

Stakeholder Evaluation of the Implementation of the Affordable Care Act in San Luis Obispo County

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Abstract

The purpose of this stakeholder evaluation is to measure the effectiveness of the implementation of the Affordable Care Act in San Luis Obispo County given that the County did not receive a Covered California grant, and to explore if “in-reach” efforts among key stakeholders is offsetting this possible disadvantage to program implementation. To evaluate the effectiveness of the implementation of the Affordable Care Act in San Luis Obispo County a process evaluations was completed. This form of evaluation was chosen because the program is not yet completely implemented. The purpose of a process evaluation is to examine to what extent a program has been implemented as planned, determine if it reached its intended target population, explain why goals and objectives may not have been achieved and to help improve its effectiveness (Wholey, Hatry, & Newcomer, 2010). The evaluation was developed using the Centers for Disease Control and Prevention (CDC) Evaluation Framework for public health programs (Koplan, Milstein, & Wetterhall, 1999). An objectives-oriented approach was used, measuring the overall effectiveness of implementation to the extent the Covered California program (2013) is able to achieve the goal to “improve the health of all Californians by assuring their access to affordable, high quality care,” as evaluated by stakeholders in the County of San Luis Obispo. Specifically, this project investigates: Given these conditions, to what extent is Covered California achieving the objectives of increased access, improved health care quality, lowered costs and improved health for eligible residents in San Luis Obispo? This evaluation is an exploratory, non-experimental design, using a case study of San Luis Obispo to evaluate the effectiveness of the implementation of the Affordable Care Act in San Luis Obispo County.

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Although a number of studies show that better health outcomes are strongly related to insurance coverage in both adults and children, for many Americans, quality health insurance has been unavailable to them due to financial constraints (Kaiser Family Foundation, 2013). In the United States, as many as 44,500 deaths per year are related to being uninsured (Bernstein, Chollet, & Peterson, 2010). One in five uninsured Californians say they have never had health insurance, and about two-thirds have gone without it for at least two years (Kaiser Family Foundation, 2013). As of the Fall 2013, obtaining coverage is now a reality for millions of Americans under the federal Patient Protection and Affordable Care Act (ACA) (2010), when key components of the law began their rollout across the nation. To succeed, the establishment of state-based health benefit exchanges - online marketplaces where individuals and small businesses can shop for insurance- is crucial. In 2010, California became the first state to establish a state-based health benefit exchange under the ACA, known today as Covered California (Covered California, 2013). The vision of the exchange is “to improve the health of all Californians by assuring their access to affordable, high quality care” and its mission is “to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value” (Covered California, 2013).

Despite a California Wellness Foundation sponsored Field Poll (2013) reporting a majority of Californians were optimistic the state would be successful in implementing the Affordable Care Act, doubts plagued even the most loyal of health care reform advocates regarding the achievability of goals and implementation of the law. In particular, there was

concern about whether the new health benefit exchange would be up and running on time for open enrollment in October of 2013. With more than 43,000 uninsured adults living in San Luis Obispo County (San Luis Obispo County Public Health Department, 2013), advocates were further concerned when the county failed to receive a Community Outreach and Education Grant provided by Covered California. Given these conditions, to what extent is Covered California achieving the objectives of increased access, improved health care quality, lowered costs and improved health for eligible residents in San Luis Obispo?

The purpose of this stakeholder evaluation is to measure the effectiveness of the implementation of the Affordable Care Act in San Luis Obispo County given that the County did not receive a Covered California grant, and to explore if “in-reach” efforts among key stakeholders is offsetting this possible disadvantage to program implementation.

Background

President Obama signed the Patient Protection and Affordable Care Act (Public Law 111-148) on March 23, 2010, mandating comprehensive health reform in the United States. The law was further amended by the Health Care and Education Reconciliation Act (Public Law 111-152), and signed on March 31, 2010. Both together are known as the Accountable Care Act, but the policy is often referred to as the Affordable Care Act (ACA), “health reform,” or “Obamacare.” The legislation includes nine titles, each focusing on a critical area of health reform, with an overarching goal of attempting to increase access to quality, affordable health care for all Americans, while improving service quality and controlling medical costs. The Congressional Budget Office (CBO, 2010) estimates that beginning in 2014 under the new law, state and federal insurance exchanges will cover more than 7 million Americans, and another 9

million will benefit from the expansion of Medicaid programs. All of this will be done while staying below an established \$900 billion cost limit set by President Obama to ensure the ACA is fully paid for, while simultaneously reducing the deficit in the next decade (CBO, 2010).

There are three components critical to achieving health care reform under the new law. First, the ACA transforms health care in the United States by requiring that all legal United States residents have health insurance coverage, either through their employer or under an individual plan, or with a few exceptions, pay a penalty. This “individual mandate,” under Section 1501 and Section 10106, ensures “the federal government, state governments, insurers, employers and individuals are given shared responsibility to reform and improve the availability, quality and affordability of health insurance coverage in the United States” (ACA, P.L. 111-148, as amended). The individual mandate seeks to prevent adverse selection—the tendency where purchasing health insurance is only financially attractive to sick consumers who will collect the most benefit and less financially attractive to younger and healthier consumers who may benefit less. When this happens, high-risk consumers may buy into the insurance pool, raising insurance costs overall, and younger, healthier individuals may opt not to buy-in at all, thereby resulting in higher overall rates and less consumers to share the increased costs (National Association of Insurance Commissioners, 2011).

Second, the law aims to end discriminatory insurance practices, by abolishing exclusions for pre-existing conditions and removing caps on lifetime and annual limits for benefits.

Finally, the reform intends to make coverage affordable for approximately 94% of the population of the United States (CBO, 2013). To encourage broad participation in the new health insurance system, in 2014, federal tax credits will be available to those earning between 100%

and 400% below the federal poverty level (FPL). In order for a family of four to qualify for Covered California's subsidized program, their 2012 annual income would range from approximately \$31,000 to \$92,000 (Covered California, 2013). Cost sharing subsidies will also be available to help reduce out-of-pocket expenses some individuals pay. The ACA includes an expansion of public programs, including the expansion of Medicaid for any eligible individuals under the age of 65 whose income is below 133% of the FPL. The CBO (2010) estimates that between 2010 and 2019 the subsidies will cost approximately \$350 billion, however the long-term effect of the ACA will be a reduction in health care expenditures due to an improvement in health care value, quality and efficiency. The key features of the ACA are described in Figure 1.

An important component in the implementation of The Affordable Care Act (ACA) is the establishment of Health Insurance Exchanges in all states by January 1, 2014. A Health Insurance Exchange, or Marketplace, is where eligible individuals can shop and compare a variety of certified health insurance plans, as well as learn what federal financial assistance they may qualify for to make coverage more affordable. The ACA provides states with the option of establishing one or more state exchanges, combining with other states in the formation of an exchange, or partner with the federal government (U.S. Government Accountability, 2013). To establish an exchange, states had to submit and receive the approval of a blueprint from the U.S. Department of Health and Human Services. Only nineteen states (see Figure 2), including District of Columbia, submitted blueprints by the December 2012 federal deadline laid out in the ACA. When open enrollment for the new health system began in October 2013, only sixteen states and the District of Columbia had passed legislation or executive orders to create a state-based health insurance exchange. There are seven states where state and federal officials are partnering to run the exchange (National Conference of State Legislatures, n.d.). The remaining

27 states have chosen to default to the federal health insurance exchange system and will have “federally facilitated exchanges” (FFE) (U.S. Government Accountability, 2013).

These state-based exchanges play a vital role in the effective implementation and successful enrollment of individuals into the new system supplied by the ACA , because they have a better understanding of the unique characteristics of their states target market and are better positioned to maximize enrollment through partnerships with local stakeholders (Jones & Greer, 2013).

The Birth of Covered California

Although many states have fought direct implementation, California has embraced the challenge to implement the ACA. On September 30, 2010, the California Health Benefit Exchange was established by Governor Arnold Schwarzenegger when AB 1602 and SB 900 were signed into law, making California the first state in the nation to pass enabling legislation to create a health benefit exchange (California State Assembly Bill 1602, 2010). This legislation is also known as the California Patient Protection and Affordable Care Act (CA-ACA). The state chose the state-based exchange model of operation. The state received two federal grants to assist in the establishment of the California Health Benefit Exchange, an Exchange Planning Grant for \$529,894 and Exchange Establishment Grant for \$909,606,370, for a total of \$910,136,264 (The Kaiser Family Foundation, 2013).

The structure of the exchange is that of a “quasi-governmental” organization, denoting the California Exchange is “an independent public entity not affiliated with any agency or department” (CA Govt Code § 100500). The Exchange was branded in October 2012 as Covered California.

The State of California is expected to have more eligible residents for its exchange than any other state. In the “Blueprint For Approval of Affordable State-Based Exchange,” Covered California (2013) outlines its plans for how it will help the estimated 5 million Californians who will be eligible to purchase plans through the exchange in 2014. The Blueprint claims Covered California will, “perform eligibility determination for advance premium tax credits and cost sharing reductions. It will also determine responsibility for individual responsibility requirements and payment exemptions. Finally California intends to use federal services to perform the risk adjustment and reinsurance functions” (Covered California, 2013).

In 2014, about 2.6 million Californians will qualify for federal assistance under Medi-Cal, tax credits or cost-sharing subsidies. Another 2.7 million will be guaranteed coverage through the exchange, or will buy insurance privately. This estimated 5 million Californians will make up the Covered California eligible target market. Latinos (46%) will make up the largest share of the state’s subsidy eligible population (Figure 3).

Importance of Stakeholder Engagement

Covered California is committed to “working in partnership with a full range of stakeholders” and has identified stakeholder consultation among its “core operating values” (Covered California, 2013). From the beginning, Covered California has engaged stakeholders, drawing on their expertise throughout the planning process and continues ongoing and regular consultation activities to gain specific input, build and sustain partnerships, and better understand how Covered California policies affects stakeholders. The stakeholder group consists of consumers, enrollment entities, advocates for target populations, small business owners, Medi-

Cal, Tribal representatives, public health experts, providers, large employers, insurance companies and agents/brokers.

Covered California refers to its integrated multichannel Statewide Marketing, Outreach & Education Program as a “bottom-up and top-down strategy” (Covered California, 2013). Using both community mobilization and paid media to reinforce messaging, Covered California expects to influence enrollment at the local level. The focal point of the Covered California Outreach and Education Strategy is a Community Grant Program, providing \$37 million to 48 lead organizations (Figure 4) to support local efforts to promote awareness and education (Covered California, 2013). Based on a marketing strategy influenced by the research of McKinsey & Company (2010), the grant program will harness the power of “word of mouth” advertising. Community grants were distributed throughout California to select organizations with trusted relationships with uninsured individuals eligible for enrollment through a grass-roots effort to reach people where they live, work, pray, and play. Some examples of the types of groups included are 211 Los Angeles County (a social services information line), SEIU Local 52, California Council of Churches, and the YMCA (Covered California, 2013). Research by McKinsey found that word-of-mouth recommendation from a trusted source is the primary justification in 20- 50% of purchasing decisions (McKinsey & Company, 2010).

Certified Covered California Educators are a critical part of the statewide marketing plan. It is through this mobilization and education of key influencers used to spread the word that the program plans to achieve the overall goal of affordable enrollment and easily accessible health coverage for eligible Californians.

The Outreach and Education Grant Program has six main objectives (Covered California, 2013).

1. Promoting public awareness and informing consumers and small businesses about their options to obtain affordable health coverage.
2. Helping to remove barriers to enrollment that keep eligible consumers and small businesses from applying.
3. Providing consumers and small businesses with information and tools so individuals and employers can enroll on their own.
4. Educating the public about the value of purchasing health coverage, health coverage costs, and options (i.e., coinsurance, copays and benefits).
5. Driving individual consumers to Certified Enrollment Entity program resources that help them with questions and enrollment.
6. Driving small businesses to Covered California to help them with questions and enrollment.

Implementing the ACA in San Luis Obispo

The County of San Luis Obispo began its formal preparation for the ACA implementation in September 2010 (San Luis Obispo County Public Health Department, 2013c). The Public Health Department led the effort convening “stakeholder representatives who comprise [the] county’s health care safety net” to form an advisory committee to study the potential for the development of a Health Care Coverage Initiative (HCCI) in the county (San Luis Obispo County Public Health Department, 2010). The HCCI program was approved under California’s “Bridge to Reform” §1115 Medicaid Demonstration Waiver in September of 2007

and initially scheduled until November of 2010, however California was approved to implement the Low Income Health Program (LIHP) effective until 2014 (Lytle et al., 2013). The main goal of the HCCI program was to expand health care coverage for eligible low-income, uninsured individuals, and during the initial phase just ten counties were selected and chose to participate (Lytle et al., 2013). Under the LIHP program counties receive partial reimbursement from the Centers for Medicare and Medicaid Services for providing health services to residents who will be newly eligible for coverage under the expanded Medi-Cal in 2014 (Lytle et al., 2013). For the County of San Luis Obispo an LIHP proved not to be feasible, after 18 months the stakeholder group chose to terminate their plans for the program, yet there was consensus that the stakeholders group should continue working together on the transition to Health Care Reform (San Luis Obispo County Public Health Department, 2012).

In August 2012, twenty-five stakeholder representatives reconvened as the ACA Planning Group. County administrators reminded the group that although organized by the San Luis Obispo Health Agency, they were “not the driver or owner and that this is a collaborative effort” (San Luis Obispo County Public Health Department, 2012). Early implementation concerns of the group revolved around the “potential impact of the ACA on their organizations and clients,” “provider network adequacy,” “Medi-Cal enrollment capacity,” “discontinuation of the County Medical Services Program,” and “the residually uninsured” (San Luis Obispo County Public Health Department, 2012). In January 2013, the group met again with a general goal of “want[ing] a unified command to coordinate the health care community during this transition” and a set of objectives, which they agreed, would be worked upon through special sub groups. The objectives of the group are to develop and support provider networks, coordinate outreach,

education and enrollment, support enrollment retention and improve system utilization (San Luis Obispo County Public Health Department, 2013).

In March 2013, the group had turned their focus towards how to encourage enrollment of eligible uninsured residents when the Covered California Outreach and Education Grant opportunities became available. At this time, the stakeholder group currently had close to fifty members. The intent of the Outreach and Education Grant Program “is to ensure participation of a wide range of organizations that are interested in providing public awareness, outreach and education activities to targeted communities and populations eligible for Covered California health care coverage” (Covered California, 2013). The Covered California Outreach and Education Grant Program had four guiding principles: target resources based on the greatest opportunity to reach the highest number of uninsured and subsidy eligible individuals, ensure that all regions and markets in the state, including the hard to move are reached, complement the Assisters Program and the broader marketing strategy, and assist employers to enroll on their own (Covered California, 2013).

Although there were an estimated 43,000 total uninsured in the county, only 17,000 were considered the primary target population for the Covered California Outreach and Education Market (Figure 5), which include those eligible for tax credits or cost-sharing subsidies through the health benefit exchange.

Of those, the County estimated 25% would be Spanish speaking (San Luis Obispo County Public Health Department, 2013). Since a collaborative effort was recommended in their application, a subgroup of stakeholders were identified to partner, each with established relationships amongst the target population. The grant would have required 70% of the effort be in conducting one-on-one education and 30% to be spent doing outreach activities. Covered

California was specifically interested in grant proposals from organizations serving specific target markets with higher than average rates of uninsured individuals and those that “experience communities that have a high number of uninsured individuals,” as well as those that “experience disproportionate barriers to accessing affordable health insurance programs” (Covered California, 2013). Figure 6 shows examples of the target markets suggested by Covered California (Covered California, 2013). A total of \$301,540 was requested “to maximize enrollment of eligible uninsured into Covered California programs through local outreach and education activities coordinated with the statewide campaign” (San Luis Obispo County Public Health Department, 2013).

In May of 2013, the group of stakeholder’s forming the ACA Planning Group were informed they would not be one of the 48 selected organizations to receive a Covered California Outreach and Education Grant. Covered California received 203 proposals, and of those, 177 applications targeted individual consumers and 26 chose to target small businesses (Covered California, 2013). The “proposals were evaluated to determine which mix of organizations had the greatest likelihood of achieving the Grant Program’s priorities” and “additional consideration was given to those organizations that proposed to serve the top 100 zip codes where Covered California’s target populations reside” (Covered California, 2013). Although funding was awarded to several statewide organizations intended to include San Luis Obispo, no organizations based on the Central Coast received funding (San Luis Obispo County Public Health Department, 2013). The decision not to fund the county collaborative was based on the relatively low levels of eligible residents in the region, based on population density (A. Gilman, personal communication, August 20, 2013) .

The news that the County was not awarded a grant from Covered California was a disappointment for the ACA Planning Group. The funding for the Outreach and Education plan would have allowed the county to reach the vulnerable and hard-to-reach populations that made up the target market of uninsured individuals. Without funding the diverse set of organizations holding ties to the local community, many of which are already financially strapped, the County of San Luis Obispo would not have the resources available to provide outreach and education.

Realizing they would be without a critical component to successfully implement the ACA in San Luis Obispo County, the group made the decision to perform Outreach, Education and Enrollment as an unfunded entity to support the Covered California Outreach and Education Grant Program. At the May 2013, ACA Planning Group meeting stakeholder's decided that "without funding for a project coordinator, each organization would instead proceed with separate populations throughout the county" and provided a recommendation of "ongoing communications and collaboration" (San Luis Obispo County Public Health Department, 2013). A Blue Shield of California Foundation grant awarded to the county to assist in transitioning the County's Medically Indigent population to the new health care system was identified as a source of funding to support collaborative meetings (ACA- Outreach, Education and Enrollment Subcommittee, 2013).

This revised strategy pursued by the Outreach, Education and Enrollment (OEE) Subcommittee emphasized "inreach," rather than "outreach." Many of the state's uninsured are currently receiving services through one or more of the many state or county programs, such as county social services and mental health, community health care clinics, in addition to having ties to many community based organizations (Wulsin, 2013). Providing education to existing

clients to maximize enrollment without funding was feasible for stakeholder's and could still prove beneficial. Four target populations were identified by the group: 1) Small business employees, 2) Young adults at local colleges, 3) Latinos, and 4) Parents through local schools (ACA- Outreach, Education and Enrollment Subcommittee, 2013). Tactics of the subcommittee included: providing education to existing clients; creating a Speakers' Bureau; conducting presentations throughout the county to community and professional organizations; leading a group training for staff from the County and community based organizations; developing collateral material for use in outreach to consumers; and holding a press conference for the media (ACA- Outreach, Education and Enrollment Subcommittee, 2013).

Overall, although the group lacked the full funding that would have been provided through the Covered California Outreach and Education Grant, stakeholder's were committed and willing to participate to the best of their organizations ability, some still offering to carry out the full range of activities delineated in the grant proposal (ACA- Outreach, Education and Enrollment Subcommittee, 2013).

Purpose of the Evaluation

To evaluate the effectiveness of the implementation of the Affordable Care Act in San Luis Obispo County a process evaluations was completed. This form of evaluation was chosen because the program is not yet completely implemented. The purpose of a process evaluation is to examine to what extent a program has been implemented as planned, determine if it reached its intended target population, explain why goals and objectives may not have been achieved and to help improve its effectiveness (Wholey, Hatry, & Newcomer, 2010).

This evaluation was completed using the Centers for Disease Control and Prevention (CDC) Evaluation Framework for public health programs (Koplan, Milstein, & Wetterhall, 1999). The Framework (Figure 7) provides a systematic way to approach evaluation, consisting of six steps and four standards to complete an evaluation. The Framework was created in collaboration with the Evaluation Working Group, consisting of representatives throughout the CDC, state and local health officials, with input from numerous other public health committees. The Framework is widely used in evaluation practice.

Objectives

An objectives-oriented approach was used, measuring the overall effectiveness of implementation to the extent the Covered California program (2013) is able to achieve the goal to “improve the health of all Californians by assuring their access to affordable, high quality care,” as evaluated by stakeholders in the County of San Luis Obispo.

For the purpose of evaluation I created four questions based on Covered California’s vision and mission statements (Covered California, 2013):

1. Is Covered California increasing access to health insurance in San Luis Obispo County?
2. Is Covered California improving health care quality in San Luis Obispo County?
3. Is Covered California lowering costs for health care for eligible residents in San Luis Obispo County?
4. Is Covered California improving the health of individuals in San Luis Obispo County?

Evaluation Methods

This evaluation is an exploratory, non-experimental design, using a case study of San Luis Obispo to evaluate the effectiveness of the implementation of the Affordable Care Act in San Luis Obispo County.

Stakeholder Process Evaluation Survey

To evaluate the extent Covered California is achieving its objectives and which policy components have contributed to success or failure a stakeholder survey of key constituencies involved in the implementation of the Covered California program throughout San Luis Obispo County was conducted.

Before beginning the evaluation, the County Health Officer and the contracted facilitator tasked with establishing and coordinating the SLO County A.C.A. Planning Group were engaged and consulted to 1) obtain approval for access to the group, and 2) for input on research design and suggested evaluation questions.

Participant Selection Criteria The process evaluation survey uses a multi-stage sampling technique (See Figure 8) with subjects selected from a number of stakeholder groups directly affected by the implementation of the Affordable Care Act in San Luis Obispo. For the purpose of this evaluation, stakeholders were divided into eight key groups: consumers, businesses, public health experts, health care providers, state Medicaid and CHIP agencies, health insurance issuers, agents and brokers and advocates for target populations. In the first stage of selection, various stakeholders involved in the A.C.A. Planning Group were invited to complete the questionnaire with a joint announcement made by the facilitator and researcher at the monthly

meeting. This was followed by an email invitation to participate in the survey by the Public Health Department. The survey link was sent to 137 A.C.A. Planning Group participants. A link was also included on the A.C.A. Planning Group website.

Next, in order to improve representation of all stakeholders, in the second stage an invitation was offered to stakeholders within the larger community of San Luis Obispo of underrepresented stakeholder groups in the A.C.A. Planning Group. This was completed with an email invitation to participate in the online survey. In this stage the survey link was sent to 106 additional participants.

Last, snowball sampling was also employed whereby survey respondents were asked to give referrals to other possible respondents.

Instruments

Process Evaluation Survey Data was collected using an online, self-report questionnaire administered through SurveyMonkey and designed for the purpose of this process evaluation. The questionnaire included open-ended and Likert scale items.

Measures

“Access” To evaluate the level at which Covered California has increased access and reduced health disparities, a series of questions were asked to measure the programs ability to increase coverage and access through education and outreach, and the removal of barriers.

“Health Care Quality” To measure the perceptions related to health care quality, the questionnaire asks two questions. The first asks stakeholders if there has been a change in health

care quality, and the second asks respondents to list “ways in which the quality of health care in SLO County has changed, if any.”

“Health Care Cost” To measure the degree to which health care costs have changed if any, two questions were asked. First, stakeholders were asked to rate if among the individuals they serve the cost of health care has changed. Second, participants were asked about ways in which Covered California had changed health care costs, if any.

“Health” To evaluate the level of health and wellness achieved, stakeholders were asked two questions. First stakeholders were asked, “Overall, how much of an impact do you believe that the full implementation of the ACA will have in improving health and wellness in SLO County?,” and a second requires them to “list three ways in which the implementation of the ACA in SLO County will improve health and wellness, if any.”

Data Analysis

A combination of descriptive analysis of quantitative responses and systematic data coding for qualitative responses was used for this evaluation.

Evaluation Results

Response Rate

Of the 243 individuals receiving email invitations to complete the survey, 58 individuals completed the survey, a 23% overall response rate, although the individual survey response rates varied by item. Of the 58, 36 completed all 15-survey items. At least 40 individuals completed 10 or more of the items. Many participants provided answers to the multiple-choice questions,

but did not participate in the open-ended part of the survey. These survey responses were included in the evaluation because the multiple-choice questions provided relevant information.

Stakeholder Profile

Survey participants provided information regarding which stakeholder group (s) they represented, as illustrated in Figure 9. The stakeholder group “Advocate (Advocate) for specific target population” made up the largest share of survey respondents (44.4%), followed by “Consumers” and “Health Care Providers” (25.93%), “Agent/Brokers” (14.81%), “Public Health” and “Business” (12.96%), “Health Insurance Issuer” (7.41%), and finally, “State Medicaid/CHIP Agency” (5.56%).

To gauge the level of involvement in ACA Outreach and Education (O&E) activities respondents were asked to report how many hours a week they spent on such activities. Figure 10 shows a breakdown by stakeholder group of involvement in O&E activities. The four groups reporting the greatest involvement in O&E activities are Public Health (85.71%), Health Care Providers (78.57%), Advocates (73.91%) and Consumers (71.43%).

I. Reducing Health Disparities

Central to Covered California’s vision and mission is the idea of increasing the number of insured by assuring access and reducing health disparities through expanded coverage. To measure this objective, stakeholders were asked to respond to a series of seven questions. First, the survey asked stakeholders to rate the level of perceived interest in participating in the three financial assistance programs available to make health insurance more affordable for all: Subsidized, Un-Subsidized and Medi-Cal . In Figure11 both Subsidized and Medi-Cal programs have large majorities of respondents reporting that their clients are either very (26.79%, 49.09%)

or somewhat (50.0%, 21.82%) interested, respectively. The Un –Subsidized program showed less interest (7.27%, 23.64%), respectively (Figure 12).

Survey respondents were also asked several questions to gauge their level of agreement with the ability of Covered California to remove barriers to enrollment and reach its target population of eligible enrollees (see Figure 13). Of the 58 respondents, 43.39% did not feel Covered California was able to reach SLO residents eligible to participate. About half of respondents (50.94%) disagreed with the statement that Covered California removed barriers to enrollment that could keep eligible consumers from enrolling, and 54.71% did not agree that funding for outreach and education efforts to recruit enrollees was sufficient.

Participants were also asked to describe what, in their experience, were the three greatest barriers to program enrollment in SLO County. Forty-four participants responded, offering a total of 129 open-ended comments overall regarding enrollment barriers. Of these, the most frequent issue identified was Website and Technical Problems, as mentioned by 33.33% of respondents. Lack of Information, including knowledge, education, awareness, and understanding was also identified as a significant barrier to enrollment (31.45%). More than a quarter of respondents (25.93%) stated problems with enrollment as a key issue, while deficiency in outreach and enrollment efforts (24.07%) followed closely behind. Also, one of the more common themes found was confusion (20.37%). The complete list of perceived barriers is in Table 1.

II. Improved Health Care Quality

In its vision and mission, Covered California's also aspires to improve and assure health care quality for Californians. To assess whether Covered California was able to meet these

objectives in San Luis Obispo stakeholders were asked several questions relating to improved quality of care.

When asked if the quality of health care in SLO County has improved (Figure 14), more than half of respondents (50.98%) either strongly disagreed or somewhat disagreed, more than a third neither agreed or disagreed (33.33%), few somewhat agreed (15.69%) and zero (0%) respondents agreed strongly.

Participants were also asked to list what, in your experience, are the three most important changes to the quality of health care services in SLO County. Thirty-nine participants responded to this question, yielding a total of 75 responses. Greater Access to health care was cited most frequently as an important change, with 33.3% of respondents mentioning it in their responses. Other top responses included Expansion of Medi-Cal (18.52%), Decreased Access to Providers, such as fewer providers, networks and less staff (18.52%) and Increased Access to Providers, such as more providers, new networks and funding for staff (18.52%). Also mentioned often was Greater Preventative Services (12.96%). These and the remaining changes are identified are listed in Table 2.

III. Reduced Costs of Health Care

Core to the vision and mission of Covered California is its ability to provide access to affordable, lower cost care, at the best value. To ascertain if it was able to achieve this objective stakeholders were asked about the changes to health care cost in San Luis Obispo County.

Survey respondents were asked to choose among the individuals they serve to what degree has health care cost under Covered California changed. Stakeholder's responses were

split almost equally (Figure 15), with 35.56% reporting, they had increased, 33.33% that they had stayed the same, and 31.11% claiming they had decreased.

When the same question regarding if the cost of healthcare has changed is compared by stakeholder groups (see Figure 16) the results suggest that both Health Insurance Carriers (100%) and Agents/Brokers (83.33%) believe it has increased, while State Medicaid/CHIP (66.67%) and Public Health (50.00%) say it has decreased. Almost half (47.37%) of Advocates say it has stayed the same.

Stakeholders were also asked in what ways Covered California has directly or indirectly changed the cost of health care. The answer given most often regarding the ways in which Covered California has changed the cost of health care was Premiums Increased Dramatically for some individuals (12.96%). These response were closely followed by the amount of respondents that believed Covered California had Made it Affordable (9.26%). These and other responses are identified in Table 3.

V. Improved Health

To judge the degree that Covered California has improved the health of all Californians respondents were asked two questions related to changes in health in San Luis Obispo as a result of the implementation of the Affordable Care Act in San Luis Obispo County.

First, stakeholders were asked to list what they believed to be the three most important changes that the implementation of the ACA will make for overall health in SLO County, if any. Of the thirty-nine participants who responded to the question, a total of 29 responses were collected. The most common responses had to do with Increased Access and Coverage, with

44.4% of stakeholders mentioning it in their response. Response about Preventative Care and Health Promotion were also high on the list of perceived changes (22.22%). A number of respondents also mentioned Increased Medi-Cal (20.37%), as well as noting the Lowered Cost and Improved Savings as a significant change (16.67%). Another major result noted was the mention of Improved Mental Health and Substance Abuse Treatment Services (14.8%). These and the remainder of the responses are listed in Table 4.

Next, respondents were asked how much of an impact they believed the full implementation of the ACA would have in improving health and wellness in SLO County (see Figure 17). More than 80% believed it would have a positive impact in improving health and wellness (42.22% minor positive impact; 40% major positive impact). Only a few believed it would have a negative impact (6.67% minor negative; 4.44% major negative impact).

Between stakeholder groups the perceived impact of full implementation varied greatly (see Figure 18). Business, Insurance Carriers and Agent/Brokers were much less likely to believe the impact will be positive.

VI. Overall Implementation Effort

As a general measurement of Covered California's program efficiency and effectiveness respondents were asked three questions related to implementation. First, stakeholders were asked to list what in their experience, have been the three greatest barriers to the efficient implementation of Covered California in San Luis Obispo County. Thirty-nine participants responded to this question, yielding a total of 84 responses overall. Of these responses, the top four barriers to efficient implementation identified were Lack of Outreach and Education (42.59%), Not Enough Providers to provide healthcare services once individuals are enrolled

(25.93%), Technical Difficulties, or Low Access for some to complete enrollment (25.93%) and last, Not Enough Enrollment Assistance, which includes not enough counselors (14.81%). All responses are identified in Table 5. Next, respondents were asked if they agreed or disagreed that Covered California's program implementation has been efficient. The majority of stakeholders disagreed Covered California's had efficiently implemented its program (35.85%, disagreed strongly; 26.42%, disagreed somewhat) (see Figure 19).

Last, respondents were asked an open-ended question, in their view what were the greatest strengths of the implementation effort (see Figure 20). Of the thirty-six stakeholders answering the question, 40 responses were gathered overall. Of those, the top response reported was greater stakeholder collaboration (43%), followed by increased access to health care (17%), the Covered California website and its Shop and Compare Tool (11%), and the statewide and local outreach and education efforts (11%). A portion of respondents said that the strengths were unknown or were not sure (9%) and some said none (9%).

Discussion

Established under the Affordable Care Act, the state of California founded the health benefit exchange Covered California with the vision "to improve the health of all Californians by assuring their access to affordable, high quality care." Its mission is "to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value" (Covered California, 2013).

Despite the lofty goals set forth by Covered California, the County of San Luis Obispo, a region with as many as 43,000 uninsured adults (San Luis Obispo County Public Health

Department, 2013), was refused funding to provide outreach and education, a key component of the implementation plan. Given these conditions, to what extent is Covered California achieving the objectives of increased access, improved health care quality, lowered costs and improved health for eligible residents in San Luis Obispo?

Objective 1: Is Covered California increasing access to health insurance in San Luis Obispo County? At the foundation of Covered California's vision and mission, is the concept of increased access and reduced health disparities. Regarding this first objective, the survey revealed some areas of consensus and other areas of disagreement. Many stakeholders agreed that people were interested in accessing coverage, either with subsidies or under Medi-Cal, an indication that the community was aware of the program and it was attractive to individuals in the target population. Yet stakeholders generally did not feel that outreach and education efforts meant to increase access and reduce health disparities were successful. A majority of stakeholders felt that barriers that could potentially keep eligible individuals from enrolling had not been removed. It is likely the absence of funding for these efforts, which stakeholders viewed as insufficient, is linked to the poor opinion about their performance. Stakeholders perceived problems with the Covered California website as the greatest barrier to program enrollment. One stakeholder wrote about system issues saying it was, "very slow; bouncing individuals out; outages." Another common barrier mentioned by stakeholders was an overall lack of information. This was expressed in a number of ways by stakeholders, including lack of awareness, lack of education, lack of information. Stakeholders found a great deal of "confusion" among the populations they served. One stakeholder shared three major barriers that were common among groups: "choosing among plans is complicated; individuals knowing about the deadline to enroll; knowing how to get help to enroll."

Objective 2: Is Covered California improving health care quality in San Luis Obispo County? Covered California also aims to improve health care quality for Californians. With respect to objective two, the majority of stakeholders believed Covered California is not improving the quality of health care in San Luis Obispo. However, a large portion of stakeholders neither agreed, or disagreed, which could be a result of the program not being fully implemented yet and stakeholder's feeling that it is still too soon to tell whether health care quality will improve. This is evident in the opinion of one stakeholder when asked what was the most important changes in the quality of health care, they said, "maybe more preventative care, verdict still out." Yet, despite these results, stakeholders claimed many important changes to the quality of health care in San Luis Obispo County, including greater access to coverage, the expansion of Medi-Cal, increases in medical provider availability, a greater emphasis on preventative health and coverage of mental health and substance abuse use disorders.

Objective 3: Is Covered California lowering costs for health care for eligible residents in San Luis Obispo County? Providing access to affordable, lower cost care, at the best value is core to the vision and mission of Covered California, and the basis of objective three. On cost, across groups stakeholder opinion was almost equally divided. However, when perceptions of cost were looked at by group, a pattern emerged likely based on the socioeconomic factors of the clientele they serve. Results found that both Health Insurance Carriers and Agents/Brokers were more likely to say that the cost of health care had increased, whereas State Medicaid/CHIP and Public Health groups were more likely to say that the cost of health care had decreased. Based on stakeholder comments, many of the middle and higher income individuals, as well as small business owners, that use stakeholder groups such as Insurance Carriers or Agents/Brokers are seeing "premiums increase dramatically for some individuals" with "unsubsidized individuals

[having] their premiums double or triple.” State Medicaid and Public Health workers often shared a different view of the changes in health care costs, tending to focus on the broader picture, such as, “It has provided healthcare for those who could never afford it. Increased prices for some, but covers more individuals.”

Objective 4: Is Covered California improving the health of individuals in San Luis Obispo County? Improving the health of all Californians is central to Covered Californians vision. Objective four of the evaluation found despite little success in the process of implementing some of the other objectives, stakeholders generally agreed full implementation of the ACA would have a positive impact in improving health and wellness in San Luis Obispo County. Still, several groups, including Business, Insurance/Carriers, and Agent/Brokers, were less likely to believe the impact will be positive. This could be a product of what was seen in their experience related to the affordability of the program for their clients, or it could be something more. Many stakeholders considered the most important changes to health as a result of the ACA is increased access to insurance, the greater emphasis on preventative health, and the expansion of Medi-Cal coverage.

In evaluating the overall implementation efforts, stakeholders generally agreed the implementation of Covered California lacked efficiency. Stakeholders saw the greatest weaknesses of the implementation in poor planning, technical problems, insufficient funding, and lack of public information. However, despite these difficulties, stakeholders experienced many strengths in relation to the implementation efforts in San Luis Obispo County. Respondents throughout the survey repeatedly noted greater stakeholder engagement, increased collaboration and improved agency communication. Whether this experience was common

throughout the state and in other areas as communities worked together to enroll eligible individuals, or if it is something unique to the County of San Luis Obispo and the necessity to pull together without funding to do its own outreach and education isn't known.

Conclusion

This study is not without its limitations. Although our sample of stakeholders involved in the implementation of the Affordable Care Act in San Luis Obispo was balanced in terms of stakeholder groups, it was not large. So due to the small size of the sample, these findings are not statistically significant and cannot be generalized to a larger population.

Overall, the stakeholder survey revealed several areas of consensus and other of disagreement. While it is evident that stakeholders believe that the implementation efforts have been inefficient, citing numerous weaknesses and concerns about the number of barriers individuals have experienced in enrollment, and doubt that the target population has been reached effectively, stakeholders are still optimistic about the long-term effects of the program. While there is still concern over the affordability for many, and numerous benefits of implementation are still yet to be seen, stakeholders generally are positive about the future as more individuals gain access to coverage. In the end, stakeholders felt the program had many strengths, and when fully implemented will have a positive impact in San Luis Obispo County. Covered California enrollment data suggests this may be true, as of the end of January the Central Coast region had passed its projected enrollment goal by 56%, enrolling more than 50,000 people (Covered California, 2014).

However, whether increased collaboration reported by stakeholders was sufficient to offset the funding other counties received through the Covered California Outreach and Education

Grant is still yet to be seen. Although regional data is available through Covered California, no county specific enrollment numbers are available. Indications from stakeholders generate concern that outreach and education , especially to the vulnerable and hard to reach populations which the grant was meant to target and assist in removing barriers, was lacking. Although the A.C.A. Planning Group labored to offset these obstacles with their own “in-reach” and limited coordinated “outreach,” time will soon tell as enrollment numbers become more readily available if populations were missed, and if lacking the resources for a robust “word of mouth” advertising campaign to supplement the state’s marketing campaign was detrimental in San Luis Obispo County.

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Appendix A

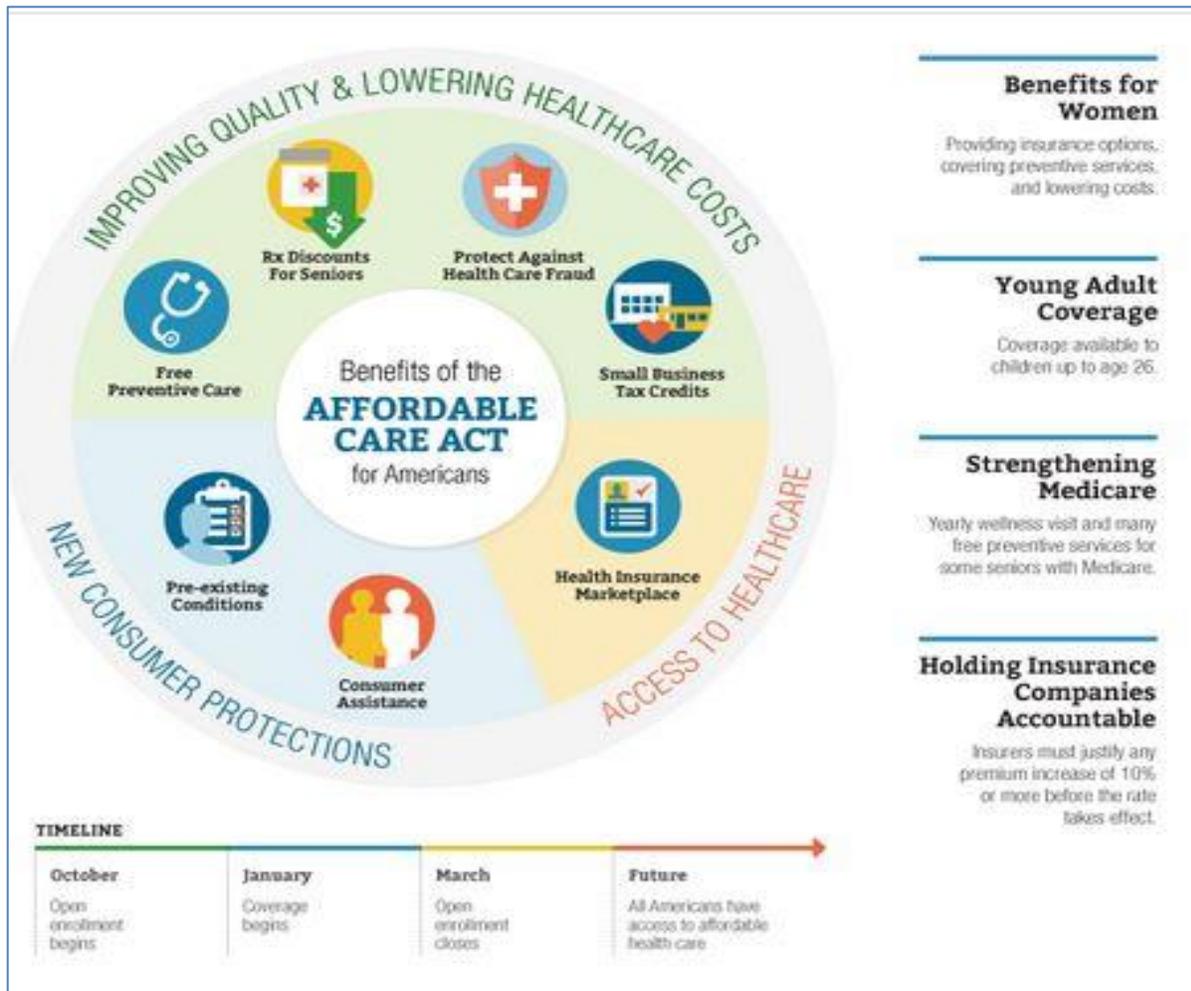


Figure 1. Key Features of the Affordable Care Act. This info graphic provides an overview of the key features of the Affordable Care Act. Reprinted from *Features of the Health Law*, from the U.S. Department of Health & Human Services website (n.d.), Retrieved December 15, 2013, from <http://www.hhs.gov/healthcare/facts/timeline/>

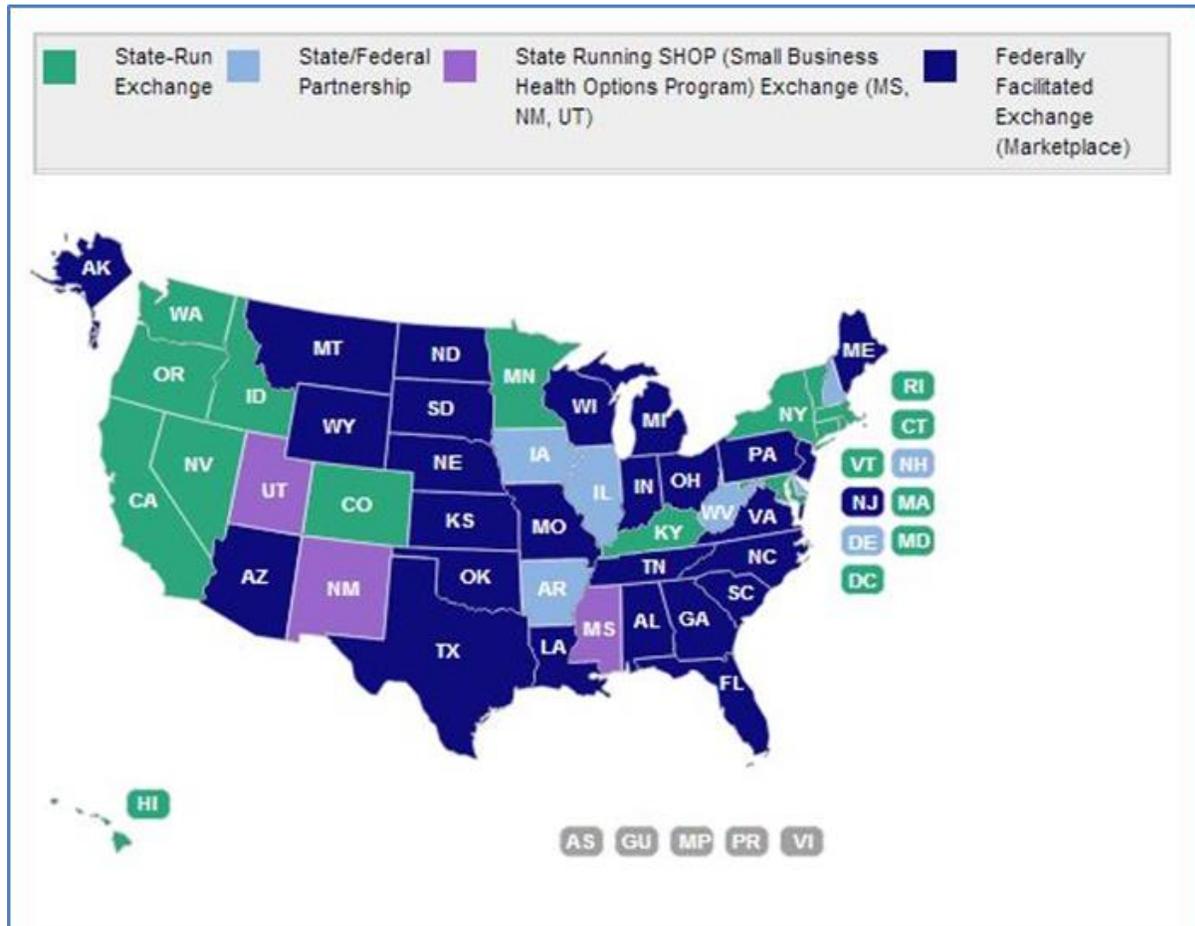


Figure 2. Map of State and Federal Exchanges. This map provides an overview of state actions to implement health insurance exchanges. Reprinted from State Actions to Address Health Insurance Exchanges, from the National Conference of State Legislatures website (2013), Retrieved on December 15, 2013, from <http://www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx>

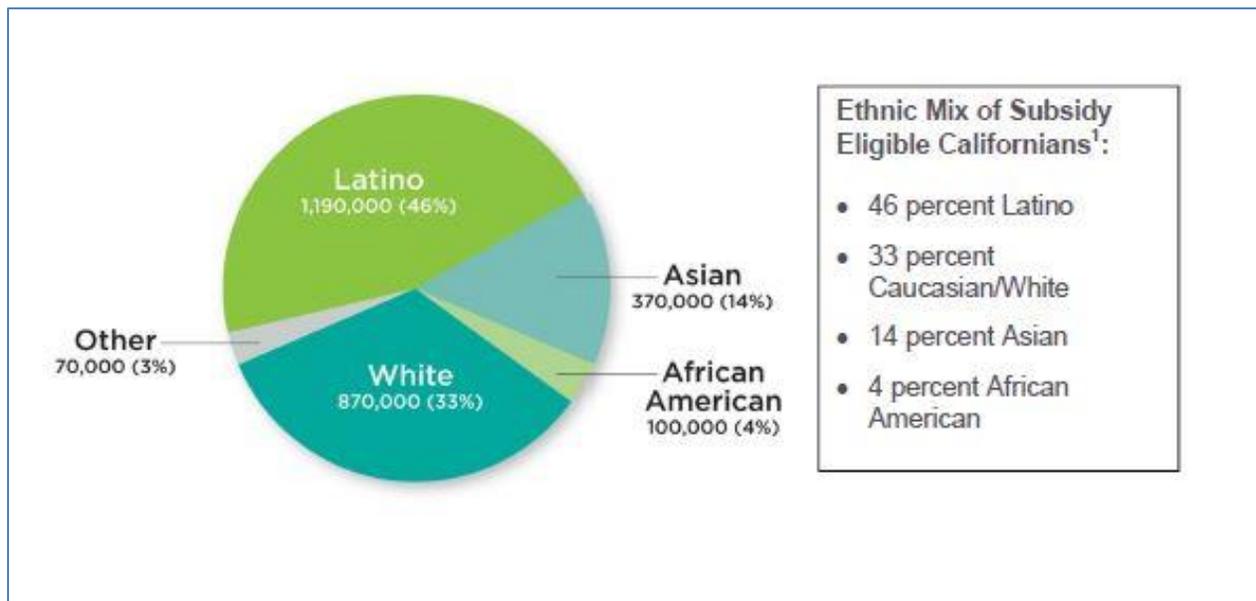
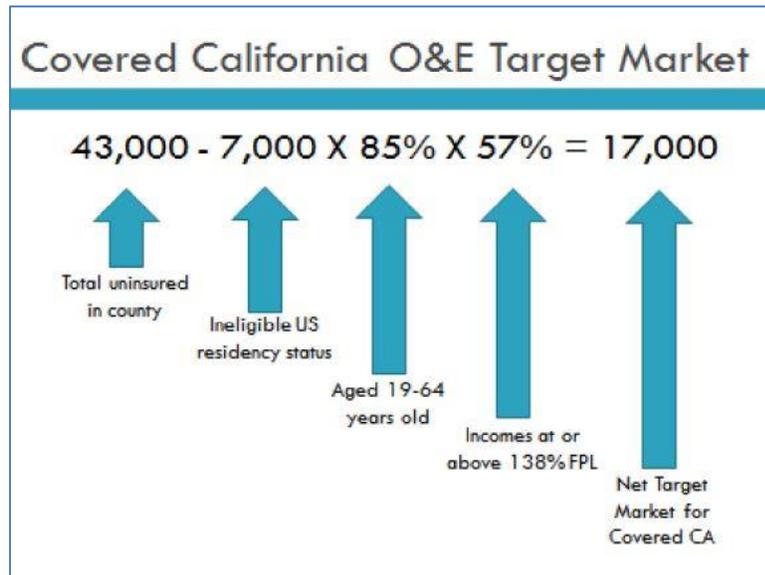


Figure 3. Ethnic Mix of Subsidy Eligible Californians. Although the demographic mix of Californians who are eligible for federal subsidies is diverse, the largest single eligible ethnic group are Latinos (46%), thus they are a major focus of Covered California's Outreach and Education campaign. Reprinted from *Enrollment Forecasts, Reporting Schedule and Background Data*, from Covered California, 2013, Retrieved on December 15, 2013, from https://www.coveredca.com/news/PDFs/CoveredCA-Enrollment_Projections-9-30-13.pdf



Figure 4. Outreach & Education Grant Program. The purpose of the Covered California Outreach and Education Grant Program is to involve local organizations with trusted relationships in the community in a grassroots effort to educate individuals where they live, work, play and pray. Reprinted from *Covered California Certified Educator Role, Participant Guide, Version 1.0*, from Covered California (2013).



The Covered California Primary Target Population

The primary target population of Covered California's marketing and outreach efforts are the 5.3 million California residents projected to be uninsured or eligible for tax credit subsidies in 2014: 2.6 million who qualify for subsidies and are eligible for Covered California qualified health plans; and 2.7 million who do not qualify for subsidies, but now benefit from guaranteed coverage and can enroll inside or outside of Covered California.

Note: Covered California's primary target population, which is used to calculate the O&E target market above, is defined below. Source: Covered California (2013)

Figure 5. San Luis Obispo County Target Market The target market in San Luis Obispo County for Outreach and Education is the Covered California Primary Target Population, those residents who are uninsured or eligible for tax subsidies in 2014. Reprinted from *ACA Planning Group Meeting Notes*, from San Luis Obispo County Public Health (2013).



Figure 6. Covered California Specific Target Markets. The list above provides examples of the special target markets Covered California specifically requested Outreach and Education grant proposals to reach. Adapted from *Outreach and Education Grant Program Application*, from Covered California (2014), Retrieved on December 15, 2013, from

[http://www.healthexchange.ca.gov/StakeHolders/Documents/Outreach and Education Grant Program.pdf](http://www.healthexchange.ca.gov/StakeHolders/Documents/Outreach_and_Education_Grant_Program.pdf)

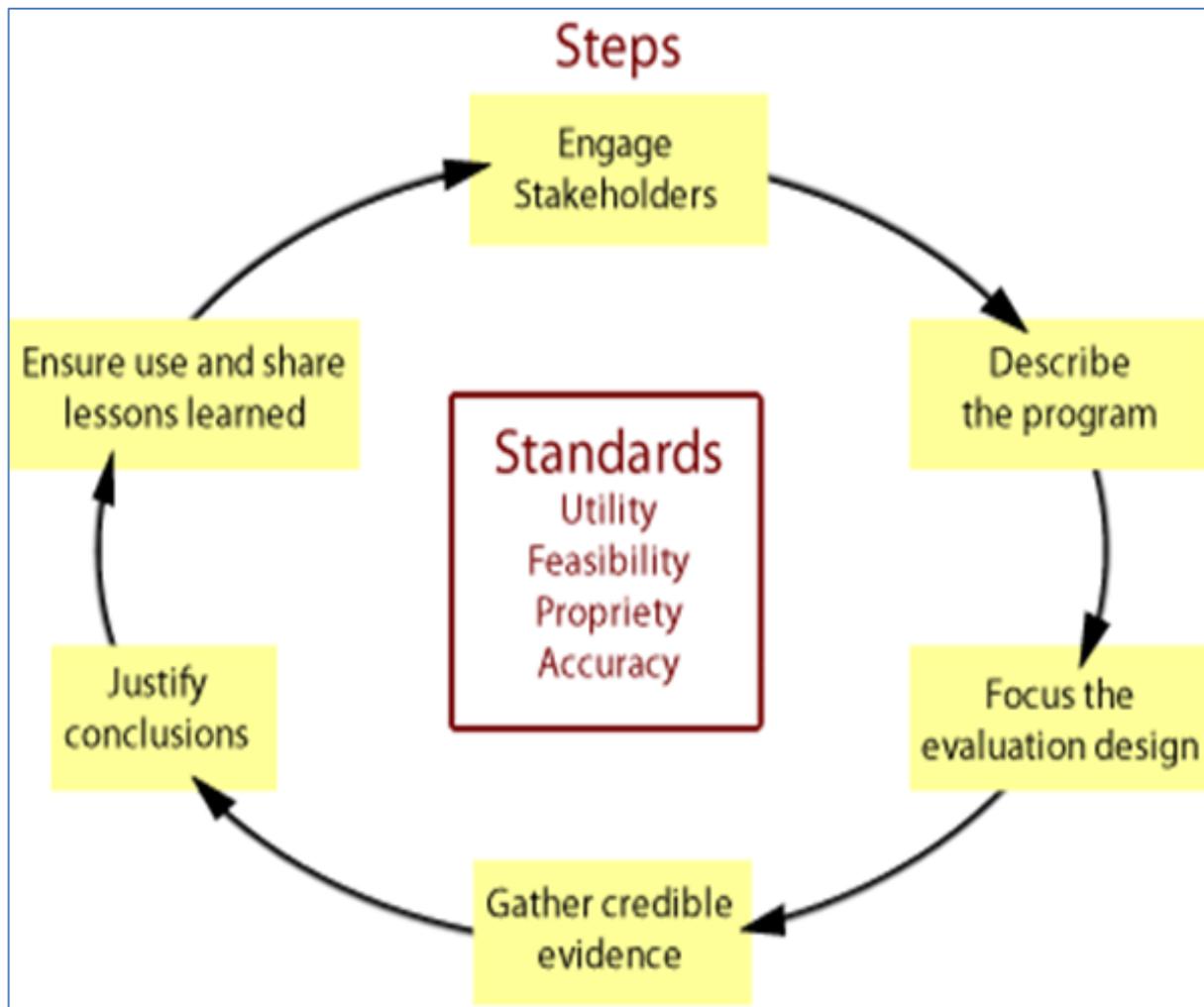


Figure 7. A Framework for Program Evaluation. The Framework provides a systematic way to approach evaluation, consisting of six steps and four standards to complete an evaluation.

Reprinted from *Program Evaluation*, from the Centers for Disease Control and Prevention website (2012), Retrieved on December 15, 2013, from

<http://www.cdc.gov/eval/framework/index.htm>

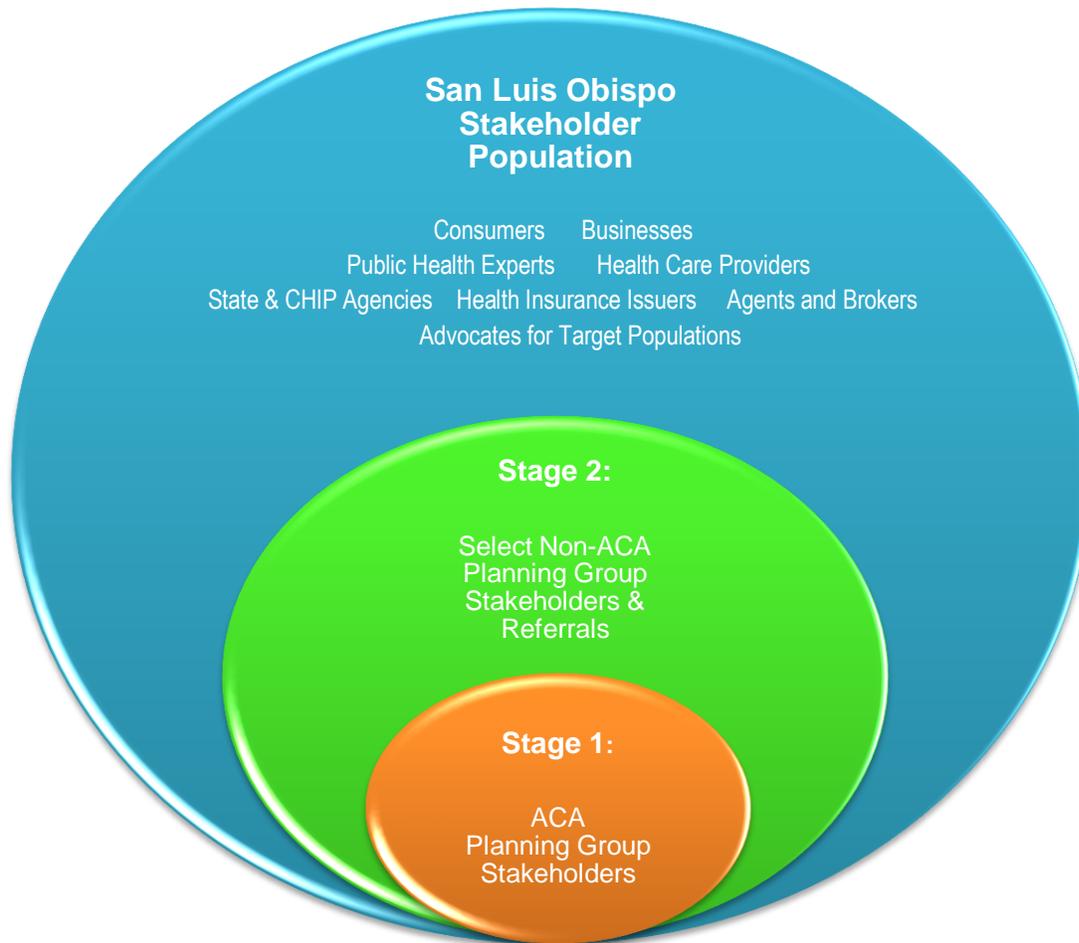


Figure 8. Data Collection Structure. The diagram provides an illustration of the multi-stage sampling technique used to select subjects from a number of stakeholder groups directly affected by the implementation of the Affordable Care Act in San Luis Obispo.

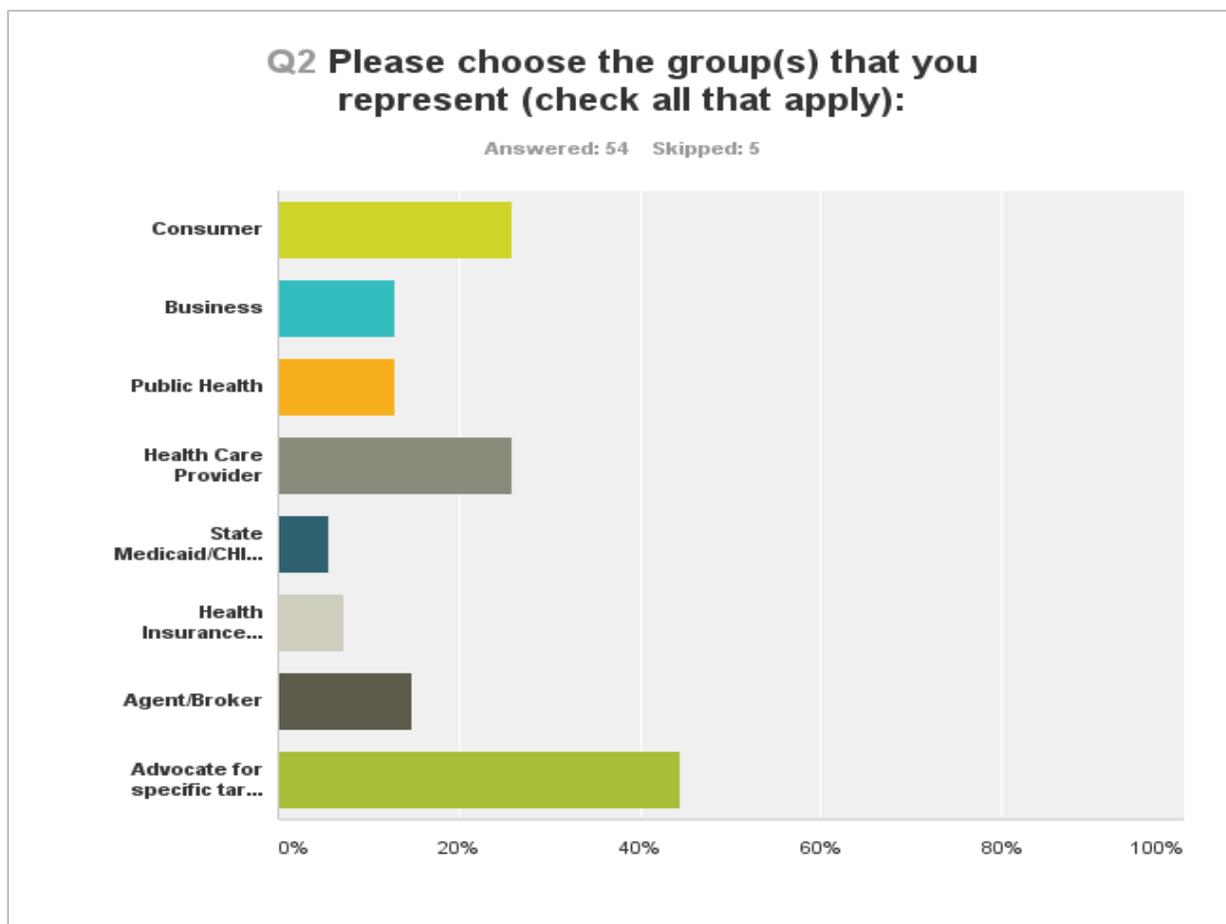


Figure 9. Stakeholder Representation. Survey participants were asked to provide information regarding which stakeholder group(s) they represented.

Q1 On average, how many hours a week have you spent on outreach and education efforts related to the Affordable Care Act?

Answered: 53 Skipped: 1

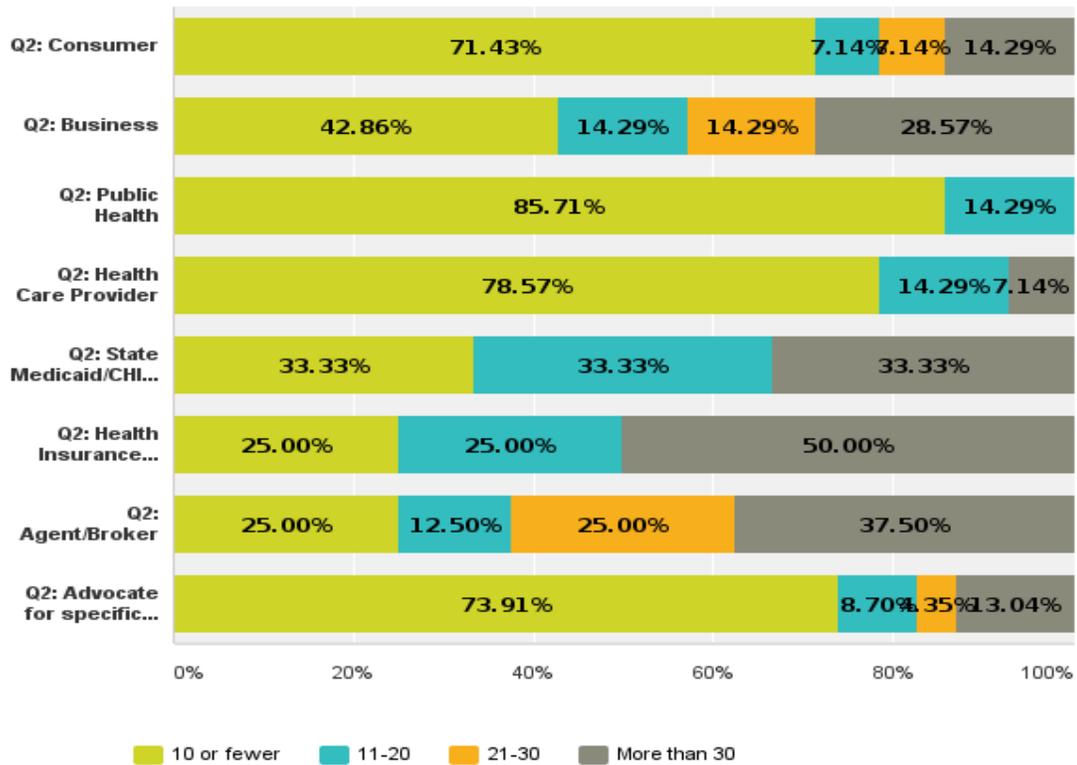


Figure 10. Level of Involvement in O&E by Stakeholder Group. To gauge the level of involvement in ACA Outreach and Education (O&E) activities respondents were asked to report how many hours a week they spent on such activities.

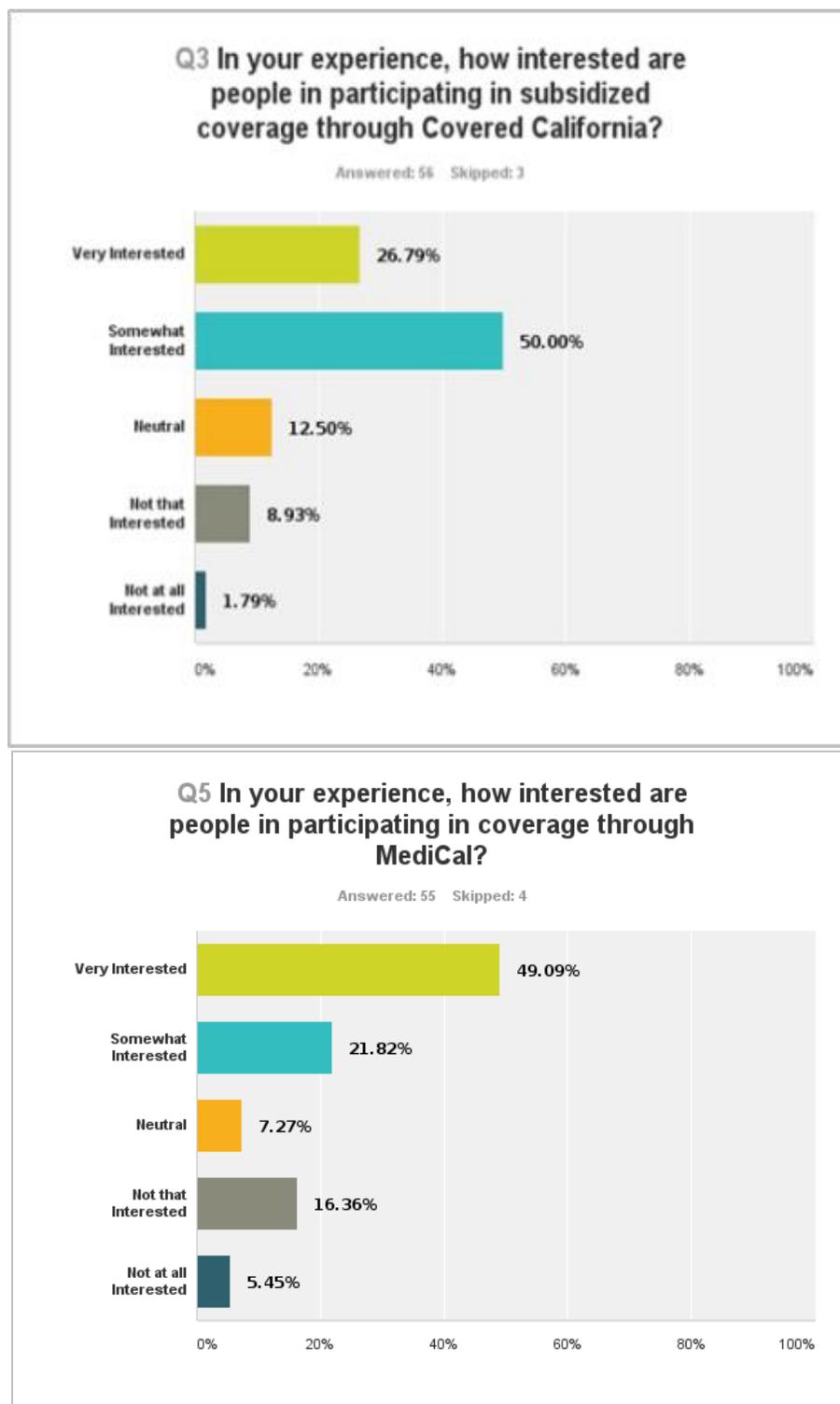


Figure 11. Perceived Interest in Subsidized and Medi-Cal Coverage. Large majorities of stakeholders reported their clients are very or somewhat interested in these two programs.

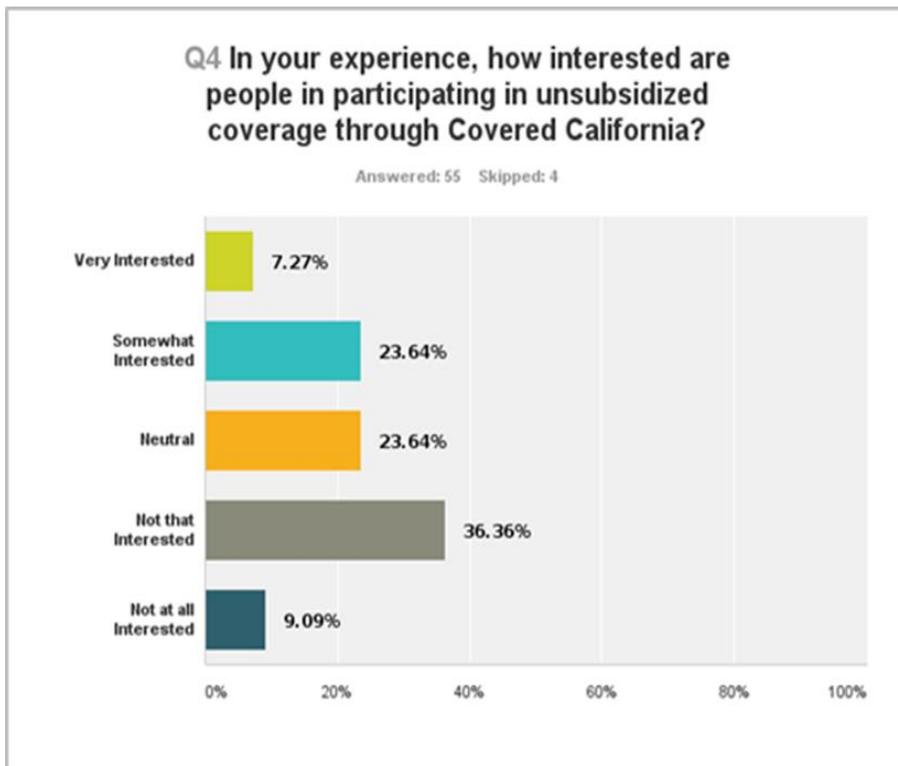


Figure 12. Perceived Interest in Unsubsidized Coverage. Most stakeholders agreed interest was not as high for Unsubsidized care.

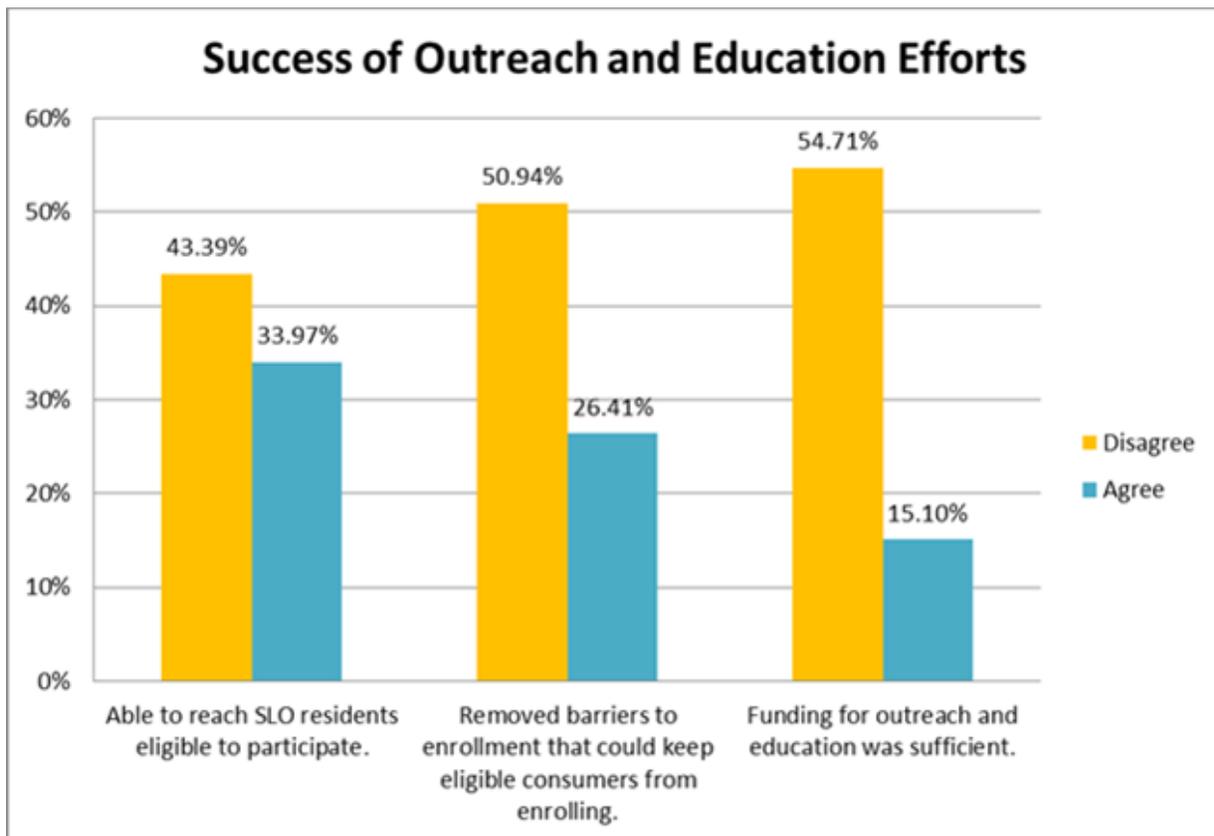


Figure 13. Removal of Enrollment Barriers and Targeting Populations. Survey respondents were asked their level of agreement with the ability of Covered California to remove barriers to enrollment and reach its target population of eligible enrollees.

Table 1

Stakeholders view of barriers to enrollment in SLO County

Barriers	Frequency	Percent
Website and Technical Problems.	18	33.33
Lack of Information (knowledge, education, awareness, understanding, etc.)	17	31.45
Problems with Enrollment Process	14	25.93
Outreach & Education Efforts	13	24.07
Confusion	11	20.37
Program Not Ready on Time	9	16.67
Difficult to Understand Insurance Options	7	12.96
Lack of Funding	6	11.11
Language (O&E to the Spanish, other language applications late, etc.)	5	9.26%
Number of Enrollment Counselors	5	9.26%
Lack of County Resources	5	9.26%
Problems With Phone System	3	5.56%
Negative Media Publicity	3	5.56%
Computer access/Computer Literacy Skills	2	3.70%
Lack of Support and Poor Communication from Covered California.	2	3.70%
Ineligibility of the Undocumented	2	3.70%
Support for Treatment/ Substance Abuse Issues	2	3.70%
Medi-Cal Enrollment	2	3.70%
Cost	2	3.70%
Provider Problems	1	1.85%

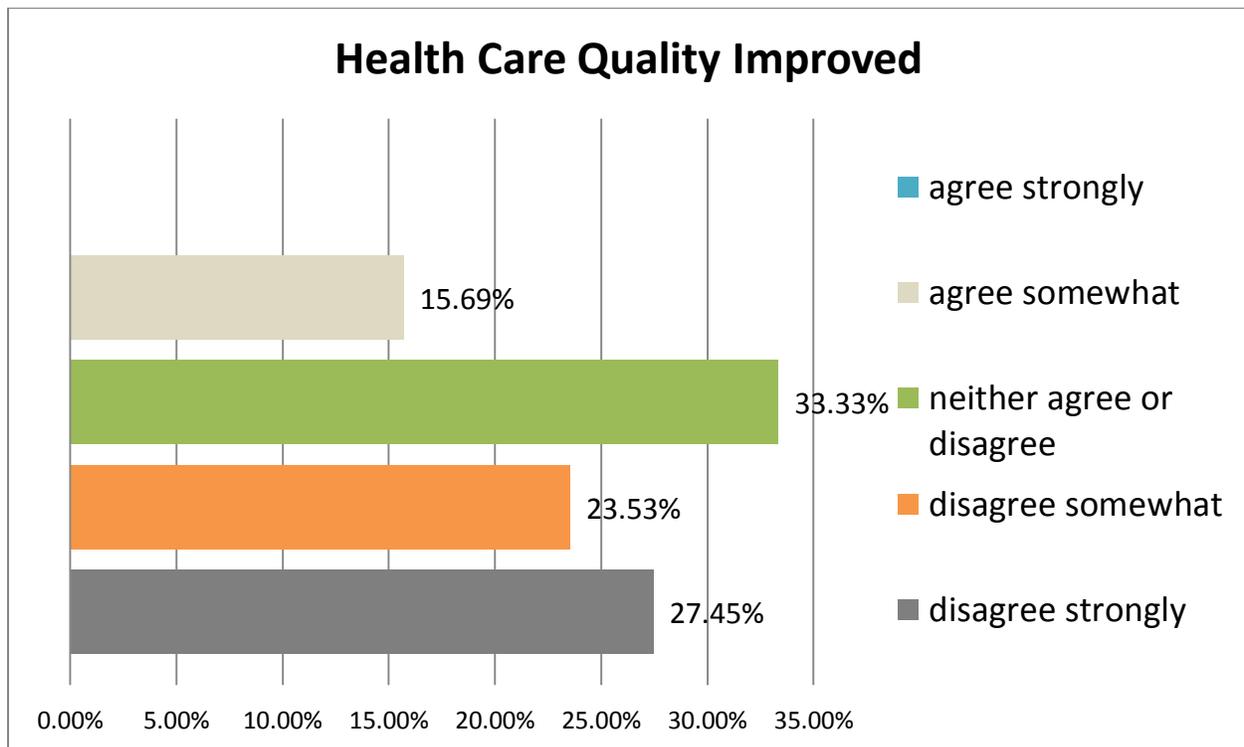


Figure 14. Health Care Quality. When asked if the quality of health care in SLO County has improved, the majority of stakeholders disagreed, or neither agreed or disagreed.

Table 2

Changes to the Quality of Health Care Services

Changes	Frequency	Percent
Greater Access (General)	18	33.33%
Expansion of Medi-Cal/Medi-Cal Services	10	18.52%
Decreased Provider Access (providers, networks, staff, etc.)	10	18.52%
Increased Provider Access (providers, networks, staff, etc.)	10	18.52%
Greater Preventive Care Services	7	12.96%
Greater Mental Health and Substance Use	5	9.26%
Too Soon, Don't Know, No Change Yet	5	9.26%
Increased Collaboration -agencies and providers	3	5.56%
No Pre-existing Exclusion	2	3.70%
Improved Savings/Lower Costs	2	3.70%
Other	2	3.70%
Improved Reimbursements/Payment Process	1	1.85%

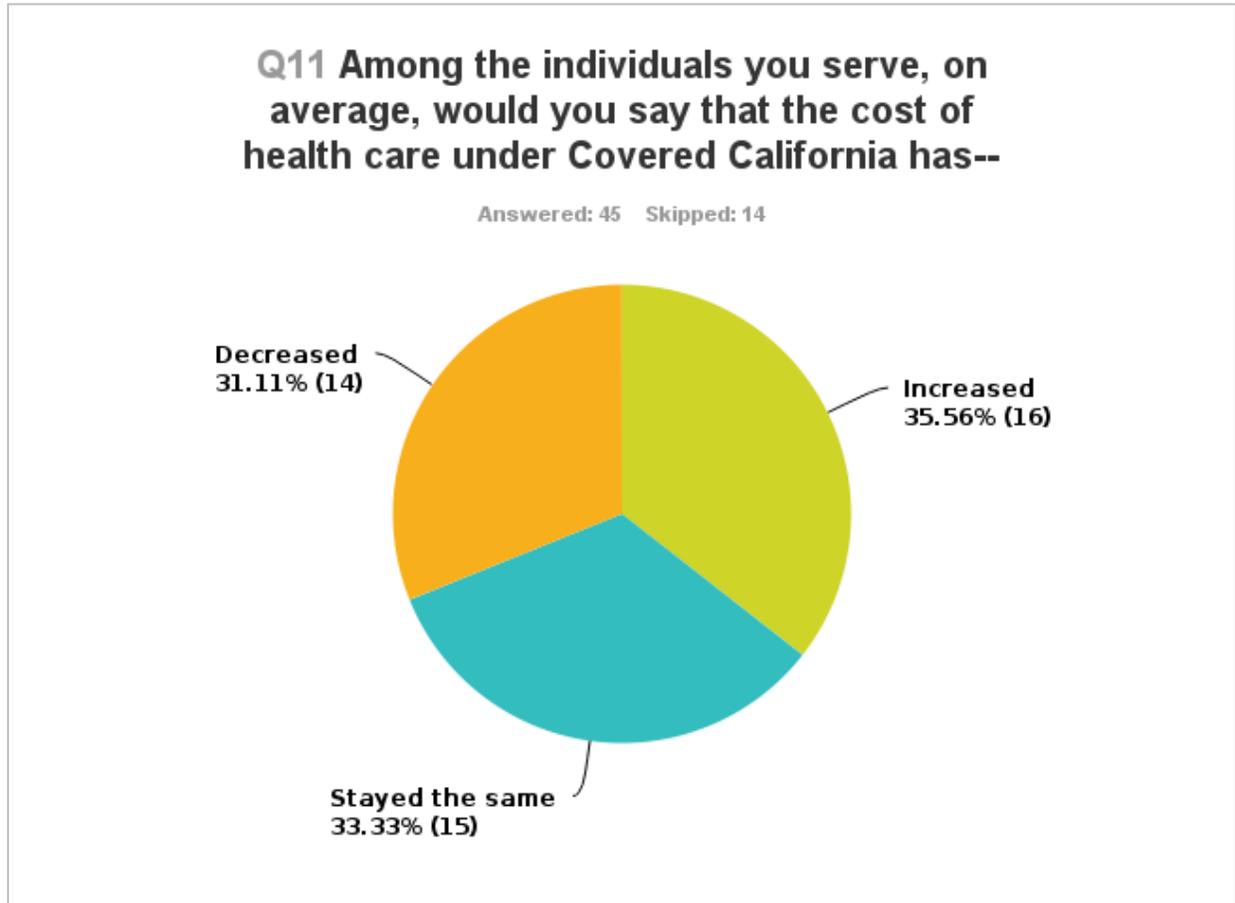


Figure 15. How Much Has the Cost of Health Care Changed. To ascertain if it was able to achieve this objective stakeholders were asked about the changes to health care cost in San Luis Obispo County.

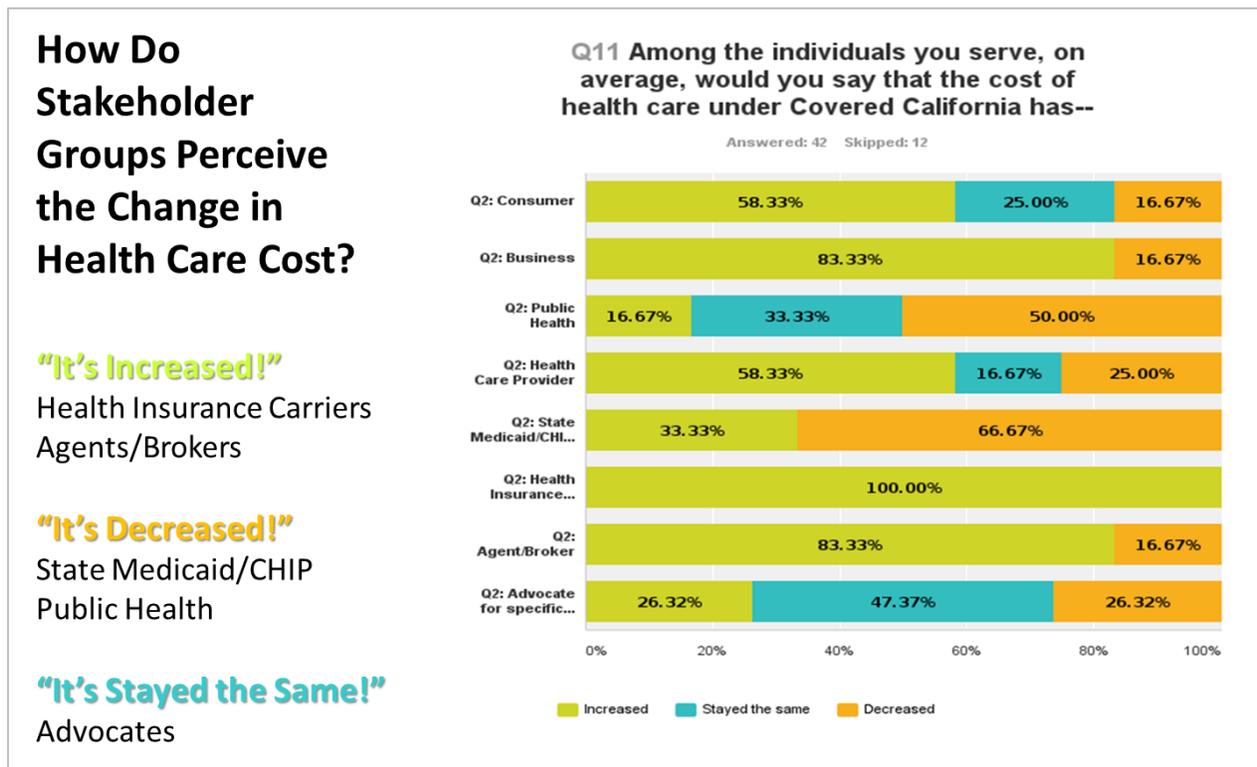


Figure 16. How Stakeholder Groups Perceive the Change in Health Care Cost. A breakdown by stakeholder groups shows major differences in perceptions related to cost, likely due to groups client base.

Table 3

How Covered California Changed Health Care Cost

Direct/Indirect Changes	Frequency	Percent
Premiums Increased Dramatically for Some	7	12.96%
Made Affordable for Those	5	9.26%
Reduce Overall Healthcare Cost/Burden	3	5.56%
Medi-Cal Expansion	3	5.56%
Not Sure Yet	3	5.56%
No Denial for Pre-Existing Conditions	2	3.70%
Focus on Preventive Health	2	3.70%
Improved Payment to Medi-Cal Providers	2	3.70%
Everyone Must Have Insurance or Pay Penalty	1	1.85%
No Change	1	1.85%

Table 4

Changes to health as a result of the ACA in SLO County

Changes	Frequency	Percent
Increased Access/Coverage General	24	44.44%
Preventative Care /Health Promotion	12	22.22%
Increased Medi-Cal	11	20.37%
Lower Cost/ Improved Savings	9	16.67%
Improved Mental Health and	8	14.81%
Decreased ER Use	6	11.11%
None, Little Change or Too Soon to Tell	4	7.41%
Increased Access to Dental/Denti-Cal	4	7.41%
Coverage of Pre-Existing Conditions	3	5.56%
Improvement in Providers/Payments	3	3.70%
Fewer Providers	2	5.56%
Other	2	3.70%
Decreased Access/Coverage General	1	1.85%
Unknown	1	1.85%

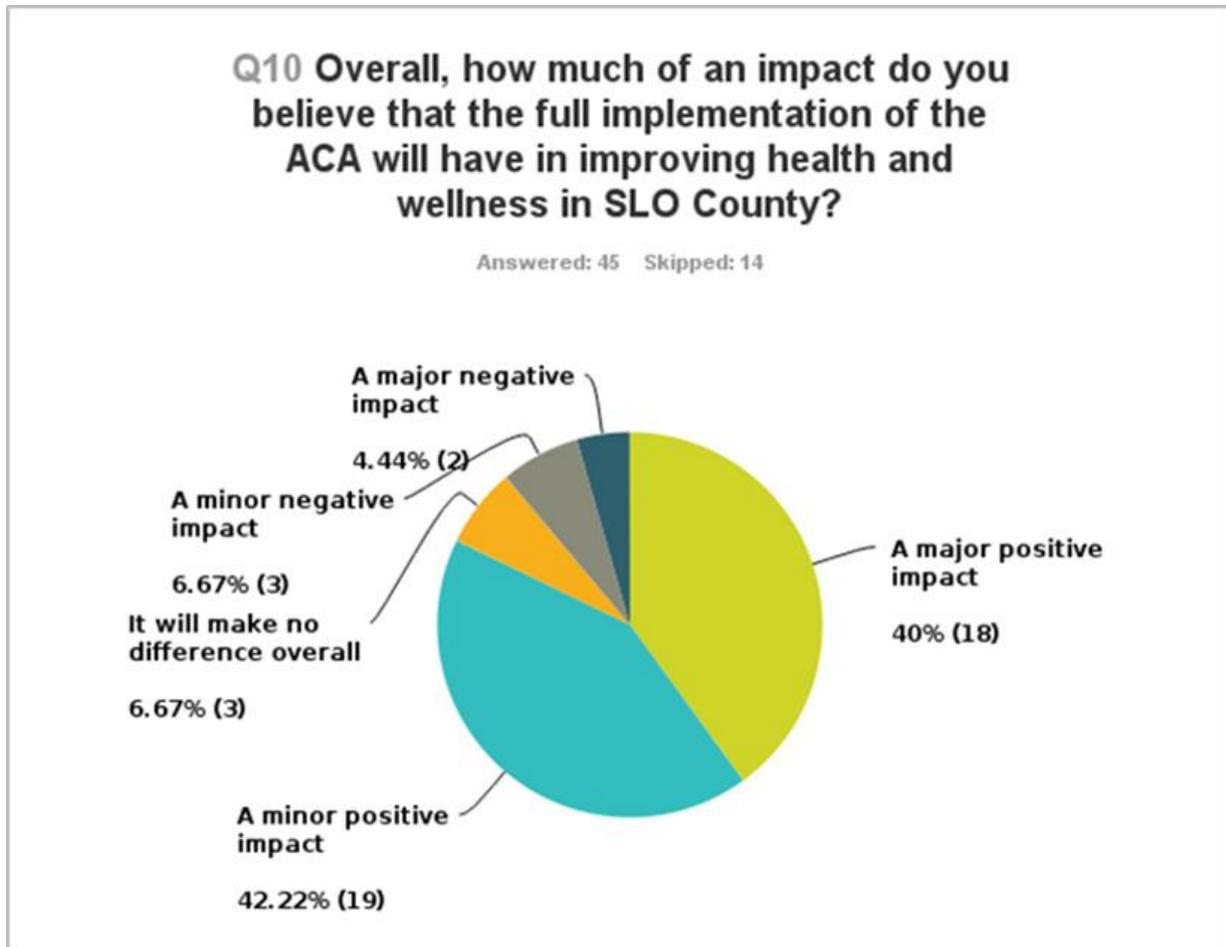


Figure 17. Impact of the ACA in Improving Health in SLO County. More than 80% of respondents believed the full implementation of the ACA would have a positive impact on health and wellness in SLO County.

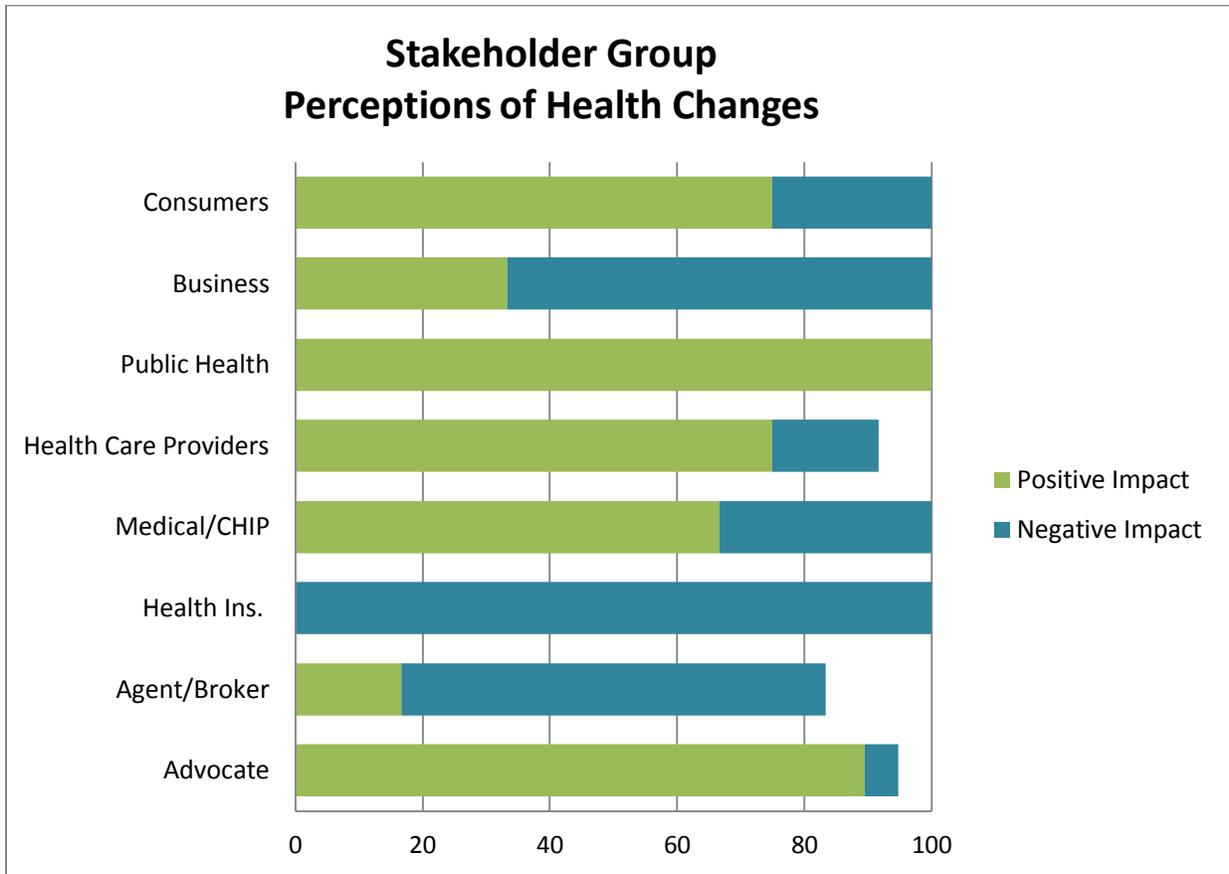


Figure 18. Health in SLO County, by stakeholder groups. The perceived impact of full implementation varied greatly between stakeholder groups.

Table 5

Barriers to efficient implementation of Covered California in SLO County

Barriers	Frequency	Percent
Lack of Outreach & Education (Insufficient Information, Not Enough Providers	23	42.59%
Technical Difficulties/Access to Technology	14	25.93%
Not Enough Enrollment Assistance	8	14.81%
Lack of Funding	5	9.26%
Needed More Support from Agencies	5	9.26%
Negative Media, Political Controversy Problems, Little Trust	4	7.41%
Cost of Coverage	3	5.56%
Timing (Too Little, Floating Timelines, Delays, etc.)	3	5.56%
Language	2	3.70%
Other	2	3.70%
Unknown	1	1.85%

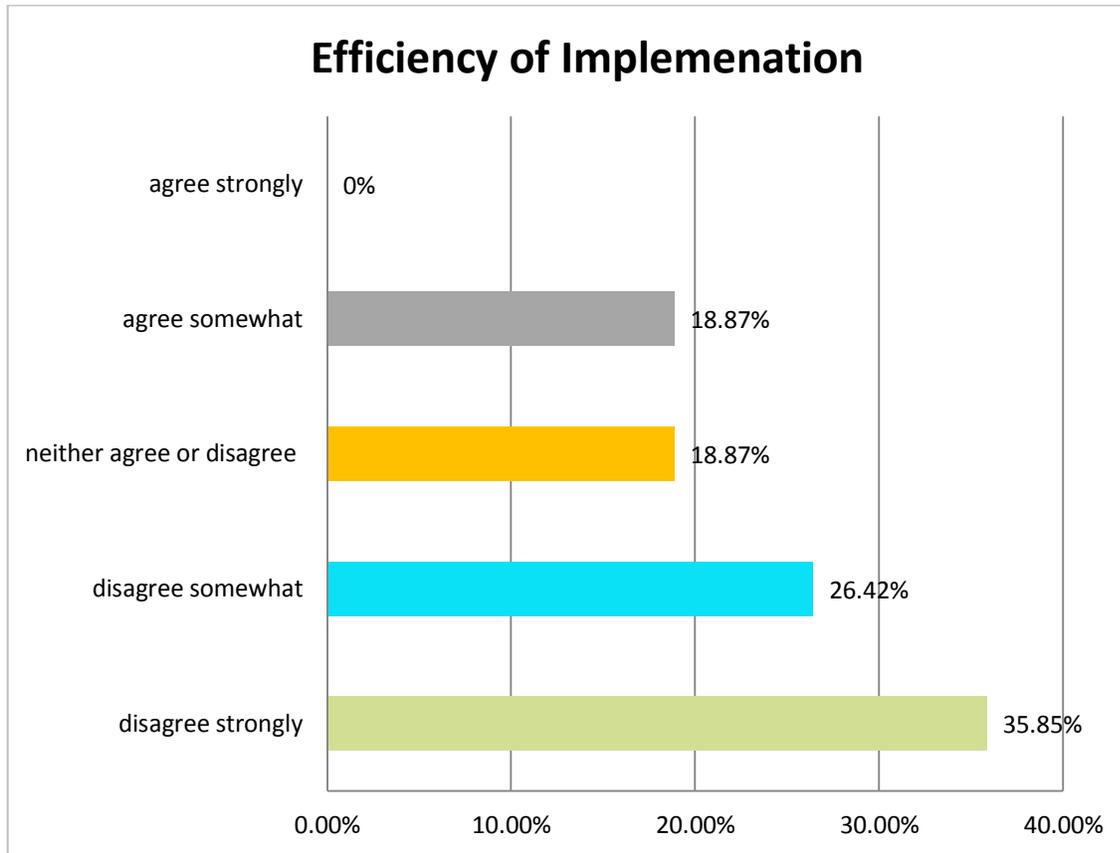


Figure 19. Efficiency of Implementation. The majority of stakeholders disagreed Covered California's had efficiently implemented its program.

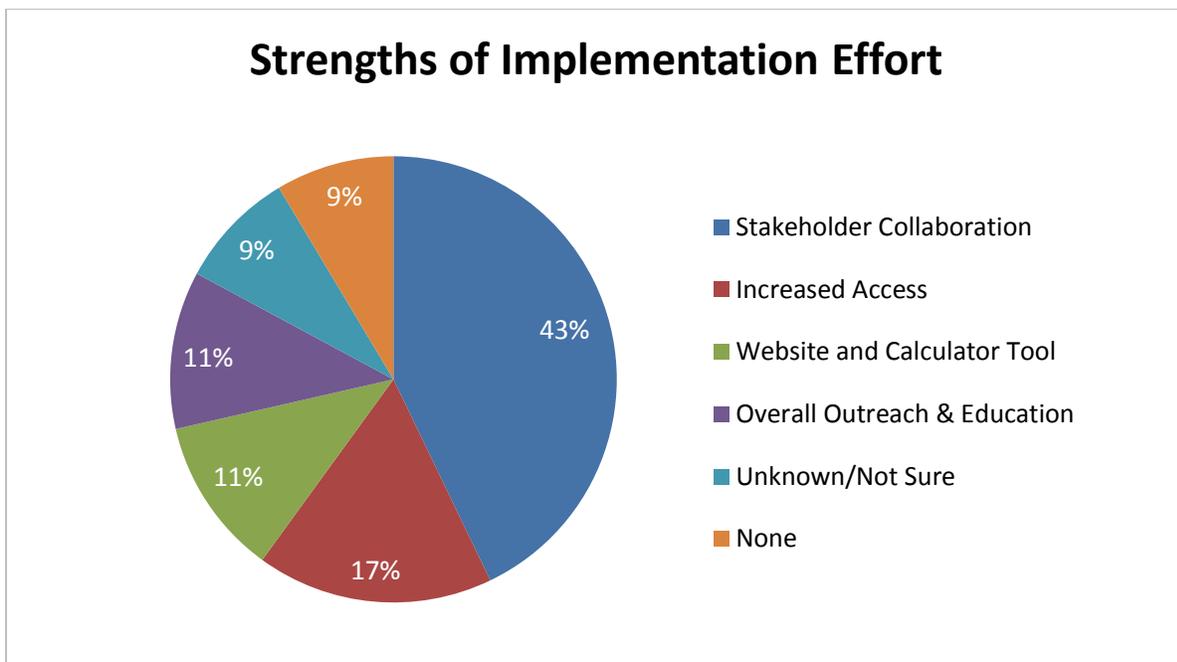


Figure 20. Greatest perceived strengths of the implementation effort. Chart shows respondents views of what were the greatest strengths of the implementation effort.