance companies from denying coverage based on pre-existing conditions or from placing lifetime limits on coverage, and assures that products sold meet standards for comprehensiveness.

- Objective 1: Enforce new health insurance coverage rules
- Objective 2: Ensure health insurance premium value
- Objective 3: Limit the impact of adverse risk on rate payers

Goal 4: Create a new marketplace for private health insurance. California's Health Benefit Exchange will make shopping for health insurance easier, make the costs and benefits of plans more understandable, and administer subsidies to qualifying applicants.

- Objective 1: Operate the Exchange
- Objective 2: Offer coverage through qualified health plans

State Action & Lead, Status, and Implementation Date

For each objective, this guide provides a brief discussion and a table that enumerates the state action and lead(s), status, and implementation date. Along with the California administration and legislature, responsible state leads are:

- The California Department of Health Care Services (DHCS)
- The California Department of Insurance (CDI)
- The California Department of Managed Health Care (DMHC)
- The California Health and Human Services Agency (CHHS)
- The California Health Benefit Exchange (CHBE, the Exchange, and Covered California)
- The Managed Risk Medical Insurance Board (MRMIB)

About This Guide

CHCF contracted with the management consulting firm Leading Resources Inc. (LRI) to develop content for this guide. LRI principals Eric Douglas and Karin Bloomer solicited and incorporated input from executive staff of DHCS, the Exchange, DMHC, MRMIB, and CDI. Jonah Frohlich and Alice Lam of Manatt Health Solutions; Deborah Kelch of Kelch Policy Group; and independent consultant Lesley Cummings also provided comments.

Information is current as of November 7, 2012, and will be updated quarterly.

Send questions and comments about this resource to Marian Mulkey, director of CHCF's Health Reform and Public Programs Initiative at mmulkey@chcf.org.

Goal 1: Expand Coverage in Public Programs

The Affordable Care Act provides for a broad expansion of Medicaid eligibility to improve access to health care services. Medi-Cal — California's Medicaid program — is projected to expand by 1.2 to 1.6 million low-income Californians, with many more eligible but not enrolled. Maximizing expansion will require consensus on a number of complex policy and financing decisions and coordination among an array of new and existing programs and providers.

Progress toward Goal 1 will be tracked under these objectives:

- Objective 1: Execute required, and assess optional, Medi-Cal eligibility changes
- Objective 2: Determine coverage options for low-income individuals
- Objective 3: Use financial incentives to improve access and quality

Goal 1, Objective 1: Execute Required, and Assess Optional, Medi-Cal Eligibility Changes

Today, the income limits by which people qualify for Medi-Cal vary by age and status. Infants and pregnant women are eligible if household income is under 200% of the federal poverty level (FPL). Children ages 1 to 5 and ages 6 to 19 in households up to 133% and 100% of FPL, respectively, are eligible for Medi-Cal. Low-income parents, elderly people, and people with disabilities also qualify, but childless adults outside those categories typically are not eligible for Medi-Cal no matter their income.

As a bridge to changes under national health reform, California has pursued a set of policies allowing an early expansion of coverage to approximately 500,000 low-income uninsured Californians via the Low Income Health Program (LIHP). Starting January 2014, Medi-Cal income eligibility must expand for those in existing eligibility categories — children, individuals, and families — to 133% of FPL (annual income of about $15,000 for a single person or $31,000 for a family of four). Furthermore, Medi-Cal coverage must be extended to young adults under 26 who were in foster care when they turned 18. The US Supreme Court's 2012 ruling made expanding Medicaid to childless adults an option for states.

Key tasks facing the state include deciding what benefit package to provide to newly eligible adults under Medi-Cal; projecting the adequacy of access to care for people who will be eligible for Medi-Cal on January 1, 2014 (current and newly eligible); and assessing policy and financing options for the newly eligible population. To preserve federal funding, the state will have to adhere to federal Maintenance of Effort requirements that preclude imposing more-restrictive requirements on current Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment until 2014 for adults and 2019 for children.

State Action & Lead	Status	Implementation Date
1. Conduct early Medi-Cal expansion via county Low Income Health Programs. Lead: DHCS	As of 6/30/2012, some 552,553 individuals enrolled in LIHPs across 49 counties.	7/1/2011 First LIHPs implemented
2. Define benchmark benefits for newly eligible adults. Lead: DHCS	Analyses on benchmark options are underway, awaiting federal guidance; selection of benchmark will be addressed in 2013 legislative special session.	1/1/2014
3. Assess policy, financing, and program changes necessary for optional Medi-Cal expansion to childless adults. Lead: DHCS	Policy and funding sources expected to be considered in 2013 legislative special session.	1/1/2014
4. Implement required eligibility rule changes, including expanding coverage to former foster children up to age 26. Lead: DHCS	Expected to be considered in 2013 legislative special session.	1/1/2014
5. Observe Medicaid/CHIP Maintenance of Effort (MOE).	Ongoing.	1/1/2014 For adults 1/1/2019 For children

Lead: DHCS, MRMIB		
6. Complete Access Report and Plan. Lead: DHCS	In progress.	1/1/2013
7. Transition LIHP enrollees into Medi-Cal. Lead: DHCS	Transition plan developed.	1/1/2014

Goal 1, Objective 2: Determine Coverage Options for Low-Income Individuals

While the Medicaid expansion paves a path for covering the poorest families and individuals in California — those with household incomes up to 133% of FPL — the ACA provides options regarding how to cover those just above this income threshold.

California has already addressed one of these options — that pertaining to enrollees in the state's Children's Health Insurance Program (CHIP), called Healthy Families. Under the ACA, about 183,000 of the roughly 863,000 Healthy Families enrollees — those with incomes between 100% and 133% of FPL — are subsumed into the expanded Medi-Cal program. This presented a policy question of what to do about the remaining children in Healthy Families — keep them in Healthy Families, move them into Medi-Cal, or offer the Exchange as the vehicle for health insurance. Under legislation enacted in 2012, the administration and legislature elected to move these children into the Medi-Cal program over a one-year period.

A policy yet to be decided is whether to offer a Basic Health Program (BHP), which would provide affordable coverage for individuals with incomes between 134% and 200% of FPL who would otherwise be eligible for premium subsidies and cost-sharing reductions in the Exchange. It could also cover legal immigrants residing in the US less than five years and below 133% of FPL who are currently eligible for state-only Medi-Cal.

In its consideration of whether to offer a BHP, the state will need to assess the program's potential impact on the viability and effectiveness of the Exchange; adequacy of federal subsidies compared to projected expenditures; implications for continuity of coverage and care as people move among Medi-Cal, the BHP, and qualified health plans (QHPs); and how administrative costs might be financed.

State Action & Lead	Status	Implementation Date
1. Transition Healthy Families enrollees to Medi-Cal. Lead: DHCS, MRMIB	Transition plan in place; enrollees will transition over one year beginning 1/1/2013.	1/1/2013
2. Determine whether to offer a Basic Health Program for individuals with incomes between 134% and 200% of FPL. Lead: Legislature and administration to determine	State awaiting federal guidance; policy expected to be addressed in 2013 legislative special session.	No federal deadline for implementation

Goal 1, Objective 3: Use Financial Incentives to Improve Access and Quality

The ACA offers enhanced federal funding for public programs. To accommodate Medicaid expansion, the ACA allows for increased reimbursement for some primary care services, bringing payment rates up to Medicare levels.

Primary care rate enhancement (required). This provision initiates 100% federal financing in 2013 and 2014 to raise Medi-Cal reimbursement rates to parity with Medicare for certain evaluation and management services provided by primary care physicians. This is an approximately 120% increase in reimbursement for these services. Access to physicians is a special concern in Medicaid because fewer physicians accept Medicaid patients relative to Medicare and privately insured patients, and low Medicaid reimbursement rates are often cited as the main reason. California has the 47th lowest Medicaid reimbursement rates in the United States.

Preventive services without copays (optional). This provision offers a one-percentage point increase in federal matching payments if the state covers certain recommended immunizations and preventive services without charging Medicaid beneficiaries a share of the cost. California is analyzing this option.

State Action & Lead	Status	Implementation Date
1. Increase reimbursements to primary care providers. Lead: DHCS	2012–13 Trailer Bill 802 authorized the increased payments.	1/1/2013
2. Leverage increased federal match for preventive services. Lead: DHCS	Analysis of option in progress.	1/1/2013 (if pursued)

Goal 2: Simplify and Streamline Eligibility and Enrollment

Expanding health insurance coverage will necessitate a consumer-friendly means for applying to and enrolling in subsidized coverage options. To that end, the Affordable Care Act requires a "no wrong door" solution that supports application, eligibility determination, and enrollment by way of the Internet, phone, and mail, as well as in person. This approach should also simplify and streamline the eligibility criteria for Medi-Cal and new coverage options. If implemented effectively, a consumer-friendly enrollment process will help millions of Californians find and keep insurance, and will help the coverage programs attract and retain enrollees with a wide range of income levels and health statuses.

In California today, Medi-Cal eligibility determination and enrollment are the responsibilities of the 58 counties, which use three different Statewide Automated Welfare Systems (SAWS). Most Medi-Cal applications are handled in person at county social services offices. A phone-based application is available through a statewide contractor for Healthy Families and Medi-Cal for Children as well as an online application, Health-e-App Public Access. Online application is available for Medi-Cal on a limited basis via the county SAWS systems. Enrollment help is offered by Certified Application Assisters, typically located at community-based organizations, and many medical providers. Eligibility determination, program and plan enrollment, re-enrollment, and case management for Medi-Cal and Exchange programs will be supported by different platforms, making coordination among these systems of paramount importance.

Progress toward Goal 2 will be tracked under these objectives:

- Objective 1: Improve the consumer experience
- Objective 2: Promote and support enrollment

Goal 2, Objective 1: Improve the Consumer Experience

Improving the consumer experience will mean ensuring: smooth hand-offs among state and county customer service representatives in the eligibility and enrollment processes, a seamless experience for families whose members may qualify for different programs, easy transitions for those whose eligibility status changes, and consumer-friendly decision support for applicants.

Create a streamlined eligibility and enrollment process. The ACA requires integrated and simplified processes for eligibility determination and enrollment that provide a first-class consumer experience. Consumers must be able to apply for public programs and coverage in the Exchange (both subsidized and unsubsidized) online, by phone, by mail, or in person. DHCS and the Exchange, in collaboration with the California Health and Human Services Agency (CHHS) and the Managed Risk Medical Insurance Board (MRMIB), have engaged Accenture to develop the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) to serve as a centralized tool for determining eligibility for and enrolling people in health insurance affordability programs; for comparing health plan benefits, cost sharing, and quality; and ultimately for enrolling in plans.

Use a simpler method to determine income eligibility. Today, Medi-Cal eligibility thresholds vary depending on applicants' medical and financial circumstances. Beginning in 2014, federal law requires that eligibility for the majority of those seeking coverage through Medi-Cal and the Exchange be established using a single income standard. This change will simplify the application process and unify eligibility rules across insurance programs to the extent possible. Importantly, the use of an assets test for Medi-Cal eligibility will be eliminated for most applicants.

State Action & Lead	Status	Implementation Date
1. Create integrated and streamlined process for eligibility and enrollment. Leads: Exchange, DHCS	CalHEERS in design and development stage.	10/1/2013 Open enrollment begins for coverage effective 1/1/2014
2. Coordinate the technical platforms of eligibility and enrollment systems. Leads: Exchange, DHCS, MRMIB, CHHS	Efforts in progress to define dependencies between CalHEERS and subprojects — SAWS systems updates, MEDS updates, and MAXe2; working with federal government on technical interchange with federal hub.	10/1/2013 Open enrollment begins for coverage effective 1/1/2014
3. Conform California law and policy to federal requirements for income eligibility, electronic data matching, self-attestation, etc., and make other policy changes to streamline eligibility systems. Leads: DHCS, Exchange	Further federal guidance needed; California policy guidance likely to be considered by legislative special session in 2013.	1/1/2014

Goal 2, Objective 2: Promote and Support Enrollment

Robust enrollment in the public and private marketplaces for health insurance coverage is an essential underpinning to achieve the ACA's goals. As federal mandates requiring coverage come into effect, and new public and private insurance options are introduced into the market, consumers will need help identifying and understanding their options and enrolling. California is responding to this need in two main ways: (1) by establishing an Assisters Program to reach diverse populations and help them enroll in the Exchange and Medi-Cal; and (2) by planning outreach and marketing activities to ensure that Californians are aware of newly available coverage programs.

Navigators and assisters: The federal law requires state exchanges to administer grants for "navigators"and provides guidance on their roles and responsibilities but leaves states discretion in designing their plan for consumer assistance. California's Exchange has proposed a program that would certify enrollment assisters, some of whom would be navigators compensated by the Exchange and others who would not be compensated.

Brokers and agents: Another way that consumers and small-business people get assistance is through the use of health insurance agents. The appropriate role of brokers, their compensation, and their relationship to assisters are topics of ongoing debate and deliberation.

Outreach: The Exchange, in concert with DHCS and MRMIB, has also established a statewide marketing, outreach, and education program to maximize enrollment — including subsidized coverage in the individual Exchange and Small Business Health Option Program (SHOP), Medi-Cal, as well as for individuals who can purchase coverage without subsidies. The campaign involves community-based organizations and other nongovernmental organizations educating people about new coverage options.

State Action & Lead	Status	Implementation Date
1. Establish and launch an Assisters Program to help people apply for coverage. Leads: Exchange, DHCS	Assisters recruited early Q1 in 2013; assister applications approved beginning Q2; assisters trained 5/2013.	7/2013 Assisters begin work with the public
2. Conduct marketing campaign and outreach and education grant program. Leads: Exchange, DHCS	Branding, messaging, and marketing materials in development; first outreach and education grant awards to be announced 2/15/2013; $40 million in federal funding budgeted over 2013 and 2014.	3/2013 Consumer outreach begins

Goal 3: Protect Health Insurance Consumers

The Affordable Care Act includes a number of provisions that reform the health insurance market, with particular emphasis on coverage sold to individuals and small employers. These reforms occur in two phases (in 2010 and 2014) and offer a host of consumer protections, including those that remove discrimination in coverage rules, ensure value for consumers' premium dollars, and mitigate risk in order to assure a stable market.

Although the ACA establishes new federal rules for health insurance consumer protections, it generally looks to states for implementation and enforcement through existing entities. For California, this means implementation roles for both the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), which regulate portions of the health insurance industry. California generally assigns regulatory responsibility to DMHC and CDI through implementing legislation.

Progress toward Goal 3 will be tracked under these objectives:

- Objective 1: Enforce new health insurance coverage rules
- Objective 2: Ensure health insurance premium value
- Objective 3: Limit the impact of adverse risk on rate payers

Goal 3, Objective 1: Enforce New Health Insurance Coverage Rules

The ACA creates a number of market rules to be enforced at the state level. Consumer protections that took effect in 2010 include:

- Guaranteed coverage for children under 19 regardless of health status.
- Expanded coverage for young adults on parent's or guardian's plan up to age 26.
- Creation of a temporary state-based, high-risk coverage program for people who have been turned down for private individual coverage because of their health status.
- Prohibition of coverage cancellation or rescission except for fraud or intentional misrepresentation.
- No lifetime benefit limits and phased elimination of most annual benefit limits.

If individuals and small businesses maintain coverage under the same "grandfathered" health plan they had in March 2010, this coverage is exempted from some ACA requirements.

Consumer protections that will take effect in 2014 include:

- Guaranteed access to coverage for adults regardless of health status, including a prohibition on denying coverage because of health status, medical history, and other related factors.
- No annual limits on essential benefits (except for grandfathered plans in effect as of March 23, 2010).
- Premium rate variation limited to geographic differences, family size, and age within specified limits.

Prior to passage of the ACA, California provided few consumer protections for coverage sold to individuals. Today, health insurance issuers can deny coverage or charge higher premiums to individuals based on health history. California does limit the use of pre-existing condition limits and requires annual renewal of coverage regardless of health status or claims experience.

State Action & Lead	Status	Implementation Date
1. Establish the Pre-Existing Condition Insurance Plan (PCIP). Lead: MRMIB	Statutory authority established in 2010 (SB 227, Chapter 31 and AB 1887, Chapter 32).	6/29/2010
2. Transition PCIP enrollees out of the expiring program and into the Exchange or individual private market. Leads: MRMIB, Exchange	Initial work plan presented to MRMIB board in 10/2012; discussions being held between MRMIB and Exchange on coordinating the transition and communications with enrollees.	12/31/2013
3. Establish state oversight programs to ensure adherence to 2010 consumer protections. Leads: DMHC, CDI	Multiple state bills enacted in 2010; program established and compliance oversight ongoing.	9/23/2010
4. Establish state oversight programs to ensure adherence to 2014 consumer protections. Leads: Legislature, DMHC, CDI	Legislation enacted for small group reform in 2012 (AB 1083, Chapter 852); legislation on individual coverage reform vetoed by the governor; likely to be revisited in 2013 legislative session.	1/1/2014

Goal 3, Objective 2: Ensure Health Insurance Premium Value

The Affordable Care Act includes provisions intended to ensure that health plans provide value to their enrollees. These provisions include: (1) establishing a minimum set of "essential health benefits" (EHBs) for individual and small employer coverage, (2) subjecting proposed health insurance premium increases to state review, and (3) ensuring that health plans spend a minimum percentage of the premium paying for health care (known as the medical loss ratio).

Essential health benefits. Under the ACA, individual and small employer policies (unless grandfathered) must cover a minimum set of benefits in 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The federal law requires the Secretary of Health and Human Services to further define covered benefits. In a December 2011 guidance bulletin, CMS's Center for Consumer Information and Insurance Oversight (CCIIO) deferred to states selection of a "benchmark plan" from among specified plans offered in the state for federal employees, state employees, and small-business employees.

Premium rate review. Starting January 2011, California requires insurance carriers to file all individual and small-group rate increases with regulators at least 60 days before taking effect. Starting September 2011, insurers seeking rate increases of 10% or more for nongrandfathered plans in the individual and small-group markets are required to publicly disclose proposed premium rate increases and the justification for them, subject to review by state regulators. In future years, CCIIO will set state-by-state premium review thresholds using data that reflect insurance and health cost trends in each state.

Minimum loss ratios. States must enforce the ACA's minimum medical loss ratio (MLR) standards, which differ by type of coverage. For small-group and individual coverage, health plans must spend 80 cents out of every premium dollar on medical claims and activities that improve the quality of care (an 80% MLR). No more than 20 cents of each premium dollar can be used to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. For large-group coverage, the federal MLR is 85%. In August 2012, health insurers issued the first premium rebates to consumers as a result.

In California today, health plans subject to DMHC regulation must cover all medically necessary basic benefits, but plans overseen by CDI do not have a minimum benefit requirement. In addition, California law mandates similar but not identical benefits for health plans under DMHC and CDI. Health plans under DMHC must limit administrative costs to 15% of premiums, and CDI plans for individuals must meet a 70% MLR.

Neither DMHC nor CDI has engaged in a premium rate review quite like the one envisioned in the ACA. Neither department can deny premium increases under state or federal law.

State Action & Lead	Status	Implementation Date
1. Implement a premium rate review process to determine if health plans' proposed premium rate increases are not unreasonable.	Statutory authority established in 2010 (SB 1163, Chapter 661); DMHC and CDI received federal grants to support rate reviews; premium rate review and	1/1/2011

Leads: DMHC, CDI	consumer education process ongoing.	
2. Enforce new medical loss ratio. Leads: DMHC, CDI	Statutory authority enacted in 2011 (SB 51, Chapter 644); oversight of health insurers' adherence to MLR ongoing.	6/1/2012
3. Select a benchmark plan for the essential health benefits of individual and small employer coverage. Leads: Legislature, DMHC, CDI	Benchmark plan established via statutory authority in 2012 (SB 951, Chapter 866 and AB 1453, Chapter 754); work underway to further identify implications of selection of plan under DMHC jurisdiction as benchmark.	1/1/2014
4. Establish state oversight programs to ensure that health insurers provide consistent EHB offerings for individuals and small employers. Leads: Legislature, DMHC, CDI	Coordinating efforts with federal government to ensure consistent implementation of EHBs by health insurers; awaiting federal guidance on how consumer cost sharing is imposed across essential benefit categories, and the extent to which substitutions among benefit categories are allowed.	1/1/2014

Goal 3, Objective 3: Limit the Impact of Adverse Risk on Rate Payers

Several ACA provisions address the potential problem of adverse selection. If states' health insurance exchanges or the private market attracts a disproportionate number of less healthy individuals, premiums will grow increasingly unaffordable, and health plan participation may suffer. The individual mandate is one strategy aimed at getting people across the health spectrum into coverage to better balance risks and costs. Three ACA programs address additional potential adverse selection: reinsurance, risk adjustment, and federal risk corridors.

Transitional re-insurance. Re-insurance is secondary insurance purchased by a health plan typically to cover costs in extreme individual cases. The ACA establishes a re-insurance program for the early years of reform to limit the financial risk that health plans will face as they and the market adjust to new circumstances. The program will collect funds from 2014 through 2016 and will remain active for as long as necessary to pay out the funds collected, but not beyond 2018. States can administer their own re-insurance or opt in to the HHS program.

Risk adjustment. Risk adjustment attempts to reduce or eliminate premium differences among health plans that result solely from unbalanced member risk in the individual and small group market. Under this program, health plans with below-average actuarial risk (lower health care claims) will pay an assessment that then supports additional payments to those health plans and issuers with above-average actuarial risk (higher health care claims). Any state operating its own exchange may also run its own risk adjustment program; otherwise, the federal government will.

Risk corridors. The ACA provides for transitional aggregate risk-sharing mechanisms, called "risk corridors," that will redistribute funds from qualified health plans with large profits to those with large losses from 2014 through 2016. HHS will administer this program.

Today, California does not have any state-administered re-insurance or risk adjustment programs for private coverage. If California establishes its own re-insurance program, it must contract with at least one "applicable re-insurance entity" (ARE) to collect contributions and could opt to modify the federal re-insurance benefit and payment parameters.

State Action & Lead	Status	Implementation Date
1. Determine whether to administer transitional re-insurance program. Leads: Legislature and administration	State legislation authorizing state administration failed in 2012; the federal government will administer this program; the state is awaiting federal guidance regarding how health plans with capitated providers will be handled, as well as defining program parameters, such as the contribution rate, and co-insurance and re-insurance caps.	1/1/2014
2. Determine whether to administer	State legislation authorizing state	1/1/2014

risk adjustment program. Leads: Legislature and administration	administration failed in 2012; the federal government will administer this program; the state is awaiting federal guidance regarding how health plans with capitated providers will be handled.

Goal 4: Create a New Marketplace for Private Health Insurance

A cornerstone of the Affordable Care Act is the establishment of state-based health insurance exchanges, intended to be competitive, organized marketplaces where consumers and small businesses can comparison shop and buy health insurance based on price, benefits, and quality. Through exchanges low-income individuals ineligible for public coverage will qualify for federal subsidies and cost sharing.

The ACA and subsequent federal decisions prescribe the eligibility rules, certification process for selecting qualified health plans, administration of subsidies, consumer assistance, and other basic functions of state exchanges. States choosing to establish an exchange are eligible for federal grants to support development and operation through 2014. If a state chooses not to administer an exchange, the federal government will.

California has moved quickly to establish the California Health Benefit Exchange, including a governing board, executive staff, and the name "Covered California." Yet much work remains to meet key milestones before and after January 1, 2014 — when new coverage takes effect.

Progress toward Goal 4 will be tracked under these objectives:

- Objective 1: Operate the Exchange
- Objective 2: Offer coverage through qualified health plans

Goal 4, Objective 1: Operate the Exchange

With the help of federal funds for planning and implementation, California's Exchange is working toward federal government certification in January 2013. The Exchange must establish policies, procedures, and systems for eligibility and enrollment; health plan selection and management; finance and accounting; information technology, privacy, and security; and consumer and stakeholder engagement and support.

Launching an exchange is a daunting challenge in the context of significant insurance market upheaval and public program eligibility changes. For example, the Exchange must determine how to interface with federal and state data sources to administer premium tax credits and cost-sharing reductions. It must develop policies and procedures for administering exemptions from the individual insurance mandate. Ultimately, the Exchange must look beyond 2014 to January 2015, by which time the Exchange must become self-supporting and sustainable through assessments paid by participating health plans.

State Action & Lead	Status	Implementation Date
1. Decide to operate a state Health Benefit Exchange rather than rely on a federal program. Leads: Legislature and Administration	Statutory authority enacted in 2010 (AB 1602, Chapter 1605 and SB 900, Chapter 659).	1/1/2011
2. Apply for and use federal grants to support state's planning and establishment of the Exchange. Leads: CHHS, Exchange	To date, three federal grants have been awarded to California to support Exchange planning and operations: $1 million planning grant (10/2010–9/2011), $39 million Level 1.1 establishment grant (8/2011–8/2012), and $196.5 million Level 1.2 establishment grant (8/2012–6/2013). New establishment grant application to be submitted on 11/15/2012.	10/1/2010
3. Obtain federal certification for the Exchange by demonstrating sufficient progress in building policies, procedures, and systems. Lead: Exchange	"Exchange Blueprint" application for certification to be submitted to the federal government on 11/16/2012; ongoing demonstration of Exchange readiness and development in progress.	1/1/2013
4. Perform all federally required duties related to determining eligibility for premium tax credits and reduced cost sharing. Lead: Exchange	Policy decisions and technology development to support this function in progress.	10/1/2013
5. Grant certificates of exemption from the individual mandate to buy health insurance. Lead: Exchange	Policy decisions and technology development to support this function in progress.	10/1/2013
6. Begin operation of the Exchange.	Development in progress, as noted by	1/1/2014

Lead: Exchange	related state actions.	
7. Demonstrate financial self-sufficiency. Lead: Exchange	Sustainability plan under development for submission in "Exchange Blueprint" application on 11/16/2012 for federal certification.	1/1/2015

Goal 4, Objective 2: Offer Coverage Through Qualified Health Plans

The ACA requires exchanges to select and offer coverage through "qualified health plans" (QHPs) certified by the exchange and to monitor QHP coverage and quality. Exchanges must offer a choice of QHPs at each of five federally specified coverage levels (platinum, gold, silver, bronze, and catastrophic) to individuals, as well as through the Small Business Health Options Program (SHOP). QHP selection must adhere to specific standards, accreditation, and quality rating and measurement processes. Federal law also directs health plans to reduce cost sharing on essential health benefits for individuals living at or below 400% of FPL in a silver-level QHP.

The Exchange is deliberating on the cost-sharing provisions for QHPs, including the extent to which cost-sharing components of benefit plans should be standardized (an option under the same law that established California's Exchange).

State Action & Lead	Status	Implementation Date
1. Determine and approve cost-sharing provisions for QHPs. Lead: Exchange	Board action pending to standardize health benefits in the Exchange.	10/1/2013
2. Select and offer QHPs in the Individual and SHOP exchanges. Lead: Exchange	Board decision pending on extent of alignment of QHPs between Individual and SHOP exchanges; request for proposals for qualified health plans to be released 11/2012; bidders' responses due 1/2013; contracts with selected QHP issuers to be executed by 6/2013 for open enrollment on 10/1/2013.	10/1/2013
3. Establish policies and operations for SHOP. Lead: Exchange	Policy decision pending on employer offerings/employee choice of plans in SHOP; solicitation for contracted vendor to manage SHOP underway; selection of vendor expected by 1/2013.	10/1/2013

Notes & Resources

I. Federal Guidance Required

The Affordable Care Act is being implemented in a variety of ways — through new programs, grants, demonstration projects, regulations, and guidance documents. The latter provides important details about how to implement key ACA provisions. For example, in March 2012 the US Department of Health and Human Services (HHS) issued guidance on establishing state exchanges, qualified health plans, and standards for employer plans.

In an August 2012 report, Medicaid Expansion: States' Implementation of the Patient Protection and Affordable Care Act (PDF), the Government Accountability Office (GAO) noted several areas where further guidance is needed:

- How to implement the new income eligibility standards in a variety of possible scenarios. One example where California and other states need guidance is how to determine eligibility of children who divide their time between two parents' households.
- How to determine whether an enrollee is newly eligible or was already eligible before the ACA expansion, taking into consideration the changed income standards imposed by the ACA. The difference is significant. For example, California would receive much more federal money — initially, a 100% federal matching rate — for newly eligible Medicaid enrollees than for enrollees eligible for Medi-Cal prior to the ACA's passage (a federal match of approximately 50%).
- How to integrate state information systems with the new federal data hub, and what kinds of information to expect from the Internal Revenue Service and other federal agencies. States will use the federal data hub to verify income and citizenship or legal immigrant status for new enrollees.

In many other areas, California needs guidance from federal agencies to fully understand its options and their implications. For example, rules regarding federal and state financial responsibilities under a Basic Health Program (BHP) have yet to be promulgated, and details regarding the inclusion of "essential community providers" in Exchange qualified health plan networks have yet to be finalized.

A website from the US Department of Health and Human Services, www.HealthCare.gov, provides an overview of and updates on ACA implementation.

II. ACA Implementation Timelines

Health Reform Source: Implementation Timeline (Kaiser Family Foundation)

State Milestones for ACA Implementation (Robert Wood Johnson Foundation, March 2012)

III. The California Context

Monitoring the Impacts of the Affordable Care Act in California: Stakeholder Input and Priorities (California HealthCare Foundation, August 2012)

California's Uninsured (California HealthCare Foundation, December 2011)

Ready for Reform? Health Insurance Regulation in California Under the ACA (California HealthCare Foundation, June 2011)

California's Individual and Small Group Markets on the Eve of Reform (California HealthCare Foundation, April 2011)

IV. How ACA Is Paid For

Financing for the ACA relies on a complex patchwork of new revenues and anticipated savings. Over the long term, the ACA is intended to yield savings through increased prevention, reduced emergency room and acute care, reduced payments to providers, and reduced waste and fraud. To pay for the immediate benefits the ACA delivers, it raises Medicare payroll taxes on single people earning more than $200,000 per year and couples earning more than $250,000 per year. It also imposes annual fees on health insurance companies and pharmaceutical and device manufacturers, as well as imposing an excise tax on high-cost insurance (so-called "Cadillac" health plans).

V. Leads: Responsible State Departments and Entities

The California Department of Health Care Services (DHCS) finances and administers a number of individual health care delivery programs, including Medi-Cal (California's Medicaid program). As such, DHCS plays a central role in the implementation of the ACA, specifically in its efforts to implement the Medi-Cal expansion to newly eligible people and its work with other state entities and counties to simplify enrollment.

The California Department of Insurance (CDI) is one of two state entities responsible for the regulation and oversight of health insurance. CDI licenses and regulates the rates and practices of insurance companies, agents, and brokers in California. The role of CDI in the implementation of the federal health care reform is to ensure that health insurers adhere to the consumer protections as mandated.

The California Department of Managed Health Care (DMHC) is one of two state entities responsible for the regulation and oversight of health insurance. DMHC primarily regulates health maintenance organizations. The role of DMHC in the implementation of federal health care reform is to ensure that health plans adhere to the consumer protections as mandated.

The California Health and Human Services Agency (CHHS) oversees 13 departments and one board that provide health care services, social services, mental health services, alcohol and drug treatment services, income assistance, and public health services to Californians. Several departments involved in the implementation of ACA are overseen by CHHS, specifically DHCS, MRMIB, and DMHC. In addition, the secretary of CHHS serves as a voting ex-officio member of the California Health Benefit Exchange Board. CHHS plays an important role of ensuring coordinated implementation across these state entities.

The California Health Benefit Exchange (Covered California), established by state law in 2010, is an independent public entity within state government with a five-member board appointed by the governor and the legislature. The Exchange was borne out of the ACA as the vehicle for providing competitive marketplaces for individuals and small employers to directly compare and purchase private health insurance coverage based on price, quality, and other factors. The Exchange will also administer an online portal to enable consumers to choose a health plan and providers that offer the best value.

The Managed Risk Medical Insurance Board (MRMIB) oversees programs that serve lower-income and high-health-risk individuals. MRMIB is involved in the implementation of ACA in a number of ways, such as in the implementation and future dissolution of the temporary Pre-Existing Condition Insurance Plan, the transition of enrollees from Healthy Families to Medi-Cal as part of Medi-Cal expansion, and the collaborative effort with DHCS and the Exchange to develop a single, streamlined eligibility process for health insurance consumers in California.