OPTIONS TO IMPROVE AFFORDABILITY IN CALIFORNIA'S INDIVIDUAL HEALTH INSURANCE MARKET

COVERED CALIFORNIA WORKING DRAFT

January 10, 2019

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EXECUTIVE SUMMARY

[RESERVED]

INTRODUCTION

OVERVIEW OF THE INDIVIDUAL MARKET PROVISIONS OF THE AFFORDABLE CARE ACT

The Affordable Care Act dramatically changed the individual health insurance market. Under the Affordable Care Act, consumers cannot be denied coverage due to preexisting conditions and premiums are only allowed to vary by an enrollee's age and geography. Annual and lifetime limits on coverage were banned and replaced with annual limits on enrollee out-of-pocket spending for certain benefits. Benefit categories and coverage levels were defined. Health benefit exchanges were created to administer new federal subsidies designed to reduce premiums and out-of-pocket expenses for low- and middle-income individuals who do not qualify for Medicaid, Medicare, or coverage through an employer. Permanent and temporary market stabilization programs were implemented to smooth the transition to, and maintenance of, these new market rules. Finally, an individual shared responsibility requirement – or individual mandate – was established to ensure that individuals maintain coverage or make a payment for non-compliance unless they are granted an exemption.

Covered California – California's health benefit exchange is the largest state-run exchange in the nation. Covered California's enabling legislation lays out a clear vision for an "organized, transparent marketplace for Californians to purchase affordable, quality health coverage."[1] Covered California must require that participating health insurers "compete on the basis of price, quality, and service, and not on risk selection." The enabling legislation also includes several innovative features such as the ability for Covered California to actively negotiate with health plans and set participation requirements in the best interest of consumers, the authority to develop benefit designs and several provisions to prevent adverse selection against Covered California from the outside market.

Benefits and Coverage Levels

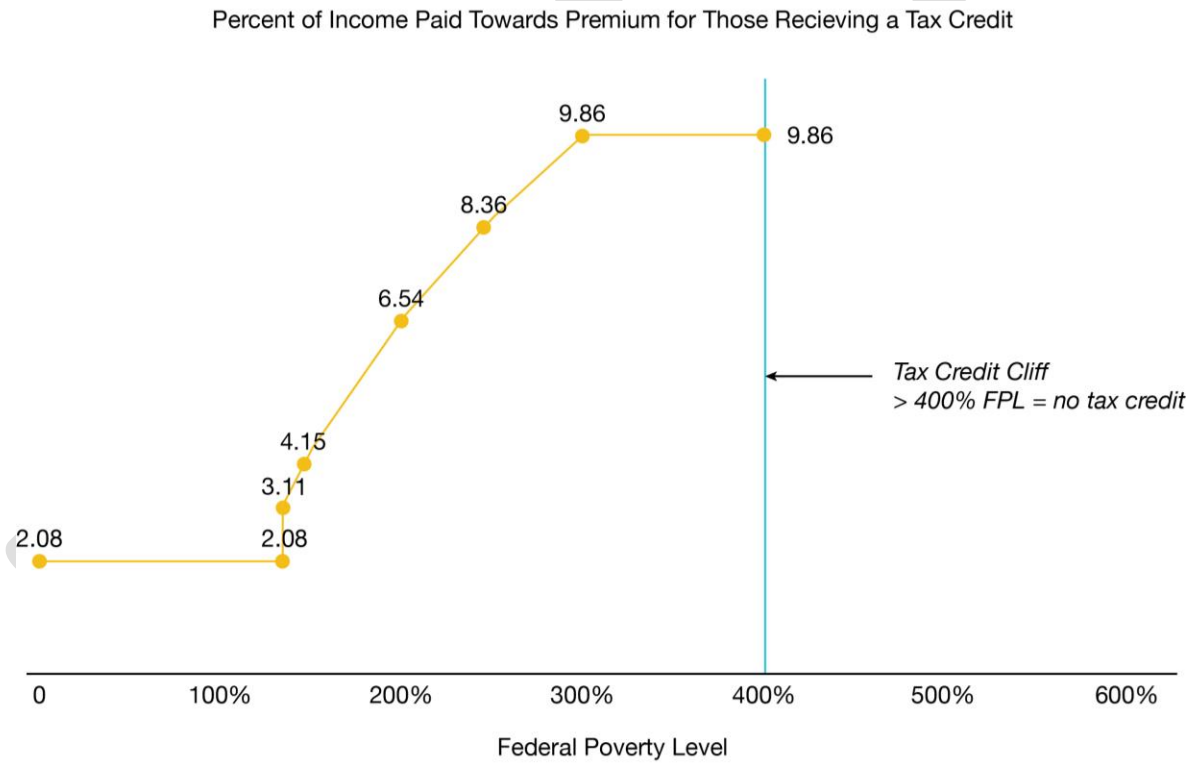
The Affordable Care Act requires that products sold in the individual market cover ten essential health benefit categories.[2] The Affordable Care Act defines four "metal tiers" of coverage for these benefits that vary by actuarial value (AV), which is the portion of the total cost of a plan that is collected through monthly premiums. The remaining portion is collected through consumer cost-sharing in the form of deductibles, copayments, and coinsurance. Plans with a lower AV have lower monthly premiums but higher cost-sharing. The four metal tiers are Bronze (60 percent AV), Silver (70 percent AV), Gold (80 percent AV) and Platinum (90 percent AV). Federal premium tax credits and cost sharing reductions – discussed in detail below – are tied to Silver coverage. Catastrophic coverage is also defined though it is only available to individuals younger than 30 or with a valid exemption from the individual mandate.

Covered California, in close collaboration with stakeholders, has developed Patient-Centered Benefit Designs for each metal tier with the goal of ensuring that cost-sharing does not prevent members from accessing necessary services. For the Silver tier and higher, outpatient care is not subject to a deductible. For the Bronze level of coverage, three outpatient visits are covered before the deductible applies. Preventive care services are free-of-charge at the point of care as required by the Affordable Care Act. Medical and pharmacy deductibles are separate to ensure access to needed medication. By state law, Covered California's designs must be offered at the same price by all health plans that sell in the individual market outside of Covered California.

Premium Tax Credits

The Affordable Care Act provides "advanceable" tax credits to lower monthly premium costs for individuals up to 400 percent of the federal poverty level (FPL) who buy coverage through exchanges. The premium tax credit structure caps the amount an individual has to pay for their monthly premiums. The member share, referred to as a "required contribution," ranges from approximately two to 10 percent of household income depending on the individual's federal poverty level (see Figure 1). The premium tax credit amount is calculated as the difference between the second-lowest cost silver plan available to the individual and the individuals' required contribution. The premium tax credit can be used to purchase any available plan at any level of coverage with the exception of catastrophic coverage. The portion of the tax credit taken in advance – known as the advanced premium tax credit or APTC – is reconciled by consumers at year's end when they file their income taxes.

Figure 1. Affordable Care Act Required Contributions for 2019



Because consumers' premium contributions are capped based on income, their premium tax credits automatically adjust to account for age and regional differences. Figure 2 shows how the value of the premium tax credit rises to account for the age-based difference in premiums, and Figure 3 shows how the value of the premium tax adjusts to account for regional premium differences. It is important to note that consumers who are not eligible for tax credits are subject to the full premium cost, which creates significantly different affordability challenges for consumers depending on where they live and how old they are.

Figure 2. Statewide Average Premiums for Subsidy-Eligible Silver Plan Enrollees in 2018, by Age, Showing Portion of Premium Paid by Enrollee and Portion Covered by Premium Tax Credit

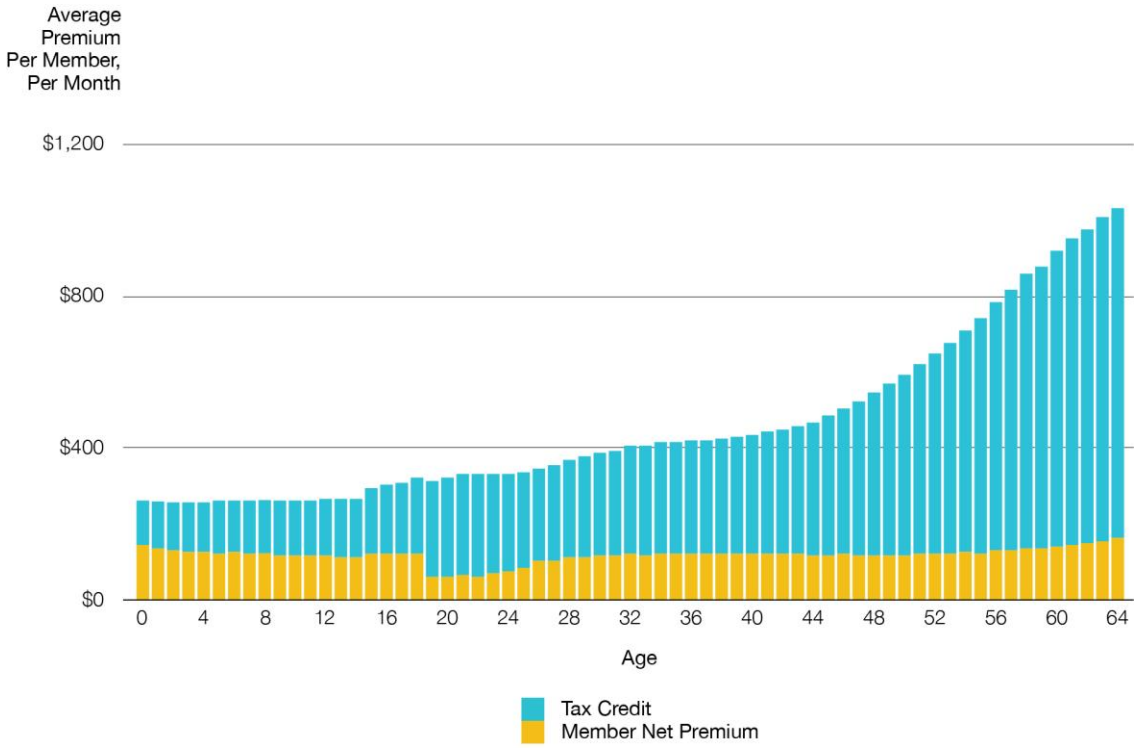
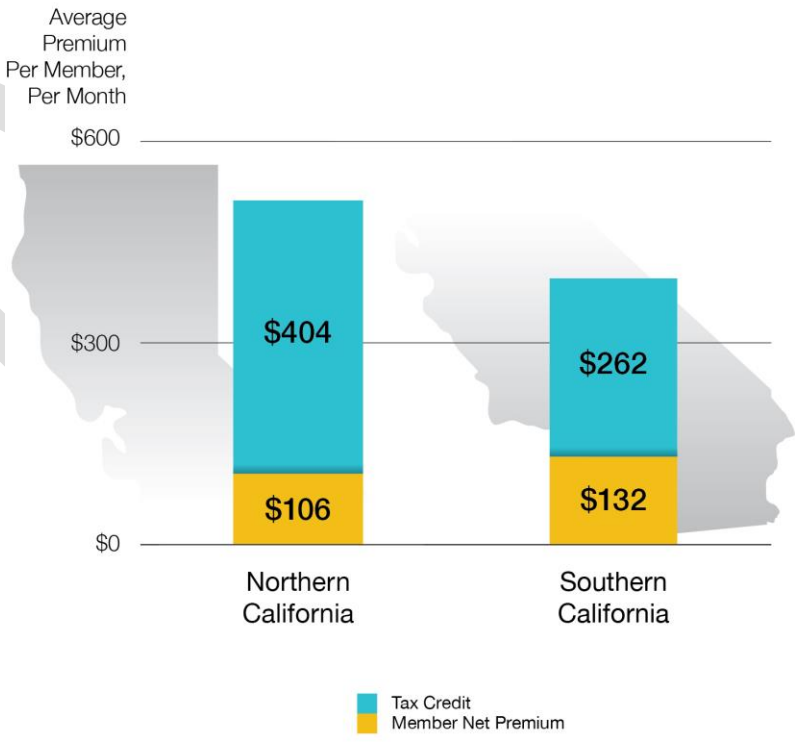


Figure 3. Average Premiums for Subsidy-Eligible Silver Plan Enrollees in Northern and Southern California in 2018, Showing Portion Paid by Enrollee and Portion Covered by Premium Tax Credits



Cost Sharing Reductions

The Affordable Care Act requires health insurers to reduce out-of-pocket maximums and cost-sharing amounts for consumers at 250 percent of the federal poverty level and below. Eligible individuals access these benefits by enrolling in what are known as cost sharing reduction plans built on Silver-level coverage. For the lowest-income enrollees, cost sharing reduction plans provide coverage at or near the Platinum level for Silver premium prices. Cost sharing reduction plans significantly reduce out-of-pocket costs at the point of care. For example, in the standard Silver plan in California, an office visits costs $40, but in Silver 94 plan the same visits costs $5. Cost sharing reduction eligibility and benefit levels are illustrated in Table 1. It is important to note that consumers forego their cost-sharing benefits if they enroll in coverage tiers other than Silver.

Table 1. Cost Sharing Reduction Plan Variations

Standard Silver	**Silver 94:** Up to 150% FPL	**Silver 87:** 151-200% FPL	**Silver 73:** 201-250% FPL
70% AV	94% AV	87% AV	73% AV

Individual Shared Responsibility Provision

The Affordable Care Act's individual mandate requires that individuals maintain "minimum essential coverage" or pay a tax penalty for noncompliance.[3] Exemptions from the mandate are granted for a variety of reasons related to income, affordability of coverage, and federally-defined hardship. The penalty for not maintaining minimum essential coverage is either a flat dollar amount or a percentage of household income above the annual tax-filing threshold, whichever is greater. The amount owed is prorated based on the number of months in the year without coverage, less the first three months. The values for the 2018 tax year are as follows:

- $695 per adult and $347.50 per child under 18 (up to a maximum of $2,085 per family); or
- 2.5% of household income above the tax filing threshold not to exceed the national average cost of a bronze-level plan

The Tax Cut and Jobs Act of 2017 set the payment for noncompliance with the individual mandate to $0 beginning in 2019.

Risk and Market Stabilization Programs

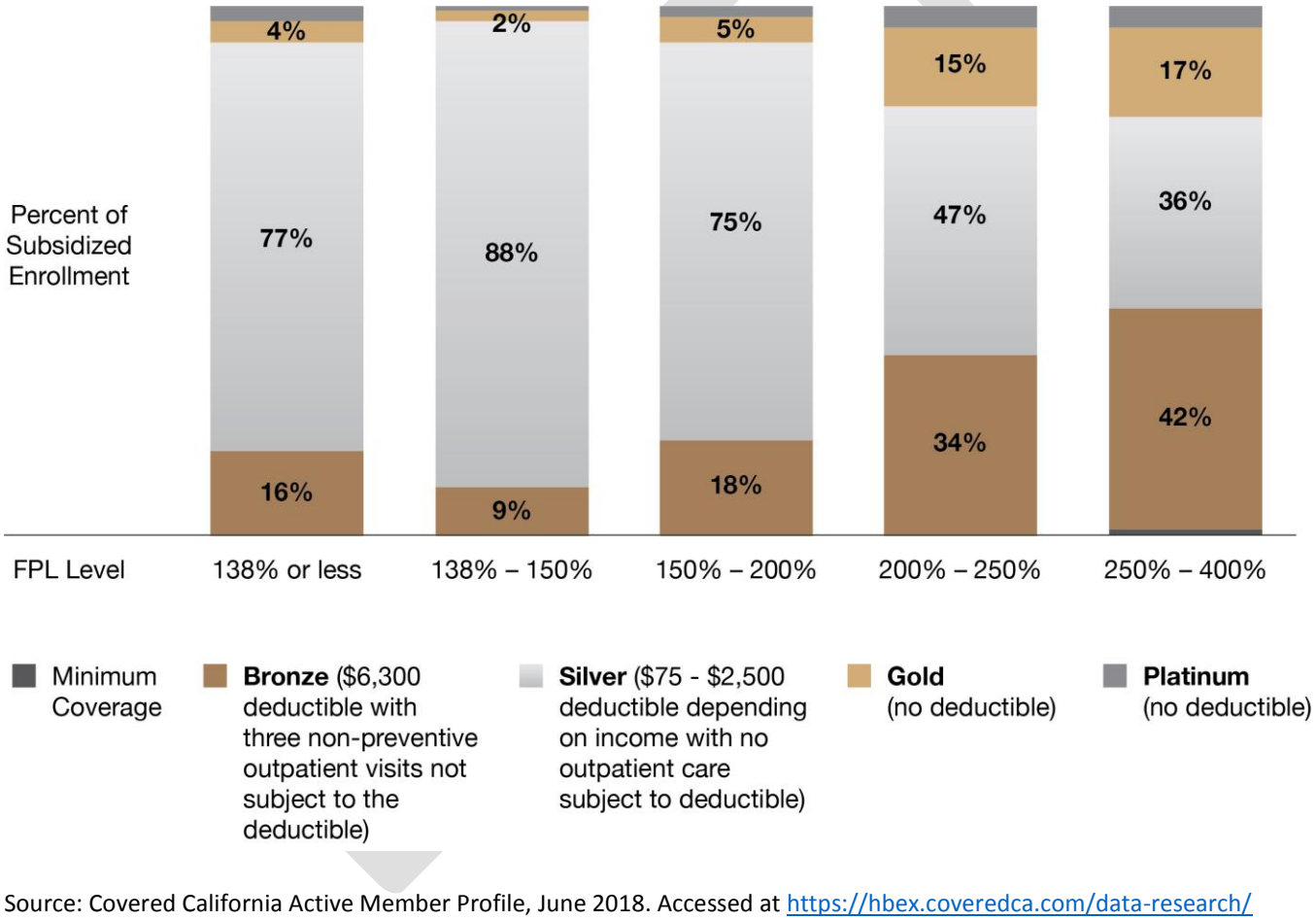
The Affordable Care Act included a temporary federal reinsurance program that lowered premiums in the individual market by about 10 percent each year between 2014 and 2016.[4] Reinsurance funding helped offset the higher costs of the known worse health risk in the individual market by providing funding to issuers for certain defined high cost claims. Since the expiration of the program, seven states have implemented reinsurance programs to stabilize premium increases in their individual markets using the federal Section 1332 "state innovation" waiver process. The Affordable Care Act also includes a

permanent risk adjustment program that transfers dollars at the end of the plan year from health insurers within a state market with lower relative risk to health insurers with higher risk.

THE IMPACT OF THE AFFORDABLE CARE ACT ON CALIFORNIA'S INDIVIDUAL MARKET

Covered California has approximately 1.4 million members of which nearly 90 percent – or 1.2 million – receive premium tax credits. Of the enrollees receiving premium tax credits – referred to as subsidized enrollees – 70 percent have household incomes below 250 percent of the federal poverty level, qualifying them for cost-sharing subsidies. Half of Covered California's subsidized enrollees purchase a cost sharing reduction plan, though the distribution of metal tier choice varies significantly between income groups as shown in Figure 4.

Figure 4. Covered California Enrollment by Income and Metal Tiers



Source: Covered California Active Member Profile, June 2018. Accessed at https://hbex.coveredca.com/data-research/

Covered California's subsidized membership is split roughly evenly by those below and above 45 years of age as shown in Table 2. Approximately two-thirds of Covered California's unsubsidized membership is under the age of 45. As noted above, premium tax credits for the subsidized membership adjust to account for age-rated premiums.

Table 2. Covered California Enrollment by Age and Subsidy Status

	Subsidized		Unsubsidized		Total	
Age Bracket	Enrollees	(column %)	Enrollees	(column %)	Enrollees	(column %)
Age 17 or less	65,220	5.3%	29,410	18.4%	**94,640**	**6.8%**
Age 18 to 25	128,670	10.5%	10,620	6.6%	**139,290**	**10.1%**
Age 26 to 34	192,170	15.7%	34,140	21.3%	**226,310**	**16.4%**
Age 35 to 44	177,990	14.5%	29,580	18.5%	**207,570**	**15.0%**
Age 45 to 54	282,310	23.1%	28,280	17.7%	**310,590**	**22.4%**
Age 55 to 64	369,360	30.2%	27,430	17.1%	**396,790**	**28.7%**
Age 65+	8,150	0.7%	690	0.4%	**8,830**	**0.6%**
Grand Total	**1,223,870**	**100.0%**	**160,150**	**100.0%**	**1,384,010**	**100.0%**

Source: Covered California Active Member Profile June 2018. Accessed at https://hbex.coveredca.com/data-research/

Covered California's subsidized members pay on average $115 per month in premiums, or about 20 percent of the average gross premium cost of $558 per month as shown in Table 3. In addition, members enrolled in cost sharing reduction plans receive reduced deductibles, copayments and coinsurance estimated to be worth roughly $131 on average. Unsubsidized consumers who do not qualify for tax credits pay on average about $446 per month in premiums. The difference in average gross premiums between the subsidized and unsubsidized membership reflects the fact that enrollment in Bronze coverage is twice as high among unsubsidized enrollees.[5]

Table 3. Average Premiums, Average APTC, and Average Cost Sharing Reduction Value by Subsidy

	Subsidized	Unsubsidized	Total
Enrollment Metrics			
Policies (subscribers)	841,000	110,180	**951,180**
Members Per Policy (average)	1.45	1.45	**1.45**
Gross Premium Per Member (average)	$558	$446	**$543**
Net Premium Per Member (average)	$115	$446	**$152**
APTC Per Member (average)	$444	N/A	

Source: Covered California Active Member Profile June 2018. Accessed at https://hbex.coveredca.com/data-research/

Actions to Support Unsubsidized Enrollees

One million Californians are estimated to have been insured in the individual market outside of Covered California in 2017, the latest year for which public data is available. An additional 160,000 unsubsidized individuals are enrolled through Covered California. While these individuals do not receive premium tax credits or cost sharing reductions to lower their monthly costs, Covered California has taken steps to hold down gross premium increases. Each year, Covered California actively negotiates rates and contract terms with health plans and aggressively markets the availability of coverage to encourage healthy individuals to sign up. Because Covered California's standard plan designs must be sold for the same price on and off the exchange, actions taken by Covered California that lower premium increases directly benefit unsubsidized consumers.

Decisions by California policymakers and the Covered California Board have contributed significantly to the stability of the individual market. Notable actions include the expansion of Medicaid; the establishment of a state-based exchange rather than a federally-facilitated exchange; and the decision to require health insurance companies to bring their non-grandfathered individual market products into compliance with Affordable Care Act-standards. In 2017, Covered California took further action to protect unsubsidized consumers from premium increases on Silver plans that resulted from the elimination of the direct payment of cost-sharing subsidies by the federal government.[6]

California's actions to promote the stability and affordability in the individual market have provided a measure of financial protection to unsubsidized consumers. Covered California's five-year average premium rate increase is just under eight percent.[7] Broadly, the California individual market has a healthy "risk mix," which has consistently ranked in the lowest ten percent of states.[8] Recent research suggests that premiums in California would have been 20 percent higher if California's risk mix mirrored the national average. [9]

AFFORDABILITY CHALLENGES IN THE INDIVIDUAL MARKET

Since the passage of the Affordable Care Act in 2010, California has made considerable progress toward lowering the number of uninsured and making high-quality health care coverage more affordable. Despite this significant progress, many Californians insured in the individual market continue to report barriers in affording their monthly health care premiums and out-of-pocket medical costs. This includes both Californians who are eligible for premium tax credits as well as hundreds of thousands of middle-class Californians who face high premiums but do not qualify for help. The discussion below summarizes key data points pertaining to affordability of individual market coverage to frame potential policy solutions.

Affordability Challenges for Low- and Middle-Income Californians Eligible for Federal Subsidies

Although the Affordable Care Act caps premium contributions for individuals with income below 400 percent of the federal poverty level, "take up" of coverage among those who are eligible for premium tax credits is just slightly above 70 percent,[10] and affordability is cited as the top reason for lacking insurance coverage among the uninsured eligible for Covered California.[11] Among those who do enroll in coverage, recent research shows that, roughly 40 percent of enrollees reported having at least some difficulty paying their monthly insurance premiums.[12] Notably, regardless of having income that allows access to premium tax credits, 39 percent of enrollees with incomes below 250 percent FPL and 41 percent with incomes between 250 and 400 percent FPL reported having "some" or "a lot" of difficulty paying their monthly premiums.[13] Consumers concerned about affordability also may face a difficult choice when deciding on metal tier, as those who choose Bronze plans to lower their monthly premiums not only pay more at point of care, but also may forego a portion of the premium tax credit for which they are eligible, and those in Bronze with income below 250 percent FPL give up access to cost sharing reductions.

Many consumers also face challenges paying for out-of-pocket costs whether or not they qualify for cost sharing reductions. Recent survey results showed that one-third of all enrollees under 400 percent FPL had difficulty paying for out-of-pocket costs.[14] In particular, eligibility for cost sharing reductions ends at

250 percent FPL, while for individuals between 200 to 250 percent FPL out-of-pocket costs for a Silver 73 plan are only marginally less expensive than a Silver plan with no cost-sharing assistance. For example, a primary care visit for a Silver 73 plan costs $35, while a basic Silver-tiered plan is $40 (see Appendix IV). Similarly, there is only a $5 difference for a visit to urgent care or for specialty care. Other costs, such as laboratory tests, emergency care, and x-ray and diagnostics are the same for both plan designs, underscoring the fact that access to cost sharing reductions does not necessarily improve affordability.[15] Enrollment in Bronze plans increases as the generosity of cost sharing reductions deceases, which can be seen in Figure 4 above.

Taken together, challenges in paying premiums and out-of-pockets costs can lead to lower utilization. Recent survey results showed that nearly 25 percent of enrollees in the individual market delayed or avoided medical care due to cost.[16] Even with federal premium assistance, the combination of premiums and out-of-pocket spending can exceed 10 percent of income for some Californians with median health use and can reach up to 30 percent of income for those with very high medical use.[17]

Affordability Challenges for Middle-Income Californians Ineligible for Federal Subsidies

Many middle-class Californians are not protected by the Affordable Care Act's cap on premium contributions because their income is above the level needed to qualify for premium tax credits. Premium tax credits are available to individuals and families with income up to 400 percent FPL, which is just over $48,000 for an individual and just over $100,000 for a family of four (see Appendix III for FPL levels for 2019). Once household income exceeds this percentage, sometimes referred to as the "tax credit cliff," consumers are abruptly cut off from any federal assistance. Premiums for consumers who are ineligible for tax credits are on average nearly *four times* the premiums of similar consumers receiving financial assistance (see Table 3 above) and they are growing more rapidly. Figure 5 illustrates the differential rate increases experienced by unsubsidized enrollees above 400 percent FPL and subsidized enrollees, as demonstrated by a five-year average annual rate increase of 7.9 percent v. 3.8 percent, respectively. These higher premiums are driving affordability challenges for many consumers: based on a survey conducted in 2017, 38 percent of respondents with income above 400 percent FPL reported having "some" or "a lot" of difficulty paying their monthly premiums.[18]

Figure 5. California's Subsidized and Unsubsidized Enrollee Premiums: Five-Year Average Rate Change

The premium tax credit cliff disproportionately impacts individuals 50 and older, and individuals with income between 400 percent and 600 percent FPL.[19] Analysis by researchers at the University of California shows that factoring in the local cost of living, the premium assistance provided for households up to four times the federal poverty level under the Affordable Care Act is equivalent to five times the federal poverty level in California as a whole and six times the federal poverty level in high-cost areas such as San Francisco.[20] Even when choosing the cheapest Bronze plan available with a $6,300 individual deductible, older consumers living in high-cost areas can face premiums equal to more than 20 percent of their income.

Recent Federal Changes Undermine the Affordable Care Act and Introduce Uncertainty

Recent changes at the federal level have compounded issues with health coverage affordability and introduced new uncertainty in the marketplace. In 2017, the federal government ended its cost sharing reduction payments despite the Affordable Care Act's requirement that health insurance companies offer cost sharing reduction plans to eligible individuals. In response to this federal action, Covered California took immediate steps to stabilize the market by directing its health plans to add a surcharge to Silver-tier premiums in the amount needed to cover the cost of the cost sharing reduction benefit. While subsidized consumers at the Silver tier saw an increase in the gross cost of their premiums, most also saw an increase in the amount of financial assistance received in the form of a larger premium tax credit. In addition, Covered California directed its health plans to offer a nearly identical Silver product off the exchange that does not include the surcharge, giving unsubsidized consumers an opportunity to

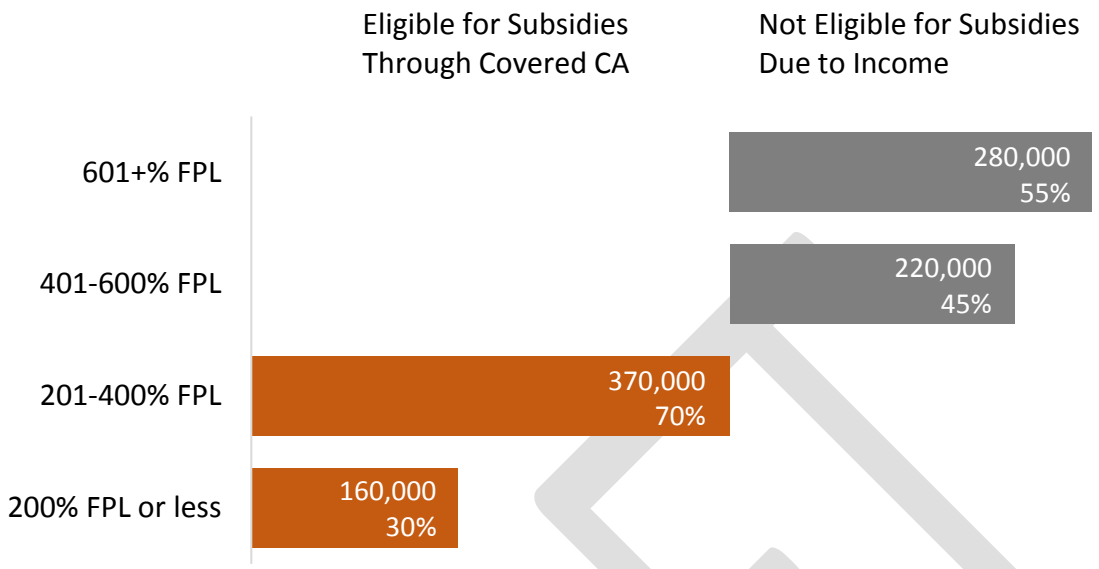
purchase a Silver-like product off exchange at a lower premium. While this workaround has protected consumers and provided market stability, it has also created a price differential between on and off exchange Silver plans that implementing state legislation sought to avoid. The pricing differences between these products is a factor to consider when contemplating potential cost sharing reduction options.

In late 2017, the Tax Cuts and Jobs Act set the tax penalty associated with the individual shared responsibility requirement to zero beginning in 2019. The Congressional Budget Office has estimated that nationally, the zero-dollar penalty will cause average premiums in the individual market to be about 10 percent higher than they would have been with the mandate in most years of the decade.[21] Likewise, researchers publishing in Health Affairs estimated that California specifically could see a four to seven percent premium increase due to the zero-dollar penalty.[22] Although the consequences of this federal action within each state will vary based on a variety of factors, including the health of the state's risk pool, carrier competition, and the strength of marketing and outreach efforts, reduced enrollment in the individual market will have direct consequences, primarily in the form of higher premiums and a sicker, costlier population.

Enrollment in Covered California is expected to suffer as a direct outcome of the zero-dollar penalty, although the full impact remains unclear. Researchers using the California Simulation of Insurance Markets (CalSIM) microsimulation model and a range of assumptions about the extent to which the penalty influences enrollment decisions, projected that 150,000 to 450,000 more Californians will be uninsured in 2020 as a result of the penalty removal. In 2023, that number is expected to grow to between 490,000 and 790,000 more uninsured, compared to the projected number for 2023 had the penalty been maintained. The most substantial enrollment changes will occur in the individual market, where enrollment is projected to decline by 10.1 percent in 2020 and 14.4 percent in 2023.[23]

In fact, University of California researchers estimate that, by 2020, approximately 530,000 subsidy-eligible individuals will be uninsured with 70 percent – or 370,000 – having income between 201 and 400 percent FPL. An additional 500,000 individuals with income above 400 percent FPL but eligible to purchase coverage in the individual market will also be without coverage.[24] In conjunction with the zero-dollar penalty, rising costs, lack of knowledge of subsidies, and affordability concerns act as deterrents to enrollment.[25]

Figure 6. California Non-Elderly Uninsured by Eligibility Category and Income, 2020 Midpoint Estimate



Source: UCLA-UC Berkeley CalSIM version 2.2. Modified from Figure 6, *California's Health Coverage Gains to Erode without Further State Action.*
Notes: Uninsured estimates rounded to the nearest 10,000 individuals. Excludes undocumented immigrants who are not eligible for subsidies or to purchase coverage through Covered California, and uninsured individuals eligible for Medi-Cal.

AB 1810 AFFORDABILITY REPORT

AB 1810 and Covered California's Legislative Charge

The 2018-19 budget trailer bill (Assembly Bill 1810, Chapter 34, Statutes of 2018) requires Covered California, in consultation with stakeholders and the Legislature, to develop a health care affordability report to the Legislature, Governor, and the new Council on Health Care Delivery Systems, by February 1, 2019. (See Appendix I for the legislative language.) In developing the Report, the legislation tasks Covered California with developing options for providing financial assistance to help low- and middle-income Californians access health care coverage, including options to assist low-income individuals paying a significant percentage of their income on premiums – even with federal financial assistance – and individuals with an annual income of up to 600 percent of the federal poverty level. The modeling in this Report does include flexible levers for policymakers to address consumers with income above 600% of federal poverty level, if desired.

This Report has been developed jointly by Covered California staff and economists Wesley Yin, PhD, University of California at Los Angeles, and Nicholas Tilipman, PhD, University of Illinois at Chicago. Drs. Yin and Tilipman have developed a robust microsimulation model, described in greater detail later in this Report, to reflect the potential impacts various policy proposals have on the health care marketplace, including impacts to enrollment, consumer health spending, and public spending.

To carry out its legislative mandate, Covered California developed a robust stakeholder engagement process. Known as the AB 1810 Affordability Workgroup, membership was comprised of 15 core members and approximately 40 interested parties. A wide variety of partners in the health care industry were represented on the workgroup, including health care advocates, health plan issuers, the California Hospital and Medical Associations, legislative staff, state government agencies, insurance agents, and members of the research community. In addition, two Covered California Board members also participated—Dr. Sandra Hernandez and Jerry Fleming. (See Appendix II for a complete membership list and a link to Covered California's AB 1810 Affordability Workgroup website.)

OVERVIEW OF AFFORDABILITY OPTIONS

POLICY OPTIONS AND ANALYSIS

Overview of Approach

The affordability challenges discussed above reflect the premium and cost-sharing burden experienced by different consumer populations. The goal of the proposed policy options is to alleviate these cost burdens, thereby expanding affordable coverage and stabilizing the individual insurance market.

Policy options in this Report were devised by first identifying specific policy interventions, either directly through state-funded subsidies, or indirectly through statutory and market mechanisms. The analysis is restricted to interventions that can *overlay* the existing federal statutory framework for subsidies and pricing. The Report then proposes three policy options—each a combination of targeted policy interventions—aimed at significantly expanding coverage in California to eligible populations, while reducing cost-sharing for households. It also proposes four "targeted" policy options aimed at improving affordability and coverage with pre-determined impacts on the State budget.

The Report uses a microsimulation model to analyze each policy option. The microsimulation model is based on administrative data on marketplace enrollment and health spending, survey data, economic theory, and empirical findings from the economics literature. The model projects the impacts of each policy option on individual market enrollment, state spending, and federal transfers to California, as well as impacts on consumer tier choice, utilization, and premiums.

Potential Policy Interventions

Premiums Subsidies That Lower Consumer Contribution Caps

A straightforward way to improve affordability is to supplement the federal premium tax credit. This can be done by lowering consumer contribution caps. As an example, for an individual earning 250 percent FPL, the current cap on annual consumer spending on the benchmark plan is 8.36 percent of household income. The State could lower this cap to, for example, five percent, by providing an additional state premium subsidy equivalent to the difference between five and 8.36 percent.

For individuals earning above 400 percent FPL (who currently receive no premium tax credit), the State could institute a cap on premium contributions. Depending on the generosity of the policy, the State could phase out this new premium subsidy at a higher income threshold, or cap premiums for all eligible Californians, eliminating the tax credit cliff altogether.

Lowering contribution caps would also generate an indirect benefit for subsidy-*ineligible* consumers. By inducing new enrollment—enrollment which is likely to be healthier—additional premium subsidies are likely to improve the risk mix in Covered California, causing premiums to fall for the entire individual market.[26] Among subsidy-eligible consumers, lower premiums would trigger equal reductions in federal premium tax credits per enrollee. In contrast, subsidy-*ineligible* consumers would experience the full benefit of any premium reduction.

Enhancing Plan Generosity Through Greater Cost Sharing Reduction Subsidies

Even when insured, cost-sharing obligations have been shown to discourage medical care utilization, including high value medical care.[27] To improve plans' coverage levels, the State could finance increases in the actuarial value of enhanced cost-sharing Silver plans. Similarly, the State could extend enhanced cost sharing reduction benefits to consumers earning above the current eligibility threshold (250 percent FPL) for cost sharing benefits.

Reinstating the Mandate Tax Penalty

Reinstating the tax penalty would likely increase enrollment, resulting in markedly improved risk mix.[28] As with reinsurance, lower premiums due to improved risk mix would apply to all individual market insurance plans—an indirect benefit of the penalty. Among people currently receiving federal subsidies, premium reductions would be further offset by commensurate reductions to their per-enrollee premium tax credit. Individuals ineligible for federal premium tax credits would benefit fully from any reductions in premiums.

Reinsurance

Reinsurance offers a direct mechanism to assist consumers who are ineligible for federal premium subsidies. By covering some portion of medical costs for enrollees who experience extremely high medical claims, a reinsurance program would lower plan costs, resulting in lower premiums for all plans sold in the individual market.

Similar to how the benefit of improved risk mix is distributed, premium reductions due to state reinsurance will trigger an equal reduction in per-enrollee federal premium tax credits (resulting in little change in a consumer's net-of-subsidy premium). Consumers who are ineligible for federal subsidies, by contrast, would experience the full benefit of lower premiums due to reinsurance. Currently, there are approximately two million subsidy-ineligible Californians who could avail themselves of lower premiums due to reinsurance, including roughly 650,000 people who have earnings below 400 percent FPL.

Summary of Policy Options

First, the Report discusses the three primary policy options that aim to expand coverage significantly, moving California toward universal coverage. These three policy options involve using state funds to significantly reduce households' premium contributions, while markedly alleviating cost sharing burden for low-income households earning below 400 percent FPL. Table 4 summarizes these three policy options.

In recognition of budgetary pressures, the Report also discusses five "targeted" policy options, in comparison to the three primary policy options. These options, discussed in the following section, aim to achieve modest expansions in coverage with milder impacts on the State budget.

Table 4. Policy Options Aimed at Significant Coverage Expansion

Policy Option 3

Policy Option 2

Policy Option 1

Premium Support: Lower Contribution Caps			+	*Cost Sharing Reduction*			+	*Penalty*		+	*Reinsurance*	
FPL	Contribution Cap (%)			FPL	Silver Plan Actuarial Value							
	Baseline (2019 ACA)	Proposed			Baseline	Proposed		Baseline	Proposed		Baseline	Proposed
0-138	0.0208	0		<150	94	94		None	Reinstate 2018		None	Fund State
138-150	0.0311-0.0415	0-0.0037		150-200	87	94			Tax Penalty			Reinsurance;
150-200	0.0415-0.0654	0.0037-0.0189		200-250	73	87						Lower Gross
200-250	0.0654-0.0836	0.0189-0.0342		250-300	70	80						Premiums 10%
250-400	0.0836-0.0986	0.0342-0.08		300-400	70	80						
400-600	No Cap	0.08-0.12		400+	70	70						
600+	No Cap	0.12-0.15										

Policy Options: Achieving Significant Coverage Expansion and Cost Sharing Reduction

Policy Option 1 – Enhanced Premium Support and Cost Sharing Reductions

This scenario lowers significantly the premium contribution cap for people at all incomes. For people earning below 400 percent FPL, state funding would be layered on top of federal premium tax credits, resulting in contribution limits ranging from zero percent at 138 percent FPL, to eight percent at 400 percent FPL (with contribution cap percentages increasing linearly in between). For individuals earning over 400 percent FPL, premium contributions would be newly capped, at eight percent of income at 400% FPL (thereby eliminating the subsidy cliff) and rising to 15 percent at its highest.[29] This effectively caps contribution limits for all eligible Californians. Figures 7 and 8 depict the current and proposed contribution caps.

This policy option also markedly reduces the cost-sharing burden for low-income individuals by using state funds to enhance actuarial values of Silver plans. Individuals earning income below 150 percent FPL could continue to avail themselves of AV 94 Silver plans. Individuals between 150 and 400 percent FPL would experience a marked increase in Silver plan generosity.

Policy Option 2 – Option 1 Plus Penalty

This policy option adds to Policy Option 1 by reinstating the mandate tax penalty. The penalty would be set to 2018 levels. This option would encourage greater enrollment than Policy Option 1, while ensuring that the tax penalty is paired with more generous premium support that makes coverage more affordable. The revenue to the state indicated by the model outputs assumes 2018 penalty amounts, but this could grow or shrink depending on the actual penalty levels chosen by policymakers.

Policy Option 3 – Option 2 Plus Reinsurance

This policy option adds to Policy Option 2 by funding a state reinsurance program. The reinsurance program would lower premiums by 10 percent. The goal of this scenario is to provide a mechanism to address affordability challenges for subsidy-*ineligible* consumers who—beyond premium declines associated with improved risk mix—would not benefit directly from the premium support proposed in Policy Options 1 and 2.

Figure 7. Premium Contributions to Policy Options 1-3

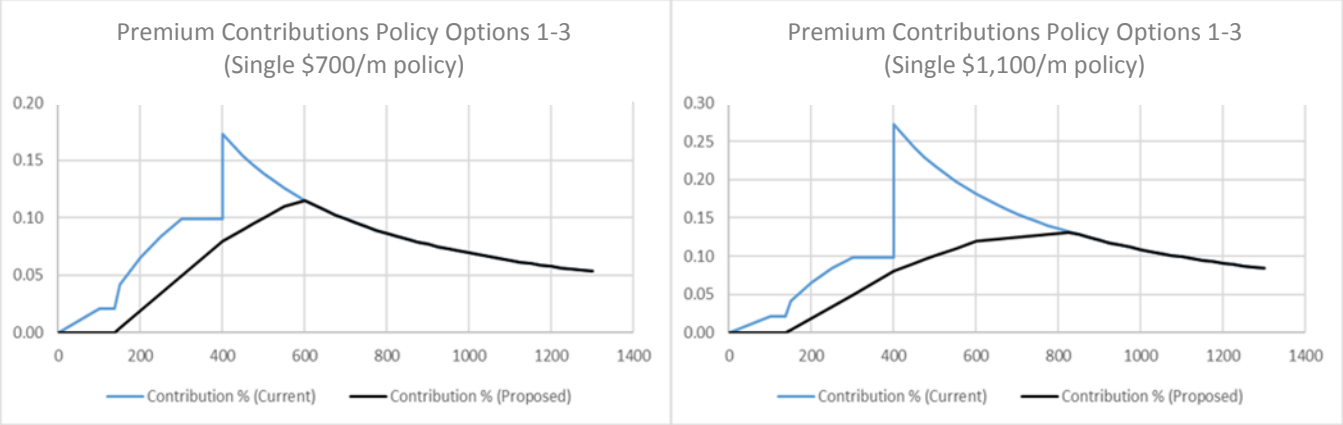
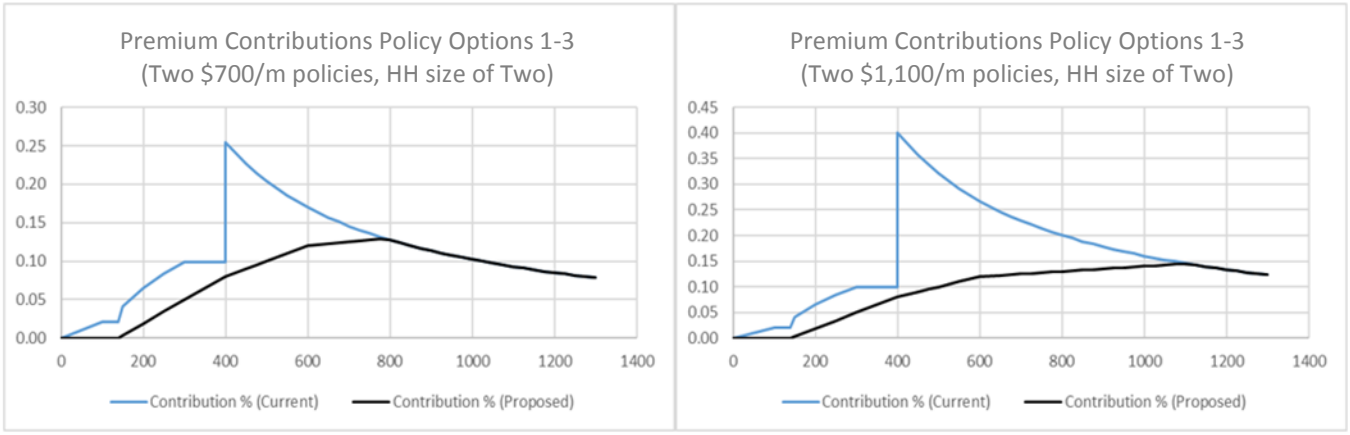


Figure 8. Premium Contributions to Policy Options 1-3



Examples

Table 5 provides hypothetical scenarios to illustrate the impacts of the three Policy Options on different types of consumers. Note: these are not necessarily "average" scenarios, but are rather shown merely to help illustrate how the state policy interventions would help a given consumer.

Table 5. Scenarios Demonstrating Consumer Impact of Policy Options (Monthly Basis)

	Alfonso		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	25	Monthly Premium (SLS)	$350	$343	$333	$299
Region	Low Cost Region	Net Premium	$136	$39	$39	$39
Income	$25,000	Net Prem Income Share	6.54%	1.89%	1.89%	1.89%
FPL	206%					
		Federal Premium Subsidy	$214	$207	$196	$163
		New Premium Subsidy	$0	$96.88	$97	$97
		AV of Silver Plan	73	87	87	87
		Annual Penalty	None	None	$695	$695
	Bianca		**Baseline**	**Policy Option 1**	**Policy Option 2**	**Policy Option 3**
Age	45	Monthly Premium (SLS)	$720	$706	$684	$616
Region	Medium Cost Region	Net Premium	$720	$354	$354	$354
Income	$50,000	Net Prem Income Share	17.28%	8.50%	8.50%	8.50%
FPL	412%					
		Federal Premium Subsidy	$0	$0	$0	$0
		New Premium Subsidy	$0	$351	$330	$261
		AV of Silver Plan	70	70	70	70
		Annual Penalty	None	None	$950	$950
	Cara		**Baseline**	**Policy Option 1**	**Policy Option 2**	**Policy Option 3**
Age	45	Monthly Premium (SLS)	$720	$706	$684	$616
Region	Medium Cost Region	Net Premium	$720	$706	$684	$616
Income	$80,000	Net Prem Income Share	10.80%	10.58%	10.26%	9.23%
FPL	659%					
		Federal Premium Subsidy	$0	$0	$0	$0
		New Premium Subsidy	$0	$0	$0	$0
		AV of Silver Plan	70	70	70	70
		Annual Penalty	None	None	$1,700	$1,700
	Dana and Erin		**Baseline**	**Policy Option 1**	**Policy Option 2**	**Policy Option 3**
Age	62	Monthly Premium (SLS)	$2,250	$2,205	$2,138	$1,924
Region	High Cost Region	Net Premium	$2,250	$578	$578	$578
Income	$75,000	Net Prem Income Share	36.00%	9.25%	9.25%	9.25%
FPL	456%					
		Federal Premium Subsidy	$0	$0	$0	$0
		New Premium Subsidy	$0	$1,627	$1,559	$1,346
		AV of Silver Plan	70	70	70	70
		Annual Penalty	None	None	$3,150	$3,150

Table 5b. Scenarios Demonstrating Consumer Impact of Policy Options (Annual Basis)

	Alfonso		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	25	Annual Premium (SLS)	$4,200	$4,116	$3,990	$3,591
Region	Low Cost Region	Net Annual Premium	$1,635	$473	$473	$473
Income	$25,000	Net Prem Income Share	6.54%	1.89%	1.89%	1.89%
FPL	206%					
		Federal Premium Subsidy	$4,064	$3,980	$3,854	$3,455
		New Premium Subsidy	$0	$1,163	$1,163	$1,163
		AV of Silver Plan	73	87	87	87
		Annual Penalty	None	None	$695	$695
	Bianca		**Baseline**	**Policy Option 1**	**Policy Option 2**	**Policy Option 3**
Age	45	Annual Premium (SLS)	$8,640	$8,467	$8,208	$7,387
Region	Medium Cost Region	Net Annual Premium	$8,640	$4,250	$4,250	$4,250
Income	$50,000	Net Prem Income Share	17.28%	8.50%	8.50%	8.50%
FPL	412%					
		Federal Premium Subsidy	$8,368	$8,195	$7,936	$7,115
		New Premium Subsidy	$0	$4,217	$3,958	$3,137
		AV of Silver Plan	70	70	70	70
		Annual Penalty	None	None	$950	$950
	Cara		**Baseline**	**Policy Option 1**	**Policy Option 2**	**Policy Option 3**
Age	45	Annual Premium (SLS)	$8,640	$8,467	$8,208	$7,387
Region	Medium Cost Region	Net Annual Premium	$8,640	$8,467	$8,208	$7,387
Income	$80,000	Net Prem Income Share	10.80%	10.58%	10.26%	9.23%
FPL	659%					
		Federal Premium Subsidy	$8,204	$8,031	$7,772	$6,951
		New Premium Subsidy	$0	$0	$0	$0
		AV of Silver Plan	70	70	70	70
		Annual Penalty	None	None	$1,700	$1,700
	Dana and Erin		**Baseline**	**Policy Option 1**	**Policy Option 2**	**Policy Option 3**
Age	62	Annual Premium (SLS)	$27,000	$26,460	$25,650	$23,085
Region	High Cost Region	Net Annual Premium	$27,000	$6,938	$6,938	$6,938
Income	$75,000	Net Prem Income Share	36.00%	9.25%	9.25%	9.25%
FPL	456%					
		Federal Premium Subsidy	$26,591	$26,051	$25,241	$22,676
		New Premium Subsidy	$0	$19,523	$18,713	$16,148
		AV of Silver Plan	70	70	70	70
		Annual Penalty	None	None	$3,150	$3,150

Alfonso represents young lower-income consumers. His federal subsidy is $214. To purchase the second lowest Silver plan, Alfonso currently would have to pay $136 per month, after receiving $214 in federal premium tax credits. Under Policy Option 1, California would contribute $97 to Alfonso's monthly premiums, lowering his contribution to $39 per month. Policy Option 2 highlights the tax penalty Alfonso would face if he did not obtain minimum coverage. Policy Option 2 also highlights how further reduction in premiums due to improved risk mix (estimated to be about five percent) lowers federal subsidies, while leaving State subsidies unchanged. A similar effect happens in response to State reinsurance. Moving to Policy Option 3, premiums fall by another 10 percent, generating an equal reduction in Alfonso's premium tax credit.

The benefit of reinsurance to California's consumers can be seen by Cara's example. Cara is self-employed, earning $80,000 per year. Under Policy Option 2, she would pay roughly 10.5 percent of her income for the benchmark Silver plan, which is below the State's premium cap of about 12 percent for someone with her earnings (659 percent FPL). While Cara would not benefit directly from the lower contribution cap subsidy, she would benefit indirectly from premium declines associated with improved risk mix and would benefit from a state reinsurance program. Like Cara, undocumented consumers in the individual market receive no federal or state premium support subsidies so they would benefit directly from declines in premiums due to reinsurance.

The benefit of extending premium support above 400 percent FPL can be seen in Bianca's example. Bianca earns $50,000 per year, just above the earnings threshold where federal premium tax credits phase out (in other words, Bianca is just over the tax credit cliff under the ACA eligibility rules). The premium contribution cap in Policy Options 1-3 dramatically lowers her monthly premiums. Bianca's case also highlights how reductions in gross premiums associated with either improved risk mix or reinsurance triggers savings for the State. This is because the federal government provides no subsidy above 400 percent FPL so that any reduction in premiums above the individual's contribution cap would result in a reduction in the State's new premium subsidy.

Owing to their age and living in a high medical cost area, Dana and Erin currently need to pay $2,250 per month for two policies. Based on their income (they earn 456 percent FPL for a two-person household), their premiums would be capped at around 9.25 percent of household income. The resulting state premium subsidy in Option 1 would lower their monthly premiums by $1,643. Just as with Bianca, any reductions in gross premiums—due to improved risk mix, or a State reinsurance program—will accrue to the state. Dana and Erin's premiums would remain $578 for two policies across Policy Options 1-3.

Summary of Microsimulation Model

The Report forecasts how each of these policies would affect five outcomes within the individual market: total enrollment, coverage rates, metal tier choice, new funding for proposed subsidies, and impacts on federal premium tax credits. Outcomes are reported for the entire individual market, and separately by consumer income.

Analyses are conducted using a microsimulation model. The model uses administrative data on enrollment, premiums, and plan characteristics, as well as survey data, to estimate how changes in premiums and subsidies affect consumer enrollment and plan choice decisions. The model also uses economic theory and the literature to estimate how premiums would respond to changes in market risk. Imposed on to the model are new subsidies, premium reductions and plan characteristics (such as cost sharing reduction benefits) implied by each Policy Option, to simulate premium, enrollment and plan choices, as well as resulting impacts on consumer premium spending and government outlays. See the Technical Appendix for more details.

For all analyses, the baseline model was calibrated to year 2021. Baseline 2021 premiums and income reflect widely-used medical cost inflation the price inflation, respectively. Eligible enrollment, by income, is calibrated to CalSIM 2.2 forecasts. Also assumed is the continued loss of the mandate tax penalty into 2021. Its impact on enrollment are calibrated using estimates from the literature and Covered California

budget estimates. In scenarios that reinstate the tax penalty, incomplete recovery of lost enrollment, due to inertial behavior is assumed. The recent federal compliance rates when estimating penalty tax revenue is also assumed. See the Technical Appendix for more details on calibration assumptions.

Impacts of Policy Options

Policy Option 1 – Enhanced Premium Support and Cost Sharing Reductions

Policy Option 1 results in an increase in enrollment by approximately 260,000 people. Most of the enrollment increase is among individuals earning below 400 percent FPL, who are more responsive to price reductions than higher income earners. Moreover, the enhanced cost-sharing benefit below 400 percent FPL, while not as salient to consumers as premium reductions, will also encourage new enrollment. (Table 6 reports the impacts of Policy Options 1-3.)

The impact on coverage goes beyond enrollment. This Policy Option also leads to increased financial protection among the insured. By design, the enhanced cost sharing reduction benefit increases Silver plan actuarial value from between seven and fourteen percentage points for eligible consumers earning between 150 and 400 percent FPL. Moreover, the market share of Silver plans (or higher) increases from 69 percent to 79 percent in response to newly insured consumers disproportionately enrolling in Silver plans, and existing lower metal tier consumers switching to now-more generous Silver plans, in response to subsidized coverage enhancement offered in Silver.

In total, this Policy Option transfers roughly $2.8 billion per year to California's individual market insured and providers. This consists of $1.5 billion in new funding for additional premium support and $650 million to finance the more generous cost sharing reduction benefit. The increased enrollment among federal subsidy-eligible consumers also triggers increases in federal outlays of $670 million.

Table 6. Summary of Projected Impacts of the Primary Policy Options

	Enrollment Increase		Non-group Coverage Baseline	Non-group Coverage Policy	Market Share In Baseline	Market Share In Policy	New Spending		Changes in Federal APTC	Potential 1332 Waiver	Penalty Inc
Policy Option 1	FPL										
	<250	66,843	0.76	0.82			Premium Support	$1,473,056,994			
	250-400	153,126	0.31	0.44			CSR Reduction	$648,542,271			
	400+	39,448	0.46	0.48			Reinsurance	$0			
	Total	259,416	0.51	0.57	0.69	0.79	Total	$2,121,599,265	$670,499,008	$0	$0
	Enrollment Increase		Non-group Coverage Baseline	Non-group Coverage Policy	Market Share In Baseline	Market Share In Policy	New Spending		Changes in Federal APTC	Potential 1332 Waiver	Penalty Inc
Policy Option 2	FPL										
	<250	119,522	0.76	0.86			Premium Support	$1,765,946,226			
	250-400	341,732	0.31	0.60			CSR Reduction	$676,363,471			
	400+	150,050	0.46	0.56			Reinsurance	$0			
	Total	611,303	0.51	0.66	0.69	0.77	Total	$2,442,309,697	$975,394,880	$0	$480,000,000
	Enrollment Increase		Non-group Coverage Rate Baseline	Non-group Coverage Rate Policy	Market Share In Silver Tier or Baseline	Market Share In Silver Tier or Policy	New Spending Spending		Changes in Federal APTC	Potential 1332 Waiver	Penalty Inc
Policy Option 3	FPL										
	<250	143,409	0.76	0.88			Premium Support	$1,729,786,823			
	250-400	360,518	0.31	0.62			CSR Reduction	$603,617,673			
	400+	241,310	0.46	0.62			Reinsurance	$1,712,027,236			
	Total	745,238	0.51	0.70	0.69	0.79	Total	$4,045,431,732	-$331,425,372	$1,132,430,687	$440,000,000

Policy Option 2 – Option 1 Plus Penalty

Policy Option 2 reinstates the tax penalty on to Policy Option 1. Compared to Policy Option 1, adding the penalty raises enrollment in the individual market by 611,000—or 350,000 more than Policy Option 1—while costing the State only $320 million more per year (or 15 percent more) in new premium support and cost-sharing subsidies. When revenue from the penalty is accounted for, Policy Option 2 would require *less* net spending by the State than Policy Option 1.[30]

Note that the estimated increase of 611,000 reflects enrollment gains generated in the individual market only. This figure understates the effect of the penalty on statewide enrollment, which could include coverage increases in Medicaid and employer-sponsored insurance.

Policy Option 3 – Option 2 Plus Reinsurance

Policy Option 3 adds to Policy Option 2 by providing funding for state reinsurance, sufficient to lower gross premiums by 10 percent. Under this scenario, enrollment in the individual market would increase by over 745,000. As expected, almost all of the enrollment gains over Policy Option 2 come from individuals who do not qualify, or are ineligible, for federal or new state premium subsidies. For subsidy-eligible consumers, the benefit of gross premium reductions is realized as lower subsidy spending. Indeed, the federal premium tax credits expenditures *fall* nearly $330 million per year in aggregate, despite the increased enrollment base.

If obtained by a Section 1332 waiver, this amount would offset new spending in Policy Option 3. Note that the $300 million in total premium tax credit savings reflects the net effect of two factors: reduced premium tax credits per enrollee and increased number of premium tax credit recipients due to the proposed premium and cost-sharing subsidies. If instead the budget impact of reinsurance were isolated (that is, using the *new* enrollment levels as a baseline in premium tax credit savings calculations), estimates show that the reinsurance program reduces federal premium tax credit expenditures by $1.13 billion per year. If obtained by a Section 1332 waiver, the transfer would offset 66 percent of the spending on the proposed reinsurance program.

Note that of the three options, Policy Option 3 generates the largest increases in enrollment, bringing coverage rates in the individual market below 250 percent FPL to 88 percent (from 78 percent), and overall individual market coverage rates to 70 percent (from 51 percent).

Limits to Coverage Expansion

There is a limit to the enrollment increases achievable through premium subsidies and a tax penalty. As conceived, the subsidies do not address the affordability challenges facing undocumented individuals, who make up a sizeable portion of the remaining uninsured in California's individual market (i.e., those ineligible for Medicaid, Medicare, or other public programs, and are not offered employer-sponsored insurance). Even if plans were made affordable, their undocumented status may have a chilling effect on enrollment.[31]

Moreover, achieving universal coverage may be a challenge even among subsidy-eligible consumers. Despite its generosity, any state premium support still requires individual premium contributions, which may deter take-up. Consumers may also lack awareness of subsidy benefits, or may be discouraged from enrolling due to inattention, hassle costs, or other behavioral frictions.[32]

This suggests that increased premium support would still lead to increased enrollment. But as funding increases beyond the levels proposed here, an increasing share of new funding would go toward reducing consumer spending among the already-insured, with decreasing effect on coverage. Increasing coverage rates to near-universal levels would likely require pairing additional funding with fundamental reforms, such as extending benefits to undocumented individuals, and the creation of default or auto-enrollment mechanisms to ease program transitions.

Policy Options Under Budget Constraints

This Report also discusses five "targeted" policy options, as compared to the three primary Policy Options analyzed, above. These budgeted options are limited by a fixed budget starting point. Table 7 summarizes the Fixed Budget Policy Options.

Table 7. Summary of Fixed Budget Policy Options

Policy Objective	Option	Policy Instrument	Fixed Budget Target
Targeted Improved Affordability for People earning <400 FPL	Policy Option F1	Premium support that lowers contribution caps below 400 FPL. Between 138-250 FPL, the new contributions caps rise linearly from 0-8%. Between 250-400 FPL, the new caps rise from 8-9%.	<$500 million/year
Targeted Improve Affordability for People Ineligible for (federal) Premium Subsidies	Policy Option F2	Premium support that caps premium contributions above 400 FPL. New contribution cap is 9.86% at 400 FPL, and rises linearly to 15% at the highest (eliminates the subsidy cliff)	<$500 million/year
	Policy option F3	Reinsurance that lowers premiums 10%	<500 million/year (with 1332 waiver for reinsurance)
Targeted Improve Affordability for People at all incomes	Policy Option F4	Premium support that lowers contribution caps at all incomes. Specifically, -Policy Option 1 for people below 400 FPL; -Cap premium contributions above 400 FPL. Caps rise from 9% at 400 FPL to 15% at the highest (eliminates the cliff).	<$500 million/year
Targeted Improve Affordability across all incomes	Policy Option F5	Premium support that markedly lowers contribution caps at all incomes. Specifically, -Between 138-400 FPL, new caps rise linearly from 0-8%; -Above 400 FPL, caps rise from 9% at 400 FPL to 15% at the highest (eliminating the cliff) Reinstate the mandate tax penalty	<$1.25 billion/year (with penalty income)

Policy Option F1 – Targeted Premium Subsidies Below 400 Percent FPL

This policy option aims to increase affordability of plans for individuals earning under 400 percent FPL and eligible to receive federal tax credits. Under this policy option, the State would lower premium contribution caps, scaled back relative to the primary Policy Options 1-3, above, so that the resulting State spending does not exceed $500 million per year.

Policy Option F2 – Targeted Premium Subsidies Above 400 Percent FPL

This policy option aims to increase affordability of plans for individuals who currently receive no federal tax credits earning above 400 percent FPL. Under this policy option, the State would finance premium support to cap premium contribution for consumers earning above 400 percent FPL. The cap at 400 percent FPL would be set at 9.86 percent and rise linearly to a maximum of 15 percent.[33] This would eliminate the subsidy cliff, and institute a premium cap for all eligible consumers. The contribution cap profile was chosen so that resulting State spending would not exceed $500 million per year.

Policy Option F3 – Reinsurance

This policy option offers an alternative to Policy Option F2 to increase affordability for all federal subsidy-ineligible consumers, not just those earning above 400 percent FPL. Under this policy option, the

State would finance a reinsurance program that lowers premiums in the individual markets by 10 percent. Net of Section 1332 waiver offsets, the resulting State spending would not exceed $500 million per year.

Policy Option F4 – Targeted Premium Subsidies Above and Below 400 Percent FPL

This policy option aims to increase affordability of plans for individuals at all incomes. This scenario lowers premium contribution caps across all incomes (effectively a combination of Policy Options F1 and F2, but with a slight adjustment around 400 percent FPL to eliminate the small discontinuity). Compared to the contribution caps of primary Policy Options 1-3, analyzed earlier, Policy Option F4 institutes smaller reductions in consumer premium contribution, so that the impact on State spending does not exceed $750 million per year.

Policy Option F5 – Targeted Premium Subsidies Above and Below 400 Percent FPL With Penalty

This policy option aims to achieve marked coverage expansions, but at lower cost to the State than the main Policy Options 1-3. To this end, Policy Option F5 institutes the same aggressive reductions in contribution caps as main Policy Options 1-3, and reinstates the penalty in order to generate greater enrollment and penalty income. This options does not, however, include enhanced or extended cost-sharing benefits. This scenario was designed to increase significantly individual market coverage rates, but without state spending exceeding $1.25 billion per year, net of tax penalty income.

Table 8. Summary of Projected Impacts of Fixed Budget Policy Options

	Enrollment Increase		Non-group Coverage Baseline	Non-group Coverage Policy	New Spending		Changes in Federal APTC	Potential 1332 Waiver	Penalty Inc
Option F1	FPL								
	<250	29,134	0.76	0.79	Premium Support	$425,126,453			
	250-400	29,180	0.31	0.34	CSR Reduction	$0			
	400+	11,484	0.46	0.46	Reinsurance	$0			
	Total	69,799	0.51	0.52	Total	$425,126,453	$124,186,222	$0	$0
	Enrollment Increase		Non-group Coverage Baseline	Non-group Coverage Policy	New Spending		Changes in Federal APTC	Potential 1332 Waiver	Penalty Inc
Option F2	FPL								
	<250	986	0.76	0.76	Premium Support	$286,312,821			
	250-400	448	0.31	0.31	CSR Reduction	$0			
	400+	20,694	0.46	0.47	Reinsurance	$0			
	Total	22,128	0.51	0.51	Total	$286,312,821	-$44,262,793	$0	$0
	Enrollment Increase		Rate Baseline	Rate Policy	New Spending		Changes in Federal APTC	Potential 1332 Waiver	Penalty Inc
Option F3	FPL								
	<250	19,805	0.76	0.78	Premium Support	$0			
	250-400	10,491	0.31	0.32	CSR Reduction	$0			
	400+	82,385	0.46	0.51	Reinsurance	$1,452,639,554			
	Total	112,681	0.51	0.54	Total	$1,452,639,554	-$877,780,174	$877,780,174	$0
	Enrollment Increase		Non-group Coverage Baseline	Non-group Coverage Policy	New Spending		Changes in Federal APTC	Potential 1332 Waiver	Penalty Inc
Option F4	FPL								
	<250	31,496	0.76	0.79	Premium Support	$707,257,795			
	250-400	30,443	0.31	0.34	CSR Reduction	$0			
	400+	35,211	0.46	0.48	Reinsurance	$0			
	Total	97,150	0.51	0.53	Total	$707,257,795	$45,504,385	$0	$0
	Enrollment Increase		Non-group Coverage Baseline	Non-group Coverage Policy	New Spending		Changes in Federal APTC	Potential 1332 Waiver	Penalty Inc
Option F5	FPL								
	<250	113,240	0.76	0.86	Premium Support	$1,695,273,315			
	250-400	313,220	0.31	0.58	CSR Reduction	$0			
	400+	141,646	0.46	0.55	Reinsurance	$0			
	Total	568,106	0.51	0.65	Total	$1,695,273,315	$913,264,529	$0	$505,000,000

Impacts of Fixed Budget Policy Options

Policy Option F1 – Targeted Premium Subsidies Below 400 Percent FPL

The policy option causes total individual market enrollment to rise by roughly 70,000. Most of this enrollment, as expected, is in the below-400 FPL segment, where this scenario targets premiums subsidies. The premium declines due to modest improvements in the risk mix leads to an increase among the unsubsidized segments of the market.

Note that without additional cost-sharing benefits, this policy option (as with Policy Options F2-F5), induces only small shifts to Silver or higher metal tiers.[34] This policy option would require roughly $425 million per year in State spending. Table 8 summarizes the impacts of Policy Options F1-F5.

Policy Option F2 – Targeted Premium Subsidies Above 400 Percent FPL

Compared to Policy Option F1, the per dollar impact of premium subsidies directed to higher income consumers has a smaller impact than when directed towards lower income consumers, who are more price-elastic. The modest impact also highlights the absence of the penalty, which when paired with slightly more generous premium support in Policy Option 2, resulted in significantly more enrollment above 400 percent FPL. The small reduction in federal advanced premium tax credits is a byproduct of the decline in gross premiums due to the small improvement in risk mix associated with the increased enrollment.

Policy Option F3 – Reinsurance

Reinsurance lowers premiums by 10 percent, resulting in improved affordability among consumers who are ineligible for federal tax credits. The increase in enrollment of 113,000 occurs almost entirely among people earning above 400 percent FPL, and to a lesser extent, consumers below 400 percent FPL purchasing in the off-exchange market. Among subsidy-eligible consumers, lower gross premiums trigger a commensurate decrease in federal tax credits, leaving net-of-subsidy premiums unchanged. Total federal savings is about $880 million per year. If transferred to the State as part of a Section 1332 waiver, this amount represents 60 percent of State spending on reinsurance, reflecting the fraction of the individual market in this scenario that is subsidized by federal tax credits.

Policy Option F4 – Targeted Premium Subsidies Above and Below 400 Percent FPL

Policy Option F4 is essentially a combination of options F1 and F2. Targeting modest subsidies above and below 400 FPL, and eliminating the subsidy cliff, raises enrollment about 100,000, with increases spread evenly across the income distribution.

Policy Option F5 – Targeted Premium Subsidies Above and Below 400 Percent FPL With Penalty

This scenario increases enrollment by nearly 568,000, only slightly lower than the gains achieved in main Policy Option 2 (which contained a more generous cost-sharing benefit). The increase in enrollment is associated with improved risk and lower gross premiums (by approximately 5-6 percent), which leads to a lower per enrollee federal tax credit, and lower per enrollee State premium subsidy for consumers above 400 FPL. The net effect of increased enrollment and lower gross premiums is an increase in federal outlays by roughly $913 million per year, and $1.70 billion in State premium subsidies.

IMPLEMENTATION CONSIDERATIONS

[RESERVED]

APPENDIX I

STATUTORY LANGUAGE OF AB 1810 (2018)

100503.3. (a) The Exchange, in consultation with stakeholders and the Legislature, shall develop options for providing financial assistance to help low- and middle-income Californians access health care coverage. On or before February 1, 2019, the Exchange shall Report those developed options to the Legislature, Governor, and Council on Health Care Delivery Systems, established pursuant to Section 1001 of the Health and Safety Code, for consideration in the 2019–20 budget process.

(b) In developing the options, the Exchange shall do both of the following:

(1) Include options to assist low-income individuals who are paying a significant percentage of their income on premiums, even with federal financial assistance, and individuals with an annual income of up to 600 percent of the federal poverty level.

(2) Consider maximizing all available federal funding and, in consultation with the State Department of Health Care Services, determine whether federal financial participation for the Medi-Cal program would otherwise be jeopardized. The Report shall include options that do not require a federal waiver authorized under Section 1332 of the federal act, as defined in subdivision (e) of Section 100501, from the United States Department of Health and Human Services.

(c) The Exchange shall make the Report publicly available on its Internet Web site.

APPENDIX II

STAKEHOLDER WORKGROUP MEMBERS

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Robert O'Reilly, Molina Healthcare
Robert Spector, Blue Shield
Teri Boughton, Senate Committee on Health
Wendy Soe, California Association of Health Plans

Board Member Participants
Jerry Fleming
Sandra Hernandez

Covered California's Affordability Webpage:
https://hbex.coveredca.com/stakeholders/AB_1810_Affordability_Workgroup/index.shtml

APPENDIX III

FEDERAL POVERTY LEVEL FOR 2019

FEDERAL POVERTY LEVEL FOR 2019									
		SILVER 94 (100%-150%)		SILVER 87 (>150%-200%)	SILVER 73 (>200%-250%)				
	% OF FPL	100%	150%	200%	250%	300%	400%	600%	1200%
HOUSEHOLD SIZE	1	$12,140	$18,210	$24,280	$30,350	$36,420	$48,560	$72,840	$145,680
	2	$16,460	$24,690	$32,920	$41,150	$49,380	$65,840	$98,760	$197,520
	3	$20,780	$31,170	$41,560	$51,950	$62,340	$83,120	$124,680	$249,360
	4	$25,100	$37,650	$50,200	$62,750	$75,300	$100,400	$150,600	$301,200
	5	$29,420	$44,130	$58,840	$73,550	$88,260	$117,680	$176,520	$353,040
	6	$33,740	$50,610	$67,480	$84,350	$101,220	$134,960	$202,440	$404,880
	7	$38,060	$57,090	$76,120	$95,150	$114,180	$152,240	$228,360	$456,720
	8	$42,380	$63,570	$84,760	$105,950	$127,140	$169,520	$254,280	$508,560
	additional person add	$4,320	$6,480	$8,640	$10,800	$12,960	$17,280	$25,920	$51,840

APPENDIX IV

2019 PATIENT-CENTERED BENEFIT DESIGNS

COVERED CALIFORNIA

2019 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers 0% until out-of-pocket maximum is met	Covers 60% average annual cost	Covers 70% average annual cost	Covers 73% average annual cost	Covers 87% average annual cost	Covers 94% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	$24,281 to $30,350 (>200% to ≤250% FPL)	$18,211 to $24,280 (>150% to ≤200% FPL)	up to $18,210 (100% to ≤150% FPL)	N/A	N/A
Annual Wellness Exam	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Vist	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	$75*	$40	$35	$15	$5	$30	$15
Urgent Care		$75*	$40	$35	$15	$5	$30	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$105*	$80	$75	$25	$8	$55	$30
Emergency Room Facility		Full cost until deductible is met	$350	$350	$100	$50	$325	$150
Laboratory Tests		$40	$35	$35	$15	$8	$35	$15
X-Rays and Diagnostics		Full cost until deductible is met	$75	$75	$30	$8	$55	$30
Imaging			$300	$300	$100	$50	$275 copay or 20% coinsurance***	$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	Full cost up to $500 after drug deductible is met	$15**	$15**	$5 or less	$3 or less	$15 or less	$5 or less
Tier 2 (Preferred Drugs)			$55**	$50**	$20**	$10 or less	$55 or less	$15 or less
Tier 3 (Non-preferred Drugs)			$80**	$75**	$35**	$15 or less	$75 or less	$25 or less
Tier 4 (Specialty Drugs)			20% up to $250** per script	20% up to $250** per script	15% up to $150** per script	10% up to $150 per script	20% up to $250 per script	10% up to $250 per script
Medical Deductible	N/A	Individual: $6,300 Family: $12,600	Individual: $2,500 Family: $5,000	Individual: $2,200 Family: $4,400	Individual: $650 Family: $1,300	Individual: $75 Family: $150	N/A	N/A
Pharmacy Deductible	N/A	Individual: $500 Family: $1,000	Individual: $200 Family: $400	Individual: $175 Family: $350	Individual: $50 Family: $100	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$7,900 individual only	$7,550 individual $15,100 family	$7,550 individual $15,100 family	$6,300 individual $12,600 family	$2,600 individual $5,200 family	$1,000 individual $2,000 family	$7,200 individual $14,400 family	$3,350 individual $6,700 family

Drug prices are for a 30 day supply.

* Copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, future visits will be at full cost until the medical deductible is met.

** Price is after pharmacy deductible amount is met.

*** See plan Evidence of Coverage for imaging cost share.

APPENDIX V

MICROSIMULATION METHODOLOGY AND DATA

[RESERVED]

APPENDIX VI

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ENDNOTES

[1] Chapter 655, California Statutes of 2010 (AB 1602). http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=200920100AB1602.

[2] 42 U.S. Code § 18022. See also: https://www.healthcare.gov/glossary/essential-health-benefits/.

[3] 26 U.S. Code § 5000A.

[4] 42 U.S. Code § 18061. See also: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html.

[5] https://hbex.coveredca.com/data-research/

[6] Covered California's supplemental guidance on rate filing instructions related to the cost sharing reduction program for the 2018 plan year, https://board.coveredca.com/meetings/2017/06-15/Background/Covered-CA-CSR%20Supplemental%20Rate%20Filing%20Instructions%206-6-17.pdf.

[7] Covered California's Health Insurance Companies and Plan Rates for 2019, p.7.

[8] Bingham A, Cohen M, Bertko J, National vs. California Comparison: Detailed Data Help Explain The Risk Differences Which Drive Covered California's Success, July 11, 2018.

[9] Bingham A, Cohen M, Bertko J, National vs. California Comparison: Detailed Data Help Explain The Risk Differences Which Drive Covered California's Success, July 11, 2018.

[10] Enrolled based on Covered California Active Member Profile from June 2016 and Wilson K, California Insurers Hold on to Previous Gains, California Health Care Foundation Blog, July 13, 2017. Uninsured based on UCLA-UCB CalSIM 2.2. Take-up rate equals ([Enrolled] /[Enrolled + Uninsured]).

[11] Lucia L and Jacobs K, Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment, UC Berkeley Labor Center, March 2018, p.2.

[12] Fung v, Liang C, Hsu J, Perceptions Among Individual Insurance Market Enrollees in California in 2017, California Health Care Foundation, May 31, 2018.

[13] Fung v, Liang C, Hsu J, Perceptions Among Individual Insurance Market Enrollees in California in 2017, California Health Care Foundation, May 31, 2018.

[14] Ibid.

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[22] Fung, V, et al., Potential Effects Of Eliminating The Individual Mandate Penalty In California, Health Affairs, Vol 38:1, January 2019.

[23] Dietz M, Lucia L, et al. California's Health Coverage Gains to Erode Without Further State Action, November 2018, p.7

[24] UCLA-UC Berkeley CalSIM version 2.2. Uninsured estimates rounded to the nearest 10,000 individuals. Excludes undocumented immigrants who are not eligible for subsidies or to purchase coverage through Covered California, and uninsured individuals eligible for Medi-Cal.

[25] Dietz M, Lucia L, et al., California's Health Coverage Gains to Erode Without Further State Action, November 2018, p.2.

[26] Due to single risk pool pricing, insurers must set a common age-rated price for the same plan in both Covered California and the off-exchange markets. Reduction in costs in one market will lead lower premiums in both individual markets, equally.

[27] [RESERVED]

[28] Individuals induced into coverage by a mandate penalty will typically be healthier than individuals enrolled by choice. Indeed, plans priced in a 3.5-4% increase in 2019 premiums in response to anticipated increases in average risk in only the first year following the loss of the mandate penalty. By 2021, the effect would be larger. In the first year of its reinstatement, the penalty would partially reverse this negative risk mix and premium impact.

[29] In these Policy Options, the contribution cap rises linearly to 15 percent at 1,200% FPL, roughly where the subsidy would naturally phase out for two-person household purchasing two 64-year old benchmark Silver plans in the most expensive region in California.

[30] This assumes that the State enforces tax penalty with the same compliance rate (approximately 75 percent in 2017) as the federal government.

[31] Note that coverage take-up estimates presented in this report – based on custom tabulations from the CalSIM 2.2 model – already assume remove the undocumented (per CalSIM) from the universe of potential non-group enrollees. Alsan, M. et al (2019)

[32] [RESERVED]

[33] As with the contribution caps imbedded in primary Policy Options 1-3, the contribution cap in Option F2 rises to 15 percent at 1200 FPL, roughly where the subsidy would naturally phase out for two-person household purchasing two 64-year old benchmark Silver plans for two 64-year old policies in the most expensive region in California.

[34] The increase in premium subsidies encourages a small shift from Bronze to higher metal tier plans. And without additional cost sharing reduction benefits, new healthier enrollees do not disproportionately enroll in Silver plans.