

A Framework for Tracking the Impacts of the Affordable Care Act in California

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Executive Summary

The federal Patient Protection and Affordable Care Act (the ACA), enacted in March 2010, will have far-reaching impacts on health insurance coverage, health care financing, and health care delivery in the United States. Understanding the state-level impacts of the ACA will contribute to a better understanding of the national impacts of the law and will provide information to shape ongoing state implementation activities.

The goal of this project was to recommend how California (and the California HealthCare Foundation) can measure and monitor the impacts of health care reform in three areas: health insurance coverage; affordability and comprehensiveness of health insurance coverage; and access to health care services.

Within each of the three focus areas for this project we identified several categories of metrics needed to monitor the impacts of the ACA. We recommend a total of 51 measures that California can use to monitor the impacts of health care reform over time: 19 related to insurance coverage, 15 related to affordability and comprehensiveness of coverage, and 17 related to access to care. The recommended measures are summarized in **Figure 1**.

Next, we reviewed and assessed existing state and national data sources to determine how each data source might be employed to measure the impacts of the ACA in California. The data sources include population surveys and employer surveys, as well as data from health care providers, health plans, and public programs (e.g., Medi-Cal, county programs for indigent care). For each source of data we compiled technical information, such as: how the data are collected and from whom; how complete or representative the data are; whether comparisons can be made to other states and U.S. averages; whether comparisons can be made for regions within California; and whether the data can be used

for monitoring trends among specific population groups such as children, people with low incomes, and by race and ethnicity. We reviewed the data collection instruments (e.g., survey questionnaires), technical documentation for the data sources, and publicly available reports that use the data. For data sources that are unique to California we also conducted key informant interviews with experts who are regular users of the data sources or who are responsible for the data collection in order to better understand the strengths and weaknesses of the data.

Selecting the “best” data source for each measure involved assessing the availability of the recommended measures from each data source, and weighing the strengths and weaknesses of potential data sources. **Figures 2, 3, and 4** present our recommended data sources for each measure, with asterisks showing where there are gaps in existing data to track these measures.

To summarize the gaps in existing data, we divided them into two categories. The first category includes measures that could be collected or modified using existing data collection infrastructure; the second includes measures that cannot be collected until full implementation of the ACA’s coverage provisions in 2014. **Figures 5 and 6** provide an “at a glance” summary of the data gaps we identified and our recommendations for filling them.

Finally, we identified different ways to analyze and present the recommended measures to policymakers and the public to inform them about the impact of health reform in California. Key elements of a successful data dissemination strategy will include organizing content in a thoughtful way, allowing users to view data in a variety of different formats, presenting measures in a way that highlights key information, and making technical documentation accessible.

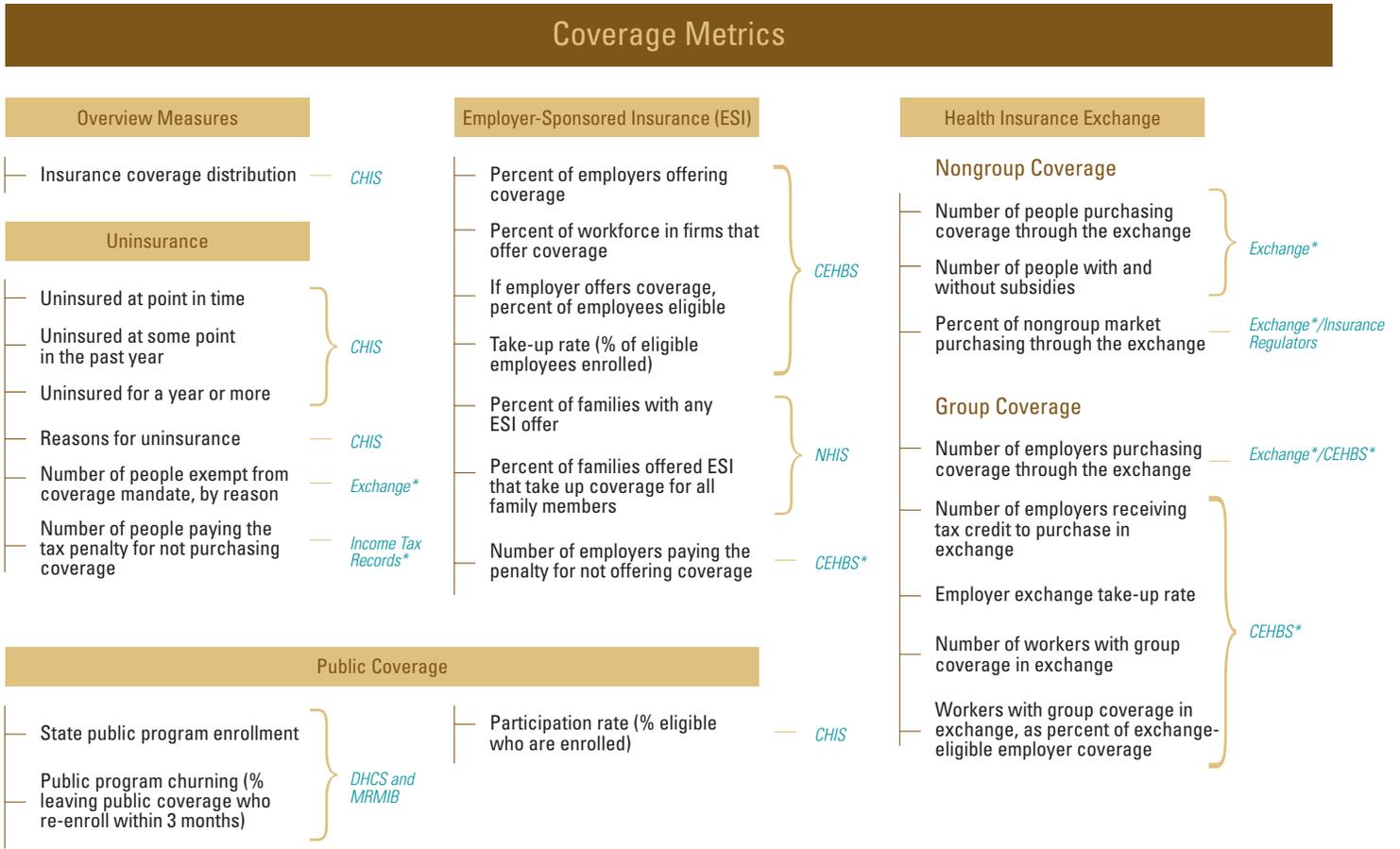
FIGURE 1. Recommended Measures for Tracking the Impacts of Health Reform in California

Coverage Metrics		Affordability and Comprehensiveness Metrics	
Coverage: Overview	Employer-Sponsored Insurance (ESI)	Insurance Premiums	Comprehensiveness of Coverage
<ul style="list-style-type: none"> Insurance coverage distribution 	<ul style="list-style-type: none"> Percent of employers offering coverage Percent of workforce in firms that offer coverage At employers offering coverage, percent of workers eligible Take-up rate (% of eligible employees enrolled) Percent of families with any ESI offer Percent of families offered ESI with all family members enrolled Number of employers paying penalty for not offering coverage 	<ul style="list-style-type: none"> ESI: Average annual premium for single coverage ESI: Average annual premium for family coverage ESI: Average annual employee contribution for single coverage ESI: Average annual employee contribution for family coverage Nongroup market: Average annual premium per enrollee 	<ul style="list-style-type: none"> ESI: % distribution of enrollment by benefit level* Nongroup market: % distribution of enrollment by benefit level* ESI: deductibles for single coverage ESI: deductibles for family coverage Nongroup market: deductibles for single coverage Nongroup market: deductibles for family coverage
Uninsurance			
<ul style="list-style-type: none"> Uninsured at point in time Uninsured at some point in the past year Uninsured for a year or more Reasons for uninsurance Number of people exempt from coverage mandate, by reason Number of people who pay the tax penalty for not purchasing coverage 			
Public Coverage	Health Insurance Exchange	Subsidies for Premiums and Cost-Sharing	Financial Burden
<ul style="list-style-type: none"> Enrollment trend in state public programs Participation rate (% eligible who are enrolled) Churning (% leaving public coverage who re-enroll within 3 months) 	<ul style="list-style-type: none"> Number of people purchasing nongroup coverage through the exchange Number of businesses and people with group coverage through the exchange 	<ul style="list-style-type: none"> Number of people receiving premium and cost-sharing subsidies in the insurance exchange Average value of premium and cost-sharing subsidies in the insurance exchange 	<ul style="list-style-type: none"> Percent of families with high cost burden "Affordable" premium as a percentage of income

*Benefit level refers to catastrophic, bronze, silver, gold, and platinum levels for actuarial value established by the ACA.

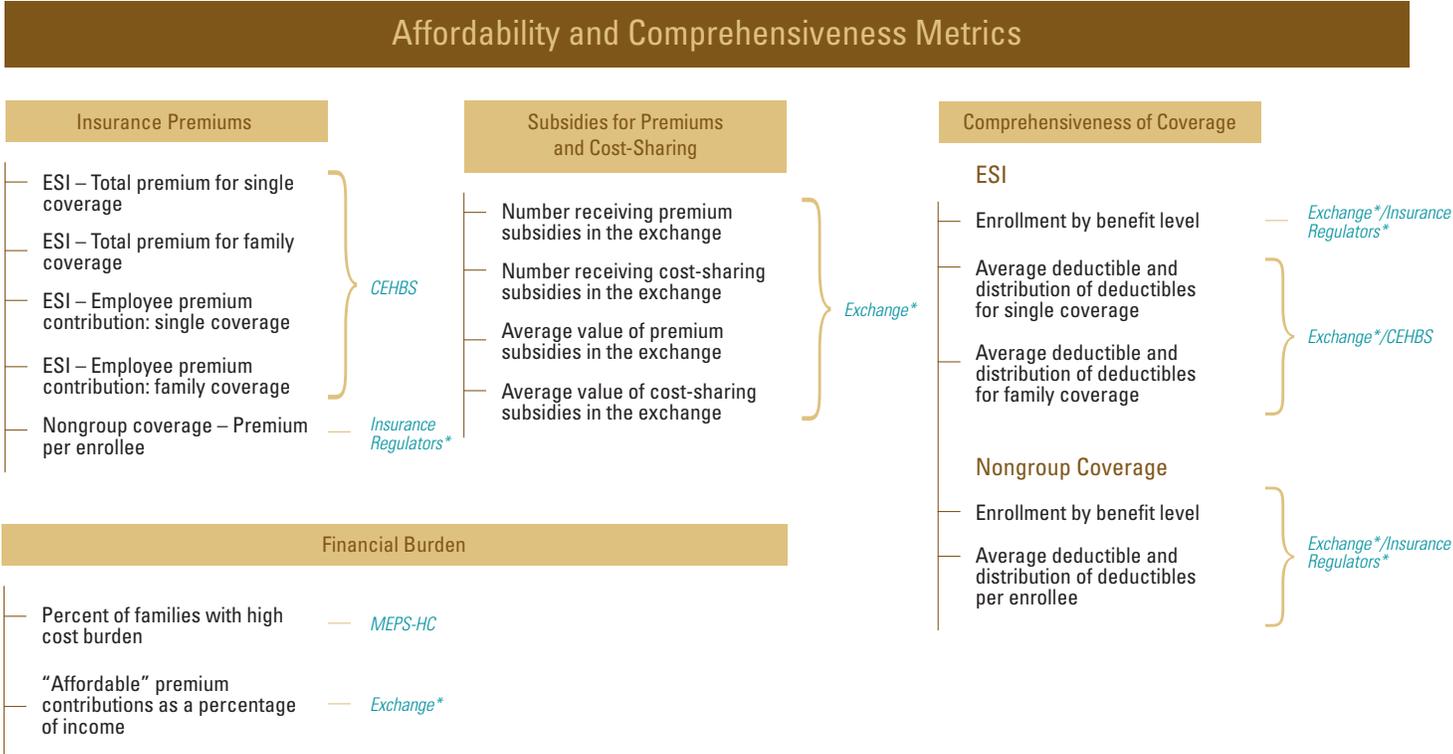
Access to Care Metrics			
Use of Services	Barriers to Care	System-Level Access	Safety Net
<ul style="list-style-type: none"> Percent of people with a usual source of care Type of place for usual source of care Percent of people who have had a doctor visit in the past year Percent of people with a preventive care visit in the past year 	<ul style="list-style-type: none"> Percent of people who forgo needed care Reasons for forgone care Percent of people who were not able to get an appointment in a timely way Percent of people who had difficulty finding a provider that would accept new patients Percent of people who had difficulty finding a provider that accepts their insurance 	<ul style="list-style-type: none"> Percent of physicians accepting new patients Percent of physicians participating in public programs Emergency room visit rates Ambulatory care sensitive hospital admissions Preventable/avoidable emergency room visits 	<ul style="list-style-type: none"> Volume and type of services provided by safety net clinics Uncompensated care County indigent care volume and cost

FIGURE 2. Recommended Data Sources for Coverage Measures



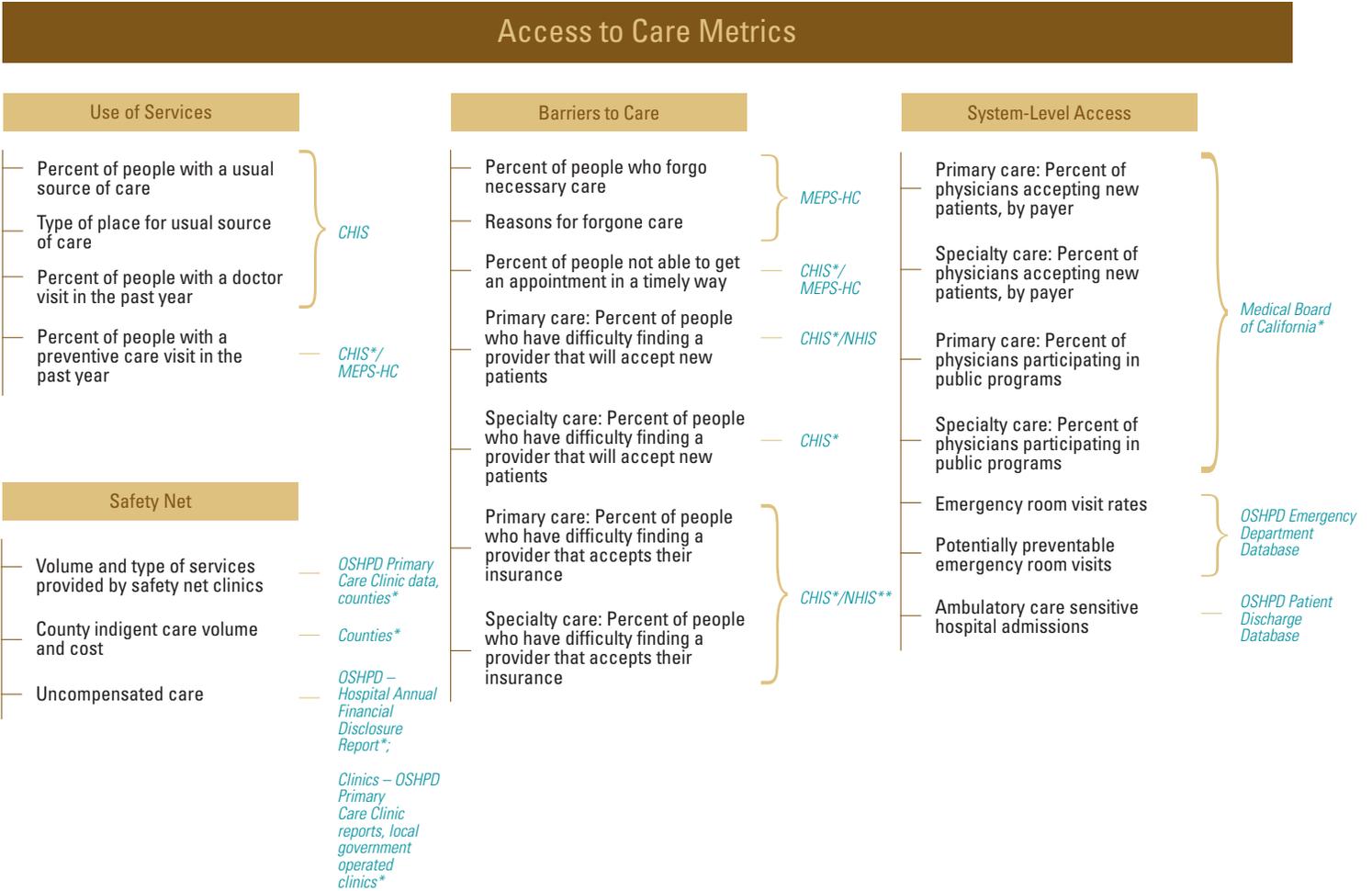
*Requires new data collection
 Notes: CHIS = California Health Interview Survey; CEHBS = California Employer Health Benefits Survey; NHIS = National Health Interview Survey; DHCS = Department of Health Care Services; MRMIB = Managed Risk Medical Insurance Board.

FIGURE 3. Recommended Data Sources for Affordability and Comprehensiveness Measures



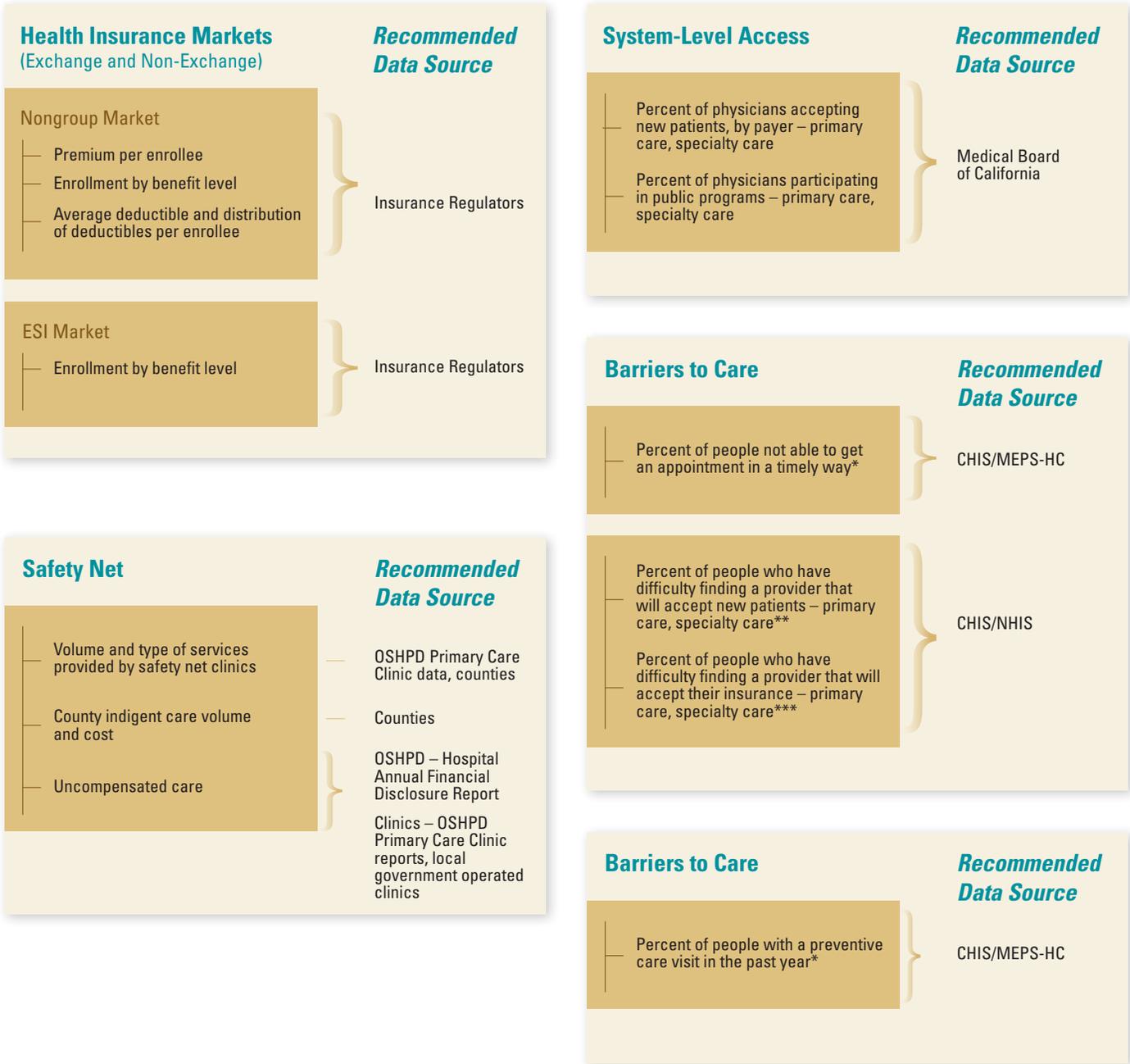
*Requires new data collection
 Notes: CEHBS = California Employer Health Benefits Survey; MEPS-HC = Medical Expenditure Panel Survey – Household Component.

FIGURE 4. Recommended Data Sources for Access to Care Measures



*Requires new data collection
 **Not able to distinguish between primary and specialty care

FIGURE 5. Filling Data Gaps: Existing Data Collection Infrastructure



*Available from MEPS-HC; consider adding to CHIS

**Measured in NHIS for primary care only; consider adding to CHIS

***Measured in NHIS without distinction between primary and specialty care; consider adding to CHIS

FIGURE 6. Data That Cannot Be Collected Until Full ACA Implementation

