Just the FACTS

The Affordable Care Act in California

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The Affordable Care Act made major changes to federal health policy.

Passed in 2010 with most provisions going into effect in 2014, the Affordable Care Act (ACA) requires insurers to offer coverage to all individuals regardless of their age or health status. The law also requires nearly everyone to have comprehensive health insurance or pay a tax penalty. To improve affordability, the ACA provided federal funds to support the expansion of state Medicaid programs and to subsidize health plans purchased through new insurance marketplaces. The ACA also included provisions to require the coverage of "essential health benefits" (e.g., mental health), reform payment systems, and improve quality of care.

California embraced the ACA and expanded health coverage.

California opted to fully implement the law—expanding Medi-Cal (California's Medicaid program) to low-income single adults without dependent children and creating a state-based insurance marketplace, Covered California. Policymakers expanded Medi-Cal eligibility to adults with incomes below 138% of the federal poverty level (about $16,700 for a single adult) and satisfactory immigration status, with the federal government currently covering 94% of total costs for this group. As of October 2017, about 3.8 million Medi-Cal enrollees had gained coverage under the ACA expansion. Californians with incomes between 100% and 400% of the federal poverty level can receive federal subsidies to purchase health plans through Covered California. Total enrollment in Covered California has held steady at between 1.2 and 1.4 million, with about 85% of enrollees receiving federal subsidies.

Uninsured rates have fallen sharply across the state.

The share of Californians with no health insurance dropped nearly 10 percentage points, hitting a historic low of 7.3% in 2016, compared with about 17% in the years prior to 2014. Low-income Californians saw the largest gains in coverage: among those with family incomes below $50,000, the share without health insurance fell more than 15 points to about 11% in 2016. All California counties saw lower uninsured rates after the ACA, ranging from a 14 point decrease in Merced to a 4 point drop in Marin.

ACA coverage expansions have been credited with improved outcomes.

According to a growing body of research, states that expanded Medicaid coverage saw increased access to care and use of preventive services (e.g., cholesterol checks), improvements in financial well-being, and greater use of prescription drugs, compared to states that did not expand Medicaid. Effects of the ACA on measures of self-reported health status and utilization patterns (e.g., visits to the emergency room) are more mixed, with some studies finding improvements and others reporting no change.

Efforts to dismantle the ACA are high on the federal agenda.

The president and congressional Republicans have pledged to roll back key provisions of the ACA, and the tax bill passed in December 2017 eliminates the tax penalty for not having comprehensive health coverage. The Congressional Budget Office estimates this change will increase the number of uninsured Americans and raise premiums. Other proposals to alter the ACA include changes to Medicaid, which could have a big effect on California since the federal government covers about two-thirds of total Medi-Cal costs. Medi-Cal provides health coverage for more than a third of Californians—and more than half of residents in some counties.

Uncertainty over federal policy has California exploring state-based options.

State legislation was introduced last year to establish a single-payer health care system (SB 562). The bill lacked key details on how such a system would operate or be financed, and while it did not move forward, it remains active in the current legislative session. State policymakers have also conducted hearings and engaged stakeholders to explore options for maintaining and expanding health coverage. Given the federal government's substantial role in financing health insurance for low-income and elderly Californians, any state plan would need to assess the potential for redirecting federal funds or explore other large revenue sources.

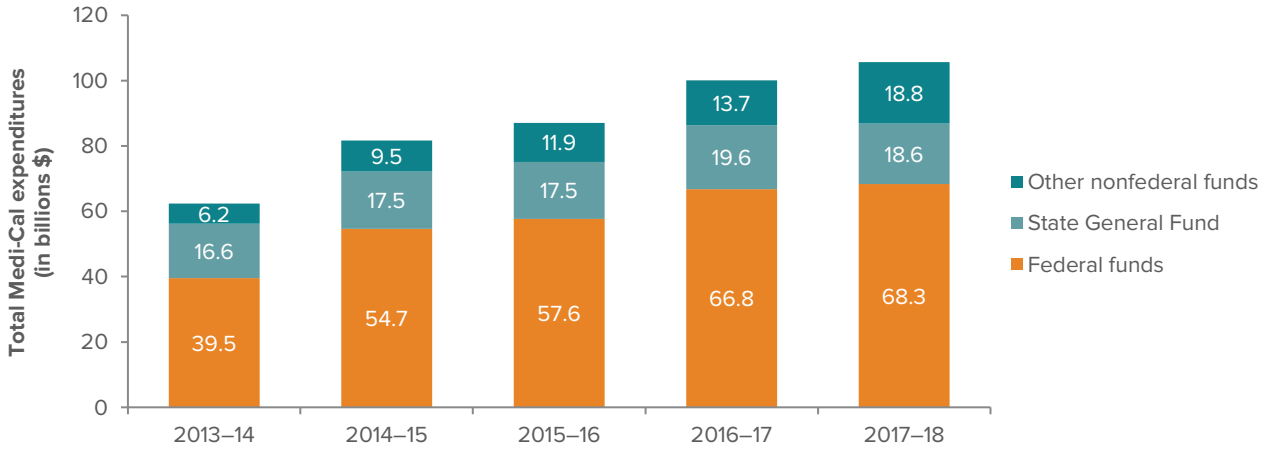
Uninsured rates have decreased in all California counties since the ACA

County/ county group	Uninsured rate, 2016	% pt drop in uninsured, 2013–2016	County/ county group	Uninsured rate, 2016	% pt drop in uninsured, 2013–2016	County/ county group	Uninsured rate, 2016	% pt drop in uninsured, 2013–2016
Statewide	**7.3%**	**9.7**	Los Angeles	9.7%	11.5	San Joaquin	6.1%	11.2
Alameda	4.4%	8.0	Madera*	6.7%	12.1	San Luis Obispo*	5.1%	6.2
Alpine, Amador, Calaveras, Inyo, Mariposa, Mono, Tuolumne*	5.0%	6.9	Marin*	3.8%	4.0	San Mateo	3.7%	5.9
Butte*	5.5%	6.8	Merced	5.9%	13.8	Santa Barbara	9.6%	9.8
Colusa, Glenn, Tehama, Trinity*	5.9%	12.7	Monterey, San Benito	9.4%	12.6	Santa Clara	4.5%	6.4
Contra Costa	5.0%	6.7	Napa*	3.0%	11.6	Santa Cruz*	4.3%	10.7
Del Norte, Lassen, Modoc, Plumas, Siskiyou*	5.0%	10.3	Nevada, Sierra*	7.0%	7.1	Shasta*	5.3%	13.2
El Dorado*	4.1%	6.0	Orange	7.3%	9.0	Solano	4.9%	8.2
Fresno	8.5%	9.7	Placer	3.9%	6.8	Sonoma	5.8%	7.3
Humboldt*	7.5%	10.4	Riverside	8.8%	10.7	Stanislaus	5.1%	13.2
Imperial*	7.1%	13.0	Sacramento	4.9%	10.4	Sutter, Yuba*	7.1%	12.3
Kern	7.4%	11.5	San Bernardino	8.3%	10.9	Tulare	9.6%	11.0
Kings*	6.9%	12.0	San Diego	7.4%	8.4	Ventura	9.7%	5.8
Lake, Mendocino*	7.5%	9.5	San Francisco	3.4%	5.5	Yolo*	4.8%	9.9

Source: American Community Survey (ACS), Public Use Microdata Sample, 2013 and 2016.

Note: Counties shown grouped cannot be individually identified in the ACS. All estimates are subject to uncertainty due to sampling variability; uncertainty is greater for less-populous counties and county groups (because of smaller sample sizes). Uninsured estimates for counties and county groups with an asterisk are based on samples of fewer than 2,000 people.

Federal funds have comprised two-thirds of the Medi-Cal budget in recent years



Source: California Department of Health Care Services, Medi-Cal Local Assistance Estimates.

Note: Other nonfederal funds include provider fees and transfers for other government entities, such as public hospital systems.

Sources: For studies on the effects of the ACA, see Ghosh, Simon, and Sommers, "The Effect of State Medicaid Expansions on Prescription Drug Use" (NBER, 2017); Brevoort, Grodzicki, and Hackman, "Medicaid and Financial Health" (NBER, 2017); Miller and Wherry, "Health and Access to Care during the First Two Years of the ACA Medicaid Expansions" (New England Journal of Medicine, 2017); Simon, Soni, and Cowly, "The Impact of Health Insurance on Preventive Care and Health Behaviors" (Journal of Policy Analysis and Management, 2017); and Sommers et al., "Three-Year Impacts of the Affordable Care Act" (Health Affairs, 2017). For a comprehensive review of studies examining the effects of Medicaid expansions under the ACA, see the Kaiser Family Foundation Issue Brief.

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