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IMPACT OF NATIONAL HEALTH CARE REFORM ON CALIFORNIA'S HEALTH WORKFORCE

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Executive Summary

The new health care reform law, formally known as Patient Protection and Affordable Care Act (PPACA), will substantially increase the number of Californians who have health insurance. Currently 8.2 million Californians, or 22% of our state's population, lack health insurance. The new law will improve access to health insurance in various ways, including developing a new high-risk health insurance pool, expanding Medi-Cal, establishing health insurance exchanges, and subsidizing health insurance premiums.

While the new law provides a major opportunity to improve the health of Californians, it also poses a major challenge for California's health care organizations. Insuring more people will increase demand for care, further straining organizations that are already having difficulty recruiting and retaining health professionals. Health care organizations in California face shortages of health professionals, maldistribution of health professionals across the state, lack of racial/ethnic diversity, and an aging workforce. These challenges are compounded by the recession which has substantially reduced State revenue and, thus, State funding for health workforce development.

Fortunately, Congress recognized the challenges facing health care organizations and included a number of provisions in the new law regarding health workforce analysis, health professions education programs, and financial assistance for health professions students.

This paper reviews the impact of national health care reform on California's health care workforce. We discuss issues relating to our state's health workforce needs and recommend strategies for expanding California's health care workforce and utilizing our present workforce more effectively.

Access to Health Insurance

PPACA will have a major impact on California's health workforce needs because it will substantially increase the number of Californians with health insurance. It will require most of California's 8.2 million uninsured to obtain health insurance or pay a tax penalty. A brief synopsis of health insurance changes in store for Californians is outlined below.

- *Medi-Cal*: As many as 2 million Californians will be newly eligible for Medi-Cal, the state's Medicaid program. Eligibility will be expanded to include all persons in families with incomes above 133% of the Federal Poverty Level (FPL), roughly equivalent to an annual income of $14,403 for a single person. (The income threshold increases as family size increases.) Total enrollment in Medi-Cal is projected to increase from seven million to nine million Californians.
- *Individual Health Insurance*: Some of the most dramatic effects of PPACA will occur in the individual insurance market. In September 2010, California established the Pre-existing Condition Insurance Plan to provide coverage to Californians with pre-existing health conditions who have been uninsured for at least six months. Beginning in 2014, insurers will be prohibited from denying coverage to persons with pre-existing conditions and from charging them higher premiums based on their health status. On September 30, 2010, Governor Schwarzenegger signed legislation that makes California the first state to establish a health insurance exchange. Beginning in 2014, persons in families with incomes between 133% and 400% of FPL (annual incomes between $14,403 and $43,320 for a single person) will be eligible for subsidies to purchase coverage through the exchange. Persons with higher incomes will be able to purchase unsubsidized coverage through the exchange. As many as 2.4 million Californians will be eligible to purchase subsidized coverage through the exchange and as many as 2.1 million will be eligible to purchase unsubsidized coverage.
- *Employer-Sponsored Health Insurance*: PPACA's impact on employer-sponsored health insurance will be greatest among small employers. Beginning in 2010, employers with less than 25 employees who employ low-wage workers will be eligible for tax credits to purchase health insurance for their employees. Beginning in 2014, employers with less than 100 employees will be eligible to purchase coverage through California's health insurance exchange. Employers with more than 50 full-time equivalent employees who do not offer health insurance may be subject to fines. Fines will be imposed if these employers have at least one employee who receives a tax credit for purchase of coverage through the exchange.
- *Medicare*: PPACA will not affect eligibility for the Medicare program, but the Act makes some changes in benefits for pharmaceuticals and preventive services. The Act also establishes an office within the Centers for Medicare and Medicaid Services to improve access to care and quality of care for persons who are dually eligible for Medicare and Medicaid.

Demand for Professionals and Services

The increase in demand for health professionals will be felt more strongly in rural and inner city areas with high proportions of low-income, uninsured residents.

Findings from numerous studies suggest that persons who have health insurance use more health care services than uninsured persons, particularly in the areas of preventive services, physician visits, and prescription medications. California will likely experience a spike in demand for these primary care services among newly insured persons as well as a sustained increase in the level at which these services are utilized.

Therefore, primary care providers (i.e., primary care physicians, physician assistants, and nurse practitioners) are likely to experience the greatest increase in demand. The increase in demand for primary care providers will also boost demand for certain other health professionals who contribute to the delivery of primary care, including:

- Clinical laboratory professionals and imaging professionals (e.g., clinical laboratory scientists, radiologic technologists) who provide screening and diagnostic tests;
- Pharmacists and other pharmacy personnel who process prescriptions; and
- Professionals who provide health education and counseling to prevent disease or manage chronic illness.

PPACA may also increase demand for care among some Californians who already have health insurance by lowering their out-of-pocket costs for care. The legislation prohibits lifetime and annual limits on the dollar value of coverage, provides subsidies to reduce cost sharing for persons under 400% FPL who purchase coverage through an exchange, and eliminates cost sharing for recommended preventive services.

Demand for professionals with expertise in health information technology will also increase because financial incentives for investment in electronic health records will be made available to providers with high Medi-Cal or Medicare patient volumes beginning in 2011.

Safety-Net Issues

Safety-net providers, including community health centers, will continue to play important roles in health care delivery. They are the only providers in some rural and inner city communities. Many persons who will be newly insured currently obtain health care from safety-net providers and will continue to do so. Furthermore, safety-net providers will be the only care source for 1.2 million uninsured undocumented immigrants in California who will not be eligible to enroll in Medi-Cal or purchase coverage through a health insurance exchange. Although the health reform legislation contains provisions that will help community health centers recruit and retain health professionals, the legislation also reduces Medi-Cal and Medicare Disproportionate Share Payments, which may limit safety net hospitals' ability to maintain residency programs and recruit personnel.

New Delivery Models Uncertain

The impact of PPACA on the manner in which health professionals are utilized is uncertain. There is widespread interest in implementing new models of care delivery and PPACA establishes demonstration projects to evaluate innovations in care delivery and reimbursement. However, it is unclear whether these demonstration projects will lead to the widespread changes in reimbursement that will be necessary to sustain innovations in care delivery. In addition, much will depend on the commitment of California's health care organizations to delivery system reform.

Reports from Massachusetts suggest that the health care reform law it enacted in 2006 led to a substantial increase in demand for health care that could not be readily absorbed by the state's health care providers.

Some programs designed to promote new health care models will be funded through grant programs requiring annual appropriations. Securing adequate appropriations will be difficult in an era of federal budget deficits.

Health Workforce Investments

PPACA authorizes funding for a large number of health workforce development programs. These initiatives build upon funding provisions of the American Reinvestment and Recovery Act (2009) and the Fiscal Year 2010 Appropriations Act for the Departments of Labor, Health and Human Services, Education and related agencies, both of which increased funding for the National Health Service Corps, financial aid for health professions students, and grants for health professions training programs.

On June 16, 2010, the Obama Administration announced it would allocate $250 million to increase the number of primary care providers. The money, drawn from the Prevention and Public Health Fund established by PPACA, is directed at six initiatives:

- *Primary care medical residency positions*: $167 million for more than 500 additional medical residency positions in primary care specialties (i.e., family practice, general internal medicine, general pediatrics);
- *Physician assistants:* $30 million to educate more than 700 additional physician assistants;
- *Advanced practice nursing students:* $31 million for financial assistance so that 600 part-time nurse practitioner and nurse midwifery students can enroll on a full-time basis and complete their degrees more rapidly;

- *Nurse-managed clinics*: $15 million for 10 nurse-managed clinics that will provide clinical education for nurse practitioner students;
- *Personal and home care aides*: $4 million for development and evaluation of a uniform curriculum to train more than 5,100 personal and home care aides; and
- *Health workforce planning:* $6 million for grants to states to for comprehensive health workforce planning.

The Administration also announced the allocation of $8 million from the Prevention and Public Health Fund to expand the Centers for Disease Control and Prevention's fellowship programs for public health professionals and $17 million for Public Health Training Centers, which enhance the skills of public health professionals and public health students.

In September 2010, the Administration announced that health professions schools and state government agencies in California had been awarded a total of $29 million in grants funded through the Prevention and Public Health Fund.

Other workforce development provisions of PPACA include authorization of funding for:

- *Health workforce needs assessments and action plans*, including grants to states for planning and implementation of health workforce development initiatives;
- *Further expansion of the National Health Service Corps;*
- *New scholarship and loan repayment programs* for nursing school faculty, pediatric specialists, and public health professionals;
- *Expansion of programs to increase racial/ethnic diversity in the health professions and prepare health professionals for practice in underserved areas,* such as the Minority Centers of Excellence, Health Career Opportunity, and Area Health Education Centers programs;
- *Expansion of existing programs and establishment of new programs to increase supply in high priority professions*, including primary care physicians, physician assistants, nurse practitioners, registered nurses, allied health professionals, geriatricians, public health professionals, direct care workers, mental and behavioral health professionals, alternative dental health care providers, and general, pediatric, and public health dentists;
- *Changes in Medicare reimbursement for graduate medical education (GME),* including providing grants for the creation or expansion of teaching health centers, removing disincentives to train residents in non-hospital settings, and redistributing unused specialty residency positions to primary care residency programs; and
- *New monetary incentives for primary care careers,* including increasing Medi-Cal payment rates for primary care physicians during 2013 and 2014, and providing a bonus payment of 10% to primary care providers for care provided to Medicare beneficiaries from 2011 through 2015.

Recommendations

In order to meet the health care workforce needs brought about by the new reform legislation, we believe California's decision makers should invest their efforts in three specific areas: analysis, coordination, and advocacy.

Analysis

- Review available data and literature to refine understanding about the implications of increasing the number of Californians with health insurance. Specifically, there is a need to assess aggregate demand for health professionals, demand for specific types of health professionals, and variation in demand across geographic areas and types of health care organizations;
- Assess the supply and distribution of health professionals in California, including the pipeline of students at K-12, undergraduate, and graduate levels;
- Evaluate the scale, sustainability, and impact of current statewide and regional health workforce development initiatives relative to demand;
- Identify reimbursement policies, scope of practice laws, and licensure and certification requirements that limit the ability of California's health care organizations to utilize health professionals more cost effectively;
- Develop a comprehensive plan for increasing the number of primary care providers and the numbers of providers in other professions in which shortages exist;
- Identify strategies for expanding telemedicine and other modalities for improving access to specialty care in rural areas; and
- Assess the feasibility of developing funding streams for health workforce development supported by the health care industry, health professionals, and consumers.

Coordination

- Establish a commission or other entity that will focus solely on health workforce development and provide the commission with sufficient resources to collaborate with existing initiatives to strengthen lines of communication and improve coordination among State government agencies, health professions training programs, organizations delivering health care services, and other major stakeholders. The commission should be composed of persons with a demonstrated commitment to collaboration across institutions and interests to address the needs of all Californians. The commission's activities should include:
    - Disseminating information about funding opportunities provided by PPACA and other federal sources;

- Enhancing the ability of California organizations to compete successfully for federal funds, especially grants that require organizations to partner with one another;
- Exchanging information about successful strategies for addressing health workforce challenges;
- Improving alignment between employers' health workforce needs and the numbers and types of health professionals educated by academic institutions;
- Developing and executing coordinated strategies to address shortages in individual health professions as well as challenges that affect multiple professions; and
- Facilitating collaboration among health care organizations and shared investment in health workforce development at both state and regional levels.

Advocacy

- Ensure that appropriations for health workforce development programs authorized under PPACA are fully funded to maximize federal resources for workforce development in California and other states;
- Secure funding to make temporary increases in Medi-Cal and Medicare payments for primary care physicians permanent;
- Institutionalize innovations in care delivery and reimbursement, including innovations in reimbursement of primary care providers for preventive and disease management services; and
- Change reimbursement policies, scope of practice laws, and licensure and certification requirements that pose obstacles to utilizing health professionals effectively and implementing innovations in care delivery.

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