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April 25, 2018

Mr. Alex Azar, Secretary of the Department of Health and Human Services
Ms. Seema Verma, Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Results of 2018 Open Enrollment and Planning for 2019; Opportunities to Lower Costs for Millions of Unsubsidized Americans

Secretary Azar and Administrator Verma,

With this letter and attached documents, Covered California is providing observations of the most recent open-enrollment period and, based on our experience, highlighting the opportunity of the administration to act to directly lower premiums for millions of Americans in 2019 by investing in marketing. These comments are anchored in the economic realities of the individual market and reflect the recently released enrollment summary for 2018 open-enrollment period. (*CMS' final report shows 11.8 million consumers enroll in 2018 Exchange coverage nationwide.)* In providing this letter, the attached analysis and the issue brief released today, "*Individual Insurance Markets: Enrollment Changes in 2018 and Potential Policies that Could Lower Premiums and Stabilize the Markets in 2019*," we hope to inform the planning efforts of the Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS) for the upcoming plan year.

The individual market is in flux due to several recent decisions at the federal level, including the impending removal of the penalty for not having coverage on those who could otherwise afford it. Covered California recently commissioned a report that found that millions of middle-class Americans face the possibility of premium increases ranging from 12 to 32 percent in 2019 as a result of this and other factors. These premium increases could reflect a three year cumulative rise of over 90 percent in many states absent federal or state action. While there are several policies that could ameliorate these increases that would require legislation, the CMS report's discussion of the marketing cutbacks indicates that the one change that can be made immediately to save consumers and taxpayers literally billions dollars is not being given due consideration. That policy is restoring and increasing critical investments in marketing and outreach that would reduce premiums by promoting enrollment and increasing the overall health of the consumer pool.

Board Members: Diana S. Dooley, Chair Paul Fearer Jerry Fleming Dr. Sandra Hernandez Art Torres Executive Director: Peter V. Lee

Looking ahead to 2019, health insurance companies across the nation will be making pricing and participation decisions in the next two months. With bipartisan agreement on the need for policies to stabilize the individual market and protect middle class Americans, Congressional leaders on both sides of the aisle worked hard to develop a stabilization package for 2019 and beyond. While there was broad agreement on policy approaches, including funding for marketing and outreach, consensus to move forward on a legislative package was not reached. However, the administration can take positive steps in the coming months to actively promote enrollment for the upcoming year. Health insurance companies nationally would consider these steps in their pricing and would reduce proposed premiums on the expectation that marketing would attract and retain a better risk mix.

The reality is clear: If the federal government maintains the current cuts in marketing and outreach, premiums will be higher than necessary, consumers will be hurt as a result and taxpayers will pay the price by supporting higher the necessary subsidies. This does not need to happen and can easily be avoided. Announcing and describing a credible marketing program would result in health plans being able to price based on a better enrollment.

The Decision to Invest in Marketing Can Be Made Now to Promote Lower Costs

The decision to support lower premiums through marketing investments is wholly in the hands of the administration and does not require an appropriation from Congress. Health plans that serve consumers in the 39 federally facilitated marketplace (FFM) states pay an assessment to CMS to recoup the costs for exchange functions, including marketing and outreach.[1] Based on the CMS Budget Justification for FY 2019, plan assessment revenue is estimated to be $1.2 billion for 2018. [2] If the FFM allocated the same one-third of its health plan assessment revenue on marketing and outreach, as did Covered California, it would invest more than $400 million on marketing and outreach.

CMS is not starting from scratch. The agency has an existing contract with a nationally recognized marketing and communications firm that has worked on FFM marketing and outreach for years.[3] The creative assets and media plans that already exist can be rapidly adjusted or adopted.

It is also not too late to act. The best time to secure media inventory — placements in television, radio, digital and other locations — is still several months out (July and August), allowing adequate time for planning and getting the best possible deals. In addition to the creative assets that CMS already owns or that could be created by its vendor we at Covered California would be happy to make our creative assets available for use. California and the other state-based marketplaces have creative assets that any of us would happily share.

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[1] Section 1311(d)(5)(A) of the Affordable Care Act and 45 CFR 155.160.

[2] Plan assessment revenue for the 2018 FY is estimated to be $1.2 billion (see page 7 of the Centers for Medicare and Medicaid Services' FY 2019 budget justification document, available at - https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2019-CJ-Final.pdf).

[3] Covered California and CMS have both utilized Weber Shandwick for marketing and outreach.

The Data From the 2018 Open-Enrollment Period Confirms the Negative Impact on Enrollment and Risk Mix From Cutting Back on Marketing

Covered California's observations are based on our five years of experience in fostering a robust and competitive market that is working for consumers — both those receiving subsidies and the more than 1 million unsubsidized Californians purchasing in and outside of our exchange. Covered California enrolled 423,484 new consumers in the most recent open-enrollment period for 2018, a 3 percent increase over the previous year. Overall, Covered California's total enrollment has remained relatively stable since 2016, and we finished the most recent open enrollment period with a total of 1.5 million consumers. Taken together, state-based marketplaces (SBMs) have seen similar stability in total enrollment, averaging roughly 3 million total consumers, with a total of 800,000 new plan selections during *each* of the past three open-enrollment periods.

In contrast, while the CMS press release says the 2018 open enrollment period was the "most cost effective and successful experience for HealthCare.gov consumers to date," and "enrollment stayed essentially the same," the underlying data highlight reasons for significant concern and underscore the direct effect of administration policy decisions to reduce marketing and outreach efforts on dampening enrollment and leading to higher premiums. Data includes:

- Total enrollment in the FFM decreased by 5 percent over last year and by 9 percent since its peak in 2016, which amounts to 900,000 fewer consumers signing up. The 9 percent decline is significant and did not occur in the states that were served by SBMs.

- The primary reason for the overall number of FFM enrollees "only" dropping by 5 percent in the past year was that renewal rates of existing consumers have remained high — driven substantially by the fact that the average net premium (after the Advanced Premium Tax Credit, or APTC, was applied) ***dropped*** by 16 percent in the FFM states. It is good news, but not surprising, to see strong renewal rates among the 85 percent of FFM enrollees receiving subsidies when on average they saw significant reductions in their premiums.

- While new enrollees eligible for subsidies would also have benefited from premiums that would have been 16 percent *lower* compared to the prior year, there was a substantial drop in "new enrollment" in 2018, down 18 percent from the previous open-enrollment period (from 3.0 to 2.5 million) and 39 percent from 2016 (from 4.0 to 2.5 million). In the same period, new enrollment in SBM states was constant.

Drops in new enrollment are a formula for a worse risk mix and higher premiums — premiums that will be borne by unsubsidized Americans and by taxpayers who will be paying for larger tax credits to those receiving subsidies. We are deeply concerned that this will mean consumers in states relying on the FFM are increasingly priced out of coverage, in part because of policy decisions to pull back on marketing.

Marketing Matters in the Individual Market and Drives Lower Premium by Improving the Risk Mix

As we detailed in our letter to CMS last September, there is clear and compelling evidence that a robust marketing and outreach campaign is critical to attract new consumers and address the reality that the individual market is one with substantial "churn." Our report, Marketing Matters, detailed how Covered California's extensive marketing and outreach campaigns contributed to one of the best take-up rates and lowest risk scores in the nation. In 2015 and 2016, California's lower risk score translated to costs that were 20 percent lower than the national average, saving consumers and the federal government $2.6 billion during this period. Covered California's marketing and outreach investment in 2015 and 2016 likely lowered premiums by 6 to 8 percent, resulting in healthier consumers enrolling because of the reduced price of insurance, which further drives down premiums and helps create a cycle of stability.

While the FFM is in the midst of a troubling downward trend in enrollment, the SBMs, which are in charge of their own marketing and outreach, fared much better with a 1.5 percent increase in total enrollment since 2016.[4]

A decision to continue the adopted policy of reduced marketing — when the FFM has collected an assessment from health plans based on the assumption that they would engage active promotion — will hurt millions of Americans, particularly those consumers who do not receive any financial help, and leave even fewer people insured. A clear commitment to either directly spend such funds, or to provide those funds to states to use to promote coverage in their state, could have a meaningful impact on rates for 2019.

An earlier analysis by Covered California estimated that if the FFM increased its marketing investment over three years, it would likely pay off with more than 1.4 million more Americans getting insurance and premiums that are 3 percent lower, yielding a more than six-to-one return on investment. A 3 percent premium reduction would mean a reduction of premiums of more than $1.6 billion dollars in 2019 alone, and a cumulative savings of $6.6 billion for the period of 2019 through 2021 (see attached for details). There are two primary beneficiaries of these savings: the millions of Americans who do not receive subsidies and taxpayers who pay a substantial portion of the premiums for those who do receive subsidies.

Understanding Individual Market Dynamics Is Vital to Informing Effective Policies

The core of this communication is to make sure that the leadership of DHHS and CMS understand the direct negative effects that will result from a decision to not fund marketing and outreach. At the same time, we are writing because of our concern that other elements of the CMS release summarizing the 2018 open-enrollment period reflect incomplete analysis or a fundamental misunderstanding of the market dynamics of individual health insurance costs,

[4] This figure examines enrollment in the 12 states currently operating their own marketplace because Kentucky switched to the federal platform in 2017.

pricing and factors considered by consumers and health plans. In the spirit of our continued efforts to collaborate and share our perspective, please see the attached document describing those issues: (Attachment: Covered California's Review of CMS's Analysis of the 2018 Open-Enrollment Period).

Conclusion: Putting Patients First

The federally facilitated marketplace, Covered California and state exchanges across the country are preparing to begin negotiations and planning for the upcoming 2019 coverage year. It is important to underscore that promoting the availability of coverage through Healthcare.gov can and should be done in ways that are about letting consumers — many eligible for financial help — know what is available and making sure they shop to make the best informed decision possible. In California, our core message is "Life can change in an instant," and health insurance is more affordable than you may think it is, so shop and find out for yourself. Our messages emphasize the value of health insurance, and that health insurance makes a difference in people's lives and provides protection from high medical costs.

We stand ready to assist you in any way we can to protect the coverage available in individual markets across the nation. Feel free to contact me if you would like to discuss this further.

Sincerely,

Peter V. Lee
Executive Director

Attachments:

- Covered California's Review of CMS's Analysis of the 2018 Open-Enrollment Period
- Individual Insurance Markets: Enrollment Changes in 2018 and Potential Policies that Could Lower Premiums and Stabilize the Markets in 2019

cc:
The Honorable Mitch McConnell, Majority Leader, United States Senate
The Honorable Charles Schumer, Democratic Leader, United States Senate
The Honorable Paul Ryan, Speaker, United States House of Representatives
The Honorable Kevin McCarthy, Majority Leader, United States House of Representatives
The Honorable Nancy Pelosi, Democratic Leader, United States House of Representatives
Randy Pate, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight
Covered California Board of Directors

April 23, 2018

Submitted electronically via www.regulations.gov

Alex Azar
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Re: Covered California Comments On Short-Term, Limited-Duration Insurance Proposed Regulations; CMS–9924–P (RIN 0938-AT48)

Dear Secretary Azar, Secretary Acosta, and Secretary Mnuchin:

Covered California submits these comments in response to the proposed regulations CMS-9924-P. These comments are informed by Covered California's five-year experience of effectively implementing policies to best serve the needs of California's consumers, and highlight concerns we have with regard to the impacts that short-term, limited-duration insurance (STLDI) could have on consumers and the individual health insurance market. We believe that as proposed, these regulations will have a significant deleterious impact on the entire individual health insurance market and will cause insurance carriers to revert back to a business model that relies on risk selection. To the extent that the Departments of Health and Human Services, Labor and Treasury (Departments) continue to pursue these regulations, we offer the following comments.

Board Members: **Diana S. Dooley, Chair** **Paul Fearer** **Jerry Fleming** **Dr. Sandra Hernandez** **Art Torres** Executive Director: **Peter V. Lee**

Preserving State Flexibility

Covered California appreciates that the Departments will continue to allow state flexibility to regulate STLDI. We believe that states are in the best position to regulate such coverage in their respective markets.

Expanding STLDI Increases Adverse Selection, Erodes Consumer Protections, and Leaves Consumers with Less Coverage for Needed Care

Historically, STLDI has been utilized to fill short gaps in health coverage, allowing consumers to access cheap coverage without many of the protections afforded to ACA-compliant plans. STLDI is excluded from the definition of individual health insurance under the Public Health Service Act, and thus is not required to provide various and important consumer protections that apply to ACA-compliant plans. As such, the business model for STLDI has historically been driven by medical underwriting, allowing carriers to deny coverage to applicants with pre-existing conditions. Additionally, carriers have been able craft policies which provide less coverage, impose annual and lifetime limits on benefits, and set excessive cost-sharing limits.

STLDI is also not subject to the federal Medical Loss Ratio (MLR) requirement that health plans spend at least 80 cents of every premium dollar on medical costs and quality care improvements. The Kaiser Family Foundation recently reported that the MLR for the top two STLDI carriers, which accounted for 80 percent of policies sold in 2016, was 50 percent.[1] This provides an opportunity for issuers to heavily market their products to young and healthy individuals. We are concerned that the proliferation of these plans will result in carriers competing on risk selection, not price and quality.

While this business model may work for some health insurance companies, consumers who enroll in STLDI will likely have less coverage and be left with uncovered medical bills when accessing needed care. As noted in the preamble, consumers who switch from ACA-compliant health coverage will likely lose access to certain essential services and providers, and may be exposed to high out-of-pocket costs and greatly increased deductibles. Consumers may also face increased financial liability if they get sick or are injured while covered under a STLDI plan.

Moreover, it is estimated these regulations would increase the number of people without comprehensive, minimum essential coverage by 2.6 million in 2019. Of the 36.9 million people without minimum essential coverage, 32.6 million would be completely uninsured.[2]

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[1] Understanding Short-Term Limited Duration Health Insurance

[2] Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending

Comprehensive Noticing Needed

The lack of consumer protections offered in STLDI plans underscores the need for clear and thorough noticing requirements. The proposed rule would revise the required notice that must appear prominently in the STLDI plan contract and in any application materials.

We agree with the Departments' concerns that expanding STLDI coverage to last almost 12 months may make it more difficult for consumers to distinguish it from ACA-compliant coverage. As such, we are particularly concerned that the proposed notice requirements do not go far enough to ensure proper disclosure of the differences between STLDI and ACA-compliant insurance. Specifically, the proposed notice language does not clearly indicate to consumers that STLDI does not provide many of the core ACA consumer protections, such as essential health benefit requirements, out-of-pocket cost limits, premium rating ratios, MLR standards, prohibitions on underwriting, and guaranteed availability. We are concerned that the current notice requirements will create a false assurance for consumers that they have coverage for benefits they do not have.

We recommend that the required federal disclosures for STLDI include understandable cost scenarios that illustrate how certain conditions; such as, childbirth, managing diabetes, a cardiac event or cancer, would be covered. This will ensure consumers can make informed choices and understand the tradeoff between premiums and out-of-pocket costs. Furthermore, we recommend that the Departments provide states with the flexibility to modify the required federal notice as long as the state-required notice is at least as consumer protective as the federal notice. States may take different approaches to regulating STLDI plans and depending on how a state implements these regulations, the required federal notice language may not be sufficient or applicable. By granting flexibility to states, notice requirements could better account for variations in state implementation of STLDI.

Potential for Negative Impact to Risk Pool

In the preamble, the Departments acknowledge that individuals who may be inclined to purchase STLDI plans are likely to be relatively young or healthy. Although California has a successful marketplace, with a healthy risk pool mix, we are concerned about healthy consumers being drawn away from the individual market and into STLDI plans. When combined with other recent policy changes, such as the elimination of the individual mandate penalty, the decrease in federal investment in advertising and enrollment assistance, and the loosening of restrictions on association health plans, marketplaces could face both a rise in premiums, as well as a decrease in enrollment in 2019.

To the extent there is a reduction in enrollment due to the availability of STLDI plans, it will result in a worsening of the risk pool and higher premiums for the entire individual market in future years. While subsidized consumers would be insulated from these

premium increases, the nearly 6 million unsubsidized, middle-income Americans in ACA-compliant plans will pay for 100 percent of premium increases resulting from disruption in the risk pool. This means that unsubsidized consumers who are not young and healthy, or, consumers who are young and healthy and want minimum essential health coverage that protects them when they need it, will have to pay more for it. These are not high-income individuals, as they have median incomes of $75,000 ($66,000 for individuals aged 19–64).[3]

Finally, we want to underscore that more choice does not always equate to better choice. While STLDI may provide healthy consumers with more coverage options, less healthy consumers, particularly those who do not qualify for premium tax credits or cost-sharing reductions, would either face higher premiums or be ineligible for STLDI plans.

Thank you for your consideration of our comments. If you have any questions or would like more information, please feel free to contact me.

Sincerely,

Peter V. Lee
Executive Director

cc: Covered California Board of Directors

[3] The Roller Coaster Continues — The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies

California Health Care Foundation

April 2018

Issue Brief

Short-Term, Limited-Duration Insurance and Risks to California's Insurance Market

California has made dramatic progress in expanding insurance coverage through the implementation of the Affordable Care Act (ACA). But the expansion of short-term, limited-duration insurance could put California's consumers — and the stability of its individual health insurance market — at risk. This paper provides an overview of the short-term insurance market in California, analysis of how changes to federal policy are likely to affect it, and policy options the state could pursue to ensure that consumers are able to purchase affordable, comprehensive insurance.

Short-term, limited-duration insurance (short-term plans or short-term insurance) is a health insurance product designed to provide insurance that protects consumers during short gaps in full coverage. Under federal law, these products do not need to comply with the consumer protections of the Affordable Care Act (ACA). Short-term insurers can deny coverage based on a person's preexisting health conditions or other factors. Short-term insurance typically covers a limited set of services and has dollar limits on claims the plan will pay.

Combined with the elimination of the individual mandate penalty, recently proposed changes to federal regulation of short-term plans could expand enrollment in — and encourage new insurers to enter — the short-term insurance market. Insurers may promote products designed to be a cheaper alternative to comprehensive individual-market plans that comply with the ACA's consumer protections and benefit requirements (plans that are ACA-compliant). Since premiums are lower for short-term plans due their limited benefits and the ability to deny coverage to people with preexisting conditions, healthy people could be siphoned out of the individual market risk pool, including Covered California. As a result, consumers looking for comprehensive coverage may find themselves facing significantly higher premiums and fewer choices in the ACA-compliant market.

But the expansion of short-term, limited-duration insurance could put California's consumers — and the stability of its individual health insurance market — at risk.

Methodology

To understand the short-term insurance market in California, the researchers reviewed relevant state and federal statutes and regulations, conducted a market analysis to see what kinds of short-term insurance plans are available for sale in California, and completed 21 structured interviews with key informants. This research provided background both on the history and current state of the short-term market and on how evolving federal regulations are likely to affect the individual health insurance market, including Covered California. The interviews included four state officials, eight brokers and agents, two insurers that are currently or have recently sold products in the short-term market, three insurers selling individual market coverage through Covered California, and four experts on California insurance markets.

What Are Short-Term Plans?

Short term plans, referred to in federal and California law as "short-term limited-duration insurance," are promoted as an option to provide health insurance for consumers with brief gaps as they move from one coverage source to another. A common example of a person who might enroll in a short-term plan is somebody who changes jobs and has a waiting period before their new employee benefits start. Prior to the ACA, this person had limited options for purchasing insurance on their own, particularly if they had preexisting conditions.[1] The ACA provides an opportunity for most people losing one form of coverage to enroll in ACA-compliant insurance through a special enrollment period, often with a premium subsidy, regardless of any preexisting conditions. However, the ACA did not eliminate short-term plans — all of which are specifically exempted from federal consumer protections and requirements that apply to other health insurance products — from the market.

How Are Short-Term Plans Currently Regulated?

The federal government defines short-term plans in regulations issued by the Departments of Health and Human Services, Labor, and Treasury. Prior to 2016, federal regulations limited the duration of short-term plans to less than 12 months, and allowed consumers to extend the contract duration with the consent of the insurer.[2] Because of concerns that people were enrolling in short-term plans for an entire year in lieu of ACA-compliant comprehensive coverage — and to ensure that short-term plans remain a temporary solution to a short gap in coverage — the Obama administration changed the definition. It issued regulations in 2016 limiting the duration of short-term plans to less than three months and prohibiting extensions or renewals. However, recently proposed federal regulations would return to the pre-2016 definition, with duration limits of less than 12 months and extensions allowed with the consent of the insurer.[3]

While HMOs and some PPOs in California are primarily regulated by the Department of Managed Health Care, short-term plans are regulated by the Department of Insurance. The California Insurance Code defines short-term, limited-duration insurance as individual health insurance coverage that remains in effect for no more than 185 days and can only be renewed or continued for one additional 185-day period.[4] Short-term plans in California are currently limited to less than three months because of the 2016 federal regulations, but if the recently proposed federal regulations are finalized and there is no change in state law, California will revert to its statutory definition of short-term plans: a duration limit of 185 days with one 185-day renewal. However, a federal duration limit of 12 months means that the effective maximum renewal period would be limited to 179 days.[5] State law does not prohibit the purchase of a different short-term plan at the end of the renewal period, so it is possible for consumers to effectively remain enrolled in short-term plans indefinitely.

As is true across the US, short-term plans in California are not subject to guaranteed issue or renewal, which means insurers can deny coverage based on health status. As a result, if a person is enrolled in short-term insurance and they become sick or injured, they may be unable to purchase new short-term coverage at the end of the contract. California does not require short-term plans to meet an annual medical loss ratio (MLR), which requires ACA-compliant plans to spend 80% of collected premium dollars on medical claims and activities to improve quality. Short-term insurance plans are not required to comply with essential health benefit requirements (including maternity and prescription drug coverage), but California does require it to cover some other specific services or conditions that apply to individual market products regulated by the Department of Insurance. These are often referred to as state benefit mandates.[6] For example, short-term plans must cover diabetes education, management, and treatment; jawbone surgery; and behavioral health services for autism.[7] The combination of a 185-day duration limit, limitation on renewals, and the application of some state benefit mandates means that California regulates

Table 1. Examples of ACA Consumer Protections Not Required in Short-Term, Limited-Duration Insurance

	APPLICABLE TO...		APPLICABLE TO NON-GRANDFATHERED...	
	SHORT-TERM, LIMITED-DURATION INSURANCE	INDIVIDUAL MARKET / COVERED CALIFORNIA PLANS	SMALL GROUP PLANS	LARGE GROUP AND SELF-INSURED EMPLOYER PLANS
Essential health benefits. Plans must cover essential health benefits as defined in the ACA, such as care for maternity, mental health and substance use, prescription drugs, and hospital services.		✔	✔	
Preventive services. Plans must cover preventive services without cost sharing.		✔	✔	✔
Ban on dollar value limits. Plans cannot apply annual or lifetime dollar value maximums.		✔	✔	✔
Limits on out-of-pocket maximums. Places limits on maximum that enrollees pay out of pocket toward covered services in-network.		✔	✔	✔
Guaranteed issue. Plans must accept any individual who applies for coverage.		✔	✔	✔
Premium rating requirements. Prohibits plans from charging a higher premium based on health status or gender; allows rates to vary based solely on the number of enrollees covered, geographic area, and age (within limits).		✔	✔	
Medical loss ratio. Health insurers must spend at least 80% to 85% of premium revenue on health care and quality improvement.		✔	✔	✔

short-term plans more strictly than many states.[8] However, there are numerous state and federal consumer protections that do not apply to this market, as illustrated in Table 1.

What Does California's Short-Term Insurance Market Look Like?

Short-term plans currently marketed for sale in California exclude services that ACA-compliant plans must cover and have broad exclusions for preexisting conditions. Many do not cover critical benefits such as maternity and newborn care, mental health services, substance use services, and outpatient prescription drugs.[9] Short-term insurance available in California also limits the total amount plans will pay per day in the hospital and for particular services, such as surgeon fees. It also imposes a maximum the plan will spend toward claims covered by the policy (see Table 2 on page 4).[10] Such limits are not allowed in ACA-compliant plans, and they put consumers at risk for expensive medical bills. While plan durations are limited to less than three months, an insurer that recently left the short-term market in California said that people are remaining enrolled in short-term plans well beyond three months by enrolling in a new plan every 90 days.

Short-term plans, in part because they cover fewer services, cost less than individual market insurance. The average premium for an individual short-term

Table 2. Limits on the Amount the Plan Pays in the "Best Seller" Short-Term Plan Marketed in California

Policy coverage limits
$750,000 maximum
$10,000 for AIDS treatment
$150,000 for organ transplants
$250 for ambulance (per-trip)
Room and board, miscellaneous charges (per day)
$1,000 for inpatient hospital regular care
$1,250 for inpatient hospital intensive or critical care
Surgical and anesthesiology services
$2,500 per surgery
$5,000 per coverage period

Source: The "Best Seller" short-term plan available in Sacramento, offered through eHealth by the one licensed insurer currently selling short-term plans in California.

insurance plan in California sold through the online broker eHealth was $184 per month in 2017.[11] By comparison, the benchmark Silver plan for a 40-year-old consumer ineligible for premium subsidies through Covered California ranged from $258 to $426 in the same period.[12] Short-term plans are also less expensive because applicants are screened for health history before being accepted, allowing plans to limit the risk that they will need to pay for costly services.[13]

Insurer Participation Has Dropped in California's Short-Term Market

The short-term market in California is currently small. Based on self-reporting by insurers, the California Department of Insurance is aware of fewer than 10,000 policies in effect.[14] Market analysis and respondents identified only one insurer currently selling short-term plans in the state. This insurer sells short-term products directly as well as by co-branding with other health insurance companies, including one insurer participating in Covered California.

When this research began in January 2018, respondents reported an additional out-of-state insurer selling short-term insurance in California through a surplus line, which is an insurance product that a state's department of insurance approves for sale by an out-of-state insurer because state-licensed insurers are not willing to sell it (see Table 3 on page 5).[15] (For example, there may be no insurers in the state willing to insure a car worth $1 million, but an out-of-state insurer may be willing to sell such a policy to a consumer through a surplus line.) In California, in-state insurers only sell short-term products that deny coverage to people with certain preexisting health conditions. An out-of-state insurer, however, was willing to sell short-term plans regardless of health status through a surplus line. This surplus line insurer has since dropped its short-term product line in California.

Before the launch of Covered California in 2014, there were more insurers selling short-term plans in California. Interview respondents noted one health insurer currently selling through Covered California that previously sold short-term plans. Numerous insurers that sell other types of health-related insurance products that are not ACA-compliant, such as travel insurance or indemnity plans, also sold short-term health insurance products.

According to the Department of Insurance, at least two carriers dropped out of the short-term market in recent years after being informed that they were not in compliance with state mandate requirements. Respondents also noted a decreased demand for short-term products both as consumers were able to purchase coverage through Covered California and because short-term plans do not fulfill the federal individual mandate requirement that remains in effect through 2018.

Other Products Are Marketed as Short-Term Coverage Options in California

There are other products that are not technically short-term plans currently being marketed in California as short-term coverage. These plans do not have to comply with the same laws that apply to short-term plans (such as limits on duration and state benefit mandates). Some web brokers display fixed indemnity plans (see Table 3 on page 5), which pay fixed fees for covered health services, as an option for individuals searching for short-term insurance.[16] Fixed indemnity plans are designed to supplement a person's major medical coverage to help cover cost-sharing expenses. The plan pays the enrollee a set dollar amount for covered services, but does not cover the full cost of care. For example, one fixed

Table 3. Comparison of Different Types of Health Insurance Coverage Available in California

	MUST COVER ESSENTIAL HEALTH BENEFITS	MUST COVER PREVENTIVE SERVICES WITHOUT COST SHARING	DOLLAR VALUE MAXIMUMS PROHIBITED	LIMITS ON OUT-OF-POCKET MAXIMUMS	GUARANTEED ISSUE	SUBSIDIES AVAILABLE TO REDUCE PREMIUM COST
Fixed indemnity plans. Health plans designed to wrap around other coverage and cover enrollee cost sharing such as deductibles, copayments, and coinsurance. Fixed indemnity plans pay a set dollar amount for covered services that is often significantly lower than the cost of services. These policies do not have to meet any of the ACA's consumer protections.						
Health care sharing ministries. Members of a health care sharing ministry (HCSM) share a common set of religious beliefs and contribute funds to pay for the qualifying medical expenses of other members. HCSM coverage does not have to meet any of the ACA's consumer protections.						
Individual market health insurance. Comprehensive health insurance plans available to individuals purchasing their own coverage. Subsidies are available to reduce the premium costs of individual market plans purchased through Covered California for eligible enrollees earning between 100% and 400% of the federal poverty level.*	✔	✔	✔	✔	✔	✔
International insurance. International insurance, which is also known as travel insurance or expatriate insurance, is available to people for short durations while traveling in a foreign country, including nonresidents traveling to the United States, students, and people working temporarily. These policies do not have to meet any of the ACA's consumer protections.						
Short-term plans. Health plans designed to fill temporary gaps in coverage. Generally, short-term plans are only available to consumers who can pass medical underwriting, and they typically provide minimal benefits and financial protection for those who become sick or injured. These policies do not have to meet any of the ACA's consumer protections.						
Surplus lines. Products designed to fill gaps in the market where there are no insurance plans available from insurers licensed by the state. In the case of short-term plans in California, the surplus lines accepted enrollees regardless of health status. However, this is not required by law. These policies do not have to meet any of the ACA's consumer protections.						

*Most California residents with household income under 138% of the federal poverty level are eligible for Medi-Cal. Individuals eligible for Medi-Cal are not eligible for the premium subsidies through Covered California.

indemnity plan available in California provides $75 per physician office visit for up to six visits a year, $200 for only one advanced diagnostic service (such as an MRI) per year, and $1,000 per day for hospitalization (capped at $30,000 per year).

At least one health care sharing ministry (see Table 3, page 5) sells short-term coverage with a duration of up to 11 months.[17] Health care sharing ministries are not regulated as insurers under federal law. While they are not exempted from the California insurance code, they are not regulated by the state. Members enrolled in health sharing ministries pay a contribution or monthly share that goes toward paying for other members' medical expenses.[18]

Some brokers also mentioned selling international plans (see Table 3) to people looking for short-term coverage options, primarily to people who live overseas and are traveling to the United States for a short period. But one broker mentioned using an international carrier as a short-term coverage option for California residents.

Federal Policy Changes Could Lead to Increased Premiums If Enrollment in Short-Term Plans Grows

Covered California insurers and market experts agreed that the combination of recent and proposed federal policy changes, including the elimination of the individual mandate penalty and the proposed expansion of short-term plans, would create a "perfect storm" that could take healthy consumers out of Covered California and lead to increased premium rates and the possibility that fewer insurers offer ACA-compliant plans. The elimination of the mandate penalty takes away an incentive for consumers to enroll in ACA-compliant plans rather than less expensive options with fewer consumer protections, such as short-term plans. Allowing short-term insurance to be sold for half a year with a renewal makes it appear like a longer-term coverage option. According to one expert in California's insurance markets, the effect on Covered California could be "devastating."

Health Insurers May Enter Short-Term Market Under Weaker Federal Rules

All three of the individual market carriers interviewed for this research are watching the short-term market. They expressed concern that competitors will siphon away their healthy enrollees if they offer short-term plans. A few respondents predicted that one insurer participating in Covered California that used to offer short-term insurance will reenter the short-term market, as would "smaller players." One Covered California insurer is considering offering short-term plans if other carriers enter the market, to protect their market share.

An insurer selling short-term plans in California said it does not market its plans as long-term options or as alternatives to ACA-compliant coverage. However, statements from Department of Health and Human Services Secretary Alex Azar suggest that federal officials would like to allow short-term plans to be renewable and available for longer than one year.[19] This could encourage other insurers to enter the short-term market with the intent of offering a lower cost, longer-term alternative to the more comprehensive ACA-compliant plans sold through Covered California.

Increased Enrollment in Short-Term Plans by Healthier Consumers Could Lead to Increased Premiums in the Individual Market

There could be significant enrollment in expanded short-term plans. A recent study estimates that 620,000 people would enroll in short-term plans in California in 2019 following the elimination of the mandate penalty combined with the proposed federal rollback of short-term plan restrictions.[20] State regulators, insurers, and industry experts interviewed for this research agreed that the lower premiums offered by short-term insurance will encourage healthy people to shift away from the more expensive ACA-compliant market. An insurer could create a new short-term plan that looks like a cheaper ACA-compliant plan, keeping premiums low by denying coverage to anybody that has a preexisting health condition.

Those most likely to be attracted by the lower cost of short-term plans are consumers eligible for little or no premium subsidy. However, not all of these people will be able to shift to short-term plans. People with preexisting conditions can have their applications rejected, and people who need benefits not typically covered by these plans, such as maternity, will likely remain in the individual market.

The marketing activity of insurance brokers could also contribute to higher short-term plan enrollment.

Brokers and insurers noted that short-term insurers in California have paid broker commissions of 10% or 15%, compared to a 1% to 5% commission for selling ACA-compliant plans.[21] Short-term enrollment does not require an eligibility determination for financial assistance and some brokers receive commissions when individuals simply enroll via a link on the broker's website, making these plans an even more attractive line of business.

With the expectation that new insurers will enter the short-term market and enrollment will grow, Covered California insurers have to consider what the effect will be on their own risk pools while developing rates for 2019. One insurer representative said some insurers that are more cautious and "have to assume the worst" could increase premiums by 10% to adjust for short-term plans, or drop out of the individual market entirely.

Regulating the Short-Term Market: Examples from Other States

There are various policy options available to protect consumers, Covered California, and the individual health insurance market from the potential effects of a developing market for short-term plans that are offered as a long-term coverage option. As of April 2018, the California legislature is considering a bill that would ban the sale of short-term, limited-duration insurance.[22] Banning short-term plans would prevent any expansion of the market.

Most states have minimal regulation of short-term plans, but some have taken steps to restrict or regulate these products. Three states — Massachusetts, New Jersey, and New York — effectively banned short-term plans in the 1990s by requiring them to comply with the extensive consumer protections, including guaranteed issue and community rating, that apply to all new health insurance policies sold in the individual market.[23] The Massachusetts and New Jersey reforms also standardized benefit designs for individual market products that apply to short-term plans.[24] Consumers looking for short-term insurance options in these states can purchase ACA-compliant plans if they are buying during an open enrollment, or if a life event qualifies them for a special enrollment period.[25]

Six states limit short-term insurance from becoming a long-term alternative to ACA-compliant coverage by restricting the sale of multiple consecutive short-term plans, preventing consumers from remaining covered by one short-term insurer indefinitely.[26] For example, Michigan does not allow someone to be covered by short-term plans through one insurer for more than 185 days in a 365-day period, which means that someone cannot remain covered through one short-term insurer for an entire year.[27]

Whether or not these restrictions effectively reduce enrollment in short-term plans is unknown. To discourage a consumer from enrolling in consecutive short-term policies through multiple insurers, a state could apply limitations to enrollment with multiple short-term insurers. For example, Colorado limits the number of short-term plans an individual can enroll in during a12-month period and requires applications for short-term plans to include the question, "Have you or any other person to be insured been covered under two or more nonrenewable short-term policies during the past 12 months?" along with a statement that reads, "If 'yes,' then this policy cannot be issued."[28] The state could require insurers to ask potential enrollees if they have previously enrolled in short-term plans and provide notice on the application that failure to disclose prior enrollment in a short-term plan could result in termination of the plan contract.

Rhode Island prohibits short-term plans from excluding coverage of preexisting conditions and applies the same MLR requirements to them as apply to individual market coverage.[29] According to state legislators, there are currently no short-term plans for sale in Rhode Island in part because the combination of the prohibition on preexisting condition exclusion and the MLR requirements lower profit margins and discourage short-term insurers from entering the market.

Most of these policy options address the existence of other products, such as fixed indemnity products, that are currently sold or marketed as short-term coverage options. They do this by applying consumer protections to these products, including to fixed indemnity lines, travel insurance, and surplus lines. Policymakers can consider applying other limitations to insurance products marketed as short-term insurance, such as prohibiting the sale of a fixed indemnity plan unless an individual is enrolled in an ACA-compliant plan, and prohibiting the sale of short-term plans through surplus lines.

Conclusion

Based on interviews and existing reporting to state regulators, the existing market for short-term plans in California appears to be small. However, if the proposed federal regulatory change allowing longer short-term plans is finalized, a new, larger market could emerge. If this happens, insurers that decide to enter the new short-term market may design plans that meet the state's current requirements but keep risk and premiums low by denying coverage based on health status. Enrollment in these plans could grow significantly as people with little or no premium subsidy look for cheaper coverage options.

Growth in this new short-term market is likely to increase costs and reduce plan choices for consumers purchasing coverage through the individual health insurance market, including Covered California. Increased costs would be felt particularly by people eligible for little or no premium subsidy. Further, consumers who enroll in short-term plans may find themselves without coverage for the health services they need. Policymakers have options to limit the growth of the short-term market in California and mitigate the potential harm to consumers.

About the Authors

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

Endnotes

1. The Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, limited group health plans from excluding coverage for preexisting conditions to 12 months. The 12-month period was lessened, or eliminated, if an individual had continuous health coverage through a type of insurance considered creditable coverage. Short-term plans are considered creditable coverage under HIPAA. See 45 CFR 144.103.
2. See Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg. 38032 (proposed June 10, 2016).
3. Short-Term, Limited Duration Insurance, 83 Fed. Reg. 7437 (proposed February 21, 2018).
4. The existing definition of "short-term limited duration health insurance" in the California Insurance Code is located at section 12671(e)(8) and defines the permissible duration as "not more than 185 days" with a single permissible renewal of "not more than 185 days." Cal. Ins. Code § 12671.
5. Per California Department of Insurance.
6. There are three benefit mandates in the California Code that explicitly do not apply to short-term limited duration insurance. Cal. Ins. Code § 10123.7 (Coverage for orthotic and prosthetic devices); Cal. Ins. Code § 10123.81 (Coverage for mammograms); and Cal. Ins. Code § 10123.865–66 (Coverage for maternity services).
7. Cal. Ins. Code §§ 10123.195, 10123.21, 10144.51.
8. Kevin Lucia et al., "State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market," The Commonwealth Fund, March 2018, www.commonwealthfund.org.
9. Based on author review of short-term plan brochures sold through eHealth in California. These findings also fit with plans that were sold when the authors started the research in January 2018 but that are no longer for sale on the market, based on author review of short-term

plan brochures marketed on a broker's website. While short-term plans exclude maternity care, many do cover services related to complications of pregnancy. Insurers define complications of pregnancy differently, but this could include services related to an ectopic pregnancy, treatment of gestational diabetes, or preeclampsia.

10. Based on author review of short-term plans sold through eHealth by the one admitted insurer selling plans in California.
11. *Short-Term Health Insurance Value, Benefits and Cost*, eHealth, March 2008, ehealthinsurance.com (PDF).
12. Amy Adams, "What Will Consumers Pay in Premiums for Covered California Silver Plans in 2017?" *The CHCF Blog*, October 20, 2016, www.chcf.org/blog.
13. Based on author review of short-term plans sold through eHealth.
14. Based on interview with CDI representative. See also Julie Appleby and Ana B. Ibarra, "Are Short-Term Plans Better Than None At All for Those Desperate for Health Coverage?," *Los Angeles Times*, December 8, 2017, www.latimes.com.
15. One example of a type of product offered as a surplus line is in automobile insurance. There are in-state insurers that offer automobile insurance, but there may not be in-state insurers willing to insure a car that costs $1 million. An individual with such a car might be able to find an out-of-state insurer willing to insure the car under a surplus line.
16. Based on author review of web brokers selling plans in California.
17. The health sharing ministry is included in this table distributed to Covered California's California Plan Management Advisory Group comparing short-term plans available in California and other states. "Plan Design Comparison: Covered California Silver Plan vs. Short-Term Limited Duration Insurance Plans (various states)," California Plan Management Advisory Group, March 7, 2018, coveredca.com (PDF).
18. For more information on health care sharing ministries, see note 8.
19. See, for example, Alex Azar, "HHS Secretary: Short-Term Health Insurance Plans Are an Affordable Option," CNN, February 23, 2018, www.cnn.com.
20. Linda Blumberg, Matthew Buettgens, and Robin Wang, *The Potential Impact of Short-Term Limited Duration Policies on Insurance Coverage, Premiums, and Federal Spending*, The Urban Institute, February 2018, www.urban.org (PDF).
21. "How Are California Health Insurance Brokers Paid?," Health for California Insurance Center, www.healthforcalifornia.com; see also Kevin Knauss, "Commissions Cut Again for Covered California Health Insurance Agents," Insure Me Kevin, November 1, 2017, insuremekevin.com.
22. "Short-Term Limited Duration Health Insurance," Cal. Sen. Bill 910, 2017–2018.
23. Insurance statutes in these three states do not mention short-term or limited-duration plans. By not specifically defining the plans within statute, they are not exempted from any consumer protections or regulations that apply to individual market health insurance. See Mass. Gen. Laws. Ann. Ch. 176M §§ 2 and 4, N.J.S.A. 17B:27A, and NY INS § 3231. See also Peter Newell, "As 2018 Open Enrollment Begins, Trump Administration Adds New Challenges for New York's Individual Market," United Hospital Fund, October 2017, uhfnyc.org and Leigh Wachenheim and Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets*, Milliman, March 2012, www.statecoverage.org (PDF).
24. Leigh Wachenheim and Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets*, Milliman, March 2012, www.statecoverage.org (PDF).
25. See note 8.
26. States are Colorado Colo. Rev. Stat. § 10-16-102(60), Michigan MCLS § 500.2213b - (9), Minnesota Minn. Stat. Ann. § 62A.65, Nevada Nev. Admin. Code § 689A.434, New Hampshire N.H. Rev. Stat. Ann. § 415:5, and Oregon Or. Rev. Stat. § 743B.005.
27. MCLS § 500.2213b - (9).
28. Colo. Rev. Stat. § 10-16-102(60).
29. Sabrina Corlette, JoAnn Volk, and Justin Giovannelli, "Short-Term, Limited Duration Insurance Proposed Rule: Summary and Options for States," State Health and Values Strategies, February 23, 2018, www.shvs.org.

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Tracking Section 1332 State Innovation Waivers

Through Section 1332 of the Affordable Care Act (ACA), states may apply for innovation waivers to alter key ACA requirements in the individual and small group insurance markets. States can use the flexibility granted by 1332 waiver authority to shore up fragile insurance markets, address unique state insurance market issues, or experiment with alternative models of providing coverage to state residents. With Congressional efforts to repeal and replace the ACA on hold, attention will likely turn to 1332 waivers as states explore ways to address access and affordability issues in their individual and small group markets.

While the ACA provides states with some flexibility to alter certain provisions using 1332 waiver authority, it establishes guardrails that limit the extent of the changes states may make. The current statutory language requires that state waiver applications must demonstrate that the innovation plan will provide coverage that is at least as comprehensive in covered benefits; at least as affordable (taking into account premiums and excessive cost sharing); cover at least a comparable number of state residents; and not increase the federal deficit. The ACA requirements states may seek to waive using Section 1332 authority include:

- Individual and employer mandates;
- Essential health benefits (EHBs);
- Limits on cost sharing for covered benefits;
- Metal tiers of coverage;
- Standards for health insurance marketplaces, including requirements to establish a website, a call center, and a navigator program; and
- Premium tax credits and cost-sharing reductions.

Additionally, states may request an aggregate payment of what residents would otherwise have received in premium tax credits and cost-sharing reductions, referred to as subsidy pass-through funding. States may not waive certain provisions through section 1332, including guaranteed issue, age rating, and prohibitions on health status and gender rating. While states can submit ACA innovation waivers in conjunction with Medicaid waivers (under Sec. 1115 of the Social Security Act), innovation waivers cannot be used to change Medicaid program requirements.

The map below shows the status of 1332 waivers requested by states.

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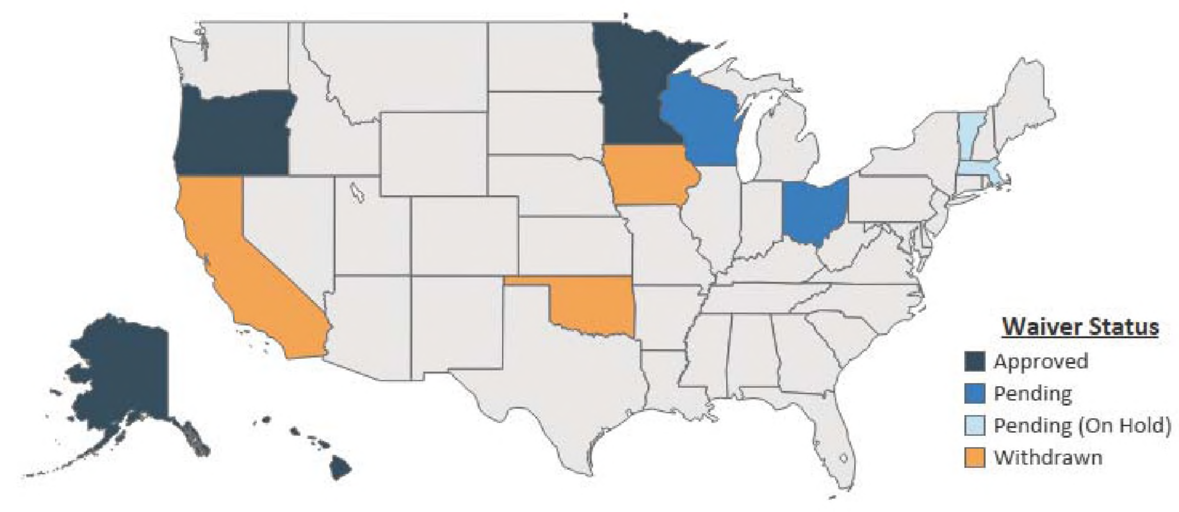

Updated 4/19/18

Additional details on state waivers are provided below.

Approved Waivers

Alaska	
Description	Allow federal pass through funding to partially finance the state's Alaska Reinsurance Program (ARP). The ARP would fully or partially reimburse insurers for incurred claims for high-risk enrollees diagnosed with certain health conditions.
Date Submitted	December 29, 2016
Date Approved	July 7, 2017
Source	Alaska 1332 waiver application and Waiver approval letter.

Hawaii	
Description	Waive ACA Small Business Health Options Program (SHOP) requirements that conflict with the state's Prepaid Health Care Act. Enacted in 1974, the Prepaid Health Care Act requires employers to provide more generous coverage than is required under the ACA. Additionally, waive the requirement that the small business tax credits only be available through the SHOP.
Date Submitted	August 10, 2016
Date Approved	December 30, 2016
Source	Hawaii 1332 waiver application and Waiver approval letter

Minnesota	
Description of Waiver	Allow federal pass-through funding to partially finance the Minnesota Premium Security Plan (MPSP), a reinsurance program that would reimburse insurers 80% of claims between $50,000 and $250,000. The waiver also seeks federal pass-through funding equal to the amount the federal government would have spent on tax credits and cost sharing subsidies for residents eligible for the state's Basic Health Program, MInnesotaCare if the reinsurance program were not in place.
Date Submitted	May 5, 2017
Date Approved	September 22, 2017. Although the federal government approved pass-through funding for the reinsurance program, it did not approve pass-through funding for BHP, thus providing the state with less federal funding than it had sought.
Source:	Minnesota 1332 waiver application and supporting materials; Letter from Governor Dayton to HHS Secretary Price; Waiver approval letter.

Oregon	
Description of Waiver	Allow federal pass-through funding to partially finance the Oregon Reinsurance Program (ORP). The ORP would reimburse insurers 50% of claims between an attachment point (to be determined) and an estimated $1 million cap.
Date Submitted	August 31, 2017
Date Approved	October 18, 2017
Source	Oregon 1332 waiver application and Waiver approval letter.

Pending or On Hold Waivers

Massachusetts	
Description	Waive cost sharing reduction (CSR) payments to insurers in Massachusetts and allow federal pass-through funding of those CSR payments and any advanced premium tax credit (APTC) payments resulting from lower premiums to partially finance a Premium Stabilization Fund (PSF). The PSF will make payments to insurers that are equivalent to the payments that would have been made through the federal CSR program.
Date Submitted	September 8, 2017
Status	Waiver is pending at CMS, but currently on hold. In a letter to the state dated October 23, 2017, CMS indicated the waiver application was incomplete, and given the required federal comment period, the waiver could not be implemented for the 2018 coverage year. The state is considering revising the waiver and resubmitting to implement changes for 2019.
Source	Massachusetts 1332 waiver application and CMS letter

Ohio	
Description	Waive the individual mandate requirement. Although Congress "zeroed out" the penalty associated with the individual mandate beginning in 2019, it did not eliminate the requirement.
Date Submitted	March 30, 2018
Status	Waiver is currently pending at CMS.
Source	Ohio 1332 waiver application

Vermont	
Description	Allow small employers to enroll directly with health insurance carriers rather than through an online SHOP web portal. The state had adopted the direct enrollment approach for small businesses after the SHOP portal developed by the state failed to launch in 2014.
Date Submitted	March 15, 2016
Status	Waiver is pending at CMS, but currently on hold. Guidance from CMS issued on April 18, 2016 delayed the required implementation of the SHOP portal until 2019. Further, the proposed Notice of Benefit and Payment Parameters for 2019 would permanently eliminate the requirement.
Source	Vermont 1332 waiver application; CMS guidance extending SHOP direct enrollment transition

Wisconsin	
Description of Waiver	Allow federal pass-through funding to partially finance the Wisconsin Healthcare Stability Plan (WIHSP). The WIHSP would reimburse insurers 50%-80% (exact percentage to be determined) of claims between $50,000 and $250,000.
Date Submitted	April 19, 2018
Status	Waiver is currently pending at CMS.
Source	Wisconsin 1332 waiver application

Withdrawn Waivers

California	
Description	The state requested approval to provide California Qualified Health Plans (CQHPs) to individuals ineligible to purchase coverage through Covered California, the state's marketplace, due to their immigration status. Individuals purchasing CQHPs would not be eligible for premium tax credits or cost sharing subsidies.
Date Submitted	December 16, 2016
Date Withdrawn	January 18, 2017
Source	California 1332 waiver application; Letter withdrawing application

Iowa	
Description	The state sought to establish the Iowa Stopgap Measure (ISM) to restructure the coverage offered in the state's individual market and to establish a reinsurance program. • Require participating insurers to offer a single, standard health plan in the ACA-compliant market with an actuarial value of 68%-72% and a deductible of $7,350/individual and $14,700/family • Provide flat premium credits based only on income and age in lieu of ACA premium tax credits, and provide premium credits to eligible consumers with income above 400% of poverty who purchase the standard plan. • Continue to provide cost sharing subsidies for individuals with incomes up to 200% FPL by increasing the actuarial value (AV) of the standard plan to 94% for those with income 133%-150% FPL and 83% for those 150%-200% FPL; eliminate cost sharing subsidies for those with incomes 200%-250% FPL • Create an alternative process for applying for premium credits and enrolling in coverage.

Iowa	
	• Use federal pass though funding to establish a reinsurance program to reimburse insurers for 85% of claims between $100,000 and $3 million, and 100% of claims above $3 million
Date Submitted	August 21, 2017
Date Withdrawn	October 23, 2017
Source	Iowa Stopgap Measure, Iowa Insurance Division, August 21, 2017 and Iowa Stopgap Measure Supplement submitted to CCIIO. Additional information available at: https://iid.iowa.gov/iowa-stopgap-measure. Letter withdrawing application

Oklahoma	
Description	The state requested federal pass-through funding to partially finance the Oklahoma Individual Health Insurance Market Stabilization Program (OMSP). The OMSP would reimburse insurers 80% of claims above $15,000 and up to $400,000. The state estimated OMSP would reduce premiums by over 30% and requested that funds the federal government would have paid in premium tax credits to eligible marketplace enrollees had the reinsurance program not been in place be provided to the state to finance the program.
Date Submitted	August 15, 2017
Date Withdrawn	September 29, 2017
Source	Oklahoma 1332 waiver application; Letter withdrawing application

Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums

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March 26, 2018

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Executive Summary[1]

This report details the rapid consolidation of the hospital, physician, and insurance markets in California from 2010 to 2016. According to the U.S. Department of Justice and Federal Trade Commission's *Horizontal Merger Guidelines*, 44 counties had highly concentrated hospital markets. For physician markets, 12 counties had highly concentrated primary care markets, 20 counties had highly concentrated orthopedics markets, 22 counties had highly concentrated cardiology markets, 24 counties had highly concentrated hematology/oncology markets, and 26 counties had highly concentrated radiology markets. The commercial insurance market was also highly concentrated with 42 counties considered highly concentrated according to the Guidelines. There was also an increasing trend of hospitals purchasing physician practices. The percent of physicians working for foundations owned by hospitals increased from 24% to 39% between 2010 and 2016.

We found evidence that highly concentrated markets are associated with higher prices for a number of hospital and physician services and Affordable Care Act (ACA) premiums. In markets with Herfindahl-Hirschman Indices (HHIs) above 1,500, average inpatient procedures prices were 79% higher than the prices in markets with HHIs below 1,500. Likewise, average outpatient physician prices ranged from 35% to 63% higher (depending on the physician specialty) in markets with HHIs above 1,500. In Northern California – which is considerably more concentrated than Southern California across all measures of health care market concentration that we analyzed – inpatient prices were 70% higher, outpatient prices were 17-55% higher (depending on the specialty of physician performing the procedure), and ACA premiums were 35% higher than they were in Southern California. Even after adjusting for input cost differences (i.e. wages) between Northern California and Southern California, procedure prices are still often 20-30% higher in Northern California than Southern California.

In sum, the pace of market consolidation in California has increased significantly. The vast majority of counties in California warrant concern and scrutiny according to the DOJ/FTC Guidelines. Consumers are paying more for health care as a result of market consolidation. It is now time for regulators and legislators to take action.

[1] We are grateful to Ted Frech (Professor of Economics, Department of Economics, University of California, Santa Barbara), Sherry Glied (Dean and Professor of Public Service, Robert F. Wagner Graduate School of Public Service, New York University), and Tom Rice (Distinguished Professor, Department of Health Policy and Management, UCLA Fielding School of Public Health, University of California, Los Angeles) for helpful comments and suggestions on this report. All remaining errors are our own.

Introduction

Following a national trend (Fulton 2017), California insurer and provider markets are becoming more concentrated (Scheffler 2017, Melnick and Fonkych 2016). Market concentration is important because it is well known that as health care markets become more concentrated, prices and premiums for consumers increase (Scheffler and Arnold 2017, Scheffler et al. 2016, Scheffler et al. 2015, Gaynor et al. 2015). This report details the changes in health care market concentration in California from 2010 to 2016. The three objectives of the report are (1) to describe trends in market concentration for hospitals, physician organizations, and insurers (2) to demonstrate the increase in the percent of physicians who work for foundations owned by hospitals or health systems (3) to analyze the relationship between market concentration and health care procedure prices, as well as Affordable Care Act (ACA) premiums.

The report proceeds as follows. In the next section, we describe the data and methods used in our analysis. The following section presents California health care market concentration trends from 2010 to 2016. We then analyze changes in the percent of physicians working foundations owned by a hospital or health system that occurred from 2010 to 2016. The report concludes with a section that describes the association between health care market concentration and health care procedure prices/ACA premiums. This section that discusses the differences in prices and premiums that exist between Northern and Southern California, and a summary of our findings.

Data and Methods

Our first set of analyses use the well-known Herfindahl-Hirschman Index (HHI) to measure insurer, hospital, and physician market concentration. HHI is used in the U.S. Department of Justice and Federal Trade Commission (DOJ/FTC)'s *Horizontal Merger Guidelines* (U.S. Department of Justice and the Federal Trade Commission 2010) and can range from 0 to 10,000. The measure is calculated by summing the squared market shares of firms. For example, if a market included two firms, one with 80% market share and the other with 20% market share, the HHI of the market would be 6,800 (or $80^2 + 20^2$). The *Horizontal Merger Guidelines* consider markets with HHIs between 1,500 and 2,500 points to be moderately concentrated and markets with HHIs in excess of 2,500 points to be highly concentrated. In the context of mergers, the Guidelines assign the highest concern and scrutiny to mergers that would increase the HHI in a market by over 200 points and leave the market with an HHI of over 2,500. Other HHI changes and levels trigger different degrees of concern and scrutiny (see Table 1 for details). For this report, we defined markets using counties, but other definitions such as metropolitan statistical areas (MSAs) are possible. We highlight the counties that increased by over 200 HHI points from 2010 to 2016 and had HHIs of over 2,500 in 2016.

Table 1. Level of Concern and Scrutiny Based on HHI Change and Resulting HHI Level

		HHI Level in 2016		
		< 1,500	1,500 to 2,500	>2,500
HHI Change 2010 to 2016	<100	Low	Low	Low
	100 to 200	Low	Moderate	Moderate
	>200	Low	Moderate	High

Low: "Unlikely to have adverse competitive effects and ordinarily require no further analysis"
Moderate: "Potentially raise significant competitive concerns and often warrant scrutiny"
High: "Presumed to be likely to enhance market power"

Source: Authors' analysis of U.S. Department of Justice and Federal Trade Commission's 2010 Horizontal Merger Guidelines (pg. 19)
Note: HHI=Herfindahl-Hirschman Index.

We measured the market shares of health insurers and hospitals using commercial enrollment (both fully- and self-insured) and inpatient admissions, respectively. Hospital systems were treated as a single firm for the purposes of our market share calculations, and we only accounted for short-term general hospitals when computing market share.[2] Our measures of the market shares of specialist and primary care groups are based on the number of physicians within each group.[3] The data sources we used to calculate these measures included: for health insurers, the Managed Market Surveyor provided by Decision Resources Group (formerly HealthLeaders-Interstudy); for hospitals, the American Hospital Association's (AHA) Annual Survey Database; and for physicians, the SK&A Office Based Physicians Database provided by QuintilesIMS.

For physicians, we computed an HHI for five separate specialties: primary care, cardiology, hematology/oncology, orthopedics, and radiology. These specialties were chosen because there was ample sample size (at least 10,000 physicians) in the data source and because the four specialty physicians are among the most highly compensated specialties.

Our second set of analyses look at the percent of physicians in a market who work for foundations owned by a hospital or health system.[4] In both the first set of analyses with HHIs and this second set, we use counties to define a market geographically. Using counties as the geographic market has been used frequently for research purposes (Frech et al. 2015, Baker et al. 2014).

Our next set of analyses correlate health care prices and ACA premiums with measures of market concentration. The prices we analyze are the median 2014 ACA rating area-level prices

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[2] Specialty hospitals (e.g. rehabilitation centers) or hospitals not open to the general public (e.g. VA hospitals) are not included.
[3] See Fulton (2017) for methodological details.
[4] Corporate practice of medicine laws in California restrict physicians from being directly employed by corporations. See Martin and Neville (2016) for details.

displayed on the California Healthcare Compare website.[5] The prices we analyze are the median amount paid by insurers and consumers for procedures in a specific rating area and were calculated using data from Truven Health MarketScan.[6] Since the prices we have available to us are rating area-level, we correlated the prices with rating area-level HHIs rather than the county-level HHIs in our first set of analyses.

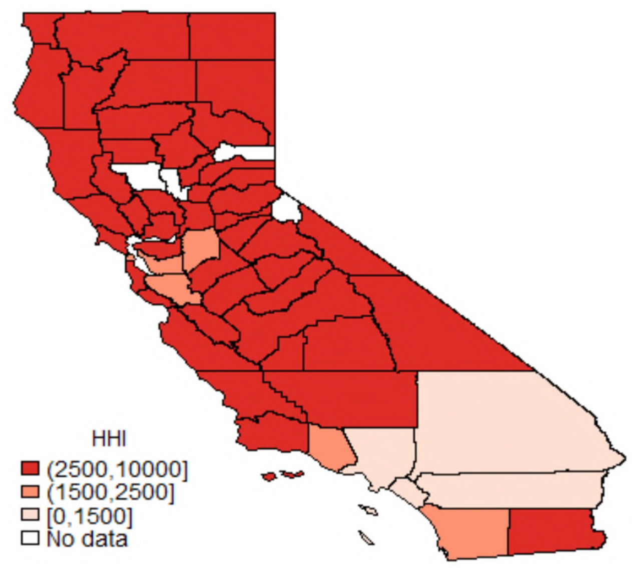
We chose which measure of market concentration to correlate with each procedure prices as follows. If the procedure was an inpatient procedure, we correlated it with hospital market concentration. If the procedure was an outpatient procedure, we identified which physician specialty would be associated with the procedure, and then correlated the market concentration of that specialty with procedure prices. For example, we correlated rating area-level cardiomyopathy prices with rating area-level cardiology HHI.

Finally, we correlate ACA premiums with the market concentration of commercial insurers using ACA rating areas.

Health Care Market Concentration Trends

Figure 1 shows the hospital HHI, by California county, in 2016. Of the 54 California counties with a hospital in 2016, 44 were highly concentrated (HHI above 2,500), and six were moderately concentrated (HHI between 1,500 and 2,500). The mean HHI across the 54 counties analyzed was a staggering 5,613 in 2016.

Figure 1. Hospital Market Concentration, 2016

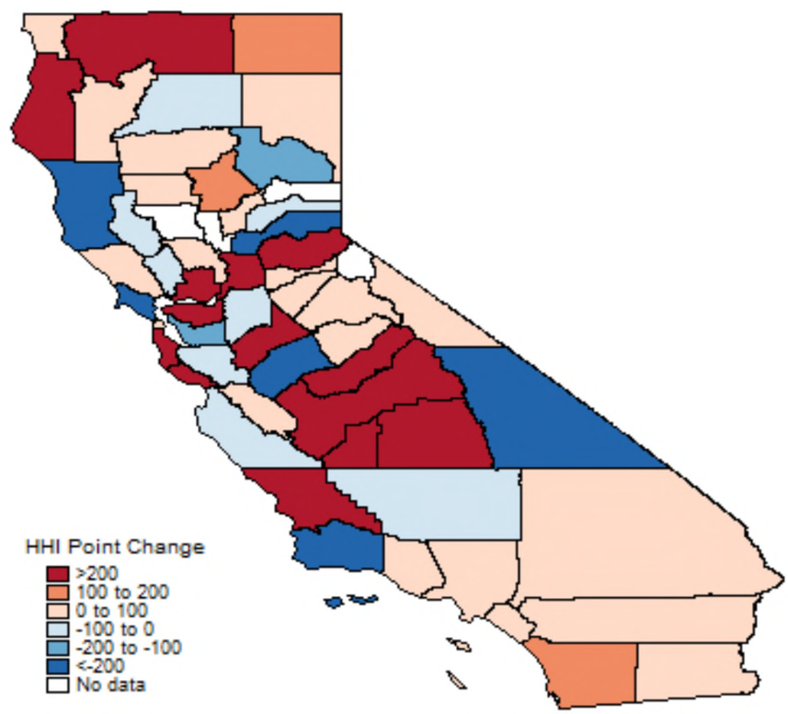


Source: Authors' analysis of the American Hospital Association's Annual Survey Databases.
Note: HHI=Herfindahl-Hirschman Index.

[5] http://www.cahealthcarecompare.org/cost_select.jsp
[6] http://article.images.consumerreports.org/prod/content/dam/cro/news_articles/health/PDFs/CAHealthCareCompare_methods.pdf

Figure 2 examines the changes in hospital HHI that occurred across counties between 2010 and 2016. Hospital concentration was stable during this period with a mean decrease of only 24 HHI points during the period. However, there was significant variation across counties, with 14 counties experiencing HHI increases of over 200 points from 2010 to 2016. These 14 counties qualify for the list of high concern and scrutiny counties according to the DOJ/FTC Guidelines (2016 HHI > 2,500 and HHI change > 200). The list of high concern and scrutiny counties is presented as Table 2.

Figure 2. Hospital Market Concentration Changes from 2010 to 2016



Source: Authors' analysis of the American Hospital Association's Annual Survey Databases.
Note: HHI=Herfindahl-Hirschman Index.

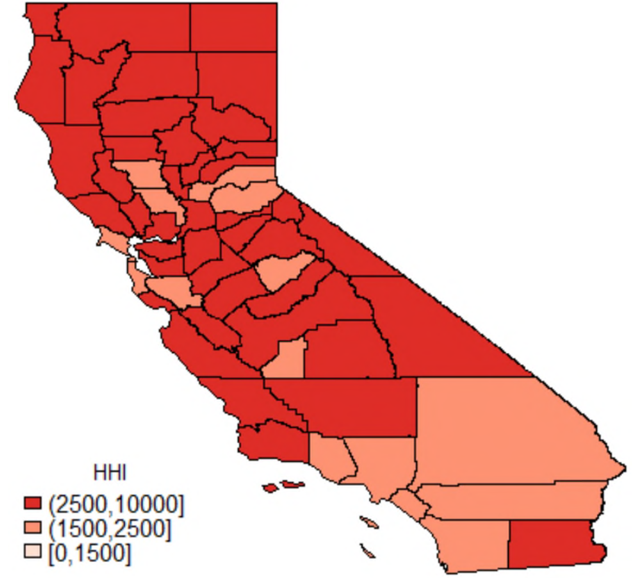
Table 2. Hospital Market Concentration – High Concern and Scrutiny Counties

County	2010 Hospital HHI	2016 Hospital HHI	HHI Change
Stanislaus	3,361	5,172	1,811
Kings	8,534	10,000	1,466
Madera	9,017	10,000	983
Tulare	4,463	5,422	958
Fresno	3,984	4,884	901
San Luis Obispo	5,208	5,753	544
Contra Costa	2,335	2,860	526
Humboldt	6,080	6,480	400
Solano	4,017	4,375	359
Sacramento	2,592	2,844	253
Siskiyou	5,027	5,272	244
San Mateo	2,303	2,543	240
Santa Cruz	5,760	5,974	214
El Dorado	5,747	5,951	203

Source: Authors' analysis of the American Hospital Association's Annual Survey Databases.
Note: HHI=Herfindahl-Hirschman Index.

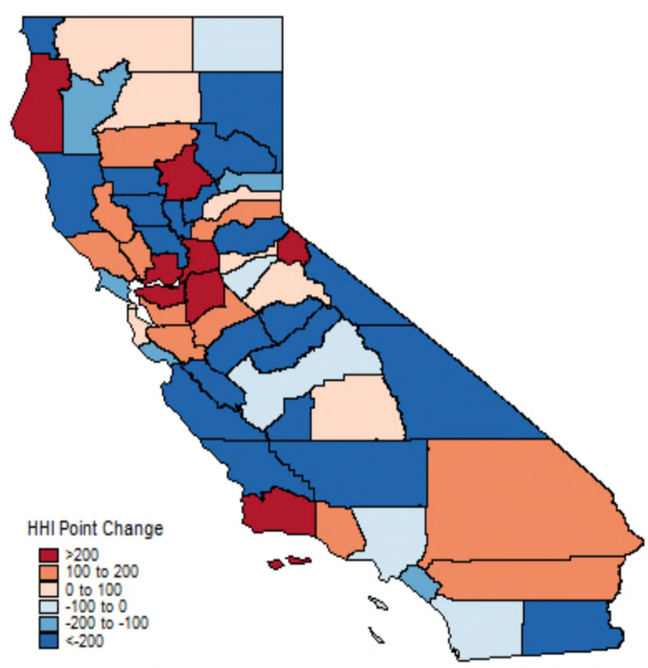
Figures 3 and 4 and Table 3 repeat the same analysis, but for insurer market concentration. Similar to the hospital market, most insurer markets are highly concentrated as of 2016. Among the 58 California counties, 42 were highly concentrated and 16 were moderately concentrated (Figure 3). The mean insurer HHI was 2,953 in 2016. Insurer concentration decreased by 203 points on average across the 58 counties between 2010 and 2016 (Figure 4). However, eight counties experienced concentration increases of greater than 200 points during this time. Seven of these eight counties qualify for the list of high concern and scrutiny counties according to the DOJ/FTC Guidelines and are listed in Table 3.

Figure 3. Insurer Market Concentration, 2016



Source: Authors' analysis of the Managed Market Surveyor provided by Decision Resources Group (formerly HealthLeaders-Interstudy).
Note: HHI=Herfindahl-Hirschman Index.

Figure 4. Insurer Market Concentration Changes from 2010 to 2016



Source: Authors' analysis of the Managed Market Surveyor provided by Decision Resources Group (formerly HealthLeaders-Interstudy).
Note: HHI=Herfindahl-Hirschman Index.

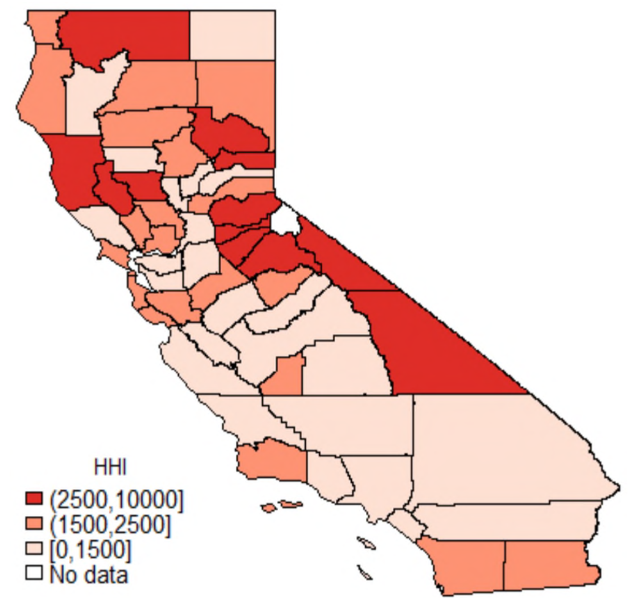
Table 3. Insurer Market Concentration – High Concern and Scrutiny Counties

County	2010 Insurer HHI	2016 Insurer HHI	HHI Change
Solano	3,333	4,742	1,409
Humboldt	3,106	3,634	528
Butte	3,815	4,286	471
San Joaquin	2,471	2,906	435
Sacramento	2,536	2,951	415
Contra Costa	2,634	2,952	318
Santa Barbara	2,803	3,008	205

Source: Authors' analysis of the Managed Market Surveyor provided by Decision Resources Group (formerly HealthLeaders-Interstudy).
Note: HHI=Herfindahl-Hirschman Index.

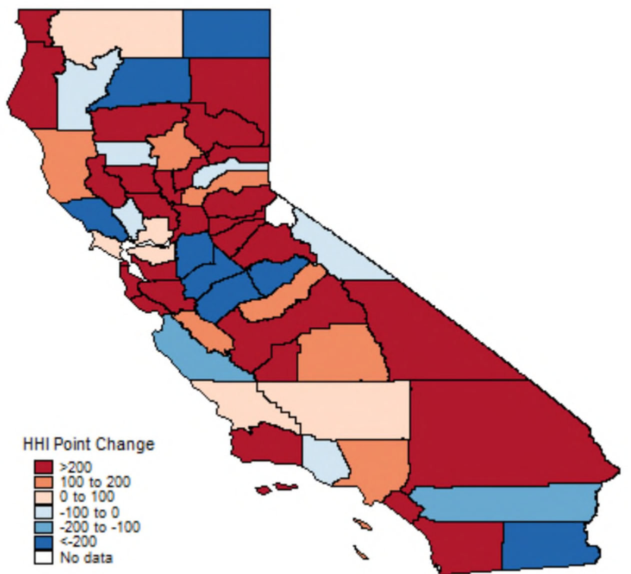
Figures 5 and 6 show the market concentration of primary care physicians in 2016 and the change in primary care market concentration between 2010 and 2016, respectively. The mean HHI across counties was 1,984 in 2016. Of the 57 counties analyzed, 12 were highly concentrated and 21 were moderately concentrated. The seven counties that warrant high concern and scrutiny according to the DOJ/FTC Guidelines are listed in Table 4.

Figure 5. Primary Care Market Concentration, 2016



Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Figure 6. Primary Care Market Concentration Changes from 2010 to 2016



Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Table 4. Primary Care Market Concentration – High Concern and Scrutiny Counties

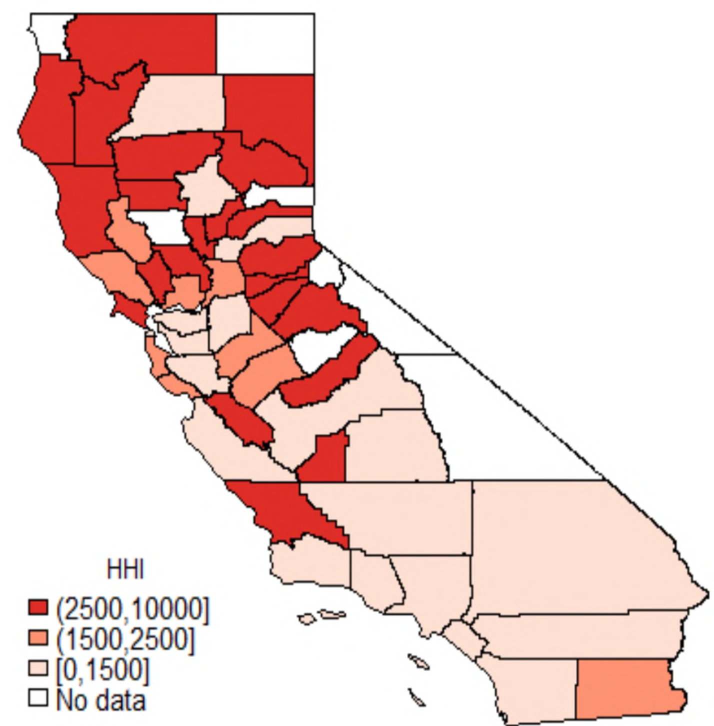
County	**2010 Primary Care HHI**	**2016 Primary Care HHI**	**HHI Change**
Amador	655	2,934	2,279
Plumas	6,303	8,515	2,212
Calaveras	2,888	4,831	1,943
Lake	799	2,505	1,707
Colusa	3,585	4,314	729
Inyo	2,166	2,873	707
El Dorado	2,526	2,902	376

Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Figures 7, 9, 11, and 13 show the levels of cardiology, hematology/oncology, orthopedics, and radiology market concentration in 2016. Figures 8, 10, 12, and 14 show the changes in market concentration of each of these four markets between 2010 and 2016. Tables 5-9 show the high concern and scrutiny counties for each of the four markets.

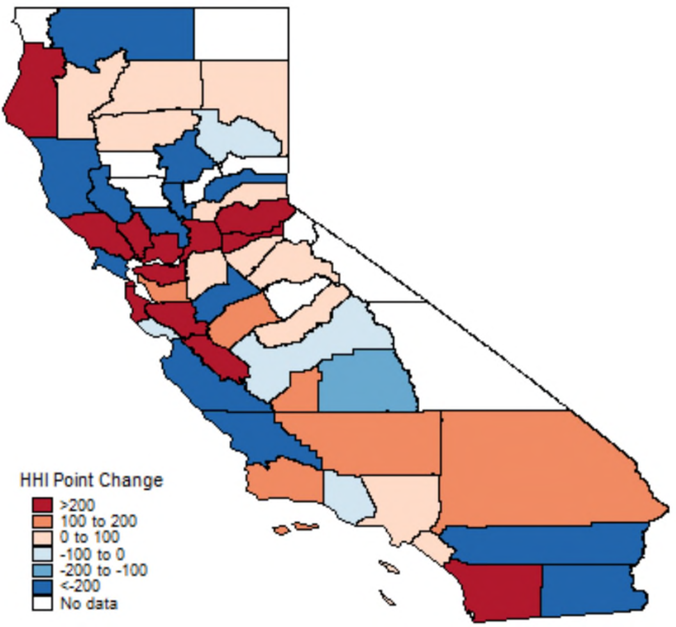
The mean cardiology HHI across counties was 3,357 in 2016 (Figure 7) and concentration increased by 134 HHI on average across counties between 2010 and 2016 (Figure 8). Five counties warrant high concern and scrutiny for cardiology markets (Table 5). For hematology/oncology markets, the mean HHI was 4,388 in 2016 (Figure 9) and concentration increased by 506 HHI on average between 2010 and 2016 (Figure 10). Ten counties warrant high concern and scrutiny for hematology/oncology markets (Table 6). The mean orthopedics HHI across counties was 3,073 in 2016 (Figure 11) and concentration increased by 691 HHI on average between 2010 and 2016 (Figure 12). Fourteen counties warrant high concern and scrutiny for orthopedics markets (Table 7). Finally, for radiology markets, the mean HHI was 4,237 in 2016 (Figure 13); concentration also increased by 438 HHI on average between 2010 and 2016 (Figure 14). Fourteen counties warrant high concern and scrutiny for radiology markets (Table 8).

Figure 7. Cardiology Market Concentration, 2016



Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Figure 8. Cardiology Market Concentration Changes from 2010 to 2016



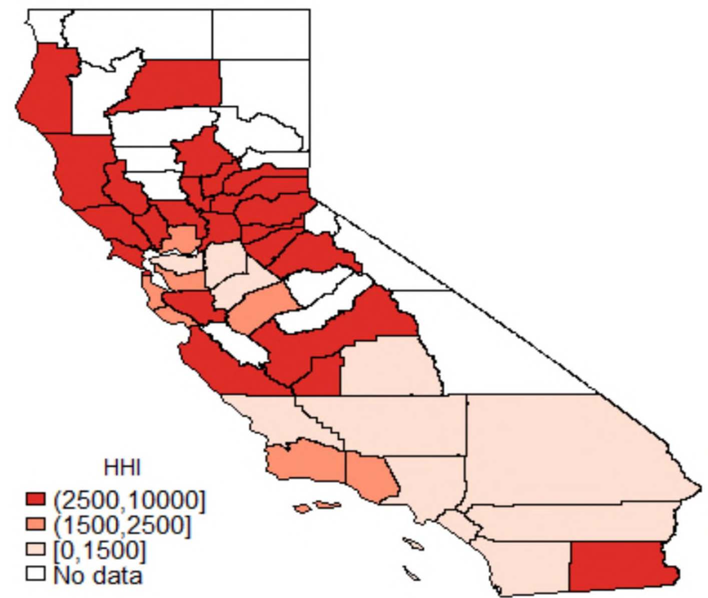
Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Table 5. Cardiology Market Concentration – High Concern and Scrutiny Counties

County	**2010 Cardiology HHI**	**2016 Cardiology HHI**	**HHI Change**
El Dorado	2,653	7,222	4,569
Humboldt	1,000	5,556	4,556
Napa	857	3,288	2,431
Amador	2,171	4,136	1,965
San Benito	3,930	5,000	1,070

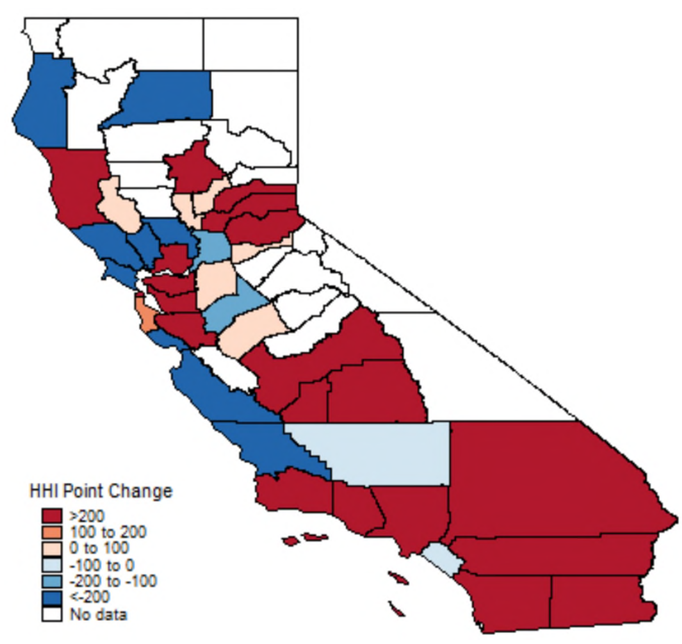
Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Figure 9. Hematology/Oncology Market Concentration, 2016



Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Figure 10. Hematology/Oncology Market Concentration Changes from 2010 to 2016



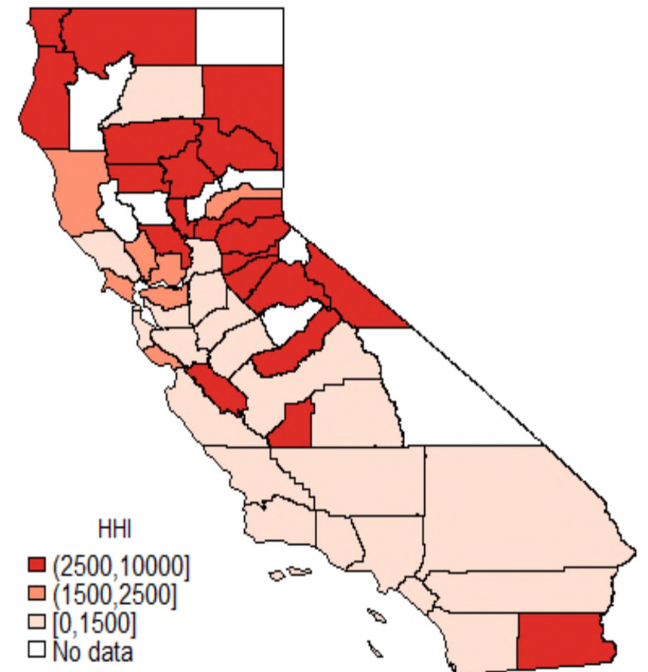
Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Table 6. Hematology/Oncology Market Concentration – High Concern and Scrutiny Counties

County	2010 Hematology/ Oncology HHI	2016 Hematology/ Oncology HHI	HHI Change
Kings	3,750	10,000	6,250
Mendocino	4,335	10,000	5,665
Imperial	5,000	10,000	5,000
Butte	1,515	5,062	3,547
San Francisco	1,343	4,192	2,849
Fresno	600	2,868	2,268
Santa Clara	1,190	3,130	1,940
Nevada	3,333	5,000	1,667
Placer	2,613	3,127	514
El Dorado	9,763	10,000	237

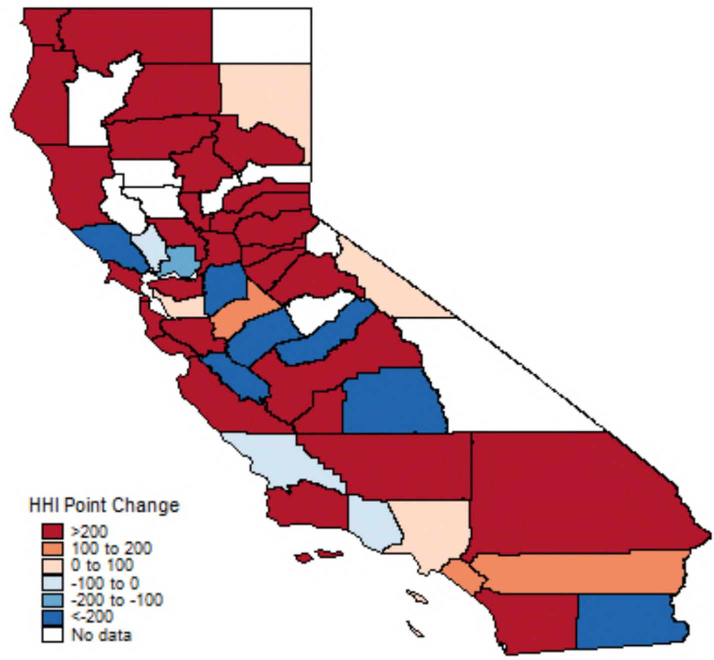
Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Figure 11. Orthopedics Market Concentration, 2016



Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Figure 12. Orthopedics Market Concentration Changes from 2010 to 2016



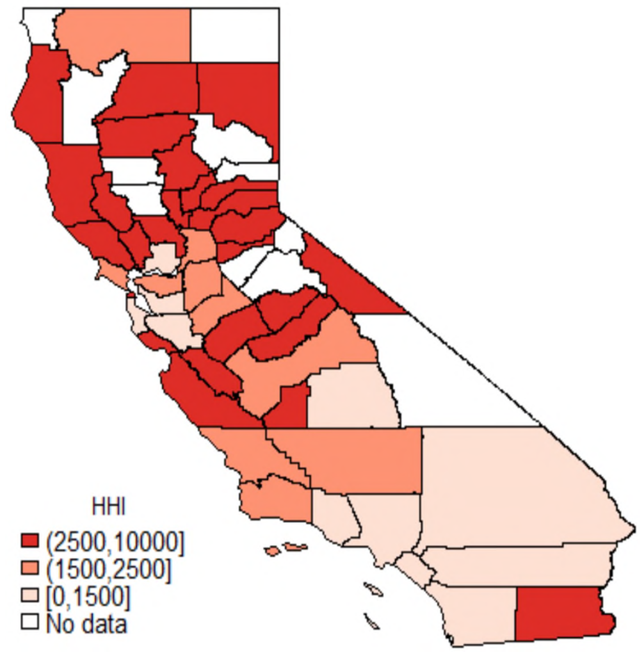
Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Table 7. Orthopedics Market Concentration – High Concern and Scrutiny Counties

County	2010 Orthopedics HHI	2016 Orthopedics HHI	HHI Change
Yolo	2,581	5,950	3,369
Siskiyou	2,203	5,556	3,353
Humboldt	1,250	4,375	3,125
Placer	1,304	4,369	3,065
Sutter	3,888	6,406	2,518
El Dorado	2,727	5,000	2,273
Tehama	3,333	5,509	2,176
Amador	3,122	4,137	1,015
Butte	2,492	3,437	945
Kings	2,800	3,421	621
Calaveras	5,125	5,556	431
Plumas	7,689	8,081	392
Marin	2,126	2,500	374
Del Norte	5,000	5,313	313

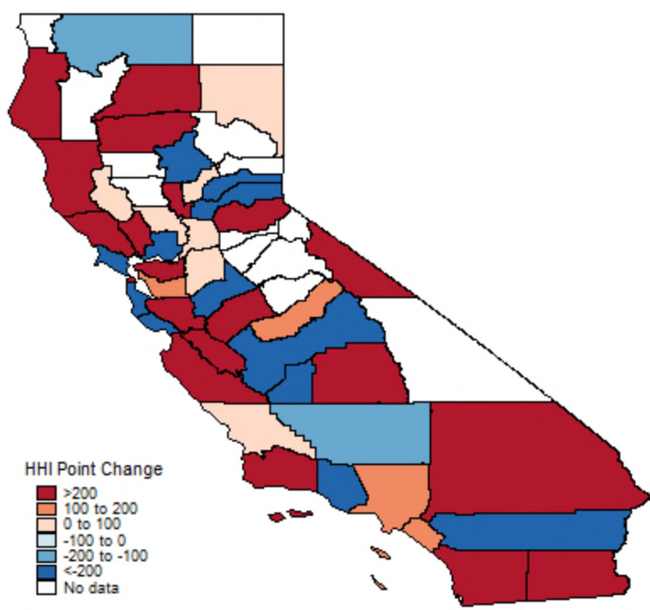
Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Figure 13. Radiology Market Concentration, 2016



Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Figure 14. Radiology Market Concentration Changes from 2010 to 2016



Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Table 8. Radiology Market Concentration – High Concern and Scrutiny Counties

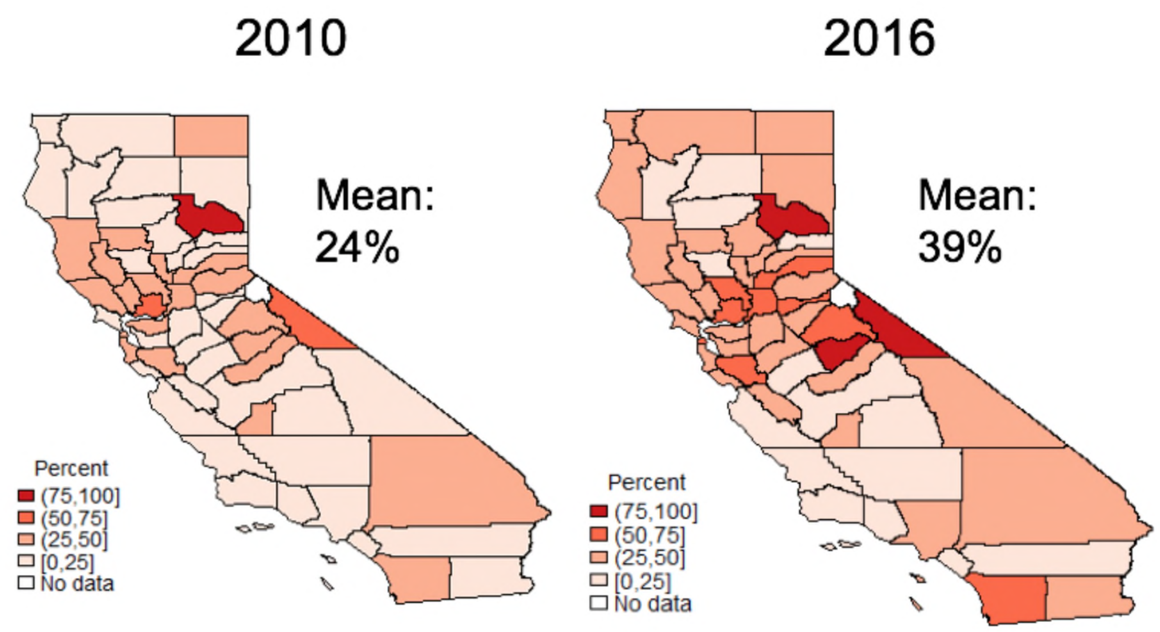
County	2010 Radiology HHI	2016 Radiology HHI	HHI Change
Mono	1,667	10,000	8,333
Humboldt	4,050	10,000	5,950
San Benito	5,000	10,000	5,000
Mendocino	3,889	6,800	2,911
San Francisco	1,385	3,781	2,396
Shasta	1,441	3,579	2,138
Sonoma	1,557	3,081	1,523
Napa	5,460	6,676	1,216
Sutter	6,600	7,813	1,213
Imperial	1,947	2,796	849
Tehama	2,500	3,333	833
Monterey	2,792	3,373	581
Merced	2,097	2,653	556
El Dorado	4,397	4,776	378

Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.
Note: HHI=Herfindahl-Hirschman Index.

Changes in the Percent of Physicians Working for Foundations Owned by a Hospital or Health System

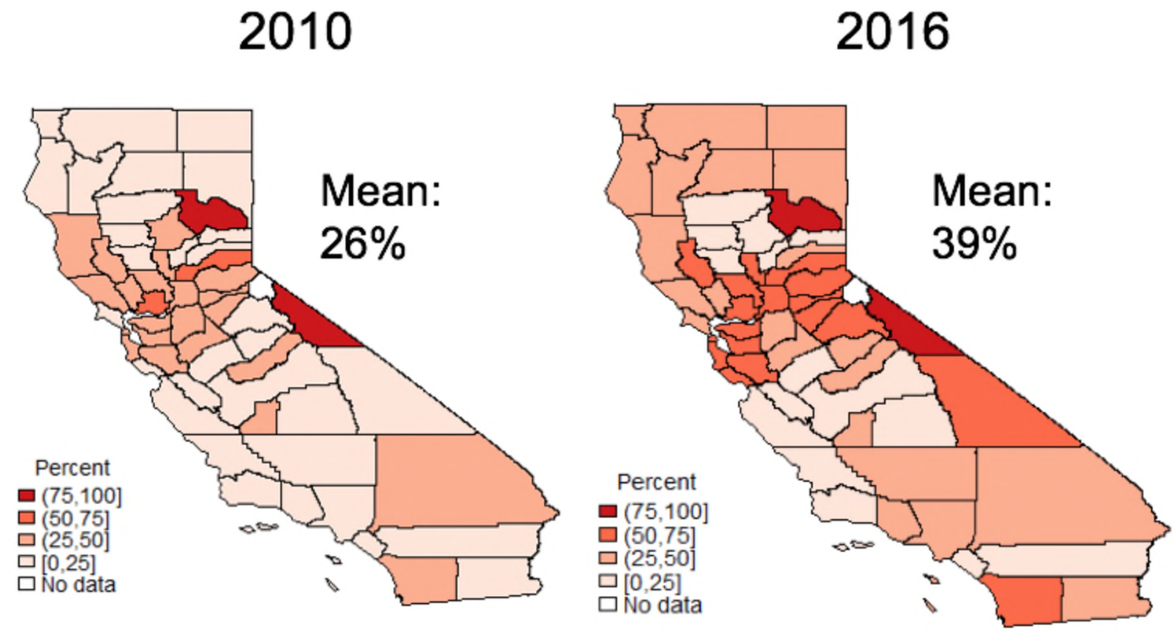
The next set of results examine how the percent of physicians working foundations owned by a hospital or health system changed from 2010 to 2016. For these analyses, we show the results for three groups: all physicians, primary care physicians, and specialist physicians, where we define specialist physicians to consist of the four specialists we analyzed previously – cardiologists, hematologists/oncologists, orthopedists, and radiologists. Figure 15 displays the results for all physicians. In 2010, 24% of a California county's physicians worked for a foundation owned by a hospital or health system, on average. By 2016, the percent had jumped to 39%. We found a similar pattern for primary care physicians. Figure 16 shows the same measure to increase from 26% to 39% between 2010 and 2016 for primary care physicians. Figure 17 shows the increase to be even more dramatic for specialist physicians. In 2010, the average county had 21% of its specialist physicians working for a foundation owned by a hospital or health system. By 2016, the average county had 50% of its specialist physicians working for a foundation owned by a hospital or health system.

Figure 15. Percent of Physicians in Each County Who Work for Foundations Owned by a Hospital or Health System



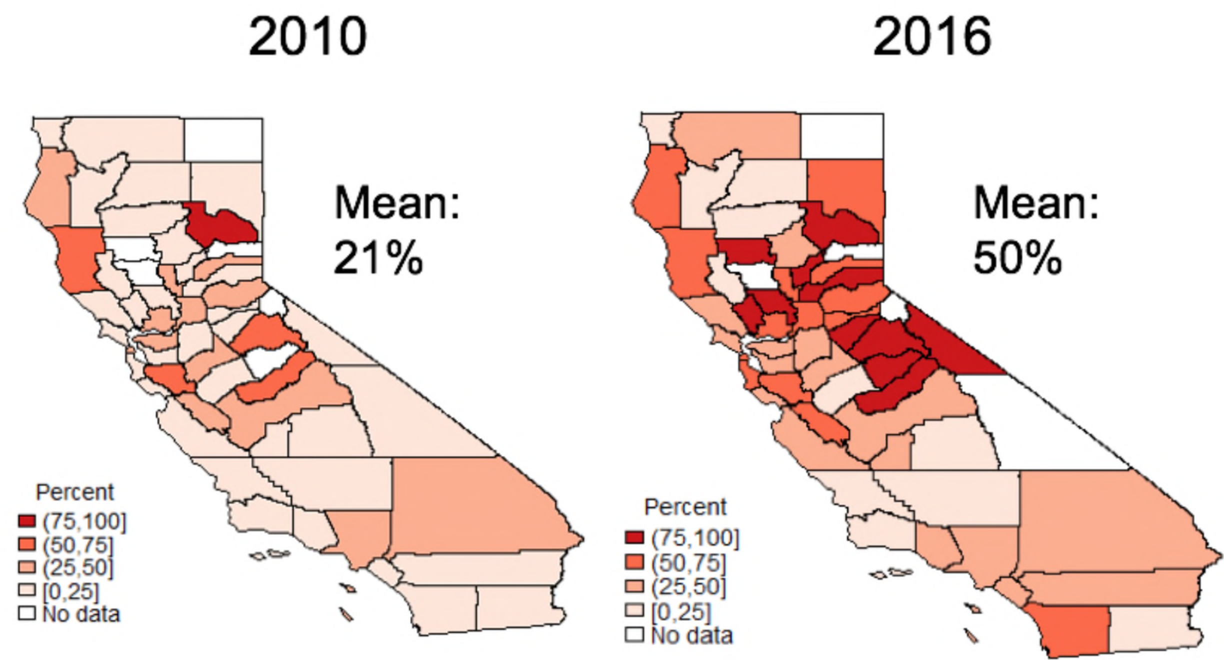
Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.

Figure 16. Percent of Primary Care Physicians in Each County Who Work for Foundations Owned by a Hospital or Health System



Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.

Figure 17. Percent of Specialist Physicians in Each County Who Work for Foundations Owned by a Hospital or Health System



Source: Authors' analysis of the SK&A Office Based Physicians Database provided by QuintilesIMS.

The Association between Health Care Market Concentration and Health Care Prices/ACA Premiums

Our next analyses examine the association between health care procedure prices and measures of market concentration. We show this association using ACA rating area-level median procedure prices. There are 19 ACA rating areas in California (see Figure A1 in the appendix for a map). The ACA rating area-level median procedure prices we utilized are publicly available from California Healthcare Compare.[7] California Healthcare Compare does not provide price information for rating area 14 (Central Valley), so the figures we present in the following section have a maximum of 18 observations. For certain procedures, price data is available for fewer than 18 rating areas. Since the prices available to use are rating area-level, we correlate them with rating area-level measures of market concentration. Table A1 in the appendix displays the rating area-level concentration measures that we used in the price correlations that follow.

Figures 19-23 graphically depict the correlation between health care market concentration and the prices of various health care procedures. In total, we selected three inpatient procedures and 18 outpatient procedures to correlate with measures of health care market concentration. We correlated the inpatient procedure prices with hospital market concentration. For each outpatient procedure, we correlated the procedure's prices with the market concentration of the specialty that performs the procedure. For instance, we correlated cardiomyopathy (heart muscle disease)

[7] http://www.cahealthcarecompare.org/cost_select.jsp

prices with measures of cardiology market concentration. The full list of the three inpatient procedures and the 18 outpatient procedures (by specialty) we analyzed are footnoted below.[8] For brevity, we discuss the results of one procedure price correlation each for hospital, primary care, cardiology, hematology/oncology, and radiology (Figure 19-23, respectively). Graphical depictions of the remaining 17 procedure price/market concentration correlations are available in the appendix (Figures A2-A17). Additionally, the regression estimates that underlie Figures 19-23 and Figures A2-A17 are also available in the appendix as Tables A3-A8. Tables A3-A8 estimate the association between both unadjusted and input cost adjusted procedure prices and market concentration. Tables A9-A14 are identical to Tables A3-A8, except that the regressions in Tables A9-A14 are weighted by rating area population to account for the fact that population varies considerably across rating areas. While all the figures presented within the main text of the report use unadjusted prices (i.e. actual prices that are paid), the regression tables in the appendix present the results for both unadjusted and input cost adjusted prices. We used the Medicare wage index to input cost adjust prices.[9] The Medicare program uses the Medicare wage index to adjust standardized amounts paid to hospitals to account for differences in hospital wage levels across regions. Results using input cost adjusted prices are similar to the unadjusted price results that we present in the main text (see the appendix for details).

Figure 19 shows the correlation between heart attack (acute myocardial infarction) prices and hospital market concentration. The average median heart attack price across the 17 rating areas analyzed was $20,809. In Los Angeles – East, which had a hospital HHI of 656 in 2014, the median price to treat a heart attack was $15,795. In contrast, in the Eastern rating area, where hospital HHI was 3,851, the median price to treat a heart attack was $28,477 – 80% above the price to treat a heart attack in Los Angeles.

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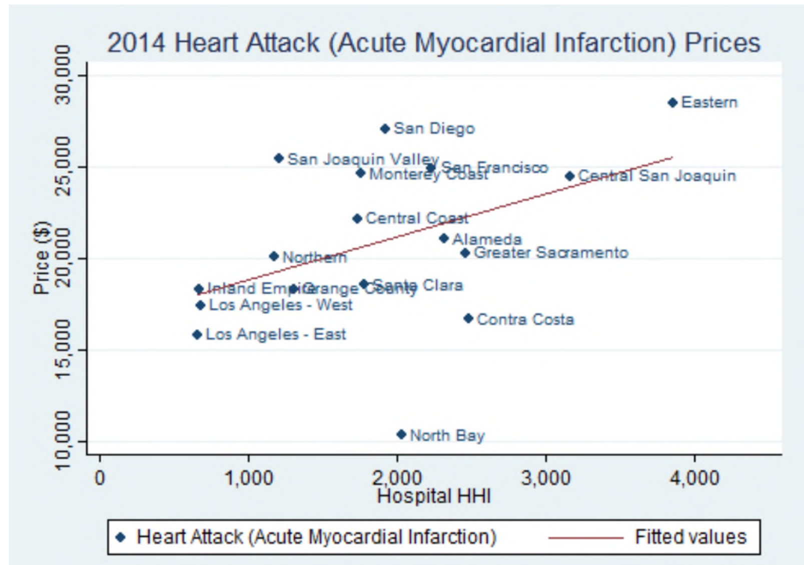
[8] **Inpatient procedures (3)**: heart attack (acute myocardial infarction), partial hip replacement revision, premature baby (extremely low weight)
Outpatient procedures (18): Primary Care (9) – cervical cancer screening converted, colon cancer screening – sigmoidoscopy, diagnostic blood fecal test, diverticular disease, fibroids, kidney (renal) failure, sore throat, upper respiratory infection/common cold (adult), urinary tract stone; Cardiology (3) – cardiomyopathy (heart muscle disease), cardiovascular symptoms (other), coronary artery disease with heart bypass surgery; Hematology/Oncology (3) – breast cancer, lung, bronchi, or mediastinum cancer, prostate cancer; Orthopedics (3) – ankle fracture/sprain, knee ligament injury, wrist or hand fracture/dislocation/sprain
[9] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html

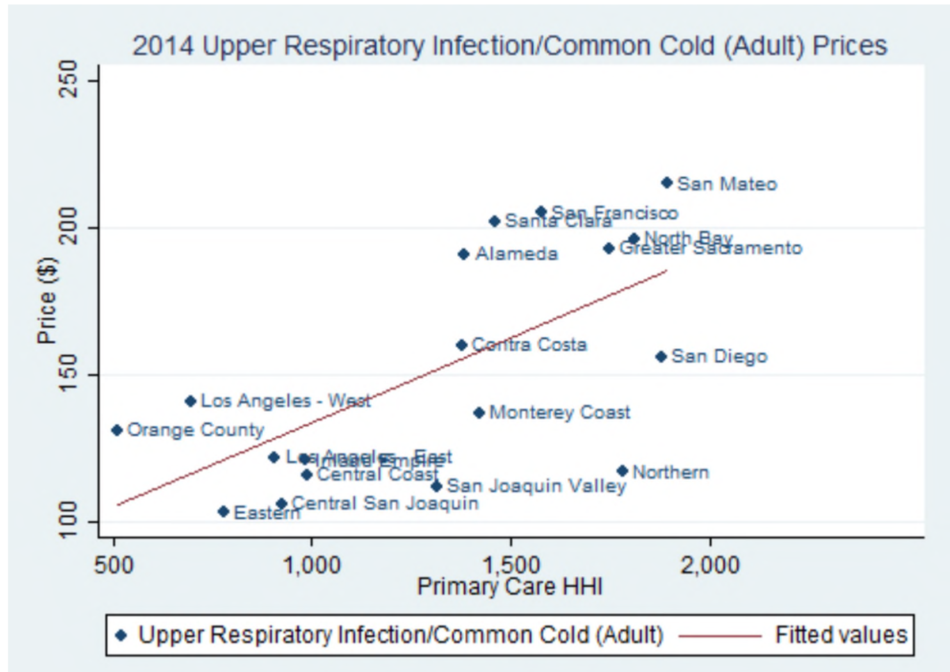
Figure 19. Heart Attack (Acute Myocardial Infarction) Price and Hospital HHI Correlation



Note: HHI=Herfindahl-Hirschman Index. The slope of the regression line in the figure is statistically significant at the p<0.10 level. See Table A3 in the appendix for the regression output that corresponds to this figure.

Our analysis of the correlation between outpatient procedure prices and the market concentrations of the physician specialties that perform the procedures begins with Figure 20. The figure shows the correlation between upper respiratory infection/common cold (adult) prices and primary care market concentration. The average median upper respiratory infection/common cold (adult) price across the 18 rating areas analyzed was $151. In Orange County, which had a primary care HHI of 513 in 2014, the median price to treat a common cold was $131. Alternatively, in San Mateo, where primary care HHI was 1,892, the median price to treat a common cold was $215 – 64% above the price to treat a common cold in Orange County.

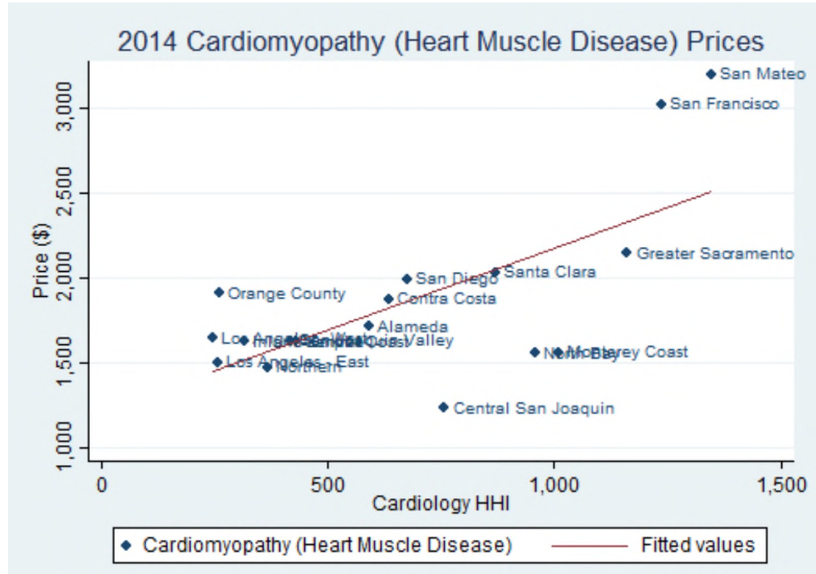
Figure 20. Upper Respiratory Infection/Common Cold Price and Primary Care HHI Correlation



Note: HHI=Herfindahl-Hirschman Index. The slope of the regression line in the figure is statistically significant at the p<0.01 level. See Table A4 in the appendix for the regression output that corresponds to this figure.

Figure 21 shows the correlation between cardiomyopathy (heart muscle disease) prices and cardiology market concentration. The average median cardiomyopathy price across the 17 rating areas analyzed was $1,867. In Los Angeles – East, which had a cardiology HHI of 259 in 2014, the median cardiomyopathy price was $1,500. In San Francisco, where cardiology HHI was 1,237, the median cardiomyopathy price was $3,023 – about double the cardiomyopathy price of Los Angeles.

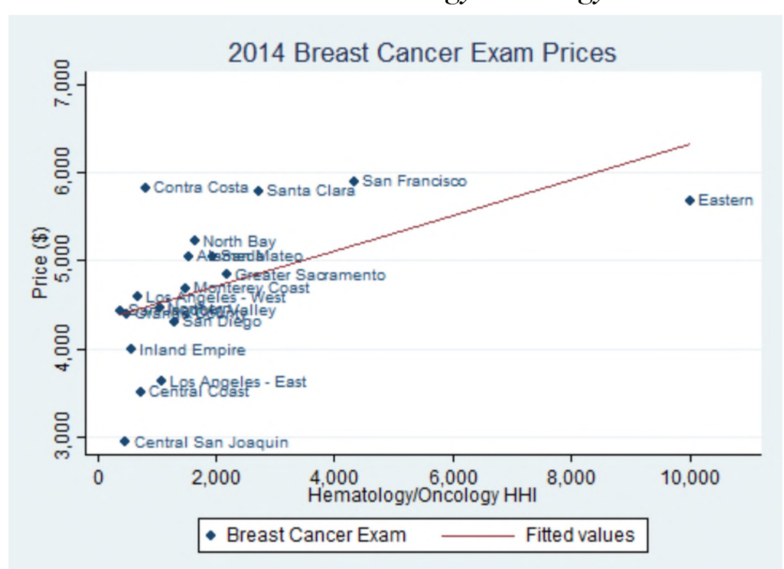
Figure 21. Cardiomyopathy (Heart Muscle Disease) Price and Cardiology HHI Correlation



Note: HHI=Herfindahl-Hirschman Index. The slope of the regression line in the figure is statistically significant at the p<0.01 level. See Table A5 in the appendix for the regression output that corresponds to this figure.

The correlation between breast cancer exam prices and hematology/oncology market concentration is shown in Figure 22. The average median breast cancer exam price across the 18 rating areas analyzed was $4,686. In San Diego, which had a hematology/oncology HHI of 1,298 in 2014, the median breast cancer exam price was $4,310. In San Francisco, where hematology/oncology HHI was 4,331, the median breast cancer exam price was $5,898 – 37% above the median breast cancer exam price in San Diego.

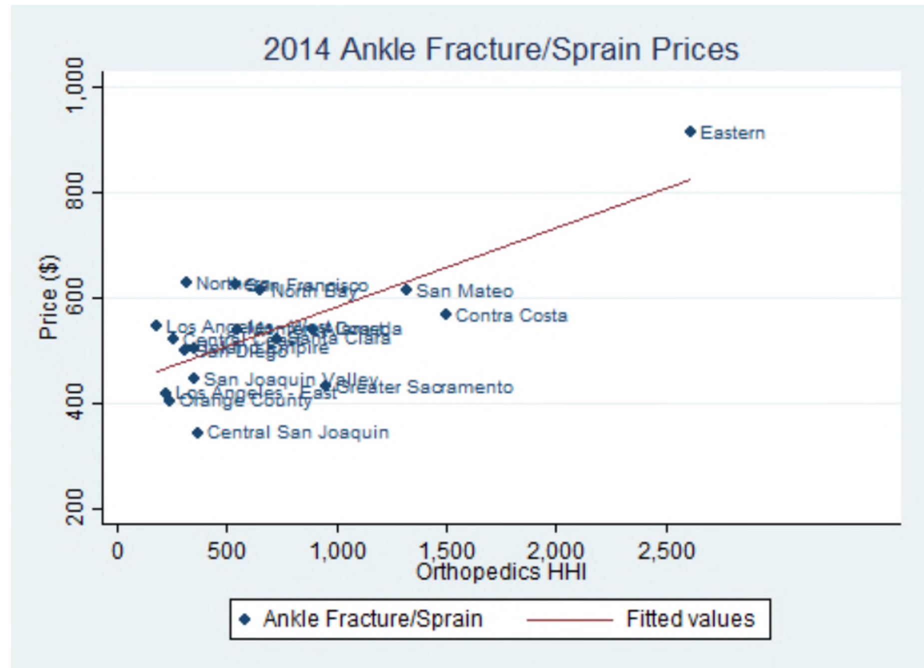
Figure 22. Breast Cancer Exam Price and Hematology/Oncology HHI Correlation



Note: HHI=Herfindahl-Hirschman Index. The slope of the regression line in the figure is statistically significant at the p<0.05 level. See Table A6 in the appendix for the regression output that corresponds to this figure.

Figure 23 shows the correlation between ankle fracture/sprain prices and orthopedics market concentration. The average median ankle fracture/sprain price across the 18 rating areas analyzed was $537. In Orange County, which had an orthopedics HHI of 240 in 2014, the median ankle fracture/sprain price was $404. In the Eastern rating area, where orthopedics HHI was 2,612, the median ankle fracture/sprain price was $911 – over double the median ankle fracture/sprain price in Orange County.

Figure 23. Ankle Fracture/Sprain Price and Orthopedics HHI Correlation



Note: HHI=Herfindahl-Hirschman Index. The slope of the regression line in the figure is statistically significant at the p<0.01 level. See Table A7 in the appendix for the regression output that corresponds to this figure.

Figure 24 shows the correlation between ACA premiums and insurer market concentration (see Table A2 in the appendix for benchmark premiums and insurer HHIs by rating area). The premiums shown in the figure are the second-lowest cost silver plan (hereafter, benchmark plan) in each rating area in 2016. The premium of the benchmark plan in each rating area is used to compute the advance premium tax credits available to household between 138% and 400% of the federal poverty level. The average monthly benchmark plan premium for an unsubsidized 40-year old across the 19 rating areas analyzed was $342 in 2016.[10] In San Diego, which had an insurer HHI of 1,539 in 2016, the average monthly benchmark plan premium was $296 for an unsubsidized 40-year-old. In the Monterey Coast rating area, where insurer HHI was 3,380, the average monthly benchmark plan premium was $421 for an unsubsidized 40-year-old – 42% above the monthly premium in San Diego.

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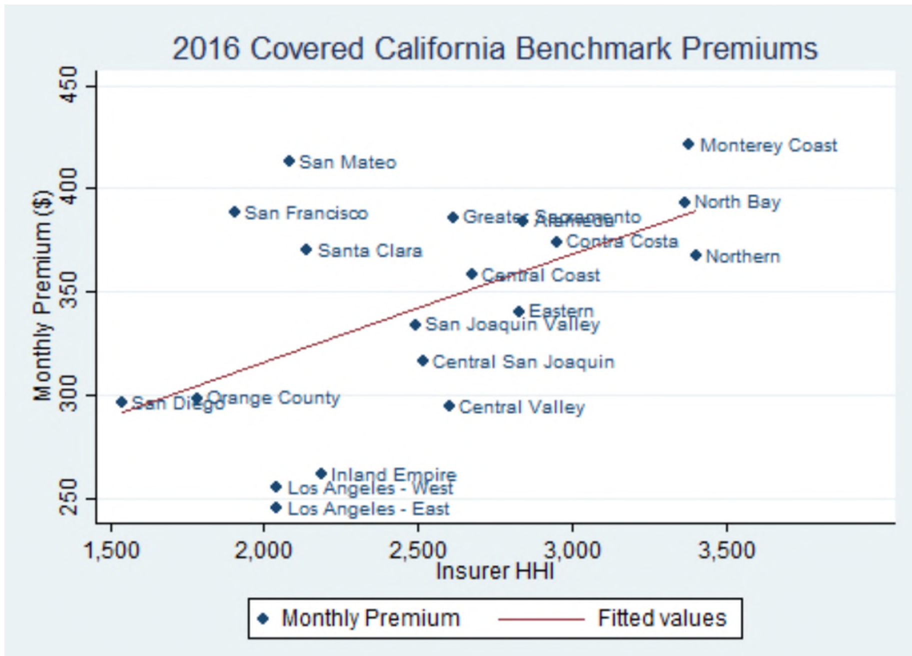
[10] http://www.chcf.org/aca-411/explore-the-data#chart%2Caffordability%2Cpremiums%2Cprem_assistance%2CRegionMap%20(totalprem)%2C2016%2Cregion12

Figure 24. Covered California Benchmark Premium and Insurer HHI Correlation



Notes: HHI=Herfindahl-Hirschman Index. The benchmark premium shown in the figure is the monthly premium an unsubsidized 40-year-old would pay for the second-lowest-cost silver plan in each rating area. The slope of the regression line in the figure is statistically significant at the p<0.01 level. See Table A8 in the appendix for the regression output that corresponds to this figure.

The Association between the Percent of Physicians Working for Foundations Owned by Hospitals or Health Systems and Outpatient Procedure Prices

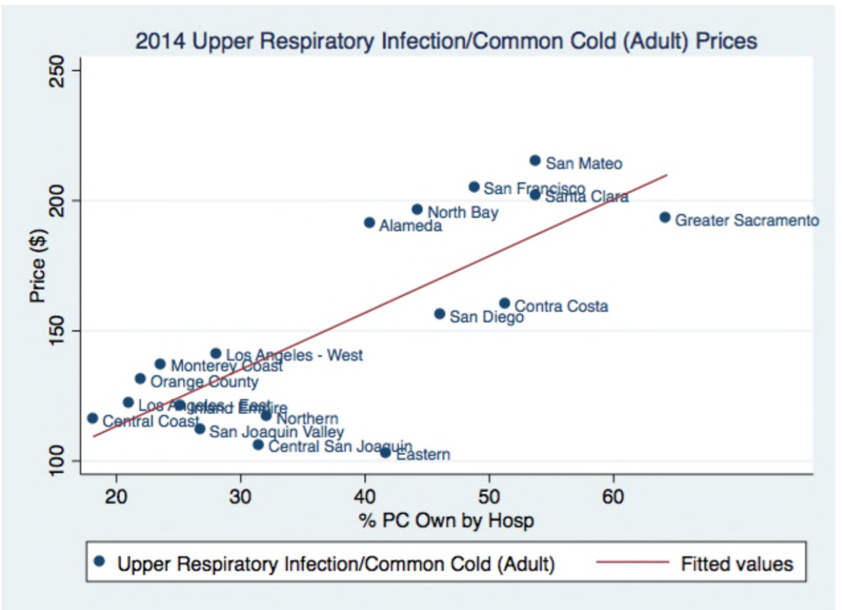
The next set of analyses (Figures 25-28) repeat the analyses in Figures 20-24 above, but with the percent of physicians who work for foundations owned by hospitals or health systems. Based on previous studies, we predict that rating areas with a higher percent of physicians working for foundations owned by hospitals or health systems will be associated with higher outpatient procedure prices (see Post et al. (2017) for a review of this literature). Table A15 in the appendix displays the rating area-level percent of physicians working for foundations owned by hospitals or health systems that we used in the price correlations that follow. We did performed the analysis for the same 18 outpatient procedures we analyzed in the previous section.[11] Again, for brevity, we show the result for one procedure with each specialty in the main text. The graphical depictions of the results for the remaining 14 procedures are available in the appendix as Figures A18-A31. The regressions from which the figures were produced are also available in the appendix. Tables A16-A19 show unweighted regressions while the regressions in Tables A20-A23 are weighted by the population in each rating area. Tables A16-

[11] **Outpatient procedures (18)**: Primary Care (9) – cervical cancer screening converted, colon cancer screening – sigmoidoscopy, diagnostic blood fecal test, diverticular disease, fibroids, kidney (renal) failure, sore throat, upper respiratory infection/common cold (adult), urinary tract stone; Cardiology (3) – cardiomyopathy (heart muscle disease), cardiovascular symptoms (other), coronary artery disease with heart bypass surgery; Hematology/Oncology (3) – breast cancer, lung, bronchi, or mediastinum cancer, prostate cancer; Orthopedics (3) – ankle fracture/sprain, knee ligament injury, wrist or hand fracture/dislocation/sprain

A23 all perform the analysis using both unadjusted prices and input cost adjusted prices. All the figures shown in the main text use unadjusted prices.

Figure 25 shows the correlation between upper respiratory infection/common cold (adult) prices and the percent of primary care physicians in a rating area who work for foundations owned by a hospital or health system. The average median upper respiratory infection/common cold (adult) price across the 18 rating areas analyzed was $151. In Orange County, which had 22% of its primary care physicians working for a foundation owned by a hospital or health system, the median price to treat a common cold was $131. Alternatively, in San Francisco, where 49% of primary care physicians work for a foundation owned by a hospital or health system, the median price to treat a common cold was $205 – 56% above the price to treat a common cold in Orange County.

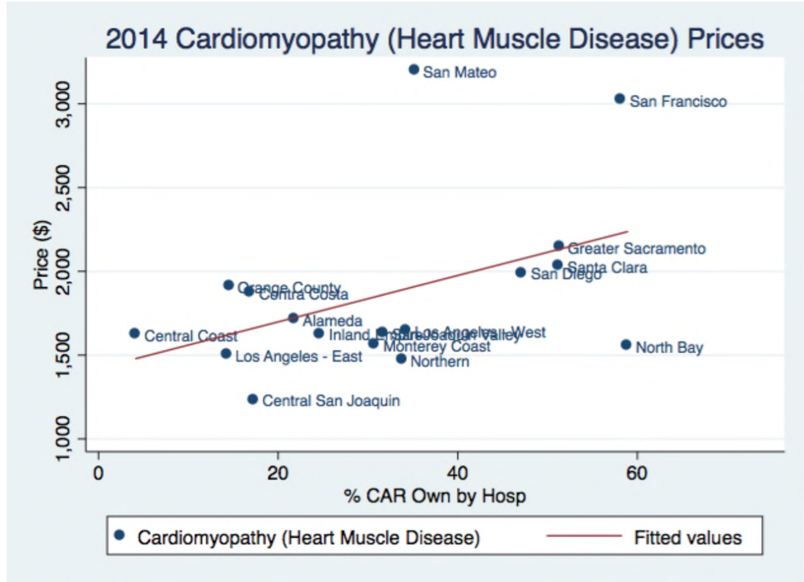
Figure 25. Upper Respiratory Infection/Common Cold Price and the Percent of Primary Care Physicians Working for Foundations Owned by a Hospital or Health System Correlation



Note: % PC Own by Hosp = the percent of primary care physicians in a rating area who work for foundations owned by hospital or health systems. The slope of the regression line in the figure is statistically significant at the p<0.01 level. See Table A16 in the appendix for the regression output that corresponds to this figure.

Figure 26 shows the correlation between cardiomyopathy (heart muscle disease) prices and the percent of cardiologists in a rating area who work for foundations owned by a hospital or health system. The average median cardiomyopathy price across the 17 rating areas analyzed was $1,867. In Los Angeles – East, which had 14% of its cardiologists working for a foundation owned by a hospital or health system, the median cardiomyopathy price was $1,500. In San Francisco, where 58% of cardiologists work for a foundation owned by a hospital or health system, the median cardiomyopathy price was $3,023 – about double the cardiomyopathy price of Los Angeles.

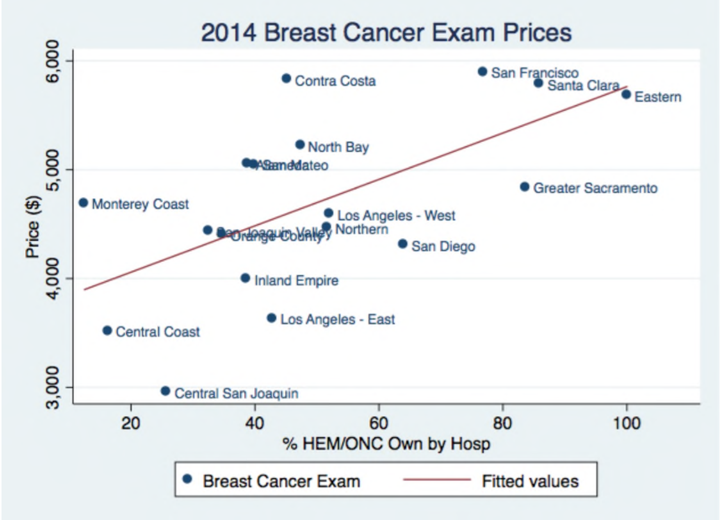
Figure 26. Cardiomyopathy (Heart Muscle Disease) Price and the Percent of Cardiologists Working for Foundations Owned by a Hospital or Health System Correlation



Note: % CAR Own by Hosp = the percent of cardiologists in a rating area who work for foundations owned by hospital or health systems. The slope of the regression line in the figure is statistically significant at the p<0.10 level. See Table A17 in the appendix for the regression output that corresponds to this figure.

The correlation between breast cancer exam prices and the percent of hematologists/oncologists in a rating area who work for foundations owned by a hospital or health system is shown in Figure 27. The average median breast cancer exam price across the 18 rating areas analyzed was $4,686. In the Central Coast, which had 16% of its hematologists/oncologists working for a foundation owned by a hospital or health system, the median breast cancer exam price was $3,516. In San Francisco, where 77% of hematologists/oncologists work for a foundation owned by a hospital or health system, the median breast cancer exam price was $5,898 – 68% above the median breast cancer exam price in the Central Coast.

Figure 27. Breast Cancer Exam Price and the Percent of Hematologists/Oncologists Working for Foundations Owned by a Hospital or Health System Correlation



Note: % HEM/ONC Own by Hosp = the percent of hematologists/oncologists in a rating area who work for foundations owned by a hospital or health system. The slope of the regression line in the figure is statistically significant at the p<0.01 level. See Table A18 in the appendix for the regression output that corresponds to this figure.

Figure 28 shows the correlation between knee ligament injury prices and the percent of orthopedists in a rating area who work for foundations owned by a hospital or health system. The average median knee ligament injury price across the 18 rating areas analyzed was $279. In Orange County, which had 17% of its orthopedists working for a foundation owned by a hospital or health system, the median knee ligament injury price was $270. In San Mateo, where 56% of orthopedists work for a foundation owned by a hospital or health system, the median knee ligament injury price was $326 – 21% above the median breast cancer exam price in the Central Coast.

Figure 28. Knee Ligament Injury Price and the Percent of Orthopedists Working for Foundations Owned by a Hospital or Health System Correlation

Note: % ORS Own by Hosp = the percent of orthopedists in a rating area who work for foundations owned by a hospital or health system. The slope of the regression line in the figure is statistically significant at the p<0.05 level. See Table A19 in the appendix for the regression output that corresponds to this figure.

Prices and Premiums in Rating Areas with HHIs Above and Below the HHI Thresholds Used by the Horizontal Merger Guidelines

Tables 9 and 10 show how prices and premiums vary in rating areas above and below *Horizontal Merger Guidelines* thresholds (U.S. Department of Justice and the Federal Trade Commission 2010). For hospital and physician prices, we use HHI=1,500 as our cutoff for dividing rating areas. According to the Guidelines, 1,500 is the threshold for a moderately concentrated market.

Table 9 shows that 6 rating areas have hospital HHIs below 1,500 while 12 rating areas have hospital HHIs above 1,500 (see Table A1 in the appendix for the list of rating area-level hospital and physician HHIs). The average inpatient procedure price was $139,909 in rating areas below HHI=1,500 and $250,203 in rating areas above HHI=1,500 – a 79% difference. The three inpatient procedures used to compute average inpatient procedure price are listed in the notes below the table. Results for individual procedures are available in Table A24 in the appendix.

Likewise, average outpatient primary care, hematology/oncology, and orthopedics procedure prices were much higher in rating areas above HHI=1,500 than in rating areas below HHI=1,500. Average outpatient primary care procedure prices were 35% higher ($898 vs. $665), average outpatient hematology/oncology procedure prices were 51% higher ($20,819 vs. $13,762), and average outpatient orthopedics procedure prices were 63% higher ($715 vs. $439).

At the bottom of Table 9, we show how ACA premiums differ in rating areas above and below HHI=2,500 – the Guidelines' threshold for a highly concentrated market. In the 9 rating areas below insurer HHI=2,500 average ACA benchmark plan monthly premiums were $318 versus $363 in the 10 rating areas with insurer above HHI=2,500 – a 14% difference.

Table 9. Prices (2014) and ACA Premiums (2016) by HHI Level

	HHI < 1,500	HHI ≥ 1,500	% Difference
Avg. Inpatient Procedure Price	**$139,909**	**$250,203**	**79%**
# of rating areas (Hospital HHI)	*6*	*12*	
Avg. Outpatient Primary Care Procedure Price	**$665**	**$898**	**35%**
*# of rating areas (Primary Care HHI***)*	*12*	*6*	
Avg. Outpatient Hematology/Oncology Procedure Price	**$13,762**	**$20,819**	**51%**
# of rating areas (Hematology/Oncology HHI)	*11*	*7*	
Avg. Outpatient Orthopedist Procedure Price	**$439**	**$715**	**63%**
# of rating areas (Orthopedics HHI)	*17*	*1*	
	HHI < 2,500	HHI ≥ 2,500	% Difference
Avg. ACA Benchmark Plan Monthly Premium	**$318**	**$363**	**14%**
# of rating areas	*9*	*10*	

*Notes: The procedures below were used to compute average prices for each provider category. The average reported above is a straight average across the procedures within each category. Cardiology prices are not reported as no rating areas had a cardiology HHI below 1,500 (see Table A1 in the appendix). The premiums listed in Table A2 were used for the analysis of Avg. ACA Benchmark Plan Monthly Premiums. *** Primary Care HHI was calculated at the primary care service area (PCSA)-level and then weighted up to the rating area-level (see Goodman et al. (2003) for details on PCSAs). All other HHIs were calculated directly at the rating area-level.*

***Inpatient procedures (3)**: heart attack (acute myocardial infarction), partial hip replacement revision, premature baby (extremely low weight)*
***Outpatient procedures (15)**:*
Primary Care (9) – cervical cancer screening converted, colon cancer screening – sigmoidoscopy, diagnostic blood fecal test, diverticular disease, fibroids, kidney (renal) failure, sore throat, upper respiratory infection/common cold (adult), urinary tract stone
Hematology/Oncology (3) – breast cancer, lung, bronchi, or mediastinum cancer, prostate cancer
Orthopedics (3) – ankle fracture/sprain, knee ligament injury, wrist or hand fracture/dislocation/sprain

Table 10 repeats the analysis performed in Table 9 but with input cost adjusted prices. Results for individual procedures are available in Table A25 in the appendix. In Table 10, all procedure prices and premiums were input cost adjusted using the Medicare wage index. The Medicare program uses the Medicare wage index to adjust standardized amounts paid to hospitals to account for differences in hospital wage levels across regions.[12] Table 10 shows that while accounting for regional input cost differences generally shrinks the price (ACA premium) difference, there are still considerable differences in procedure prices (ACA premiums) in rating areas above and below HHI=1,500 (HHI=2,500). For instance, unadjusted inpatient procedure prices are 79% higher in rating areas above HHI=1,500 than in rating areas below HHI=1,500 (Table 9), while input cost adjusted inpatient procedure prices are 52% higher in rating areas above HHI=1,500 than in rating areas below HHI=1,500 (Table 10).

[12] The Centers for Medicare & Medicaid Services currently defines "hospital geographic areas (labor markets areas) based on the definitions of Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget and announced in December 2003." We population-weighted CBSA-level Medicare wage indices to construct the rating area-level Medicare wage indices used in our analysis.

Table 10. Input cost adjusted Prices (2014) and ACA Premiums (2016) by HHI Level

	HHI < 1,500	HHI ≥ 1,500	% Difference
Input cost adjusted Avg. Inpatient Procedure Price	**$108,483**	**$165,119**	**52%**
# of rating areas	*6*	*12*	
Input cost adjusted Avg. Outpatient Primary Care Procedure Price* ***	**$472**	**$622**	**32%**
# of rating areas	*12*	*6*	
Input cost adjusted Avg. Outpatient Hematology/Oncology Procedure Price	**$10,370**	**$13,269**	**28%**
# of rating areas	*11*	*7*	
Input cost adjusted Avg. Outpatient Orthopedist Procedure Price	**$311**	**$577**	**85%**
# of rating areas	*17*	*1*	
	HHI < 2,500	HHI ≥ 2,500	% Difference
Input cost adjusted Avg. ACA Benchmark Plan Monthly Premium	**$233**	**$256**	**10%**
# of rating areas	*9*	*10*	

*Notes: The procedures below were used to compute average prices for each provider category. The average reported above is a straight average across the procedures within each category. Cardiology prices are not reported as no rating areas had a cardiology HHI below 1,500 (see Table A1 in the appendix). The premiums listed in Table A2 were used for the analysis of Avg. ACA Benchmark Plan Monthly Premiums. Prices and ACA premiums were input cost adjusted using the Medicare wage index to adjust for input cost differences across regions. The Centers for Medicare & Medicaid Services currently defines "hospital geographic areas (labor markets areas) based on the definitions of Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget and announced in December 2003." We population-weighted CBSA-level Medicare wage indices to construct the rating area-level Medicare wage indices used in our analysis. *** Primary Care HHI was calculated at the primary care service area (PCSA)-level and then weighted up to the rating area-level (see Goodman et al. (2003) for details on PCSAs). All other HHIs were calculated directly at the rating area-level.*

Inpatient procedures (3)*: heart attack (acute myocardial infarction), partial hip replacement revision, premature baby (extremely low weight)*
Outpatient procedures (15)*:*
Primary Care (9) – cervical cancer screening converted, colon cancer screening – sigmoidoscopy, diagnostic blood fecal test, diverticular disease, fibroids, kidney (renal) failure, sore throat, upper respiratory infection/common cold (adult), urinary tract stone
Hematology/Oncology (3) – breast cancer, lung, bronchi, or mediastinum cancer, prostate cancer
Orthopedics (3) – ankle fracture/sprain, knee ligament injury, wrist or hand fracture/dislocation/sprain

A Tale of Prices and Premiums in Northern vs. Southern California

There are stark differences in prices and ACA premiums between Northern and Southern California. Covered California defines Northern California as rating areas 1-14 and Southern California as rating areas 15-19.[13] Table 11 compares the average median price in Northern California to the average median price in Southern California for the same 21 procedure prices we have been analyzing throughout the report. Results for individual procedures are available in Table A26 in the appendix. Inpatient procedure prices were 70% higher in Northern California than Southern California $131,586 vs. $223,278) while hospital HHI was 110% higher in Northern California than Southern California (2,202 vs. 1,047) in 2014. Among outpatient procedures, Northern California prices were 17-55% higher than Southern California prices in 2014, depending on the physician specialty. The average outpatient hematology/oncology procedure price was 17% higher in Northern California than Southern California ($11,905 vs. $18,445) while hematology/oncology HHI was 174% higher in Northern California than Southern California (2,257 vs. 823). Average outpatient cardiology procedure price was 55% higher in Northern California than Southern California ($17,653 vs. $28,955) while cardiology HHI was 143% higher in Northern California than Southern California (857 vs. 352).

ACA premiums were similarly much higher in Northern California than Southern California. In 2016, benchmark monthly premiums for an unsubsidized 40-year-old were 35% higher in Northern California than Southern California ($367 vs. $271) while insurer HHI was 41% higher in Northern California than Southern California (2,700 vs. 1,919).

[13] Rating Areas (#-name): 1-Northern counties, 2-North Bay counties, 3-Greater Sacramento, 4-San Francisco, 5-Contra Costa, 6-Alameda, 7-Santa Clara, 8-San Mateo, 9-Central Coast, 10-Central Valley, 11-Central Valley, 12-Central Coast, 13-Eastern Region, 14-Central Valley, 15-Los Angeles (Northeast), 16-Los Angeles (Southwest), 17-Inland Empire, 18-Orange County, 19-San Diego. No pricing data for rating area 14 was available from California Health Care Compare, so the north vs. south price comparison we show is for rating areas 1-13 (north) vs. rating areas 15-19 (south).

Table 11. Northern California vs. Southern California Prices (2014) and ACA Premiums (2016)

	Southern California	Northern California	% Difference
Avg. Inpatient Procedure Price	**$131,586**	**$223,278**	**70%**
Avg. Hospital HHI	*1,047*	*2,202*	*110%*
Avg. Outpatient Primary Care Procedure Price	**$588**	**$802**	**36%**
*Avg. Primary Care HHI****	*996*	*1,420*	*43%*
Avg. Outpatient Cardiology Procedure Price	**$17,653**	**$28,955**	**55%**
Avg. Cardiology HHI	*352*	*857*	*143%*
Avg. Outpatient Hematology/Oncology Procedure Price	**$11,905**	**$18,445**	**17%**
Avg. Hematology/Oncology HHI	*823*	*2,257*	*174%*
Avg. Outpatient Orthopedist Procedure Price	**$396**	**$477**	**20%**
Avg. Orthopedist HHI	*263*	*851*	*224%*
Avg. ACA Benchmark Plan Monthly Premium	**$271**	**$367**	**35%**
Avg. Insurer HHI	*1,919*	*2,700*	*41%*

Notes:
Procedures included in each price average:
***Inpatient procedures (3)**: heart attack (acute myocardial infarction), partial hip replacement revision, premature baby (extremely low weight)*
***Outpatient procedures (15)**:*
Primary Care (9) – cervical cancer screening converted, colon cancer screening – sigmoidoscopy, diagnostic blood fecal test, diverticular disease, fibroids, kidney (renal) failure, sore throat, upper respiratory infection/common cold (adult), urinary tract stone
Cardiology (3) – cardiomyopathy (heart muscle disease), cardiovascular symptoms (other), coronary artery disease with heart bypass surgery
Hematology/Oncology (3) – breast cancer, lung, bronchi, or mediastinum cancer, prostate cancer
Orthopedics (3) – ankle fracture/sprain, knee ligament injury, wrist or hand fracture/dislocation/sprain

- *Covered California defines Northern California as rating areas 1-14 and Southern California as rating areas 15-19. Rating Areas (#-name): 1-Northern counties, 2-North Bay counties, 3-Greater Sacramento, 4-San Francisco, 5-Contra Costa, 6-Alameda, 7-Santa Clara, 8-San Mateo, 9-Central Coast, 10-Central Valley, 11-Central Valley, 12-Central Coast, 13-Eastern Region, 14-Central Valley, 15-Los Angeles (Northeast), 16-Los Angeles (Southwest), 17-Inland Empire, 18-Orange County, 19-San Diego*
- *The average Northern California HHIs were computed by taking a straight average across the HHIs in rating areas 1-14 and the Southern California HHIs were straight average across the HHIs in rating areas 15-19. No procedure price data was available for rating area 14 and thus the hospital and physician average HHIs above do not include rating area 14.*
- **** Primary Care HHI was calculated at the primary care service area (PCSA)-level and then weighted up to the rating area-level (see Goodman et al. (2003) for details on PCSAs). All other HHIs were calculated directly at the rating area-level.*

Table 12 repeats the analysis of Table 11 but with input cost adjusted prices. Results for individual procedures are available in Table A27 in the appendix. In Table 12, all procedure prices and premiums were input cost adjusted using the Medicare wage index.[14] Table 12 shows that while accounting for regional input cost differences generally shrinks the price difference between Northern and Southern California, the difference is still often considerable in magnitude. For instance, unadjusted inpatient procedure prices are 70% higher in Northern California than Southern California (Table 11), while input cost adjusted inpatient procedure prices are 32% higher in Northern California than Southern California .

[14] The Centers for Medicare & Medicaid Services currently defines "hospital geographic areas (labor markets areas) based on the definitions of Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget and announced in December 2003." We population-weighted CBSA-level Medicare wage indices to construct the rating area-level Medicare wage indices used in our analysis.

Table 12. Input Cost Adjusted Northern California vs. Southern California Prices (2014) and ACA Premiums (2016)

	Southern California	Northern California	% Difference
Input Cost Adjusted Avg. Inpatient Procedure Price	**$111,816**	**$147,922**	**32%**
Avg. Hospital HHI	*1,047*	*2,202*	*110%*
Input Cost Adjusted Avg. Outpatient Primary Care Procedure Price	**$495**	**$532**	**8%**
*Avg. Primary Care HHI****	*996*	*1,420*	*43%*
Input Cost Adjusted Avg. Outpatient Cardiology Procedure Price	**$14,844**	**$18,954**	**28%**
Avg. Cardiology HHI	*352*	*857*	*143%*
Input Cost Adjusted Avg. Outpatient Hematology/Oncology Procedure Price	**$10,042**	**$12,071**	**20%**
Avg. Hematology/Oncology HHI	*823*	*2,257*	*174%*
Input Cost Adjusted Avg. Outpatient Orthopedist Procedure Price	**$333**	**$324**	**-3%**
Avg. Orthopedist HHI	*263*	*851*	*224%*
Input Cost Adjusted Avg. ACA Benchmark Plan Monthly Premium	**$228**	**$251**	**10%**
Avg. Insurer HHI	*1,919*	*2,700*	*41%*

Notes:
Procedures included in each price average:
***Inpatient procedures (3)**: heart attack (acute myocardial infarction), partial hip replacement revision, premature baby (extremely low weight)*
***Outpatient procedures (15)**:*
Primary Care (9) – cervical cancer screening converted, colon cancer screening – sigmoidoscopy, diagnostic blood fecal test, diverticular disease, fibroids, kidney (renal) failure, sore throat, upper respiratory infection/common cold (adult), urinary tract stone
Cardiology (3) – cardiomyopathy (heart muscle disease), cardiovascular symptoms (other), coronary artery disease with heart bypass surgery
Hematology/Oncology (3) – breast cancer, lung, bronchi, or mediastinum cancer, prostate cancer
Orthopedics (3) – ankle fracture/sprain, knee ligament injury, wrist or hand fracture/dislocation/sprain

- *Covered California defines Northern California as rating areas 1-14 and Southern California as rating areas 15-19. Rating Areas (#-name): 1-Northern counties, 2-North Bay counties, 3-Greater Sacramento, 4-San Francisco, 5-Contra Costa, 6-Alameda, 7-Santa Clara, 8-San Mateo, 9-Central Coast, 10-Central Valley, 11-Central Valley, 12-Central Coast, 13-Eastern Region, 14-Central Valley, 15-Los Angeles (Northeast), 16-Los Angeles (Southwest), 17-Inland Empire, 18-Orange County, 19-San Diego*
- *The average Northern California HHIs were computed by taking a straight average across the HHIs in rating areas 1-14 and the Southern California HHIs were straight average across the HHIs in rating areas 15-19. No procedure price data was available for rating area 14 and thus the hospital and physician average HHIs above do not include rating area 14.*
- **** Primary Care HHI was calculated at the primary care service area (PCSA)-level and then weighted up to the rating area-level (see Goodman et al. (2003) for details on PCSAs). All other HHIs were calculated directly at the rating area-level.*

- *All procedure prices and premiums were input cost adjusted using the Medicare wage index. The Centers for Medicare & Medicaid Services currently defines "hospital geographic areas (labor markets areas) based on the definitions of Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget and announced in December 2003." We population-weighted CBSA-level Medicare wage indices to construct the rating area-level Medicare wage indices used in our analysis.*

Limitations

Our analyses of the association between prices of hospital and physician services in California and the market power of hospitals and physicians does have limitations. The analyses are based on one year of price data. With more years of price data we would be able to relate the changes in market power to the changes in prices. Moreover, with additional data, we would be able to have more measures of prices, including the mean prices and the variation of prices within areas. Finally, we have not adjusted for possible quality differences between hospitals and physicians in different regions of California.

Conclusion

It is clear that the market for health care and health insurance is now highly concentrated in California. The vast majority of counties in California warrant concern and scrutiny according to the DOJ/FTC Guidelines. This has likely reduced the level of competition, which has resulted in higher prices and ACA premiums in California. The significant variation in prices and ACA premiums across the state suggests regulatory and legislative solutions need to be implemented. Consumers are paying prices for health care that are considerably above what a more competitive market would produce.

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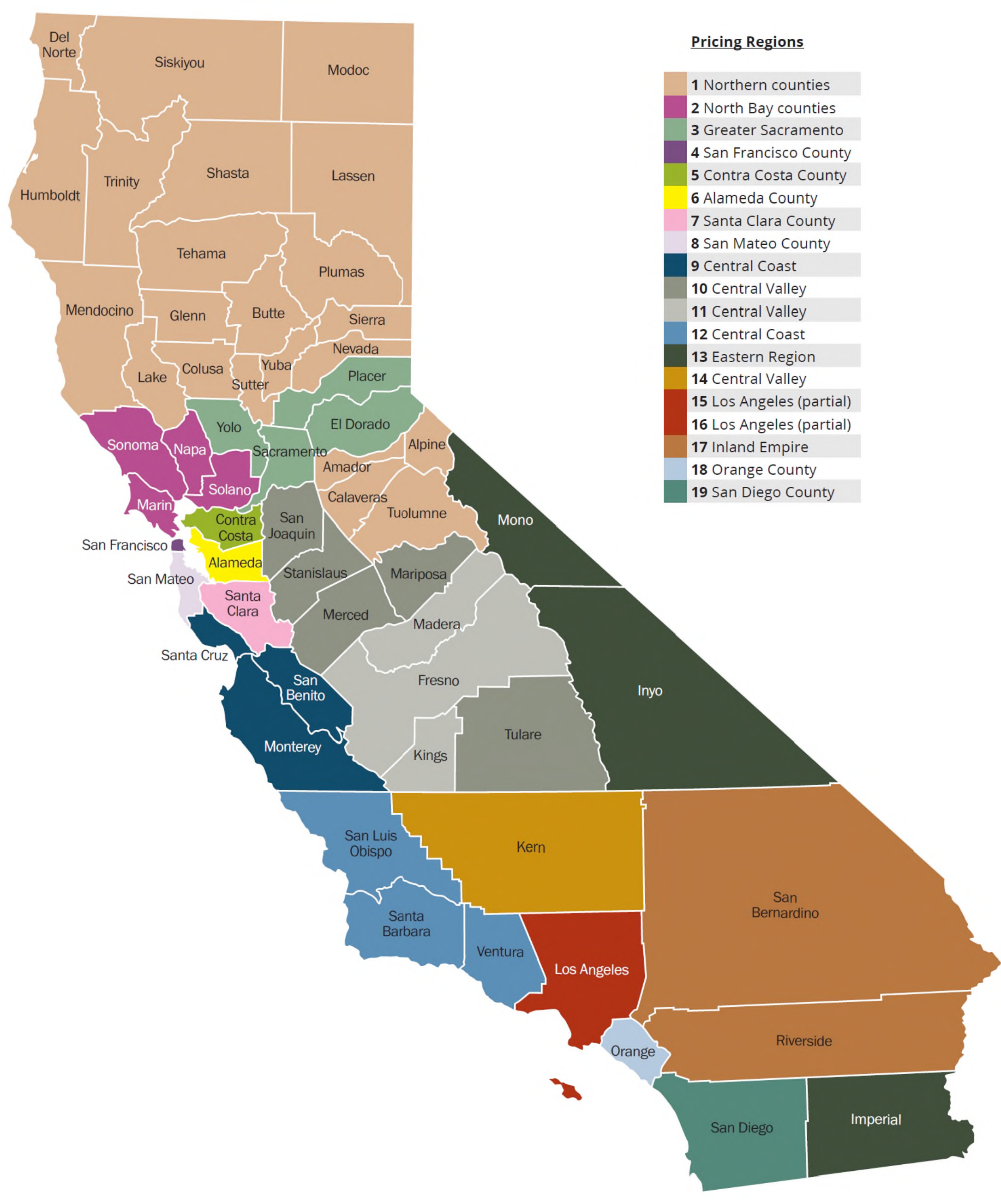
Appendix

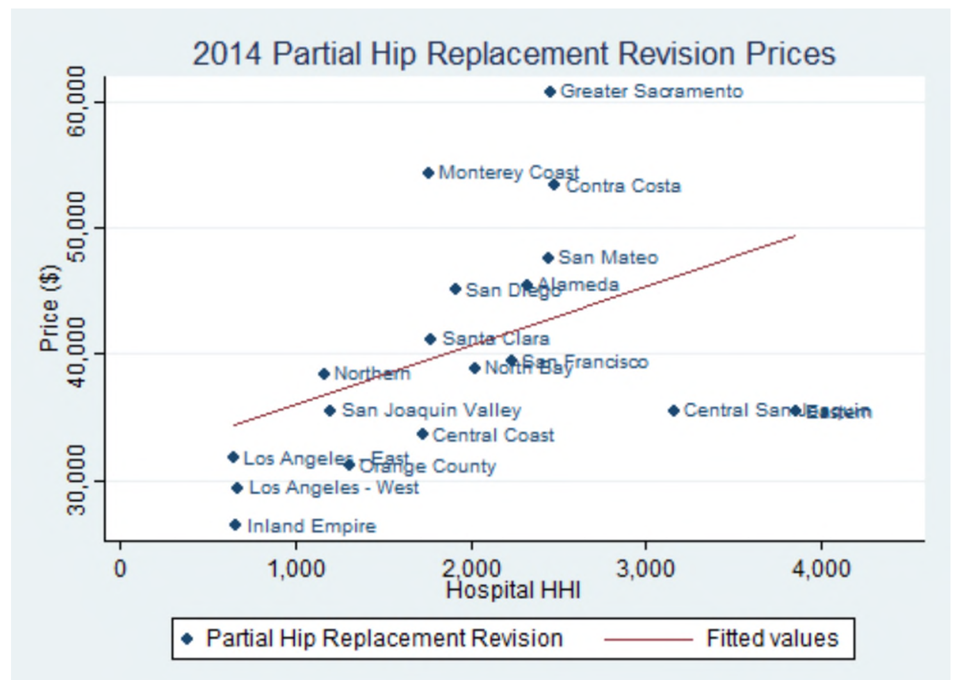
Appendix Figures

Figure A1. Covered California Rating Areas



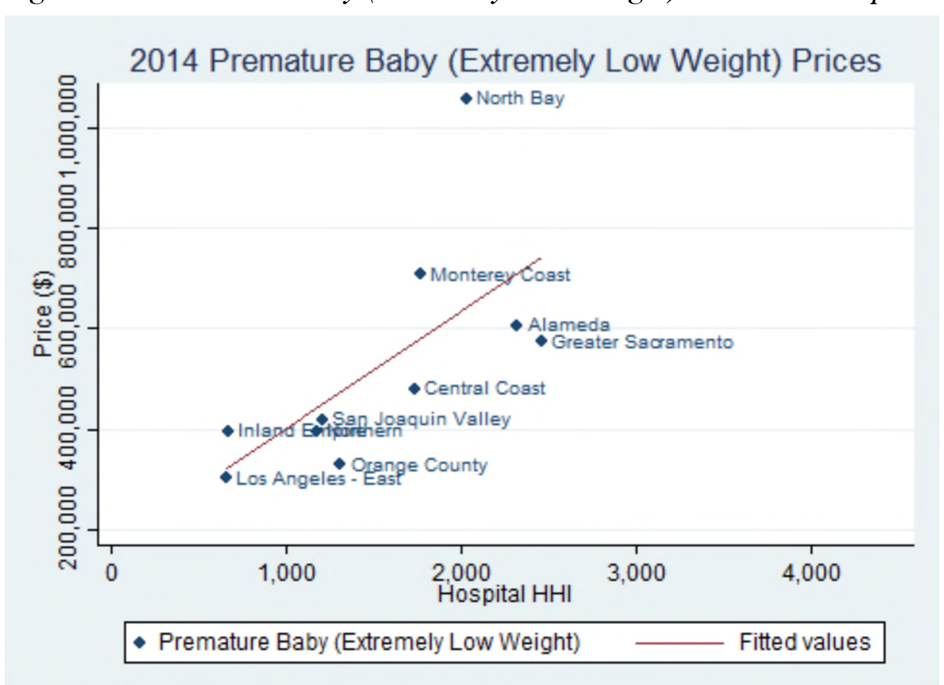
Source: Covered California. 2014. "Health Insurance Companies and Plan Rates for 2015." https://coveredca.com/PDFs/CC-health-plans-booklet-2015.pdf

Figure A2. Partial Hip Replacement Revision Price and Hospital HHI Correlation



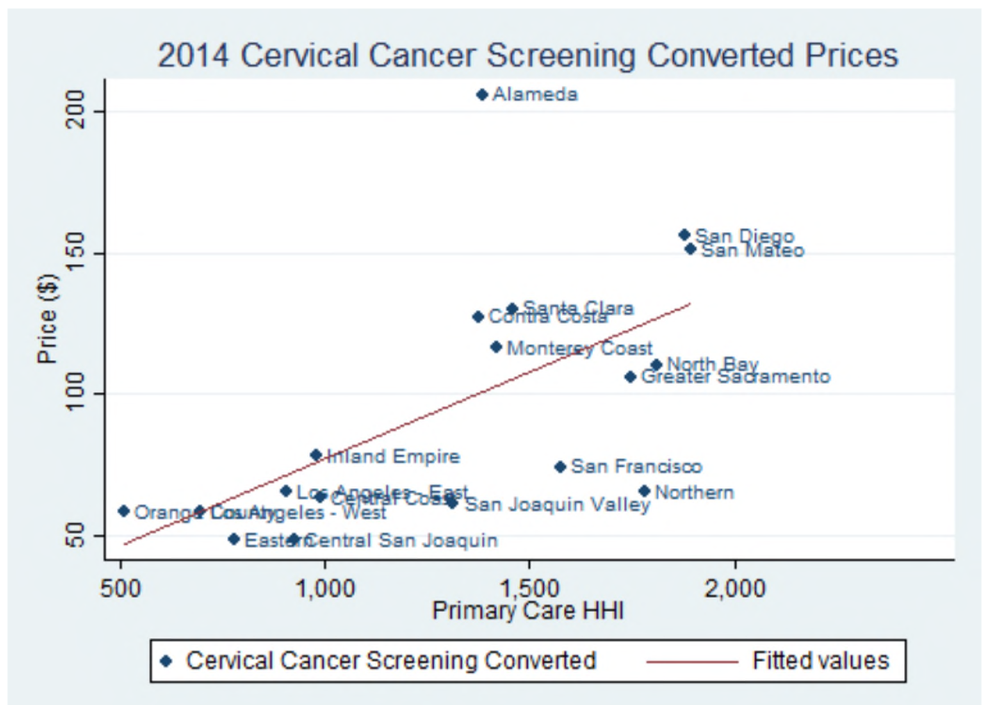
Note: HHI=Herfindahl-Hirschman Index.

Figure A3. Premature Baby (Extremely Low Weight) Price and Hospital HHI Correlation



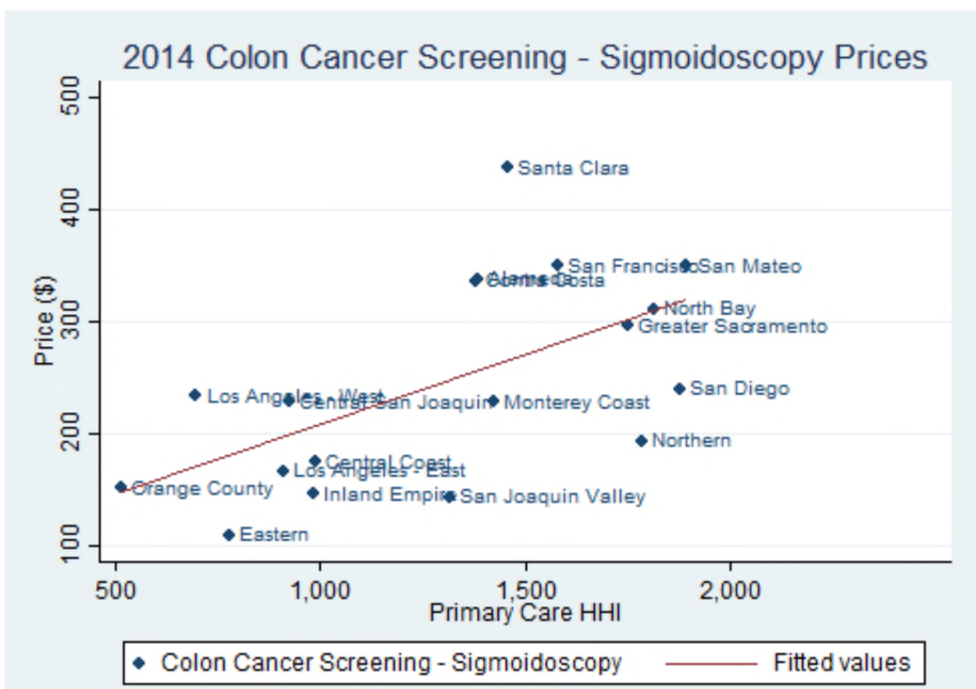
Note: HHI=Herfindahl-Hirschman Index.

Figure A4. Cervical Cancer Screening Converted Price and Primary Care HHI Correlation



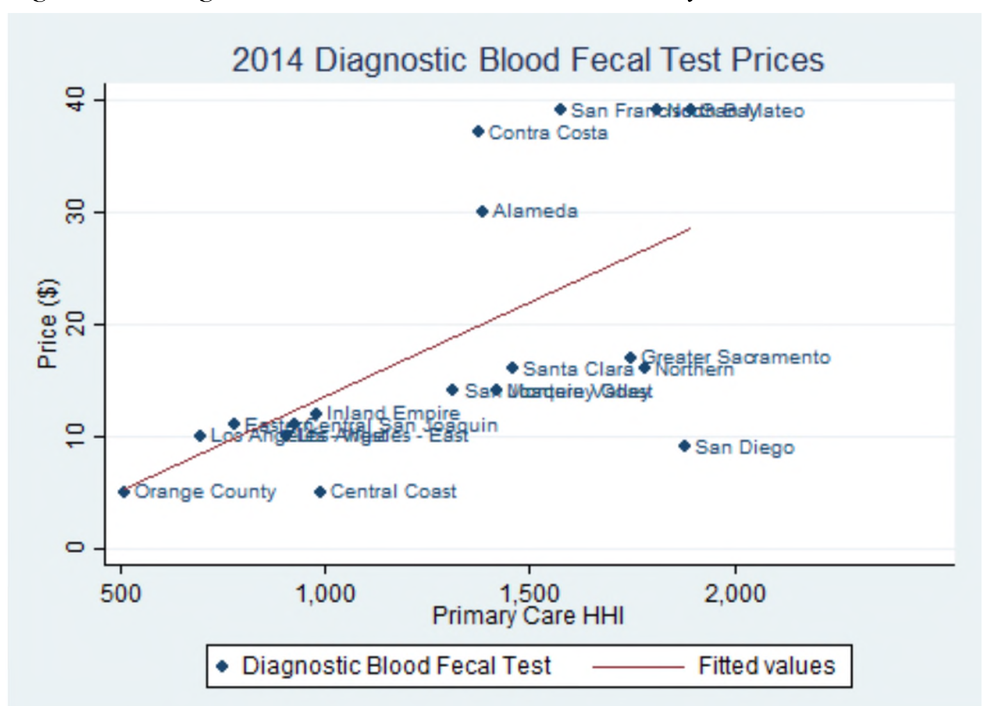
Note: HHI=Herfindahl-Hirschman Index.

Figure A5. Colon Cancer Screening Price and Primary Care HHI Correlation



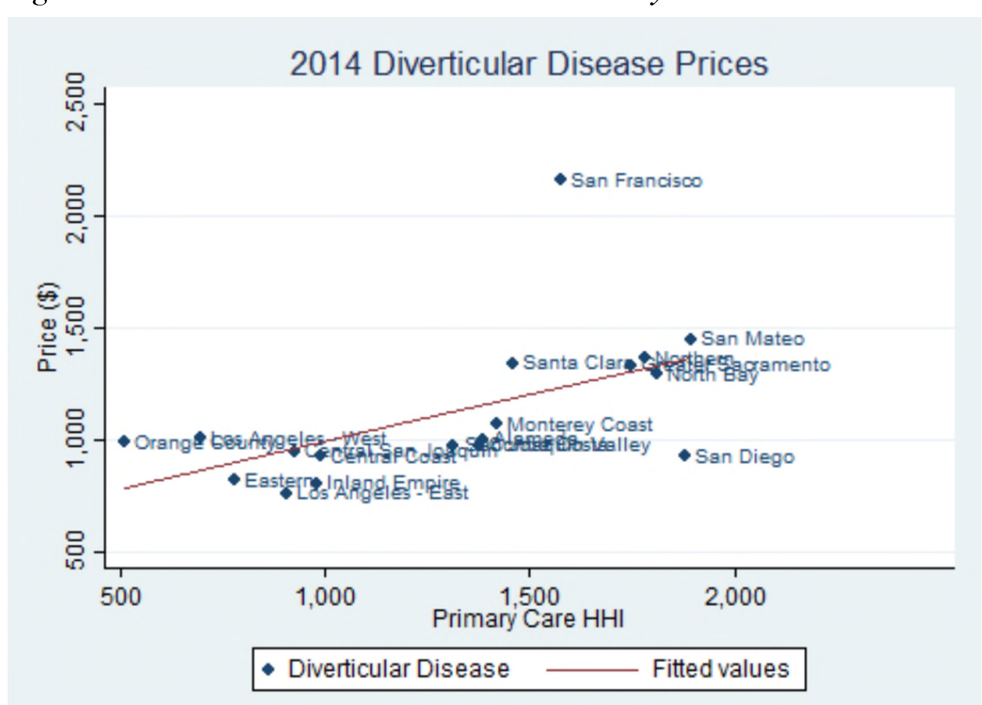
Note: HHI=Herfindahl-Hirschman Index.

Figure A6. Diagnostic Blood Fecal Price and Primary Care HHI Correlation



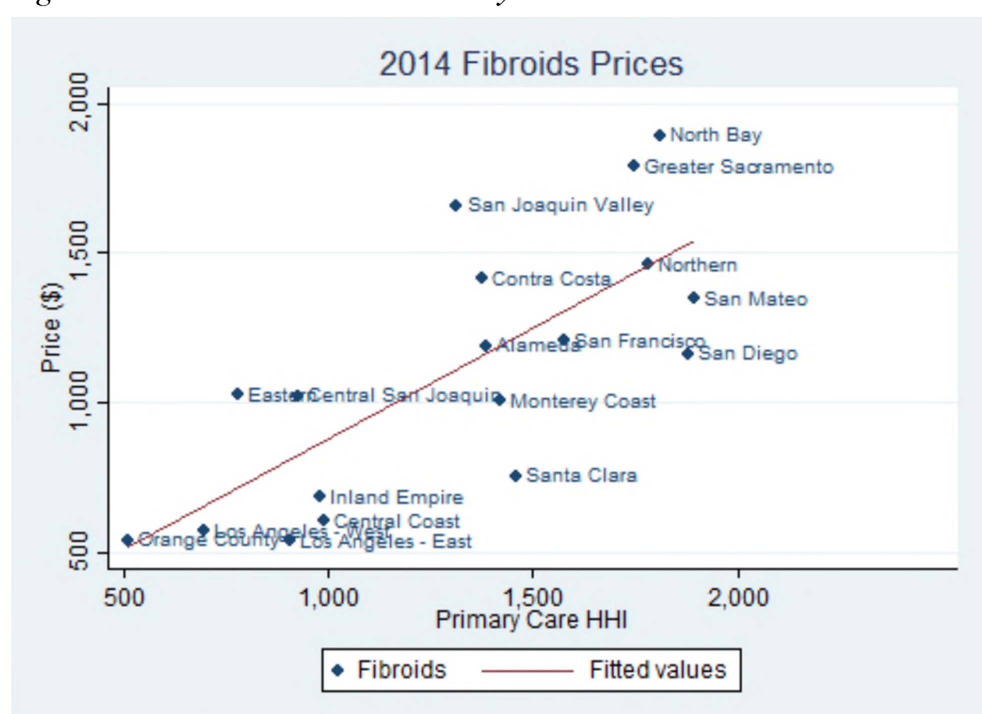
Note: HHI=Herfindahl-Hirschman Index.

Figure A7. Diverticular Disease Price and Primary Care HHI Correlation



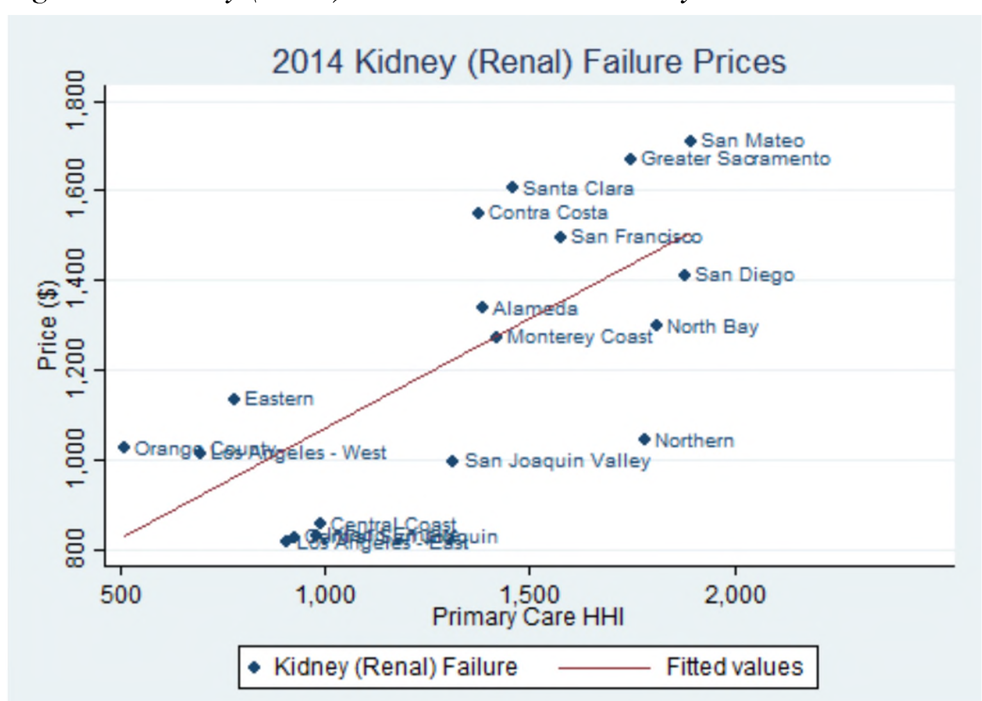
Note: HHI=Herfindahl-Hirschman Index.

Figure A8. Fibroids Price and Primary Care HHI Correlation



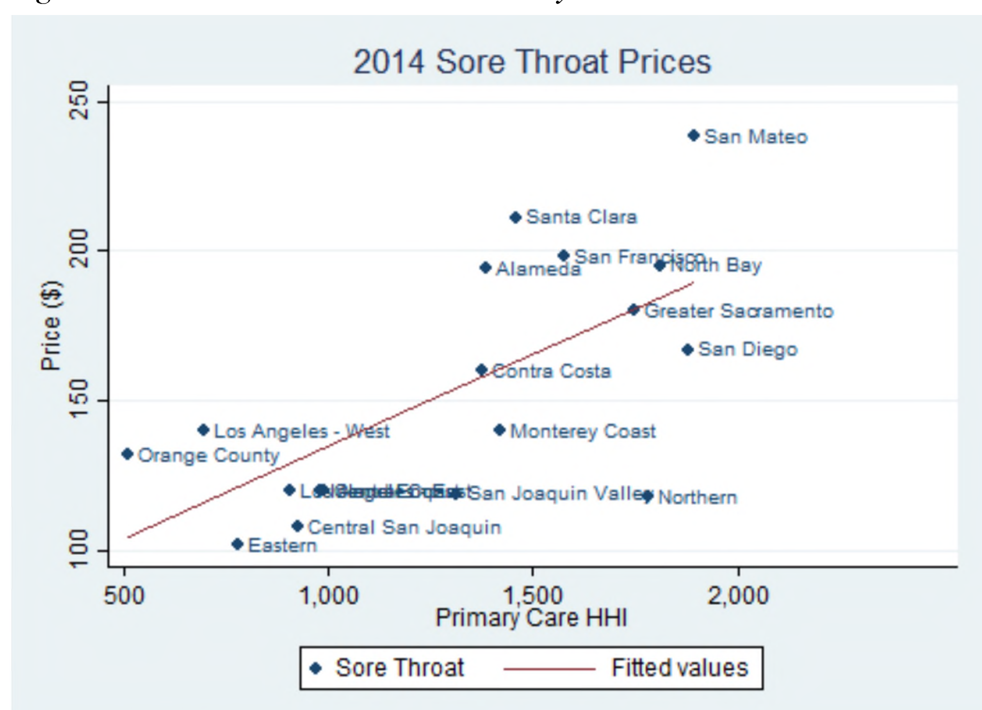
Note: HHI=Herfindahl-Hirschman Index.

Figure A9. Kidney (Renal) Failure Price and Primary Care HHI Correlation



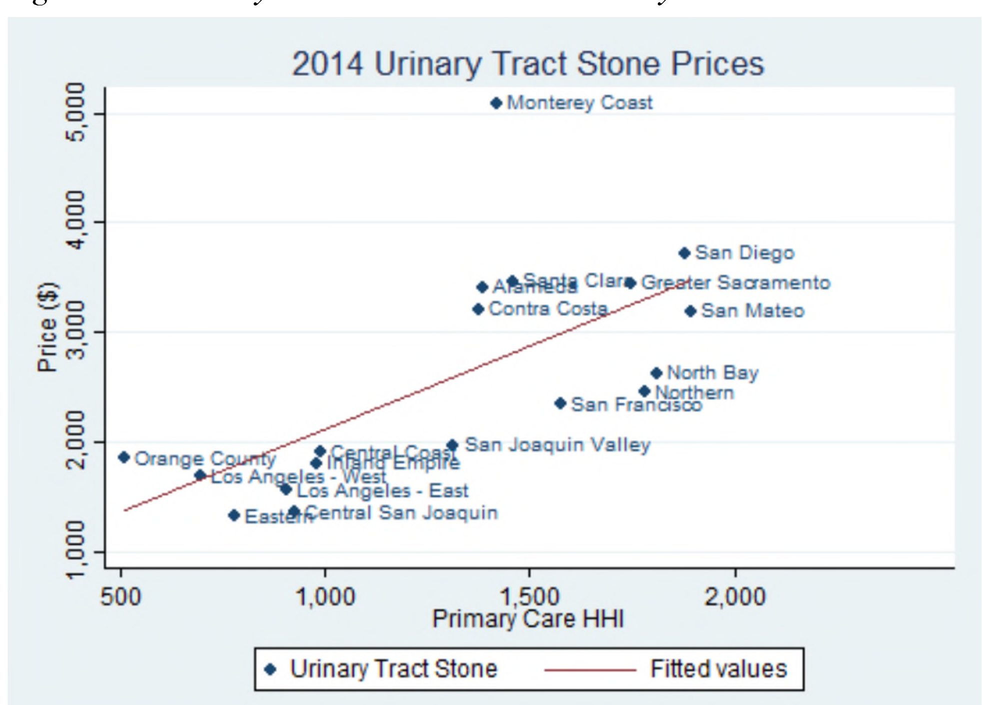
Note: HHI=Herfindahl-Hirschman Index.

Figure A10. Sore Throat Price and Primary Care HHI Correlation



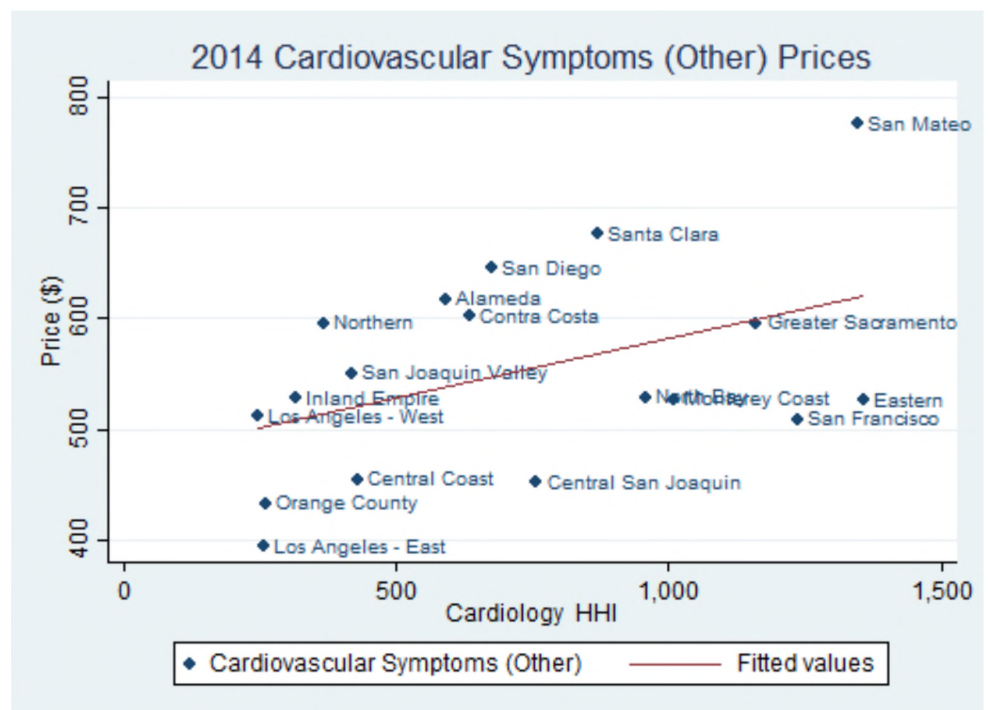
Note: HHI=Herfindahl-Hirschman Index.

Figure A11. Urinary Tract Stone Price and Primary Care HHI Correlation



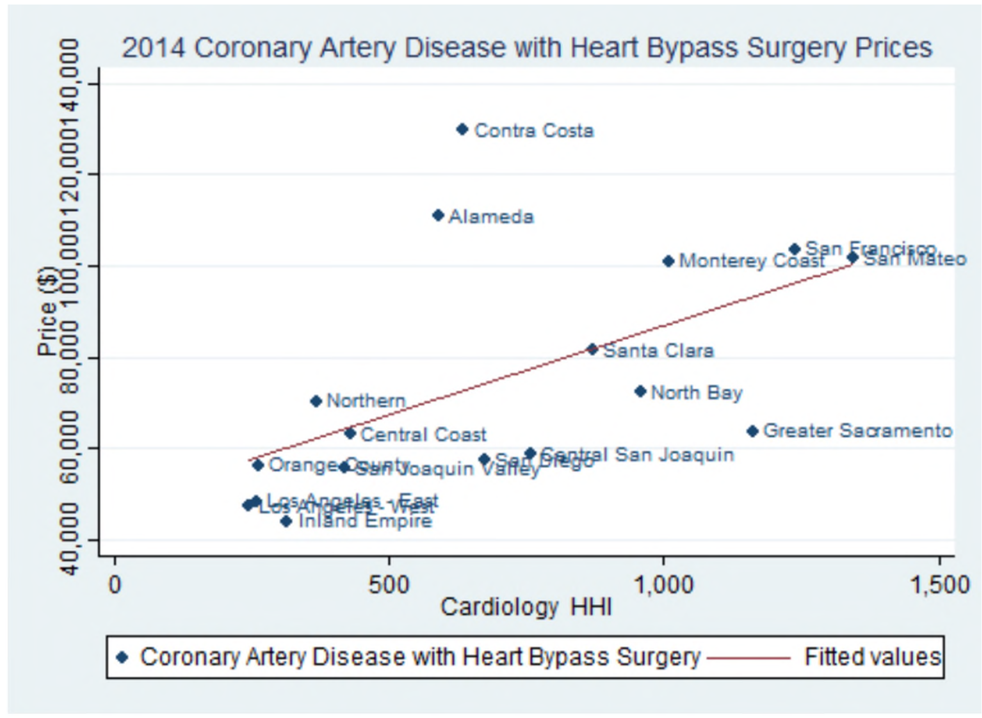
Note: HHI=Herfindahl-Hirschman Index.

Figure A12. Cardiovascular Symptoms (Other) Price and Cardiology HHI Correlation



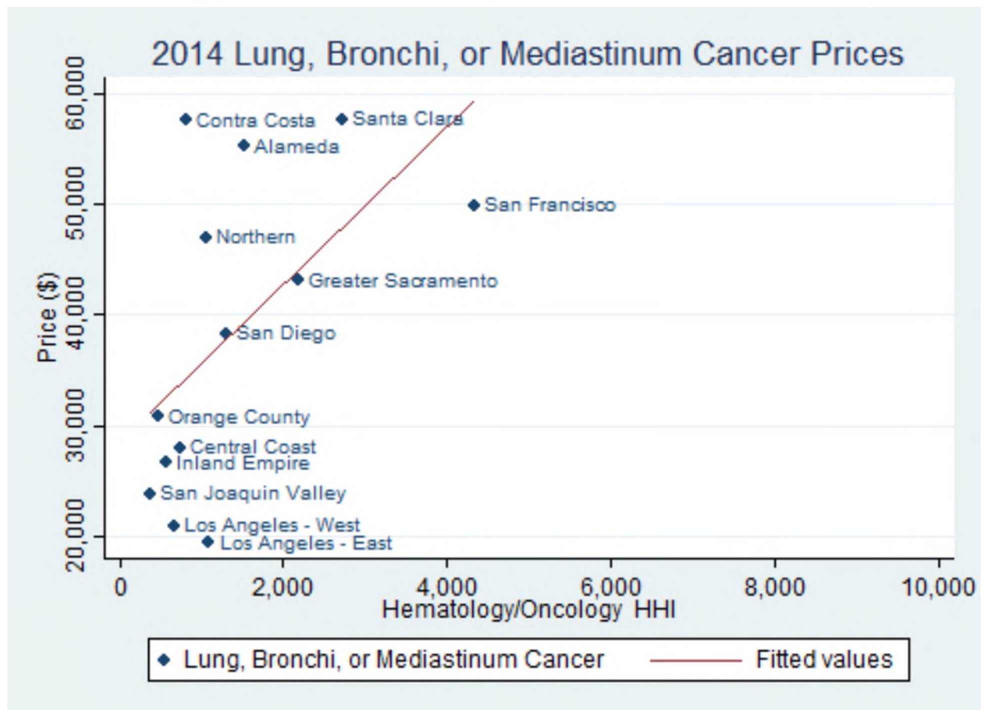
Note: HHI=Herfindahl-Hirschman Index.

Figure A13. Coronary Artery Diseases with Heart Bypass Surgery Price and Cardiology HHI Correlation



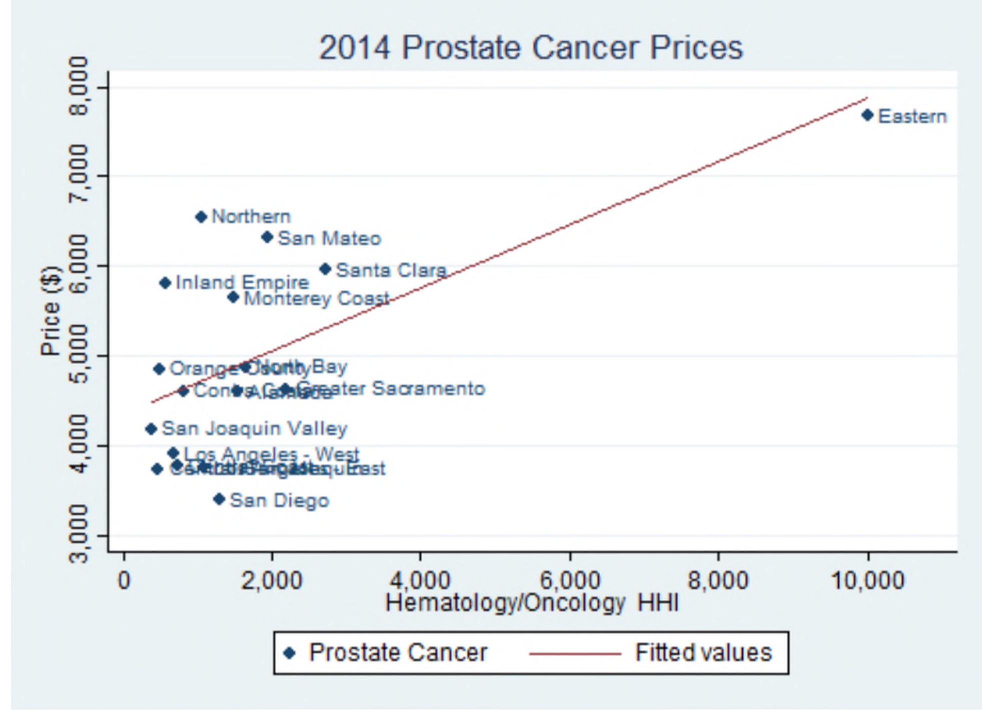
Note: HHI=Herfindahl-Hirschman Index.

Figure A14. Lung, Bronchi, or Mediastinum Cancer Price and Hematology/Oncology HHI Correlation



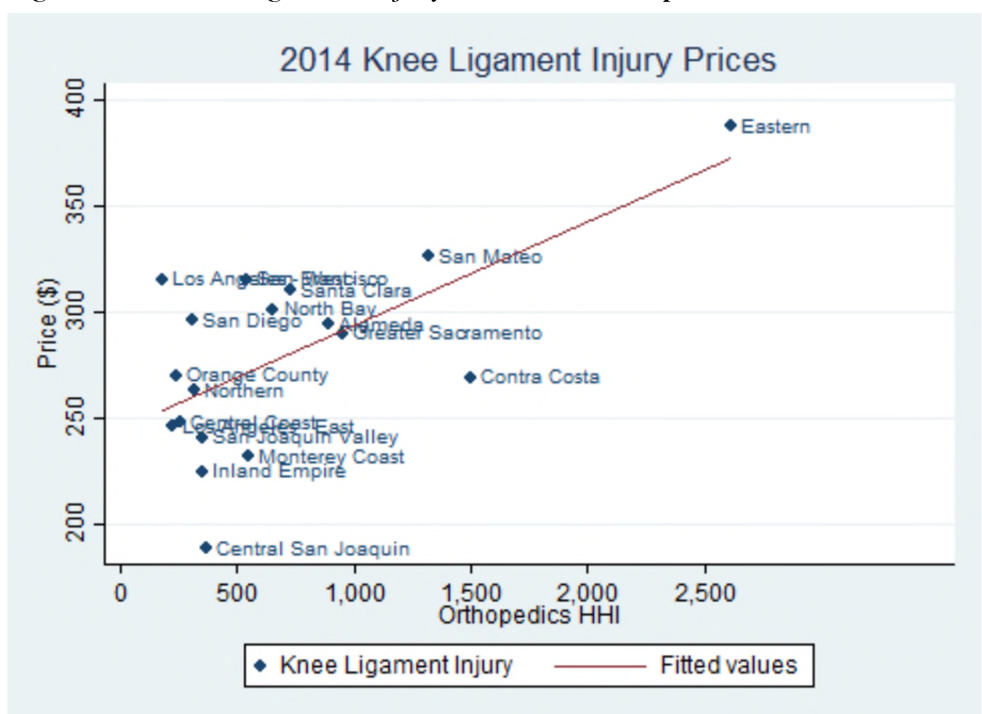
Note: HHI=Herfindahl-Hirschman Index.

Figure A15. Prostate Cancer Price and Hematology/Oncology HHI Correlation



Note: HHI=Herfindahl-Hirschman Index.

Figure A16. Knee Ligament Injury Price and Orthopedics HHI Correlation



Note: HHI=Herfindahl-Hirschman Index.

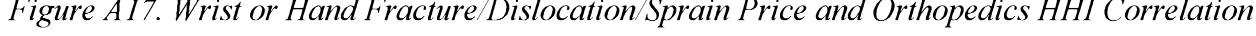
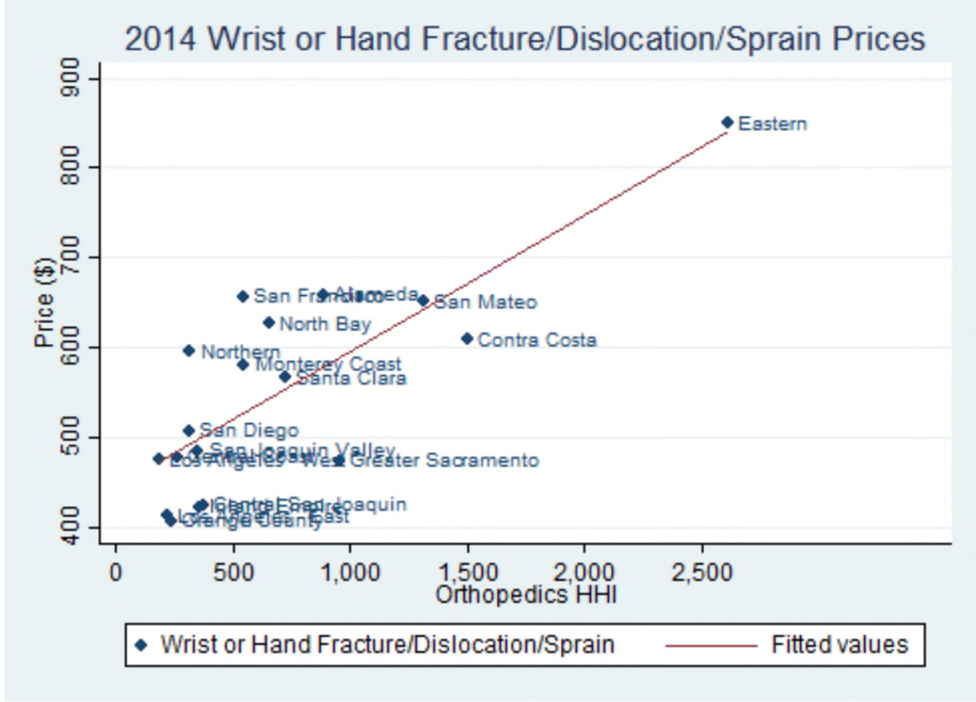
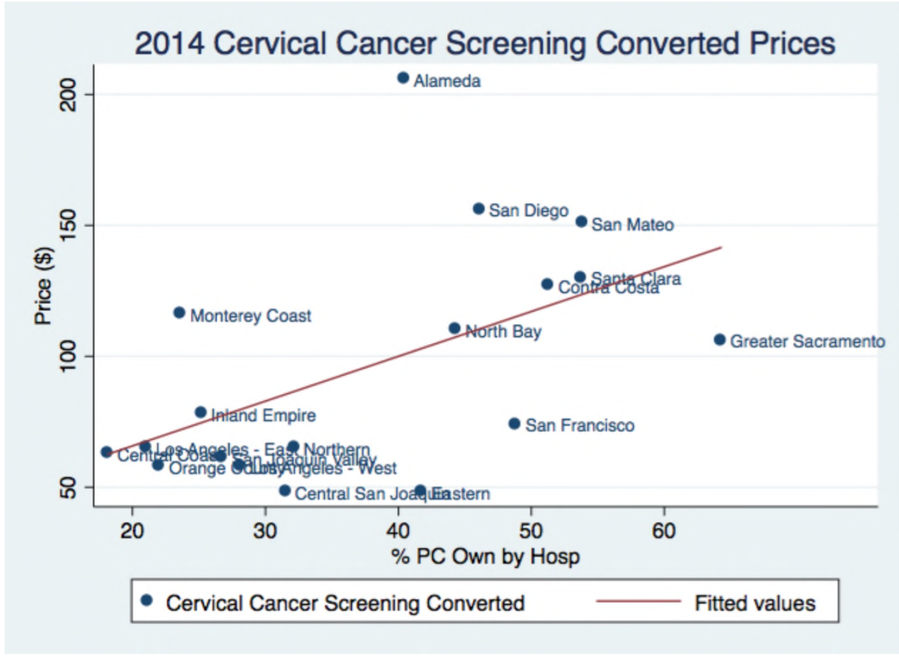


Figure A17. Wrist or Hand Fracture/Dislocation/Sprain Price and Orthopedics HHI Correlation



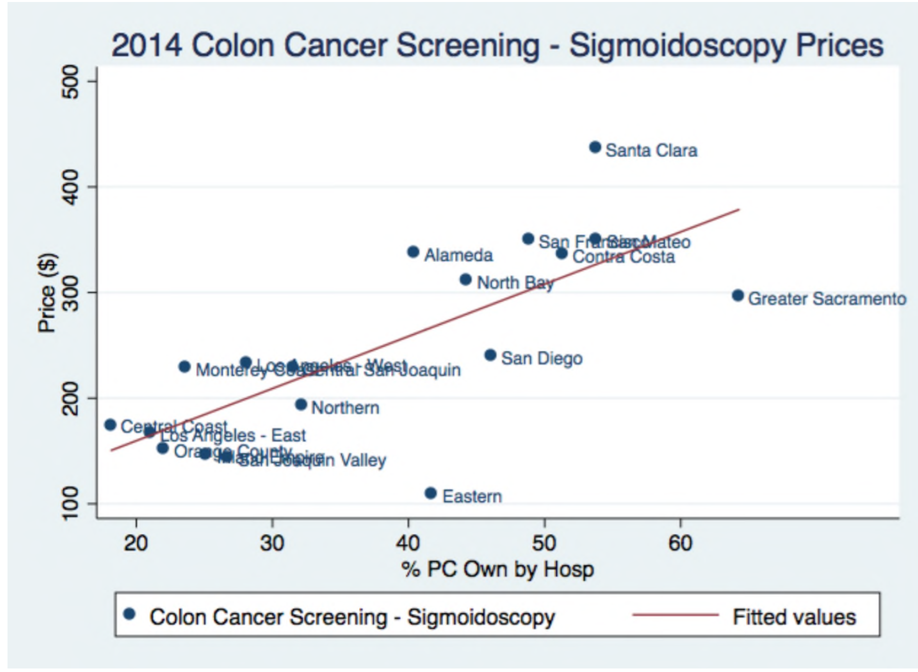
Note: HHI=Herfindahl-Hirschman Index.

Figure A18. Cervical Cancer Screening Converted Prices and the Percent of Primary Care Physicians Working for Foundations Owned by a Hospital or Health System Correlation



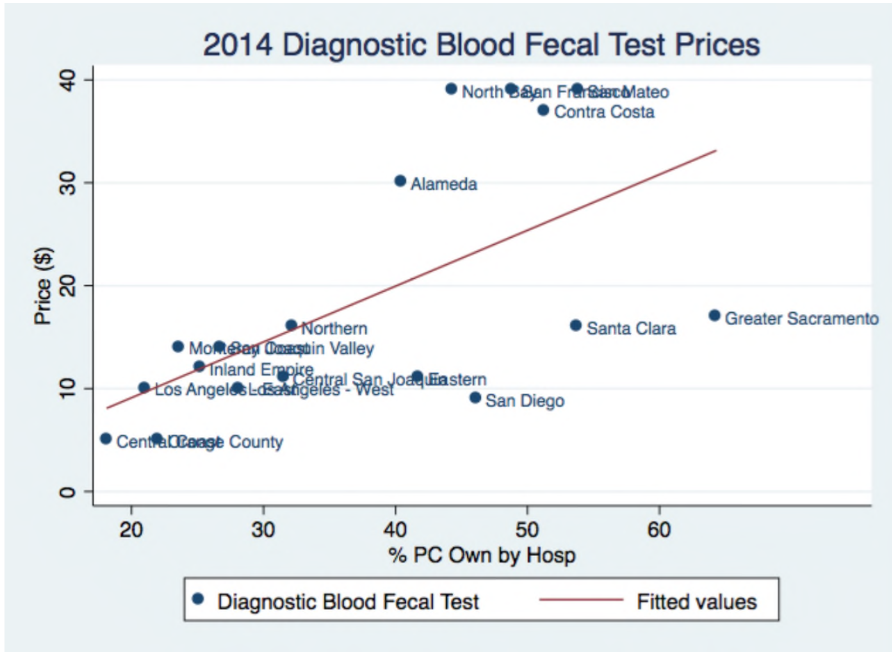
Note: % PC Own by Hosp = the percent of primary care physicians in a rating area who work for foundations owned by a hospital or health system

Figure A19. Colon Cancer Screening Price and the Percent of Primary Care Physicians Working for Foundations Owned by a Hospital or Health System Correlation



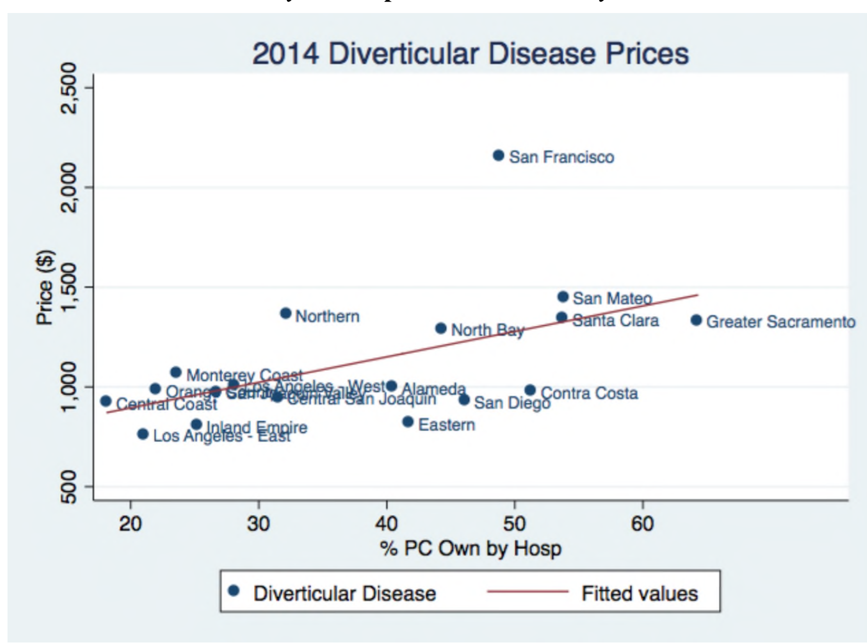
Note: % PC Own by Hosp = the percent of primary care physicians in a rating area who work for foundations owned by a hospital or health system

Figure A20. Diagnostic Blood Fecal Price and the Percent of Primary Care Physicians Working for Foundations Owned by a Hospital or Health System Correlation



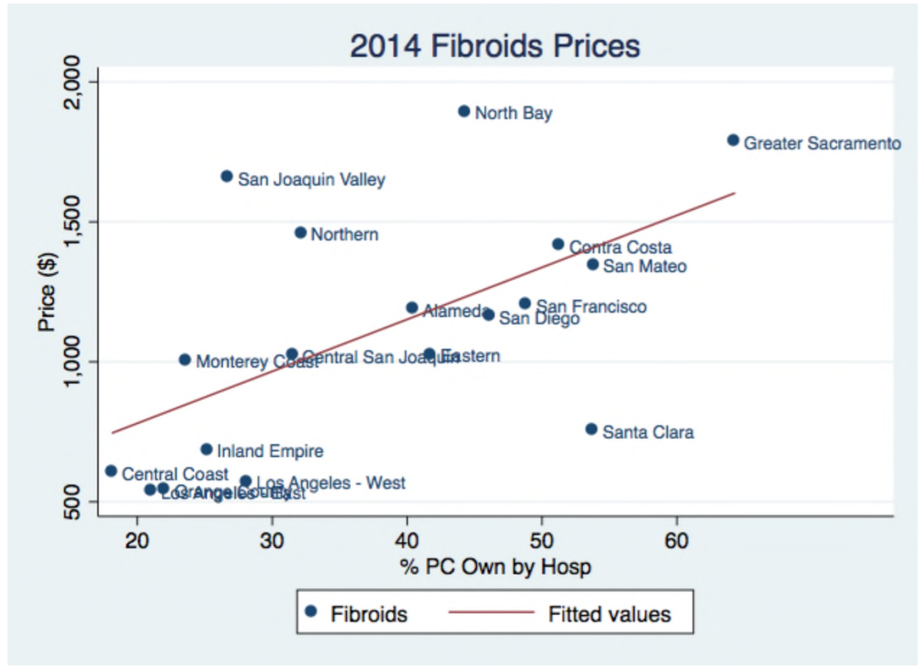
Note: % PC Own by Hosp = the percent of primary care physicians in a rating area who work for foundations owned by a hospital or health system

Figure A21. Diverticular Disease Price and the Percent of Primary Care Physicians Working for Foundations Owned by a Hospital or Health System Correlation



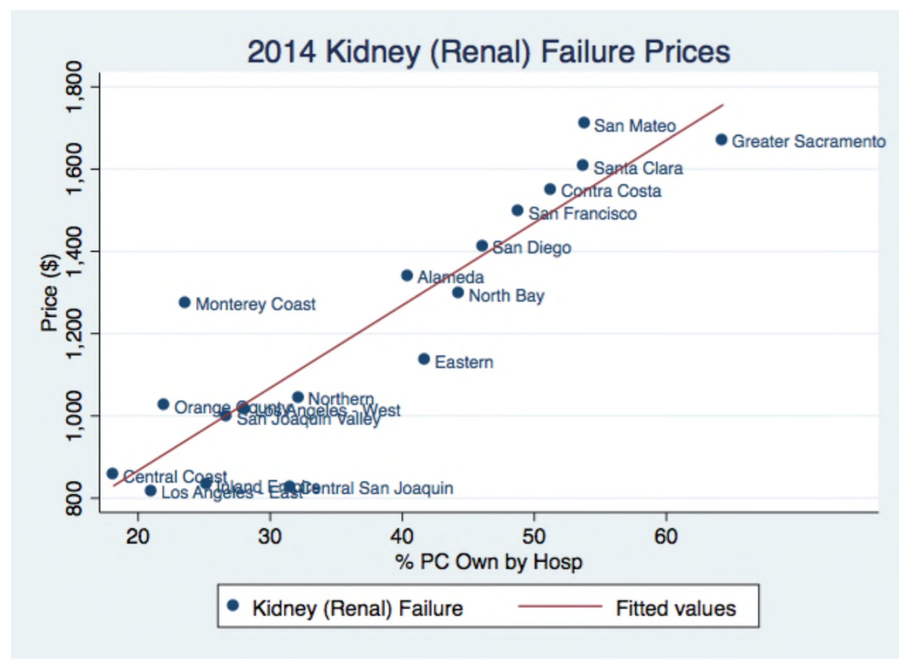
Note: % PC Own by Hosp = the percent of primary care physicians in a rating area who work for foundations owned by a hospital or health system

Figure A22. Fibroids Price and the Percent of Primary Care Physicians Working for Foundations Owned by a Hospital or Health System Correlation



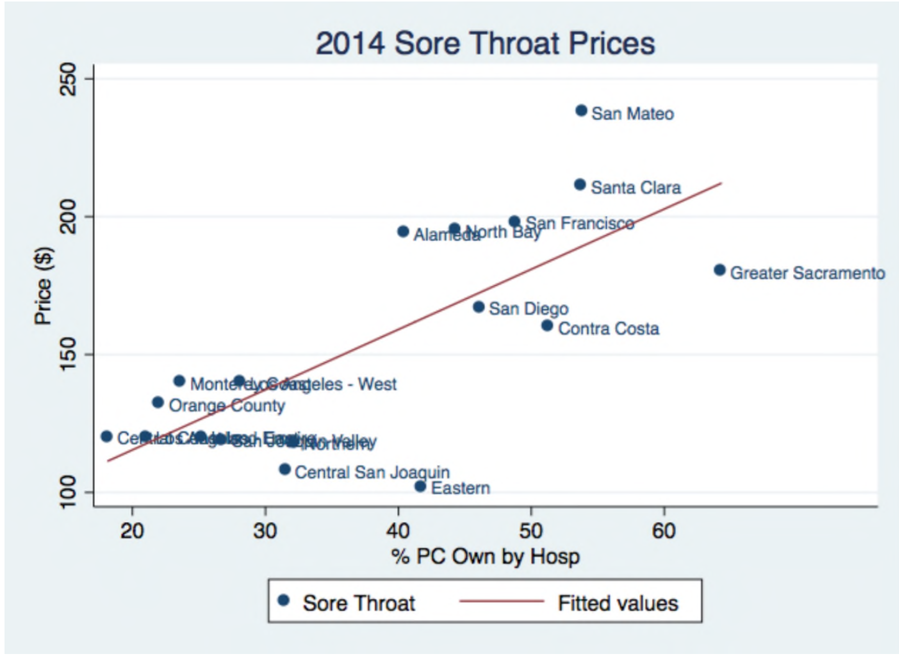
Note: % PC Own by Hosp = the percent of primary care physicians in a rating area who work for foundations owned by a hospital or health system

Figure A23. Kidney (Renal) Failure Price and the Percent of Primary Care Physicians Working for Foundations Owned by a Hospital or Health System Correlation



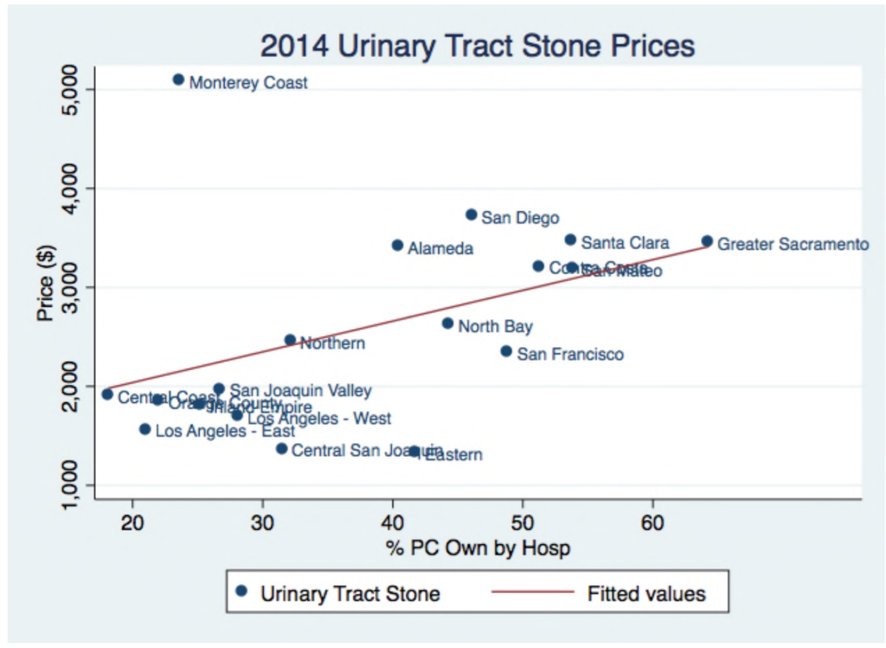
Note: % PC Own by Hosp = the percent of primary care physicians in a rating area who work for foundations owned by a hospital or health system

Figure A24. Sore Throat Price and the Percent of Primary Care Physicians Working for Foundations Owned by a Hospital or Health System Correlation



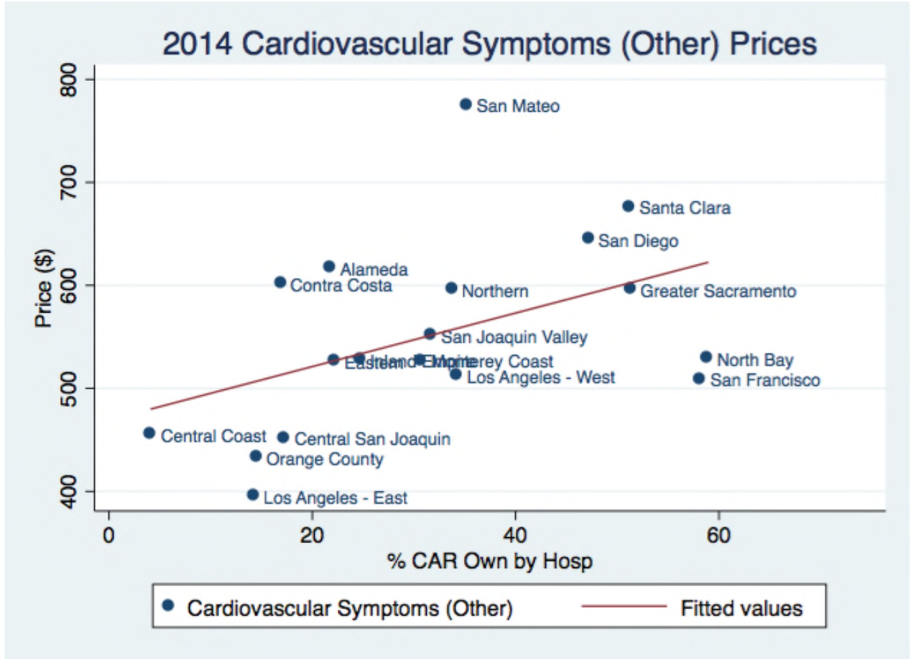
Note: % PC Own by Hosp = the percent of primary care physicians in a rating area who work for foundations owned by a hospital or health system

Figure A25. Urinary Tract Stone Price and the Percent of Primary Care Physicians Working for Foundations Owned by a Hospital or Health System Correlation



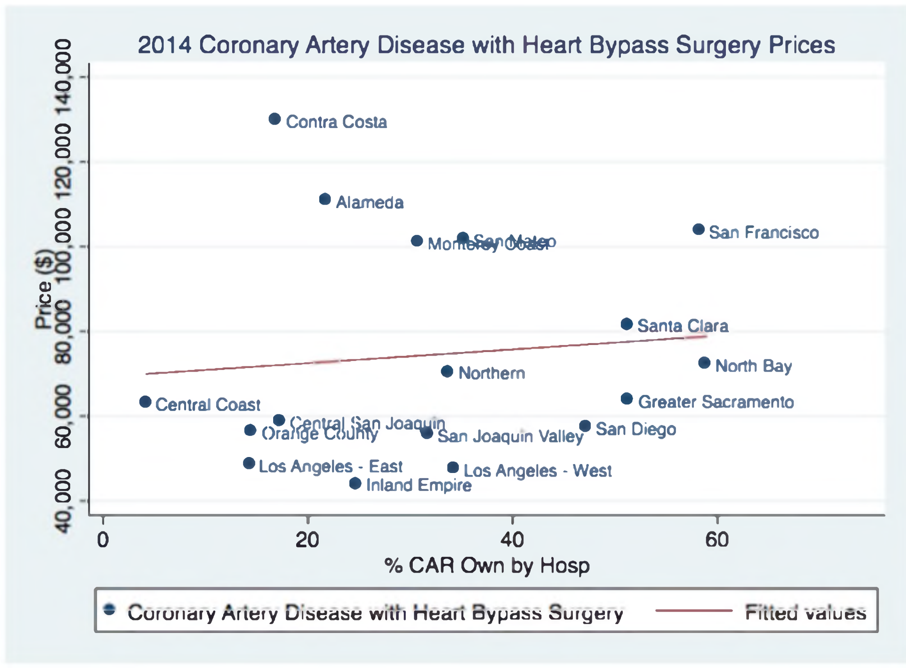
Note: % PC Own by Hosp = the percent of primary care physicians in a rating area who work for foundations owned by a hospital or health system

Figure A26. Cardiovascular Symptoms (Other) Price and the Percent of Cardiologists Working for Foundations Owned by a Hospital or Health System Correlation



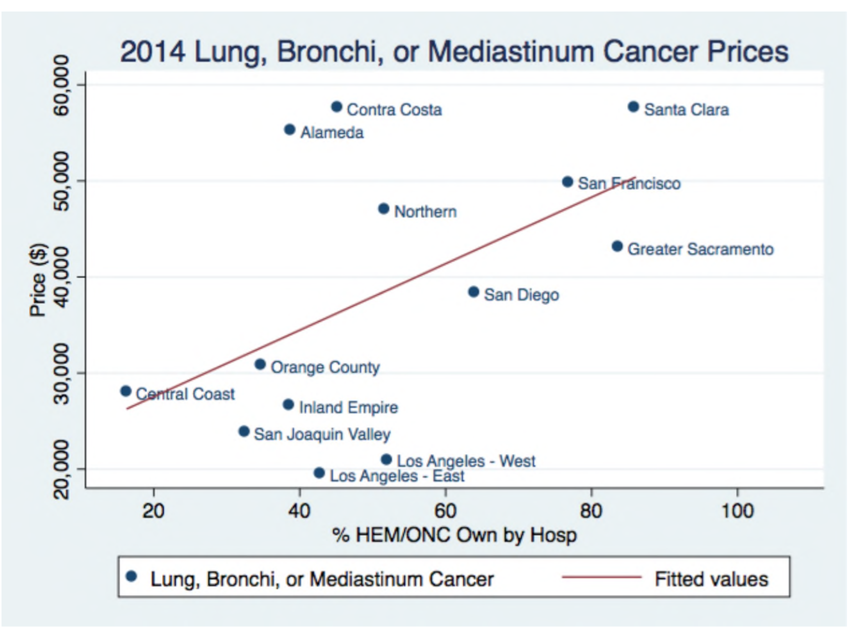
Note: % CAR Own by Hosp = the percent of cardiologists in a rating area who work for foundations owned by a hospital or health system

Figure A27. Coronary Artery Diseases with Heart Bypass Surgery Price and the Percent of Cardiologists Working for Foundations Owned by a Hospital or Health System Correlation



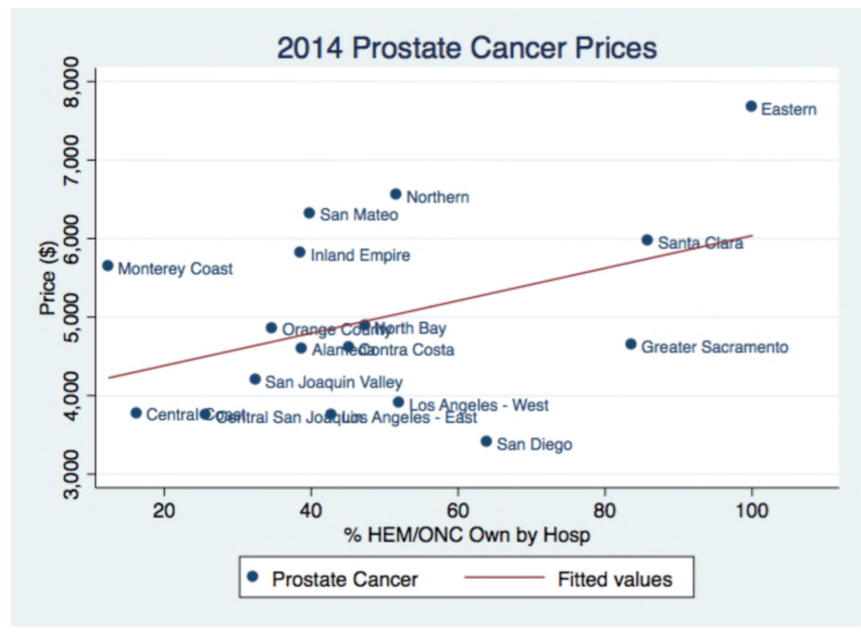
Note: % CAR Own by Hosp = the percent of cardiologists in a rating area who work for foundations owned by a hospital or health system

Figure A28. Lung, Bronchi, or Mediastinum Cancer Price and the Percent of Hematologists/Oncologists Working for Foundations Owned by a Hospital or Health System Correlation



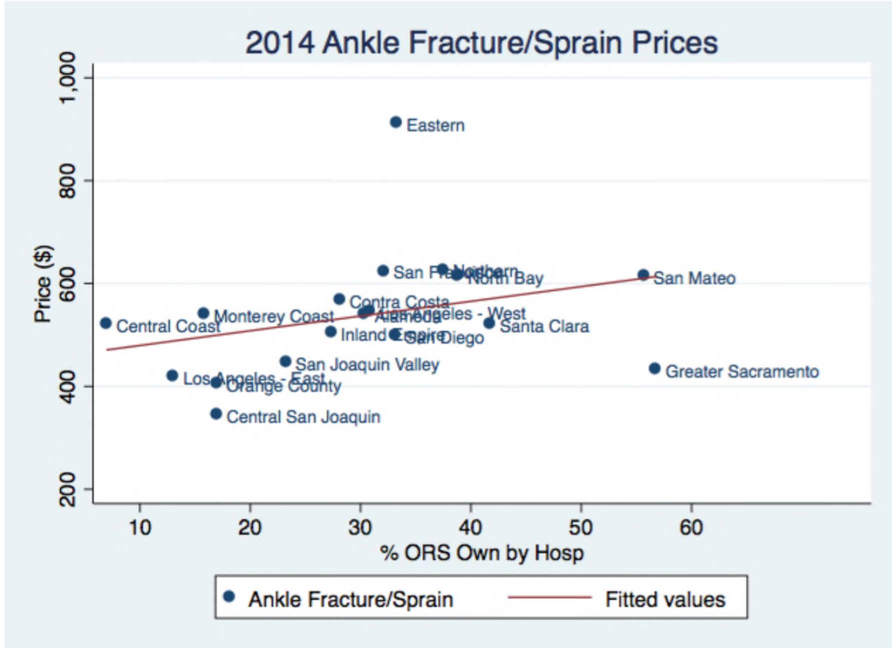
Note: % HEM/ONC Own by Hosp = the percent of hematologists/oncologists in a rating area who work for foundations owned by a hospital or health system

Figure A29. Prostate Cancer Price and the Percent of Hematologists/Oncologists Working for Foundations Owned by a Hospital or Health System Correlation



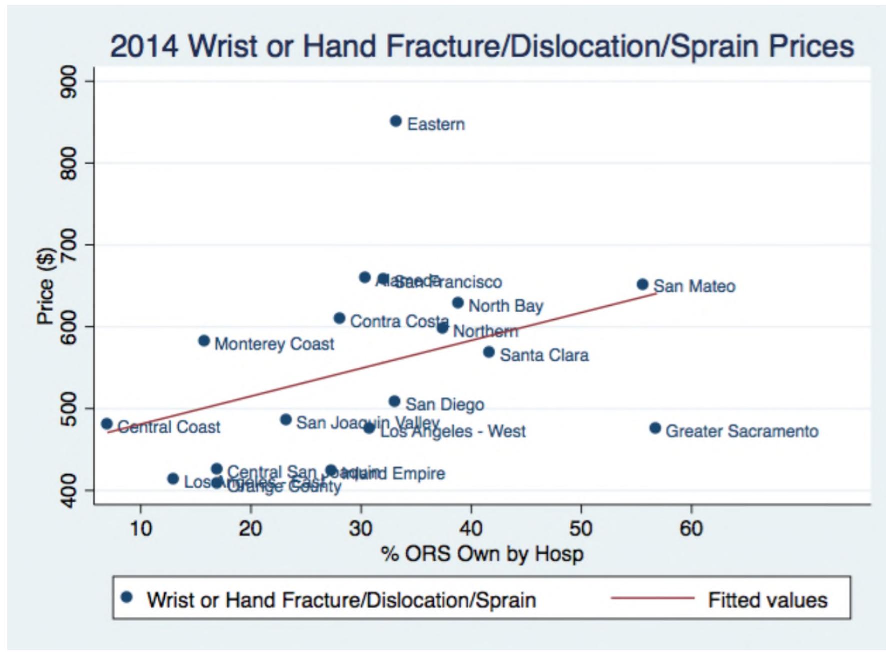
Note: % HEM/ONC Own by Hosp = the percent of hematologists/oncologists in a rating area who work for foundations owned by a hospital or health system

Figure A30. Ankle Fracture/Sprain Price and the Percent of Orthopedists Working for Foundations Owned by a Hospital or Health System Correlation



Note: % ORS Own by Hosp = the percent of orthopedists in a rating area who work for foundations owned by a hospital or health system

Figure A31. Wrist or Hand Fracture/Dislocation/Sprain Price and the Percent of Orthopedists Working for Foundations Owned by a Hospital or Health System Correlation



Note: % ORS Own by Hosp = the percent of orthopedists in a rating area who work for foundations owned by a hospital or health system

Appendix Tables

Table A1: Rating Area-Level Hospital and Physician HHIs, 2014

Rating Area #	Rating Area Name	Hospital HHI	Primary Care HHI	Cardiology HHI	Hematology/ Oncology HHI	Orthopedics HHI	Radiology HHI
1	Northern	1,171	1,781	367	1,063	319	663
2	North Bay	2,031	1,811	957	1,638	657	1,102
3	Sacramento Valley	2,459	1,748	1,161	2,188	955	2,097
4	San Francisco	2,233	1,576	1,237	4,331	544	2,820
5	Contra Costa	2,483	1,377	636	811	1,499	2,366
6	Alameda	2,319	1,384	590	1,529	889	1,067
7	Santa Clara	1,779	1,458	870	2,728	727	1,372
8	San Mateo	2,443	1,893	1,345	1,948	1,318	1,277
9	Monterey Coast	1,760	1,422	1,010	1,493	550	2,012
10	San Joaquin Valley	1,207	1,315	420	383	354	501
11	Central San Joaquin	3,160	925	758	480	373	1,693
12	Central Coast	1,731	990	429	743	262	442
13	Eastern	3,851	779	1,358	10,000	2,613	3,421
15	Los Angeles - East	656	908	259	1,093	224	266
16	Los Angeles - West	680	698	246	674	185	537
17	Inland Empire	669	982	316	568	354	693
18	Orange	1,308	513	263	481	240	567
19	San Diego	1,920	1,878	675	1,298	313	675
	AVERAGE	1,881	1,302	717	1,858	688	1,310

Note: HHI=Herfindahl-Hirschman Index.

Table A2: Insurer HHIs and Covered California Benchmark Plan Monthly Premiums, 2016

Rating Area #	Rating Area Name	Insurer HHI	Benchmark Plan Monthly Premium
1	Northern	3,403	$367
2	North Bay	3,362	$393
3	Sacramento Valley	2,615	$386
4	San Francisco	1,906	$388
5	Contra Costa	2,952	$374
6	Alameda	2,842	$384
7	Santa Clara	2,140	$370
8	San Mateo	2,084	$413
9	Monterey Coast	3,380	$421
10	San Joaquin Valley	2,491	$334
11	Central San Joaquin	2,518	$316
12	Central Coast	2,673	$358
13	Eastern	2,828	$340
14	Central Valley	2,602	$294
15	Los Angeles - East	2,042	$245
16	Los Angeles - West	2,042	$255
17	Inland Empire	2,185	$261
18	Orange	1,785	$298
19	San Diego	1,539	$296
	AVERAGE	2,494	$342

Notes: HHI=Herfindahl-Hirschman Index. The premiums quoted here are the monthly premium an unsubsidized 40-year-old would pay for the benchmark plan (second-lowest-cost silver plan) in a rating area. Insurer HHI is computed using the commercial enrollment of insurers.

Table A3. The association between inpatient procedure prices and hospital market concentration (HHI), 2014.

Unadjusted Prices

	Heart Attack (Acute Myocardial Infarction)	Partial Hip Replacement Revision	Premature Baby (Extremely Low Weight)
Hospital HHI	2.351*	4.716*	231.8**
	(0.0754)	(0.0710)	(0.0419)
Observations	17	18	10
Avg. Median Price	$20,809	$40,162	$526,580
R-squared	0.196	0.189	0.423

Input cost adjusted Prices

	Heart Attack (Acute Myocardial Infarction)	Partial Hip Replacement Revision	Premature Baby (Extremely Low Weight)
Hospital HHI	1.576	2.592*	112.7
	(0.194)	(0.0618)	(0.108)
Observations	17	18	10
Input cost adjusted Avg. Median Price	$15,193	$28,460	$367,682
R-squared	0.110	0.201	0.290

*Notes: HHI=Herfindahl-Hirschman Index. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A4. The association between outpatient primary care procedure prices and primary care market concentration (HHI), 2014.

Unadjusted Prices

	Cervical Cancer Screening Converted	Colon Cancer Screening - Sigmoidoscopy	Diagnostic Blood Fecal Test	Diverticular Disease	Fibroids
Primary Care HHI	0.0617***	0.124**	0.0167***	0.421**	0.738***
	(0.00807)	(0.0103)	(0.00882)	(0.0170)	(0.000374)
Observations	18	18	18	18	18
Avg. Median Price	$96	$246	$19	$1,118	$1,104
R-squared	0.364	0.346	0.357	0.307	0.557

	Kidney (Renal) Failure	Sore Throat	Upper Respiratory Infection/ Common Cold (Adult)	Urinary Tract Stone
Primary Care HHI	0.490***	0.0615***	0.0573***	1.518***
	(0.00125)	(0.00276)	(0.00393)	(0.00326)
Observations	18	18	18	18
Avg. Median Price	$1,217	$153	$151	$2,580
R-squared	0.489	0.438	0.415	0.427

Input cost adjusted Prices

	Cervical Cancer Screening Converted	Colon Cancer Screening - Sigmoidoscopy	Diagnostic Blood Fecal Test	Diverticular Disease	Fibroids
Primary Care HHI	0.0347**	0.0578**	0.0096**	0.146	0.406***
	(0.0187)	(0.0321)	(0.0124)	(0.156)	(0.00312)
Observations	18	18	18	18	18
Input cost adjusted Avg. Median Price	$67	$172	$12	$791	$776
R-squared	0.300	0.256	0.332	0.121	0.430

	Kidney (Renal) Failure	Sore Throat	Upper Respiratory Infection/ Common Cold (Adult)	Urinary Tract Stone
Primary Care HHI	0.198**	0.0238**	0.0208*	0.817***
	(0.0269)	(0.0464)	(0.0708)	(0.00612)
Observations	18	18	18	18
Input cost adjusted Avg. Median Price	$860	$109	$107	$1,801
R-squared	0.271	0.226	0.190	0.384

*Notes: HHI=Herfindahl-Hirschman Index. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A5. The association between outpatient cardiology procedure prices and cardiology market concentration (HHI), 2014.

Unadjusted Prices

	Cardiomyopathy (Heart Muscle Disease)	Cardiovascular Symptoms (Other)	Coronary Artery Disease with Heart Bypass Surgery
Cardiology HHI	0.960***	0.107*	38.74**
	(0.00329)	(0.0648)	(0.0224)
Observations	17	18	17
Avg. Median Price	$1,867	$551	$74,476
R-squared	0.448	0.197	0.302

Input cost adjusted Prices

	Cardiomyopathy (Heart Muscle Disease)	Cardiovascular Symptoms (Other)	Coronary Artery Disease with Heart Bypass Surgery
Cardiology HHI	0.327	0.0134	15.74*
	(0.150)	(0.735)	(0.0537)
Observations	17	18	17
Input cost adjusted Avg. Median Price	$1,324	$394	$51,517
R-squared	0.133	0.007	0.226

*Notes: HHI=Herfindahl-Hirschman Index. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A6. The association between outpatient hematology/oncology procedure prices and hematology/oncology market concentration (HHI), 2014.

Unadjusted Prices

	Breast Cancer	Lung, Bronchi, or Mediastinum Cancer	Prostate Cancer
Hematology/Oncology HHI	0.201**	7.147**	0.352***
	(0.0199)	(0.0452)	(0.00399)
Observations	18	13	17
Avg. Median Price	$4,686	$38,299	$4,957
R-squared	0.295	0.317	0.435

Input cost adjusted Prices

	Breast Cancer	Lung, Bronchi, or Mediastinum Cancer	Prostate Cancer
Hematology/Oncology HHI	0.148***	3.245*	0.283***
	(0.00243)	(0.0880)	(0.00314)
Observations	18	13	17
Input cost adjusted Avg. Median Price	$3,340	$26,912	$3,584
R-squared	0.447	0.242	0.451

*Notes: HHI=Herfindahl-Hirschman Index. p-values in parentheses. *** $p<0.01$, ** $p<0.05$, * $p<0.1$*

Table A7. The association between outpatient orthopedics procedure prices and orthopedics market concentration (HHI), 2014.

Unadjusted Prices

	Ankle Fracture/ Sprain	Knee Ligament Injury	Wrist or Hand Fracture/ Dislocation/ Sprain
Orthopedics HHI	0.150***	0.0488***	0.152***
	(0.000440)	(0.00343)	(6.85e-05)
Observations	18	18	18
Avg. Median Price	$537	$279	$549
R-squared	0.548	0.424	0.639

Input cost adjusted Prices

	Ankle Fracture/ Sprain	Knee Ligament Injury	Wrist or Hand Fracture/ Dislocation/ Sprain
Orthopedics HHI	0.0993***	0.0274*	0.0989***
	(0.00918)	(0.0938)	(0.000371)
Observations	18	18	18
Input cost adjusted Avg. Median Price	$386	$201	$392
R-squared	0.354	0.166	0.558

*Notes: HHI=Herfindahl-Hirschman Index. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A8. The association between ACA premiums and insurer market concentration (HHI), 2016.

Unadjusted Monthly Premiums

	Benchmark Plan Monthly Premium
Insurer HHI	0.0526***
	(0.007)
Observations	19
Avg. Monthly Premium	$342
R-squared	0.283

Input cost adjusted Monthly Premiums

	Benchmark Plan Monthly Premium
Insurer HHI	0.0218*
	(0.063)
Observations	19
Input cost adjusted Avg. Monthly Premium	$245
R-squared	0.094

*Notes: HHI=Herfindahl-Hirschman Index. p-values in parentheses. *** $p<0.01$, ** $p<0.05$, * $p<0.1$*

Table A9. The association between inpatient procedure prices and hospital market concentration (HHI), 2014. (weighted by rating area population)

Unadjusted Prices

	Heart Attack (Acute Myocardial Infarction)	Partial Hip Replacement Revision	Premature Baby (Extremely Low Weight)
Hospital HHI	2.375*	9.302***	195.7**
	(0.0696)	(0.0003)	(0.0295)
Observations	17	18	10
Weighted Avg. Median Price	$19,716	$37,099	$459,341
R-squared	0.203	0.558	0.467

Input cost adjusted Prices

	Heart Attack (Acute Myocardial Infarction)	Partial Hip Replacement Revision	Premature Baby (Extremely Low Weight)
Hospital HHI	0.741	4.459***	88.44
	(0.537)	(0.0050)	(0.110)
Observations	17	18	10
Input cost adjusted Weighted Avg. Median Price	$15,114	$27,795	$340,143
R-squared	0.026	0.398	0.288

*Notes: HHI=Herfindahl-Hirschman Index. p-values in parentheses. *** $p<0.01$, ** $p<0.05$, * $p<0.1$*

Table A10. The association between outpatient primary care procedure prices and primary care market concentration (HHI), 2014. (weighted by rating area population)

Unadjusted Prices

	Cervical Cancer Screening Converted	Colon Cancer Screening - Sigmoidoscopy	Diagnostic Blood Fecal Test	Diverticular Disease	Fibroids
Primary Care HHI	0.0632***	0.0946**	0.0117**	0.278**	0.794***
	(0.00152)	(0.0243)	(0.0194)	(0.0394)	(5.57e-05)
Observations	18	18	18	18	18
Weighted Avg. Median Price	$90	$229	$15	$1,032	$955
R-squared	0.477	0.279	0.297	0.239	0.648

	Kidney (Renal) Failure	Sore Throat	Upper Respiratory Infection/ Common Cold (Adult)	Urinary Tract Stone
Primary Care HHI	0.470***	0.0453***	0.0415**	1.529***
	(0.000688)	(0.00585)	(0.0104)	(0.000148)
Observations	18	18	18	18
Weighted Avg. Median Price	$1,132	$147	$146	$2,372
R-squared	0.524	0.387	0.345	0.604

Input cost adjusted Prices

	Cervical Cancer Screening Converted	Colon Cancer Screening - Sigmoidoscopy	Diagnostic Blood Fecal Test	Diverticular Disease	Fibroids
Primary Care HHI	0.0388***	0.0418*	0.00657**	0.0701	0.486***
	(0.00446)	(0.0724)	(0.0268)	(0.352)	(9.27e-05)
Observations	18	18	18	18	18
Input cost adjusted Weighted Avg. Median Price	$67	$169	$11	$775	$704
R-squared	0.406	0.188	0.271	0.054	0.626

	Kidney (Renal) Failure	Sore Throat	Upper Respiratory Infection/ Common Cold (Adult)	Urinary Tract Stone
Primary Care HHI	0.217**	0.0157	0.0127	0.899***
	(0.0107)	(0.102)	(0.175)	(0.000696)
Observations	18	18	18	18
Input cost adjusted Weighted Avg. Median Price	$848	$110	$110	$1,764
R-squared	0.342	0.158	0.112	0.523

*Notes: HHI=Herfindahl-Hirschman Index. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A11. The association between outpatient cardiology procedure prices and cardiology market concentration (HHI), 2014. (weighted by rating area population)

Unadjusted Prices

	Cardiomyopathy (Heart Muscle Disease)	Cardiovascular Symptoms (Other)	Coronary Artery Disease with Heart Bypass Surgery
Cardiology HHI	0.706***	0.156**	39.82**
	(0.00551)	(0.0105)	(0.0114)
Observations	17	18	17
Weighted Avg. Median Price	$1,774	$533	$63,191
R-squared	0.411	0.344	0.356

Input cost adjusted Prices

	Cardiomyopathy (Heart Muscle Disease)	Cardiovascular Symptoms (Other)	Coronary Artery Disease with Heart Bypass Surgery
Cardiology HHI	0.135	0.0155	15.97**
	(0.494)	(0.747)	(0.0335)
Observations	17	18	17
Input cost adjusted Weighted Avg. Median Price	$1,345	$403	$46,652
R-squared	0.032	0.007	0.267

*Notes: HHI=Herfindahl-Hirschman Index. p-values in parentheses. *** $p<0.01$, ** $p<0.05$, * $p<0.1$*

Table A12. The association between outpatient hematology/oncology procedure prices and hematology/oncology market concentration (HHI), 2014. (weighted by rating area population)

Unadjusted Prices

	Breast Cancer	Lung, Bronchi, or Mediastinum Cancer	Prostate Cancer
Hematology/Oncology HHI	0.373**	10.22**	0.350
	(0.0163)	(0.0172)	(0.187)
Observations	18	13	17
Weighted Avg. Median Price	$4,461	$32,759	$4,594
R-squared	0.310	0.417	0.113

Input cost adjusted Prices

	Breast Cancer	Lung, Bronchi, or Mediastinum Cancer	Prostate Cancer
Hematology/Oncology HHI	0.0740	4.751*	0.0409
	(0.428)	(0.0544)	(0.853)
Observations	18	13	17
Input cost adjusted Weighted Avg. Median Price	$3,369	$24,449	$3,504
R-squared	0.040	0.296	0.002

*Notes: HHI=Herfindahl-Hirschman Index. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A13. The association between outpatient orthopedics procedure prices and orthopedics market concentration (HHI), 2014. (weighted by rating area population)

Unadjusted Prices

	Ankle Fracture/ Sprain	Knee Ligament Injury	Wrist or Hand Fracture/ Dislocation/ Sprain
Orthopedics HHI	0.0849	0.0287	0.159***
	(0.103)	(0.258)	(0.00186)
Observations	18	18	18
Weighted Avg. Median Price	$500	$273	$496
R-squared	0.157	0.079	0.464

Input cost adjusted Prices

	Ankle Fracture/ Sprain	Knee Ligament Injury	Wrist or Hand Fracture/ Dislocation/ Sprain
Orthopedics HHI	-0.0219	-0.0263	0.0299
	(0.620)	(0.254)	(0.288)
Observations	18	18	18
Input cost adjusted Weighted Avg. Median Price	$380	$208	$373
R-squared	0.016	0.080	0.070

*Notes: HHI=Herfindahl-Hirschman Index. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A14. The association between ACA premiums and insurer market concentration (HHI), 2016. (weighted by rating area population)

Unadjusted Monthly Premiums

	Benchmark Plan Monthly Premium
Insurer HHI	0.0715***
	(0.001)
Observations	19
Weighted Avg. Monthly Premium	$313
R-squared	0.394

Input cost adjusted Monthly Premiums

	Benchmark Plan Monthly Premium
Insurer HHI	0.0151
	(0.171)
Observations	19
Input cost adjusted Weighted Avg. Monthly Premium	$236
R-squared	0.109

*Notes: HHI=Herfindahl-Hirschman Index. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A15: Rating Area-Level Percent of Physicians Working for Foundations Owned by Hospitals or Health Systems, 2014

Rating Area #	Rating Area Name	% PC Own by Hosp	% CAR Own by Hosp	% HEM/ONC Own by Hosp	% ORS Own by Hosp
1	Northern	32	34	52	38
2	North Bay	44	59	47	39
3	Sacramento Valley	64	51	84	57
4	San Francisco	49	58	77	32
5	Contra Costa	51	17	45	28
6	Alameda	40	22	39	30
7	Santa Clara	54	51	86	42
8	San Mateo	54	35	40	56
9	Monterey Coast	24	31	13	16
10	San Joaquin Valley	27	32	33	23
11	Central San Joaquin	32	17	26	17
12	Central Coast	18	4	16	7
13	Eastern	42	22	100	33
15	Los Angeles - East	21	14	43	13
16	Los Angeles - West	28	34	52	31
17	Inland Empire	25	25	39	27
18	Orange	22	15	35	17
19	San Diego	46	47	64	33
	Avg. across rating areas	37	32	49	30

Note: PC = primary care physician, CAR = cardiologists, HEM/ONC = hematologists/oncologists, ORS = orthopedists

Table A16. The association between primary care procedure prices and the percent of primary care physicians in a rating area who work for foundations owned by a hospital or health system, 2014.

UNADJUSTED PRICES

	Cervical Cancer Screening Converted	Colon Cancer Screening - Sigmoidoscopy	Diagnostic Blood Fecal Test	Diverticular Disease	Fibroids
% PC Own by Hosp	1.711**	4.944***	0.542***	12.77**	18.57***
	(0.0252)	(0.000474)	(0.00729)	(0.0244)	(0.00999)
Observations	18	18	18	18	18
Avg. Median Price	$96	$246	$19	$1,118	$1,104
R-squared	0.276	0.544	0.371	0.279	0.348

	Kidney (Renal) Failure	Sore Throat	Upper Respiratory Infection/ Common Cold (Adult)	Urinary Tract Stone
% PC Own by Hosp	20.08***	2.183***	2.178***	31.06*
	(3.98e-07)	(0.000470)	(0.000195)	(0.0825)
Observations	18	18	18	18
Avg. Median Price	$1,217	$153	$151	$2,580
R-squared	0.808	0.545	0.591	0.177

INPUT COST ADJUSTED PRICES

	Cervical Cancer Screening Converted	Colon Cancer Screening - Sigmoidoscopy	Diagnostic Blood Fecal Test	Diverticular Disease	Fibroids
% PC Own by Hosp	0.929*	2.580***	0.318***	5.127	10.40**
	(0.0544)	(0.000975)	(0.00853)	(0.117)	(0.0245)
Observations	18	18	18	18	18
Input cost adjusted Avg. Median Price	$67	$172	$12	$791	$776
R-squared	0.212	0.503	0.360	0.147	0.278

	Kidney (Renal) Failure	Sore Throat	Upper Respiratory Infection/ Common Cold (Adult)	Urinary Tract Stone
% PC Own by Hosp	10.22***	0.989***	0.988***	15.75
	(9.87e-06)	(0.00598)	(0.00355)	(0.125)
Observations	18	18	18	18
Input cost adjusted Avg. Median Price	$860	$109	$107	$1,801
R-squared	0.715	0.385	0.421	0.141

Notes: % PC Own by Hosp = % of primary care physicians who work for a foundation owned by a hospital or health system. Input cost adjusted prices were computed by deflating unadjusted prices by the Medicare Wage Index https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html *. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A17. The association between cardiology procedure prices and the percent of cardiologists in a rating area who work for foundations owned by a hospital or health system, 2014.

UNADJUSTED PRICES

	Cardiomyopathy (Heart Muscle Disease)	Cardiovascular Symptoms (Other)	Coronary Artery Disease with Heart Bypass Surgery
% CAR Own by Hosp	13.84*	2.599*	161.6
	(0.0776)	(0.0596)	(0.690)
Observations	17	18	17
Avg. Median Price	$1,867	$551	$74,476
R-squared	0.193	0.204	0.011

INPUT COST ADJUSTED PRICES

	Cardiomyopathy (Heart Muscle Disease)	Cardiovascular Symptoms (Other)	Coronary Artery Disease with Heart Bypass Surgery
% CAR Own by Hosp	5.537	0.743	-12.11
	(0.275)	(0.430)	(0.949)
Observations	17	18	17
Input cost adjusted Avg. Median Price	$1,324	$394	$51,517
R-squared	0.079	0.039	0.000

Notes: % CAR Own by Hosp = % of cardiologists who work for a foundation owned by a hospital or health system. Input cost adjusted prices were computed by deflating unadjusted prices by the Medicare Wage Index https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html *. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A18. The association between hematology/oncology procedure prices and the percent of hematologists/oncologists in a rating area who work for foundations owned by a hospital or health system, 2014.

UNADJUSTED PRICES

	Breast Cancer	Lung, Bronchi, or Mediastinum Cancer	Prostate Cancer
% HEM/ONC Own by Hosp	21.32***	345.9*	20.69*
	(0.00633)	(0.0732)	(0.0981)
Observations	18	13	17
Avg. Median Price	$4,686	$38,299	$4,957
R-squared	0.381	0.263	0.172

INPUT COST ADJUSTED PRICES

	Breast Cancer	Lung, Bronchi, or Mediastinum Cancer	Prostate Cancer
% HEM/ONC Own by Hosp	15.31***	179.9*	16.85*
	(0.000419)	(0.0731)	(0.0869)
Observations	18	13	17
Input cost adjusted Avg. Median Price	$3,340	$26,912	$3,584
R-squared	0.551	0.263	0.183

Notes: % HEM/ONC Own by Hosp = % of hematologists/oncologists who work for a foundation owned by a hospital or health system. Input cost adjusted prices were computed by deflating unadjusted prices by the Medicare Wage Index https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html *. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A19. The association between orthopedics procedure prices and the percent of orthopedists in a rating area who work for foundations owned by a hospital or health system, 2014.

UNADJUSTED PRICES

	Ankle Fracture/ Sprain	Knee Ligament Injury	Wrist or Hand Fracture/ Dislocation/ Sprain
% ORS Own by Hosp	2.862	1.980**	3.407
	(0.207)	(0.0113)	(0.104)
Observations	18	18	18
Avg. Median Price	$537	$279	$549
R-squared	0.097	0.339	0.156

INPUT COST ADJUSTED PRICES

	Ankle Fracture/ Sprain	Knee Ligament Injury	Wrist or Hand Fracture/ Dislocation/ Sprain
% ORS Own by Hosp	0.817	0.671	1.158
	(0.670)	(0.381)	(0.444)
Observations	18	18	18
Input cost adjusted Avg. Median Price	$386	$201	$392
R-squared	0.012	0.048	0.037

Notes: % ORS Own by Hosp = % of orthopedists who work for a foundation owned by a hospital or health system. Input cost adjusted prices were computed by deflating unadjusted prices by the Medicare Wage Index https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html *. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A20. The association between primary care procedure prices and the percent of primary care physicians in a rating area who work for foundations owned by a hospital or health system, 2014 (weighted by rating area population)

UNADJUSTED PRICES

	Cervical Cancer Screening Converted	Colon Cancer Screening - Sigmoidoscopy	Diagnostic Blood Fecal Test	Diverticular Disease	Fibroids
% PC Own by Hosp	2.005***	4.878***	0.413**	11.95***	22.64***
	(0.00389)	(6.45e-05)	(0.0143)	(0.00617)	(0.00207)
Observations	18	18	18	18	18
Weighted Avg. Median Price	$90	$229	$15	$1,032	$955
R-squared	0.415	0.642	0.320	0.383	0.457

	Kidney (Renal) Failure	Sore Throat	Upper Respiratory Infection/ Common Cold (Adult)	Urinary Tract Stone
% PC Own by Hosp	20.70***	2.031***	2.020***	47.86***
	(1.00e-08)	(2.89e-05)	(1.16e-05)	(0.000835)
Observations	18	18	18	18
Weighted Avg. Median Price	$1,132	$147	$146	$2,372
R-squared	0.878	0.675	0.709	0.512

INPUT COST ADJUSTED PRICES

	Cervical Cancer Screening Converted	Colon Cancer Screening - Sigmoidoscopy	Diagnostic Blood Fecal Test	Diverticular Disease	Fibroids
% PC Own by Hosp	1.126**	2.500***	0.228**	4.212*	13.20***
	(0.0194)	(0.000233)	(0.0231)	(0.0892)	(0.00486)
Observations	18	18	18	18	18
Input cost adjusted Weighted Avg. Median Price	$67	$169	$11	$775	$704
R-squared	0.297	0.582	0.283	0.170	0.400

	Kidney (Renal) Failure	Sore Throat	Upper Respiratory Infection/ Common Cold (Adult)	Urinary Tract Stone
% PC Own by Hosp	10.36***	0.840***	0.569**	26.43***
	(3.04e-05)	(0.00539)	(0.0176)	(0.00546)
Observations	18	18	18	18
Input cost adjusted Weighted Avg. Median Price	$848	$110	$110	$1,764
R-squared	0.673	0.393	0.304	0.392

Notes: % PC Own by Hosp = % of primary care physicians who work for a foundation owned by a hospital or health system. Input cost adjusted prices were computed by deflating unadjusted prices by the Medicare Wage Index https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html *. Regressions are weighted by rating area population. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A21. The association between cardiology procedure prices and the percent of cardiologists in a rating area who work for foundations owned by a hospital or health system, 2014 (weighted by rating area population)

UNADJUSTED PRICES

	Cardiomyopathy (Heart Muscle Disease)	Cardiovascular Symptoms (Other)	Coronary Artery Disease with Heart Bypass Surgery
% CAR Own by Hosp	11.08*	3.825***	216.4
	(0.0625)	(0.00375)	(0.569)
Observations	17	18	17
Weighted Avg. Median Price	$1,774	$533	$63,191
R-squared	0.213	0.418	0.022

INPUT COST ADJUSTED PRICES

	Cardiomyopathy (Heart Muscle Disease)	Cardiovascular Symptoms (Other)	Coronary Artery Disease with Heart Bypass Surgery
% CAR Own by Hosp	3.698	1.716*	20.78
	(0.388)	(0.0930)	(0.906)
Observations	17	18	17
Input cost adjusted Weighted Avg. Median Price	$1,345	$403	$46,652
R-squared	0.050	0.166	0.001

*Notes: % CAR Own by Hosp = % of cardiologists who work for a foundation owned by a hospital or health system. Input cost adjusted prices were computed by deflating unadjusted prices by the Medicare Wage Index https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html . Regressions are weighted by rating area population. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A22. The association between hematology/oncology procedure prices and the percent of hematologists/oncologists in a rating area who work for foundations owned by a hospital or health system, 2014 (weighted by rating area population)

UNADJUSTED PRICES

	Breast Cancer	Lung, Bronchi, or Mediastinum Cancer	Prostate Cancer
% HEM/ONC Own by Hosp	21.69**	367.6*	4.928
	(0.0116)	(0.0771)	(0.722)
Observations	18	13	17
Weighted Avg. Median Price	$4,461	$32,759	$4,594
R-squared	0.337	0.257	0.009

INPUT COST ADJUSTED PRICES

	Breast Cancer	Lung, Bronchi, or Mediastinum Cancer	Prostate Cancer
% HEM/ONC Own by Hosp	10.29**	192.9*	-2.520
	(0.0360)	(0.0949)	(0.822)
Observations	18	13	17
Input cost adjusted Weighted Avg. Median Price	$3,369	$24,449	$3,504
R-squared	0.247	0.233	0.003

Notes: % HEM/ONC Own by Hosp = % of hematologists/oncologists who work for a foundation owned by a hospital or health system. Input cost adjusted prices were computed by deflating unadjusted prices by the Medicare Wage Index https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html *. Regressions are weighted by rating area population. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A23. The association between orthopedics procedure prices and the percent of orthopedists in a rating area who work for foundations owned by a hospital or health system, 2014 (weighted by rating area population)

UNADJUSTED PRICES

	Ankle Fracture/ Sprain	Knee Ligament Injury	Wrist or Hand Fracture/ Dislocation/ Sprain
% ORS Own by Hosp	2.439	1.712**	3.178*
	(0.113)	(0.0135)	(0.0535)
Observations	18	18	18
Weighted Avg. Median Price	$500	$273	$496
R-squared	0.149	0.325	0.214

INPUT COST ADJUSTED PRICES

	Ankle Fracture/ Sprain	Knee Ligament Injury	Wrist or Hand Fracture/ Dislocation/ Sprain
% ORS Own by Hosp	0.308	0.373	0.777
	(0.814)	(0.590)	(0.350)
Observations	18	18	18
Input cost adjusted Weighted Avg. Median Price	$380	$208	$373
R-squared	0.004	0.019	0.055

*Notes: % ORS Own by Hosp = % of orthopedists who work for a foundation owned by a hospital or health system. Input cost adjusted prices were computed by deflating unadjusted prices by the Medicare Wage Index https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html . Regressions are weighted by rating area population. p-values in parentheses. *** p<0.01, ** p<0.05, * p<0.1*

Table A24. Individual Procedure Prices (2014) and ACA Premiums (2016) by HHI Level

	HHI < 1,500	HHI ≥ 1,500	% Difference
Avg. Inpatient Procedure Price	**$139,909**	**$250,203**	**79%**
# of rating areas (Hospital HHI)	*6*	*12*	
Heart Attack (Acute Myocardial Infarction)	*$19,210*	*$21,681*	*13%*
Partial Hip Replacement Revision	*$32,086*	*44,200*	*38%*
Premature Baby (Extremely Low Weight)	*$368,431*	*$684,728*	*86%*
Avg. Outpatient Primary Care Procedure Price	**$665**	**$898**	**35%**
*# of rating areas (Primary Care HHI***)*	*12*	*6*	
Cervical Cancer Screening Converted	*$88*	*$110*	*25%*
Colon Cancer Screening – Sigmoidoscopy	*$224*	*$290*	*29%*
Diagnostic Blood Fecal Test	*$15*	*$27*	*80%*
Diverticular Disease	*$967*	*$1,419*	*47%*
Fibroids	*$918*	*$1,475*	*61%*
Kidney (Renal) Failure	*$1,106*	*$1,438*	*30%*
Sore Throat	*$139*	*$183*	*32%*
Upper Respiratory Infection/Common Cold (Adult)	*$137*	*$180*	*31%*
Urinary Tract Stone	*$2,388*	*$2,964*	*24%*
Avg. Outpatient Hematology/Oncology Procedure Price	**$13,762**	**$20,819**	**51%**
# of rating areas (Hematology/Oncology HHI)	*11*	*7*	
Breast Cancer	*$4,255*	*$5,362*	*26%*
Lung, Bronchi, or Mediastinum Cancer	*$32,466*	*$51,421*	*58%*
Prostate Cancer	*$4,564*	*$5,675*	*24%*
Avg. Outpatient Orthopedist Procedure Price	**$439**	**$715**	**63%**
# of rating areas (Orthopedics HHI)	*17*	*1*	
Ankle Fracture/Sprain	*$515*	*$911*	*77%*
Knee Ligament Injury	*$272*	*$387*	*42%*
Wrist or Hand Fracture / Dislocation / Sprain	*$531*	*$849*	*60%*
	HHI < 2,500	HHI ≥ 2,500	% Difference
Avg. ACA Benchmark Plan Monthly Premium	**$318**	**$363**	**14%**
# of rating areas	*9*	*10*	

*Notes: The average reported above is a straight average across the procedures within each category. Cardiology prices are not reported as no rating areas had a cardiology HHI below 1,500 (see Table A1 in the appendix). The premiums listed in Table A2 were used for the analysis of Avg. ACA Benchmark Plan Monthly Premiums. *** Primary Care HHI was calculated at the primary care service area (PCSA)-level and then weighted up to the rating area-level (see Goodman et al. (2003) for details on PCSAs). All other HHIs were calculated directly at the rating area-level.*

Table A25. Input Cost Adjusted Individual Procedure Prices (2014) and ACA Premiums (2016) by HHI Level

	HHI < 1,500	HHI ≥ 1,500	% Difference
Input Cost Adjusted Avg. Inpatient Procedure Price	**$108,483**	**$165,119**	**52%**
# of rating areas (Hospital HHI)	*6*	*12*	
Heart Attack (Acute Myocardial Infarction)	*$14,933*	*$15,334*	*3%*
Partial Hip Replacement Revision	*$24,974*	*$30,202*	*21%*
Premature Baby (Extremely Low Weight)	*$285,543*	*$449,820*	*58%*
Input Cost Adjusted Avg. Outpatient Primary Care Procedure Price	**$472**	**$622**	**32%**
*# of rating areas (Primary Care HHI***)*	*12*	*6*	
Cervical Cancer Screening Converted	*$61*	*$78*	*28%*
Colon Cancer Screening – Sigmoidoscopy	*$159*	*$198*	*25%*
Diagnostic Blood Fecal Test	*$10*	*$18*	*80%*
Diverticular Disease	*$704*	*$965*	*37%*
Fibroids	*$656*	*$1,017*	*55%*
Kidney (Renal) Failure	*$794*	*$993*	*25%*
Sore Throat	*$100*	*$126*	*26%*
Upper Respiratory Infection/Common Cold (Adult)	*$99*	*$124*	*25%*
Urinary Tract Stone	*$1,662*	*$2,078*	*25%*
Input Cost Adjusted Avg. Outpatient Hematology/Oncology Procedure Price	**$10,370**	**$13,269**	**28%**
# of rating areas (Hematology/Oncology HHI)	*11*	*7*	
Breast Cancer	*$3,198*	*$3,562*	*11%*
Lung, Bronchi, or Mediastinum Cancer	*$24,470*	*$32,404*	*32%*
Prostate Cancer	*$3,442*	*$3,842*	*12%*
Input Cost Adjusted Avg. Outpatient Orthopedist Procedure Price	**$311**	**$577**	**85%**
# of rating areas (Orthopedics HHI)	*17*	*1*	
Ankle Fracture/Sprain	*$365*	*$735*	*101%*
Knee Ligament Injury	*$194*	*$312*	*61%*
Wrist or Hand Fracture / Dislocation / Sprain	*$375*	*$685*	*83%*
	HHI < 2,500	HHI ≥ 2,500	% Difference
Avg. ACA Benchmark Plan Monthly Premium	**$233**	**$256**	**10%**
# of rating areas	*9*	*10*	

*Notes: The average reported above is a straight average across the procedures within each category. Cardiology prices are not reported as no rating areas had a cardiology HHI below 1,500 (see Table A1 in the appendix). *** Primary Care HHI was calculated at the primary care service area (PCSA)-level and then weighted up to the rating area-level (see Goodman et al. (2003) for details on PCSAs). All other HHIs were calculated directly at the rating area-level.*

Table A26. Northern California vs. Southern California Individual Procedure Prices (2014) and ACA Premiums (2016)

	South	North	% Difference
Avg. Inpatient Procedure Price	**$131,586**	**$223,278**	**70%**
Avg. Hospital HHI	*1,047*	*2,202*	*110%*
Heart Attack (Acute Myocardial Infarction)	*$19,371*	*$21,408*	*11%*
Partial Hip Replacement Revision	*$32,741*	*$43,017*	*31%*
Premature Baby (Extremely Low Weight)	*$342,646*	*$605,408*	*77%*
Avg. Outpatient Primary Care Procedure Price	**$588**	**$802**	**36%**
*Avg. Primary Care HHI****	*996*	*1,420*	*43%*
Cervical Cancer Screening Converted	*$83*	*$100*	*20%*
Colon Cancer Screening – Sigmoidoscopy	*$187*	*$268*	*43%*
Diagnostic Blood Fecal Test	*$9*	*$22*	*144%*
Diverticular Disease	*$897*	*$1,203*	*34%*
Fibroids	*$700*	*$1,259*	*80%*
Kidney (Renal) Failure	*$1,020*	*$1,292*	*27%*
Sore Throat	*$136*	*$160*	*18%*
Upper Respiratory Infection/Common Cold (Adult)	*$134*	*$158*	*18%*
Urinary Tract Stone	*$2,125*	*$2,755*	*30%*
Avg. Outpatient Cardiology Procedure Price	**$17,653**	**$28,955**	**64%**
Avg. Cardiology HHI	*352*	*857*	*143%*
Cardiomyopathy (Heart Muscle Disease)	*$1,735*	*$1,922*	*11%*
Cardiovascular Symptoms (Other)	*$503*	*$570*	*13%*
Coronary Artery Disease with Heart Bypass Surgery	*$50,720*	*$84,374*	*66%*
Avg. Outpatient Hematology/Oncology Procedure Price	**$11,905**	**$18,445**	**55%**
Avg. Hematology/Oncology HHI	*823*	*2,257*	*174%*
Breast Cancer	*$4,185*	*$4,878*	*17%*
Lung, Bronchi, or Mediastinum Cancer	*$27,187*	*$45,243*	*66%*
Prostate Cancer	*$4,343*	*$5,213*	*20%*
Avg. Outpatient Orthopedist Procedure Price	**$396**	**$477**	**20%**
Avg. Orthopedist HHI	*263*	*851*	*224%*
Ankle Fracture/Sprain	*$474*	*$561*	*18%*
Knee Ligament Injury	*$270*	*$282*	*4%*
Wrist or Hand Fracture / Dislocation / Sprain	*$445*	*$589*	*32%*
Avg. ACA Benchmark Plan Monthly Premium	**$271**	**$367**	**35%**
Avg. Insurer HHI	*1,919*	*2,700*	*41%*

*Notes: The average reported above is a straight average across the procedures within each category. Cardiology prices are not reported as no rating areas had a cardiology HHI below 1,500 (see Table A1 in the appendix). The premiums listed in Table A2 were used for the analysis of Avg. ACA Benchmark Plan Monthly Premiums. *** Primary Care HHI was calculated at the primary care service area (PCSA)-level and then weighted up to the rating area-level (see Goodman et al. (2003) for details on PCSAs). All other HHIs were calculated directly at the rating area-level.*

Table A27. Northern California vs. Southern California Input Cost Adjusted Individual Procedure Prices (2014) and ACA Premiums (2016)

	South	North	% Difference
Input Cost Adjusted Avg. Inpatient Procedure Price	**$111,816**	**$147,922**	**32%**
Avg. Hospital HHI	*1,047*	*2,202*	*110%*
Heart Attack (Acute Myocardial Infarction)	*$16,315*	*$14,725*	*-10%*
Partial Hip Replacement Revision	*$27,517*	*$28,822*	*5%*
Premature Baby (Extremely Low Weight)	*$291,615*	*$400,218*	*37%*
Input Cost Adjusted Avg. Outpatient Primary Care Procedure Price	**$495**	**$532**	**8%**
*Avg. Primary Care HHI****	*996*	*1,420*	*43%*
Cervical Cancer Screening Converted	*$70*	*$66*	*-6%*
Colon Cancer Screening – Sigmoidoscopy	*$157*	*$178*	*13%*
Diagnostic Blood Fecal Test	*$8*	*$15*	*88%*
Diverticular Disease	*$754*	*$806*	*7%*
Fibroids	*$590*	*$848*	*44%*
Kidney (Renal) Failure	*$858*	*$861*	*0%*
Sore Throat	*$114*	*$106*	*-7%*
Upper Respiratory Infection/Common Cold (Adult)	*$113*	*$105*	*-7%*
Urinary Tract Stone	*$1,790*	*$1,805*	*1%*
Input Cost Adjusted Avg. Outpatient Cardiology Procedure Price	**$14,844**	**$18,954**	**28%**
Avg. Cardiology HHI	*352*	*857*	*143%*
Cardiomyopathy (Heart Muscle Disease)	*$1,460*	*$1,267*	*-13%*
Cardiovascular Symptoms (Other)	*$423*	*$383*	*-9%*
Coronary Artery Disease with Heart Bypass Surgery	*$42,648*	*$55,212*	*29%*
Input Cost Adjusted Avg. Outpatient Hematology/Oncology Procedure Price	**$10,042**	**$12,071**	**20%**
Avg. Hematology/Oncology HHI	*823*	*2,257*	*174%*
Breast Cancer	*$3,521*	*$3,270*	*-7%*
Lung, Bronchi, or Mediastinum Cancer	*$22,934*	*$29,397*	*28%*
Prostate Cancer	*$3,670*	*$3,547*	*-3%*
Input Cost Adjusted Avg. Outpatient Orthopedics Procedure Price	**$333**	**$324**	**-3%**
Avg. Orthopedist HHI	*263*	*851*	*224%*
Ankle Fracture/Sprain	*$399*	*$381*	*-5%*
Knee Ligament Injury	*$227*	*$191*	*-16%*
Wrist or Hand Fracture / Dislocation / Sprain	*$374*	*$399*	*7%*
Input Cost Adjusted Avg. ACA Benchmark Plan Monthly Premium	**$228**	**$251**	**10%**
Avg. Insurer HHI	*1,919*	*2,700*	*41%*

*Notes: The average reported above is a straight average across the procedures within each category. *** Primary Care HHI was calculated at the primary care service area (PCSA)-level and then weighted up to the rating area-level (see Goodman et al. (2003) for details on PCSAs). All other HHIs were calculated directly at the rating area-level.*

Issue Brief

March 19, 2018

Exploring Public Options in California

Key Issues and Considerations

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This report explores public plan choice, often referred to as the "public option," through a California lens. This report highlights for policymakers and stakeholders the issues and options related to public plan choice given California's unique history, delivery system, health insurance landscape and health reform experience. To help frame the policy conversation, this report identifies how a public option might be developed in California and, through scenario-based analysis, identifies key issues and questions that will need to be addressed.

Introduction

California remains focused on protecting existing health care programs on the one hand, while continuing to advance state-based reforms on the other. California policymakers are considering state-level proposals to improve health care and coverage, from incremental coverage expansions for the remaining uninsured to large-scale system change, such as enactment of a state single payer program.

As part of the current health reform debate, California policymakers and stakeholders are exploring whether the state can (or should) adopt a form of public option, similar to proposals Congress rejected in the lead up to the ACA. While there is energy and enthusiasm for the public option among many California stakeholders, there are also very different views as to what it would look like or accomplish. This report underscores the unique character and structure of public and private health care in California and how it will impact the advisability and feasibility of a state public option. Section 5 offers principles for policymakers to consider as they evaluate public options for California, including setting clear goals and expectations for the policy changes.

Fundamentally, there are two threshold issues in considering implementation of public plan choice in California: (1) what is the problem that policymakers are trying to solve and (2) in what ways is expanded public plan choice a workable and effective solution to the problem?

I. PUBLIC PLAN CHOICE AT THE FEDERAL LEVEL (Pre-ACA)

As Congress was considering legislative proposals leading to passage of the ACA, debate in the final days centered on the issue of "public plan choice" – whether Americans younger than 65 who lack employment-based coverage should have the choice of enrolling in a new public health insurance plan modeled after Medicare.[1] Although present in several interim bills and November 2009 legislation passed by the U.S. House of Representatives, Congress omitted the public option from the ACA bill package finally passed by both houses and signed by President Obama in March 2010.

From the beginning of the public option debate there was confusion not only about what a public option needed to look like but also what it would mean for the American health care system.[2] Observers at the time acknowledged that one reason for the confusion, and resulting controversy, was that general outlines of how the public option would work were sometimes unclear, allowing both supporters and opponents to project their greatest fears and hopes onto the idea.[3] In addition, observers recognized the public option was a highly visible symbol of the deep divide on the proper role of government in achieving universal coverage, which characterized the broader health reform debate, as well as prior national health reform debates over many decades.[4]

Advocates for public plan choice, also known as the public option, promote it as *a publicly insured plan in direct competition with other options for private health insurance coverage*, with the hope that the features of a publicly sponsored option, and the competition it would bring to markets, will drive down both premiums and underlying health care costs.[5]

Proponents believe that the public option will have inherent advantages that make it a lower cost choice, including not having to pay profits, low overhead costs (e.g., no need for marketing) and sufficient enrollment to achieve volume discounts with providers.[6] Another stated intent of the public option is to replace "unhealthy" market competition, in which health plans compete to attract the healthiest individuals, with "healthy" competition based on a broader set of plan features.[7] This view holds that healthy competition, with meaningfully different choices, would spur lower costs and improve quality. In addition, many proponents of public plan choice promote the policy specifically because of the benefits they see in *publicly operated* coverage. These benefits include, in their view, public governance, greater transparency and accountability, and the absence of shareholders or a profit motive.

During the national debate, supporters envisioned a new public plan exemplifying the basic principles of Medicare – inclusive, affordable, transparent coverage with a broad choice of providers – that could both spur Medicare toward improved care delivery and cost containment and ultimately light the way toward universal health security.[8]

For background and illustration, the section below highlights features of two competing versions of the public option considered by Congress in 2009.

Congressional Public Option Proposals (2009)

On November 7, 2009, the U.S. House of Representatives approved the H.R. 3962, the Affordable Health Care for America Act (House version) and on November 21, 2009 the majority leader of the Senate, Senator Harry Reid, introduced S.Amdt. 2786 to H.R. 3590 (Senate amendment). Both bills included language for a public option.[9]

The two bills would give the Secretary of Health and Human Services start-up funding and authority to enter into contracts for the establishment and administration of a public option. The Secretary would establish geographically adjusted premiums to cover medical claims, administration, a contingency margin (reserves for anticipated claims), and repayment of start-up funds.

The Senate amendment would allow states to opt out of offering the public option on the state exchange. The House version did not allow states to opt out. Both bills would require the public option to, at a minimum, offer the same benefits as in the exchange, as specifically defined in each bill, and the Senate amendment allowed states with the public option in the state exchange to require coverage of additional benefits in the public plan.

Other key provisions include:

- ***Eligibility.*** Individuals eligible for the exchange, including those eligible for exchange subsidies, could choose the public option in both versions.
- ***Contract administrator.*** The Senate amendment set criteria for the contract administrator, including that it must be competitively bid and a nonprofit entity. If the administrator was a for-profit entity, the administrator would be required to repay any start-up funds and would be permanently prohibited from offering a qualified health plan (QHP) on the exchange. There was no similar provision in the House version.
- ***Provider network.*** In the House version, the provider network for the public option would be established through deeming Medicare providers to be in the public plan, unless they opted out, and providers could participate as both preferred or non-preferred providers. The Senate amendment specified that providers would voluntarily participate in the public option with no comparable provision relating to preferred providers.
- ***Provider payment rates.*** The Secretary would negotiate provider payment rates in both bills. In the House bill, rates could not be lower than Medicare rates or higher than average rates paid by qualified health plans (QHPs) in the exchange. Under the Senate amendment, rates could be no higher than average QHP rates.
- ***Consumer protections.*** Under the House version, enrollees would have access to the federal courts for the enforcement of rights as in Medicare, while under the Senate amendment the consumer protection laws of each state would apply to the public option. The amendment required states that did not opt out to establish a State Advisory Council to advise the Secretary on the operation of the public option.

- ***Federal funding.*** The House version prohibited the public option from receiving federal funds if it became insolvent. The Senate amendment required the public option to meet state solvency standards, as well as new federal solvency standards to be established by the Secretary. In the event of the plan's insolvency, the Senate amendment required the President to submit federal legislation that would remedy the insolvency and Congress would have to consider the proposal.

A preliminary Congressional Budget Office (CBO) analysis of the public option included in the House version in 2009 (H.R. 3962) underscores the multiple complex factors that determine whether a public option will succeed in offering a less costly coverage choice. CBO concluded:

> *… a public plan paying negotiated rates would attract a broad network of providers but typically have premiums somewhat higher than the average premiums for the private plans in the exchanges. The rates the public plan pays to providers would, on average, probably be comparable to the rates paid by private insurers participating in the exchanges. The public plan would have lower administrative costs but would probably engage in less management of utilization by its enrollees and attract a less healthy pool of enrollees …*[10]

II. THE CALIFORNIA CONTEXT FOR PUBLIC PLAN CHOICE

Pre-ACA, the size and scale of California, including the geographic and health delivery system diversity that characterizes its numerous health care markets and regions, heavily influenced the development of public and private health plans in the state. California has one of the highest managed care "penetration rates" (percent of the population enrolled in managed care) in the country and some form of managed care is nearly universal in public and private health care coverage. For example, 60 percent of Californians are enrolled in HMOs, compared to an average of 32 percent nationally.[11]

California's successful implementation of the ACA included formation of a dynamic state exchange marketplace, companion market rules for individual and small employer coverage that exceed federal requirements, along with dramatic expansion of Medi-Cal enrollment and growth in the state's health care safety net. Because of this, the California context for considering public plan choice is different than before the ACA and different than the 2009 debate surrounding a national public option. It is also generally true that policy options that may be feasible and desirable on a national scale may require significant modification to be workable at the state level or may not be viable for states to successfully implement.

Finally, federal policy and federal funding play a significant role in how states like California can organize, deliver and pay for health care, making it challenging to contemplate major health system changes absent a constructive and collaborative relationship with federal health officials. The current Administration in Washington has different priorities and focuses on different strategies, including efforts to rollback existing health care programs and reforms. The new federal context will limit what

California can do to expand public health plan choice in the near term, likely necessitating significant state investment to move forward, with little additional federal support or flexibility.

California Characteristics Relevant for Designing Public Options

This section highlights California-specific factors that will influence options the state has to expand public plan choice and identifies key policy questions. Unique California characteristics include:

- ***Active purchaser exchange.*** Unlike most other state exchanges, Covered California is authorized to select participating health plans through a competitive process. State law specifically requires the exchange to contract with health plans that "offer the optimal combination of choice, value, quality, and service." The exchange enabling statute also requires Covered California to offer a choice of qualified health plans (QHPs) at each of the five coverage levels in each region of the state. For each coverage year, Covered California selectively contracts with health plans that meet state and federal QHP requirements, and actively negotiates with potential plans on premiums, networks and geographic coverage. In addition, Covered California health plan contracts impose contract requirements adopted by the independent Covered California Board related to quality, performance and public reporting. As authorized in California law, Covered California also requires health plans to offer standard benefit designs to help consumers more easily compare available QHPs on price, networks, and quality.

  Question: Will additional public plan choices in the exchange offer lower premiums and introduce additional competition to drive down overall premiums beyond what Covered California has accomplished as an active purchaser?

- ***Existing network of local public health plans.*** California developed a network of local public health plans to serve Medi-Cal recipients starting in the early 1980s. Local health plans are authorized in state law and established at the county level through local ordinances and/or joint powers agreements. California's local public plans contract with the state to provide services to Medi-Cal beneficiaries and operate in 35 California counties in two models – Local Initiative Health Plans (LIs) and County Organized Health Systems (COHS). In COHS counties, one county-wide health plan serves as the single public plan for all Medi-Cal beneficiaries and in LI counties a local public plan competes with a commercial health plan. Local public plans in California are publicly governed with governing bodies that typically include a mix of local elected officials and consumer and provider representatives, depending on the specific local plan authority and model. As public entities they are more transparent than private plans subject to California's open meeting laws, including public meetings, disclosure of financial performance and public review of community investments. In many respects, the Med-Cal managed care (MCMC) program, especially in Two-Plan model counties, already embodies a form of public plan choice.

Question: Do California's local public plans have the capacity to expand beyond Medi-Cal, or to serve additional geographic regions, and with what impacts on access and quality in the Medi-Cal program?

- ***Strong California standards and consumer protections.*** California has some of the strongest consumer protection laws and health plan regulations in the country, including individual and small group market rules that exceed federal ACA requirements. Under the Knox-Keene Health Care Service Plan Act (Knox-Keene), the Department of Managed Health Care (DMHC) licenses health plans and enforces standards related to minimum and essential benefits, financial solvency and capacity, network adequacy, consumer disclosure, grievances and appeals, and review of quality and utilization management systems. The California Department of Insurance (CDI) enforces the same market rules in the individual and small employer markets, including essential health benefits, and regulates insurer solvency, network adequacy, claims payment and appeals, and market conduct. To participate as a qualified health plan in Covered California health plans must be licensed by DMHC or certificated by CDI. In the Medi-Cal program, LIs must be licensed under Knox-Keene but COHS plans are exempt from licensure unless they choose to voluntarily apply.

  Question: If California expands public plan choice to compete with private health plans, should publicly sponsored plans meet the same standards and follow the same rules as private health plans operating in those markets?

- ***California communities with severe provider shortages and lack of competition.*** In many underserved areas of California, particularly remote and rural areas, consumers have only one or two health plan choices in the exchange, and also may have limited choice in employer and other private coverage, often leading to premiums much higher than other regions of the state. For 2018, Covered California has approximately 213 zip codes and partial zip codes (or approximately 8 percent of zip codes in California) with only one health plan. Five percent of Covered California enrollees (66,000 individuals) have one health plan choice.[12] Covered California consumers experiencing a premium increase can often select another health plan in the same region to reduce costs. However, in areas with limited health plan choice, such as the rural North, consumers can still face significant premium increases even if they switch to another plan in the region. Geographic inaccessibility, provider shortages and provider concentration within markets can make it challenging for health plans to develop an adequate network and/or lead to high provider prices, increasing premiums and potentially motivating health plans to leave the area.

  Question: Will publicly sponsored plans effectively overcome the barriers in underserved areas that currently lead to limited health plan choice and higher premiums?

- ***State safety net linked to public health plans.*** California developed local public health plans in the Medi-Cal program in part to embrace the potential benefits of managed care, while preserving the state's health care safety net, including public health systems and community clinics and health centers. From the beginning in the 1980s, COHS plans included all willing and qualified Medi-Cal providers in the counties served, including safety-net hospitals and clinics. In the early 1990's, with state policymakers committed to expanding MCMC beyond COHS counties, the Department of Health Services (DHS at the time) proposed the "Two-Plan managed care model in counties with public hospitals and county-operated ambulatory care clinic networks. The Local Initiative developed in Two-Plan counties was specifically designed to incorporate public and private providers to maintain the vibrancy of the safety net.[13] This strong partnership between safety-net providers and local public plans continues. For example, the Department of Health Care Services (DHCS) reported that between September 2013 and April 2015 60 percent of Medi-Cal enrollment growth in local public plans was attributed to safety-net clinics, compared to 42.2 percent in commercial MCMC plans.[14]

  Question: As California explores public plan choice, what are the potential benefits or risks in terms of funding and viability of the state's safety net?

Local Public Plans in California

California's local health plans serve a majority of Medi-Cal beneficiaries enrolled in MCMC. COHS plans enroll all MCMC enrollees in the counties served. As of December 2017, 2.2 million Medi-Cal enrollees are enrolled in six COHS plans in 22 counties (17 percent of Medi-Cal beneficiaries). LIs participate in the "Two-Plan model" of MCMC, where they serve as the public plan choice in a county alongside a commercial, non-governmental health plan. There are more than five million Medi-Cal enrollees in nine LIs in 13 counties (37 percent of Medi-Cal beneficiaries). Statewide, 75 percent of MCMC enrollees in Two-Plan counties are enrolled in the LI.[15]

While local plans primarily serve Medi-Cal enrollees, they may also have other lines of business such as Medicare Advantage and health coverage for county employees. Local plans that administer the Cal-MediConnect program, a three-year demonstration project to improve care coordination for individuals with both Medi-Cal and Medicare coverage who enroll voluntarily, compete for enrollment with other Medicare options available to potential enrollees, including Medicare Advantage. Table 1 profiles California's existing local health plans including the lines of business each plan offers and MCMC enrollment.

Table 1
Profile of Local Health Plans in California
State Licensure and Enrollment, by Plan and Model Type, 2017

Local Initiative (LI) Health Plans (9 plans, 13 counties)	Lines of Business[16 17] (as of January 2017)	Enrollment[18] (December 2017)	Penetration[19]
Authorized in state law and established by county ordinance and/or joint powers agreement, LIs participate in the "Two-Plan model" of MCMC, serving as the public plan choice alongside a commercial, non-governmental health plan	LIs must be state-licensed under the Knox-Keene Act for Medi-Cal, and any other lines of business they offer, under the jurisdiction of the Department of Managed Health Care (DMHC)	**Total Statewide LI Enrollment** **5,083,549**	Statewide, 75% of Medi-Cal Managed Care enrollees in Two-Plan counties are enrolled in the LI. Most but not all Medi-Cal recipients must enroll in one of the two plans
Alameda Alliance for Health	Medi-Cal, In-Home Supportive Services (IHSS)	264,480	80%
Contra Costa Health Plan	Medi-Cal, IHSS, Medicare Advantage, County Employees	182,985	87%
CalViva Health	Medi-Cal	Fresno – 299,170	73%
		Kings – 27,661	58%
		Madera – 36,532	66%
Kern Family Health	Medi-Cal	248,244	77%
LA Care	Medi-Cal, Cal MediConnect/ Medicare Advantage, IHSS, Covered California	2,057,191	67%
Inland Empire Health Plan	Medi-Cal, Cal MediConnect/ Medicare Advantage	Riverside – 601,361	87%
		San Bernardino – 623,542	89%
San Francisco Health Plan	Medi-Cal, IHSS, Healthy Kids	133,936	87%
Health Plan of San Joaquin	Medi-Cal, Medi-Cal Access Program (AIM)	San Joaquin – 219,589	91%
		Stanislaus – 129,418	64%
Santa Clara Family Plan	Medi-Cal, Cal MediConnect/ Medicare Advantage, Healthy Kids	259,440	78%

Table 1
Profile of Local Health Plans in California
State Licensure and Enrollment, by Plan and Model Type, 2017

County Organized Health System (COHS) (6 plans 22 Counties)	Lines of Business[20 21] (as of January 2017)	Enrollment[22] (December 2017)	Penetration[23]
One county-wide health plan authorized in federal and state law serves as the single public plan for all Medi-Cal beneficiaries	State law exempts COHS plans from licensure for Medi-Cal but no other lines of business	**Total Statewide COHS Enrollment 2,177,868**	COHS plans enroll all Medi-Cal managed care enrollees in the counties served with a few exceptions
CalOptima	Medicare Advantage, Cal MediConnect, Program of All Inclusive Care for the Elderly	767,433	"
CenCal	AIM	San Luis Obispo – 54,202	"
		Santa Barbara – 125,435	"
Central California Alliance for Health	IHSS and AIM	Merced – 126,304	"
		Monterey – 155,564	"
		Santa Cruz – 68,410	"
Gold Coast Health Plan		202,817	"
Health Plan of San Mateo	Medi-Cal (voluntarily), IHSS, Healthy Kids, Medicare Advantage, County Coverage Program	109,842	"
Partnership HealthPlan	Previously licensed for Healthy Kids programs which are no longer active	Del Norte – 11,430	
		Humboldt – 52,273	"
		Lake – 30,928	"
		Lassen – 7,423	"
		Marin – 39,266	"
		Mendocino – 38,452	"
		Modoc – 3,121	"
		Napa – 28,526	"
		Shasta – 59,282	"
		Siskiyou – 17,435	"
		Solano – 110,513	"
		Sonoma – 111,399	"
		Trinity – 4,321	"
		Yolo – 53,492	"

Source: Insure the Uninsured Project; California Department of Health Care Services; California Department of Managed Health Care; Local Health Plans of California. See source details in end notes.

III. CONSIDERING PUBLIC OPTIONS FOR CALIFORNIA: THREE SCENARIOS

As a framework through which to identify issues and options, ITUP developed three scenarios of how a public plan choice might be organized in California. The scenarios acknowledge California's extensive network of local public health plans and the heavy concentration of managed care in the existing Medi-Cal program.

Key Concepts and Definitions

As background, the following key concepts highlight potential "public" roles in the provision of health care coverage.

- ***Public Program.*** A program *administered and funded* by government (typically federal, state and/or local) generally with established rules of eligibility, benefits and payment rates. A public program may contract with governmental (public) and/or non-governmental (private) health plans and providers to organize and deliver the services. In California, both Medi-Cal and Medicare contract with public and private plans.
- ***Publicly financed.*** Coverage funded in whole, or in part, by the federal, state and/or local governments.
- ***Publicly operated.*** Coverage *developed, administered and managed* by a public, governmental entity.

In developing the scenarios, ITUP used the following definitions:

- ***Public Option*** means a publicly operated health plan choice that directly competes with private health plans in specified target markets. A public option does **not** include public programs such as Medicare, Medi-Cal or CHIP, but may be modeled after, or offered as an adjunct to, public programs.
- ***Exchange Public Option*** means a public plan(s) choice that competes with private health plans in the state Affordable Care Act (ACA) exchange, Covered California. (Scenarios 1 and 2.)
- ***Medi-Cal Buy-in Public Option*** means a public plan choice for individuals not eligible for Medi-Cal who purchase coverage through the Medi-Cal program infrastructure rather than through a private health plan. A Medi-Cal buy-in might have different benefits and providers than Medi-Cal and could also include public financing, using state funds to lower premiums or out-of-pocket costs for some or all the individuals purchasing coverage. (Scenario 3.)
- ***Medi-Cal expansion*** means modifying the eligibility rules for Medi-Cal, a public program, which may include changes in age, income, immigration status or other eligibility factors, to increase the number of Californians eligible for the program. A Medi-Cal expansion is publicly financed either by federal/state funds, or if the population or program does not qualify for federal matching funds, with state-only/local funds.

Three Scenarios

The scenarios that follow are meant to provide a concrete framework by which to identify the issues, questions and legal constraints related to public options in California. In this first round of analysis, the

scenarios speculate on foundational issues for each approach, including potential structure, policy objectives, relevant state and federal laws, and financing.

If policymakers consider a public option within the state's current health care system, the public option model will need to be designed taking into account how California insurance markets operate, including Covered California, and the potential limitations of federal program rules, including federal Medicaid requirements. As the scenarios in this report suggest, public plan choice in California would most likely be accomplished through either additional public plan choices in the state exchange, or a public plan choice developed through the Medi-Cal infrastructure.

Scenario 1 – Exchange Public Option: Local Health Plans

Scenario 1 considers how the state might increase the participation of local public health plans in the exchange. In 2018, there is one LI, L.A. Care Health Plan, and one non Medi-Cal county-operated health plan, Valley Health Plan successfully participating in Covered California. This scenario raises numerous administrative, operational and legal challenges to expanding local plan participation in Covered California (discussed in more detail in Section V). State, federal and contractual requirements that apply to any health plan seeking certification as a QHP can be costly and are significantly different than the requirements for MCMC plans. California explored some of these issues when it considered developing a Bridge Plan prior to ACA implementation. See Appendix A for more on the Bridge Plan in California.

Scenario 2 – Exchange Public Option: New State Health Plan

Scenario 2 contemplates an alternative approach to increasing public plan choice in the exchange in the event local health plans are unable or unwilling to expand or for regions where there is no local health plan. A state health plan option raises many of the same challenges as for local public plans but additionally presents the challenge of how a new state plan might be structured, administered and funded. In addition to the start-up costs and challenges, there are complex issues surrounding regulation and oversight of a state-operated health plan. A baseline question is whether the state plan would be licensed and regulated according to state and federal requirements for individual or small group coverage and, if not, what oversight there might be. Finally, depending on the configuration of the state plan, it might be practical to organize the plan using a for-profit administrator or health plan(s), possibly making it less desirable to those promoting the public option as an alternative to private plans.

Scenario 3 – Medi-Cal Buy-in Public Option

Scenario 3 explores development of a competing coverage choice through the existing Medi-Cal infrastructure. This scenario is distinct from expanding eligibility for Medi-Cal using state funds through a state-only Medi-Cal expansion. Scenario 3 contemplates allowing individuals not eligible for Medi-Cal to buy coverage through the Medi-Cal infrastructure. By competing with private health plans to cover individuals not enrolled in Medi-Cal, the buy-in of Scenario 3 is consistent with the pre-ACA vision of a national public option. While Scenario 3 relies on the existing statewide Medi-Cal infrastructure, a buy-in program would likely need significant adjustments to serve as a viable public plan choice competing

against private health plans. Depending on whether the buy-in competes in the individual market and is subject to market rules, and state health insurance regulation, the state otherwise has unlimited flexibility to set benefits, premiums and provider networks in a state-only buy-in program. However, this scenario could require federal waivers or approvals if the state wanted to allow exchange eligible individuals to buy-in and continue to receive federal ACA subsidies. California explored some of these issues when it considered developing a Basic Health Plan prior to ACA implementation. See Appendix B for issues surrounging a possible Basic Health Plan in California.

Table 2
Scenarios for Public Options in California
(For Analysis Purposes Only)

	Scenario 1 Exchange Public Option (Existing Local health plans)*	Scenario 2 Exchange Public Option (New state health plan)	Scenario 3 Medi-Cal Buy-in Public Option
Description	Increased participation of local public health plans in the state exchange, as the public plan choice in Covered California and individual market	A state-operated public health plan choice offered through the state exchange and outside individual market	Public coverage choice offered for private purchase through the Medi-Cal program infrastructure
Potential Policy Objectives	Offer publicly operated alternative to compete with private health plans Improve affordability through choice and competition that lowers premiums and health care costs Increase choice in underserved areas with only one plan on the exchange Improve continuity for individuals whose eligibility fluctuates between exchange and Medi-Cal Make it easier for families to choose the same health plan if some family members are in Medi-Cal and some in the exchange Strengthen the state safety net	Offer publicly operated alternative to compete with private health plans Improve affordability through choice and competition that lowers premiums and health care costs Increase choice in underserved areas with only one plan on the exchange Offer a public plan choice in areas without local health plans available or willing to participate	Offer publicly operated alternative to compete with private health plans Improve affordability through choice and competition that lowers premiums and health care costs Increase coverage choices in areas with only one or two health plan choices Strengthen the state safety net

Table 2
Scenarios for Public Options in California
(For Analysis Purposes Only)

	Scenario 1 Exchange Public Option (Existing Local health plans)*	Scenario 2 Exchange Public Option (New state health plan)	Scenario 3 Medi-Cal Buy-in Public Option
Target population: Eligibility	1) Individuals not eligible for Medi-Cal who are eligible to enroll in the exchange or are seeking to purchase non-group, individual coverage outside of the exchange 2) Could also include small employers through Covered California for Small Business	1) Individuals eligible to buy coverage through the exchange or seeking non-group, individual coverage outside of the exchange 2) Could also include small employers through Covered California for small business	Individuals not eligible for Medi-Cal who are either: 1) Not eligible for exchange subsidies because of income or immigration status, and/or 2) Eligible for subsidies in the exchange **(with federal ACA Section 1332 waiver or approved Basic Health Plan)** 3) Could include small employers
Program Structure	1) Individual local health plans <u>or</u> 2) Consortium of existing local health plans sharing common infrastructure and operational resources to facilitate greater participation in the exchange or 3) Combined health plan choice through one lead local health plan that subcontracts with some or all existing local plans, collectively offered as one health plan option	State would design and implement a state health plan choice that could include: 1) Direct operation of the health plan by the state (provider contracting, claims payment, quality and utilization management, customer service, etc.) <u>or</u> 2) Subcontract(s) with external administrator to organize the network and manage some or all operational elements	Existing Medi-Cal infrastructure State contracts with local health plans and private health plans in MCMC Benefits need to be adjusted beyond what MCMC plans currently cover because of MCMC "carve-outs," such as mental health and substance use disorder services
Administering agency	Covered California	State agency (other than Covered California) with expertise in contracting for health coverage (e.g., CalPERS, County Medical Services Program, DHCS) <u>or</u> New state agency with independent board; governance structure like Covered California	Department of Health Care Services (DHCS) Depending on the program design, DHCS may not have existing capacity to organize and operate a public health plan choice to compete with private insurers DHCS would also have to ensure separate tracking and accounting of federal Medicaid funds

Table 2
Scenarios for Public Options in California
(For Analysis Purposes Only)

	Scenario 1 Exchange Public Option (Existing Local health plans)*	Scenario 2 Exchange Public Option (New state health plan)	Scenario 3 Medi-Cal Buy-in Public Option
Federal authority	Affordable Care Act, including requirements for exchange QHPs, unless federally exempted or waived	Affordable Care Act, including requirements for exchange QHPs, unless federally exempted or waived	No federal restrictions on program design for a state-administered and funded program; states can determine eligibility, benefits, cost sharing, delivery system, etc. Federal approval/waiver required to use federal exchange subsidies Federal requirements for health insurance issuers would potentially apply if the buy-in offers coverage to individuals and small employers
State authority	State ACA implementing laws, state licensure to meet QHP requirements (Knox-Keene license or California Department of Insurance certificate) In California, Local Initiatives must be licensed for Medi-Cal. Most County-Organized Health Systems are exempt and not licensed for Medi-Cal. If one lead local health plan contracts with other local health plans for assignment of lives and risk, contracted plans may require a Knox-Keene full service or restricted license depending on the risk arrangement May require changes to state enabling statutes for local plans and/or to local ordinance authority for each plan	State legislation would be required to establish the program Enabling legislation would need to address, in addition to issues above: ▪ Extent to which the state health plan must meet federal and state requirements for QHPs, including state licensure and regulatory oversight ▪ Terms of negotiation between the state plan and the exchange, including whether Covered California would be required to include the state health plan as a choice in regions where available	State legislation would be required to establish and define the program Enabling legislation would need to address, in addition to issues above: ▪ Whether health plans participating in the buy-in would meet the same requirements as MCMC plans <u>or</u> ▪ All buy-in plans must be state licensed, and ▪ State funding level and timeline, including whether the buy-in would have to be financially self-sustaining

Table 2
Scenarios for Public Options in California
(For Analysis Purposes Only)

	Scenario 1 Exchange Public Option (Existing Local health plans)*	Scenario 2 Exchange Public Option (New state health plan)	Scenario 3 Medi-Cal Buy-in Public Option
Financing	Possible significant start-up and product development costs, which could be repaid over time through premiums Once operational, existing ACA revenues: ▪ Individual premiums ▪ Federal premium tax credits for eligible individuals ▪ Federal cost-sharing reduction (CSR) payments (not currently available pursuant to federal administrative action)	Significant state funding for the start-up costs of a new state program and for development of a new competitive health plan choice, including funds for initial financial reserves Once operational, existing ACA revenues: ▪ Individual premiums ▪ Federal premium tax credits and CSR payments ▪ Ongoing state costs, unless the new plan is financially viable and self-sustaining	Significant state funding for the start-up costs, development and ongoing operation of the buy-in plan, including funds for initial financial reserves Once operational: ▪ Private premium payments ▪ Ongoing state costs, unless the buy-in program is financially viable and self-sustaining ▪ Potential for ongoing state funds to subsidize premiums and/or cost-sharing

Source: Insure the Uninsured Project, February 2018.
**Current federal and state law requires eligible individuals between 138-400 percent of the Federal Poverty Level (FPL) seeking coverage to enroll in the exchange to receive premium and cost sharing subsidies. Moving exchange subsidy eligible individuals to a Medi-Cal buy-in program requires a federal Section 1332 ACA waiver, or establishment of a basic health plan under federal rules, to maintain federal premium and cost sharing subsidies. See Appendix B on the Basic Health Plan.*

Covered California Underserved Areas and Local Health Plans

As noted in Table 2, one policy objective for a public option would be to offer a public plan choice in regions where exchange enrollees do not have adequate health plan choice. In 2018, Covered California enrollees are limited to one health plan in Inyo, Mono, Monterey, San Benito, San Luis Obispo, and Santa Barbara counties, and over half of Kings county. El Dorado, Fresno, Madera and Placer counties have only one Covered California health plan operating in many of the zip codes and partial zip codes in these counties - between 14 and 33 percent of the zip codes in these counties.

Developing a viable local plan option in underserved counties could prove problematic, given the low number of individuals a public plan could enroll and the costs associated with developing a competitive QHP that complies with exchange standards. Table 3 lists the counties (or partial counties) with just one health plan offering in Covered California and shows whether there is a local health plan in the county. The enrollment data for Covered California highlights the relatively low overall exchange enrollment available in those regions, potentially complicating the viability of offering a public plan to address the current lack of health plan choice.

Table 3
Counties with One Plan Choice in Covered California

County	Local Health Plan	Zip Codes in the County with One Plan Choice	Covered California Enrollment (September 2017)
El Dorado	No LHP	33%	420
Fresno	CalViva Health	14%	23,680
Inyo	No LHP	All Zip Codes	670
Kings	CalViva Health	58%	2,320
Madera	CalViva Health	16%	4,180
Mono	No LHP	All	930
Monterey	Central CA Alliance for Health	All	13,110
Placer	No LHP	27%	14,540
San Benito	No LHP	All	1,590
San Luis Obispo	CenCal	All	12,470
Santa Barbara	CenCal	All	16,040

Source: Insure the Uninsured Project; Covered California 2018 Products by Zip Code, March 2018; Covered California 2017 September Active Member Profiles.

IV. OPERATIONAL CONSIDERATIONS FOR PUBLIC PLANS IN THE EXCHANGE

Any public plan option to be offered on the exchange, existing or new, local or state-administered, could experience challenges and costs related to QHP operational and certification requirements, including state licensure for the state health plan and for COHS plans not already licensed under Knox-Keene.

In evaluating the potential for an exchange public option in California, policymakers will need to consider the costs and effects of public plans complying with exchange standards. There may be compelling reasons to adjust the standards for public plan offerings while still ensuring quality and consumer protections are maintained.

Local public plans in particular may encounter operational challenges related to exchange requirements that differ significantly from Medi-Cal requirements, including: (1) Specific member support for billing issues, including subsidy determination, (2) Billing and collecting monthly premiums from enrollees, and (3) Paying the health plan assessment at 4 percent of premium. In addition, plans sold on the exchange must be National Committee on Quality Assurance (NCQA)-certified and offer the same products inside and outside the exchange. The list below highlights major areas of difference between Medi-Cal managed care and Covered California.

- ***Agent/Broker Support and Engagement.*** Agents/brokers have been responsible for over 40 percent of enrollment in Covered California for the past three years. Consumers have the option to enroll directly with the exchange, enroll through Community Based Organizations (known as Certified Enrollment Entities), or utilize a California licensed agent/broker. Covered California

does not compensate licensed agents for enrolling new members; therefore, participating plans are required to register, pay and support licensed agents who enroll members into their plan.

- ***Customer Service Capacity and Technology.*** Covered California currently has 1.3 million members enrolled in 11 health plans. Participating plans are required to support enrollees with billing and enrollment issues. Health plans in Covered California experience increased call volumes during open enrollment periods. To accommodate increased volumes during peak periods, most plans utilize value-added technology, telephony, and website services. Medi-Cal enrollment occurs throughout the year, rather than during a limited open enrollment period, and therefore does not generate the same type of high volume peak periods.
- ***Marketing.*** Covered California health plans must compete for market share in each region where they offer coverage. Covered California spends approximately $100 million each year on marketing and encourages participating plans to allocate significant funding for their own marketing purposes. Medi-Cal does not allow MCMC plans to market directly to enrollees.[24]
- ***Premium Collection.*** The exchange does not provide premium collection and aggregation services for participating health plans. Covered California plans are responsible for collecting monthly premiums from members, based on advance premium tax credit eligibility, and tracking member out-of-pocket expenditures. Medi-Cal does not collect premiums and MCMC plans do not have to track enrollee out-of-pocket costs.
- ***Fees.*** The exchange requires participating plans to pay a monthly assessment of 4 percent of total exchange premiums to support operation of the exchange. Medi-Cal does not impose a similar administrative fee.
- ***Market and Off Market.*** Plans participating in Covered California must offer the same products to individuals and small employers outside of the exchange and guarantee availability to all applicants. The commercial market is unfamiliar to most local health plans; competition with commercial health plans could be an expensive challenge and could lead to the public plans taking on a more high-risk population.
- ***Quality Reporting.*** Both the exchange and Medi-Cal require plans to participate in state and federal quality programs. However, the Exchange has unique quality measurement and reporting requirements that differ from other state and federal coverage programs.
- ***Qualified Health Plan Requirements.*** The ACA and state law require all health plans participating in the exchange to meet specific requirements related to state licensure, product offerings and rating rules, guaranteed availability and renewability, pooling of risks and regulatory review of premiums. California law requires Covered California to set minimum requirements for participating carriers as well as the standards and criteria for selecting qualified health plans and to apply the standards equally to all health plans in the exchange.[25]
- ***Reporting***. Both Covered California and Medi-Cal have quarterly and annual reporting requirements. The exchange has additional and unique data requirements applicable to participating plans that exceed Medi-Cal requirements.[26]

Local health plans participating in the Cal MediConnect program may be best prepared to meet exchange requirements due to similarities in operations between Cal-MediConnect and the exchange. Operational similarities between Cal MediConnect and the Exchange include: (1) The use of licensed insurance agents as a distribution channel, (2) Plans must submit proposals/bids and set rates, and (3) Core benefits are determined by the federal program rules for the exchange and for Cal MediConnect. Local plans that participate in Cal MediConnect include CalOptima, Health Plan of San Mateo, Inland Empire Health Plan, L.A. Care Health Plan, and Santa Clara Family Health Plan.[27]

Table 4 below highlights some of the operational and QHP certification requirements for participation in Covered California.

Addressing operational challenges for public plans

California law authorizes Covered California to take on various administrative processes such as premium collection, customer service and agent support.[28] In collaboration with public plans, Covered California could support key administrative functions that might reduce costs and complexity and facilitate greater participation by public plans.

California explored ways to reduce the administrative requirements of public plan participation in the exchange when it attempted to develop a "bridge plan" option in the lead up to ACA implementation. Under California's proposal at the time, Covered California would contract with MCMC plans to offer QHP products for specific populations under 250 percent of the federal poverty level. (See Appendix A for more on the Bridge Plan program considered in California.) The Bridge Plan approach focused on continuity of coverage, reducing disruptions in care as individuals change plans between the exchange and Medi-Cal and creating access to more affordable coverage.[29]

As part of the state's proposal for federal approval, Covered California proposed, along with other features, streamlining the QHP certification process for MCMC plans that only offer coverage in the non-commercial market:

- Allow Medi-Cal Managed Care plans to defer those elements of the solicitation that have not been applicable to a non-commercial health plan (e.g., waive quality data collection and tracking in 2014).
- Accept state Medi-Cal quality and performance requirements as satisfying exchange quality requirements during 2014.
- Coordinate with Department of Managed Health Care to streamline regulatory approval that may be required.
- Develop a separate timeline for certifying Bridge qualified health plans for 2014 and later years.
- Waive the state requirement that QHPs offer all coverage levels and catastrophic coverage, as well as the requirement to sell the same plans outside of Covered California, and limit public plan offerings to silver and gold coverage levels as required in federal law.

Table 4

Exchange Public Option

Operational Challenges for Public Health Plans in the Exchange

	Capacities Needed for Exchange Participation
Agents/Brokers	▪ Internal support to assist agents/brokers in addressing calls, payments, certification/enrollment ▪ System for tracking agent activity/sales ▪ Compliance process for agent activity
Customer Service	▪ Online tools for determining eligibility and tracking coverage and payments ▪ Provide access to web-based education materials and/or real-time assistance via chat or phone ▪ Capacity planning and management of high-volume periods (e.g., open enrollment) ▪ Back-office functions, e.g., eligibility verification documentation ▪ Staff to handle complex calls related to network, open enrollment, special enrollment, eligibility and calculation of subsidies, premiums, and out-of-pocket requirements
Fees/Funding	▪ Plans pay 4% of each premium received to Exchange
Marketing	▪ Expansion of marketing resources to reach additional territory ▪ Development of robust website, digital marketing, and collateral
Premium Collection	▪ Need for additional financial personnel ▪ System for collecting and tracking payments ▪ System for reporting subsidy payments to federal government
Quality Programs	▪ NCQA certification required ▪ Enrollees must be assigned to a primary care provider ▪ Ability to aggregate data across health plans ▪ Monthly submission of data elements to Truven Health Analytics
Rate Review Process	▪ Hiring of additional personnel to conduct product development, rate determination/actuarial service
Reporting	▪ Monthly submission of data elements to Truven Health Analytics ▪ Annual submission of quality performance data via EValue8 ▪ System for reporting subsidy payments to Federal government
Risk Sharing Program	▪ Financial ability to participate in Federal risk sharing program
Selling On/Off Exchange	▪ Online tools for determining eligibility and tracking coverage and payments ▪ Provide access to web-based education materials and/or real-time assistance via chat or phone

Source: Insure the Uninsured Project, 2018

V. PRINCIPLES FOR POLICYMAKERS

As policymakers and stakeholders consider the costs and benefits of expanded public plan choice in California, ITUP recommends the following guiding principles:

- ***Identify the problem and consider whether public plan choice will effectively address the problem.*** There are two threshold issues in considering public plan choice: (1) what is the problem that policymakers are trying to solve and (2) is public plan choice the most effective and efficient way to solve the problem? For example, while there may be potential for public options to address lack of health plan competition and choice in some underserved areas, it is less likely that public options, on their own, could address the problem of the remaining uninsured, given that 81 percent have incomes below 400 percent FPL.[30] It is unlikely that offering more public plan choices, without state funding for financial assistance, will help low-income uninsured individuals get coverage. Even if premiums for public plans are lower, the difference will likely not be enough for those who have to pay the full cost of the premium.
- ***Preserve consumer protections in law and regulation.*** California has strong consumer protections that apply to health plans in the state, ranging from financial solvency review to extensive consumer rights and disclosures. The decision on whether to maintain key consumer protections and regulatory oversight, and whether the goal in establishing public options is to ensure a level playing field between public and private health plans, is a central question for consideration. In large measure, state licensure and regulatory oversight of health plans originated in the early, scandal filled days of MCMC, which included fraud and financial insolvency. If current standards are not necessary, meaningful or effective, and need only apply to some types of health plans, the question remains whether the rules themselves need to be revisited.
- ***Evaluate the feasibility and cost benefit of public plan choice to achieve specific policy goals.*** While public plan choice may address specific policy goals, in theory, it will be important to consider state costs and relative public benefits from any proposal. Depending on the approach, the costs or potential unintended consequences might outweigh the benefits. As proposals emerge, each should be evaluated for feasibility, costs, benefits and legal constraints that will determine advisability of the proposal. For example, while adding local public plans in the exchange might be desirable, the relatively small number of enrollees any one plan, or even a consortium of plans, would likely secure might be insufficient to ensure viability, or to justify the allocation of capitol and human resources needed to comply with relevant standards and develop additional capacity.
- ***Maximize federal funding.*** As the scenarios highlight, many approaches to expand public plan choice would be most effective with federal collaboration and could require federal approval and/or waivers. Federal cooperation under the current Administration and political climate may be less likely than at other times. While states have flexibility in state funded programs, there may be features the state needs to include, or avoid, to preserve and maximize federal funds available to the state.

- ***Prioritize approaches that benefit consumers.*** Prioritize approaches likely to accomplish tangible and measurable improvements in consumer choice, affordability, access and continuity of care. It will also be critically important to consider potential positive and negative impacts on the ability of existing programs, including Covered California and Medi-Cal, or local health plans and the state safety net, to effectively serve the interests of consumers.

VI. CONCLUSION

This report initiates a series of issue briefs to inform the California discussion about expanding public plan choice in the state. The premise of the series is that California has a unique history and current infrastructure of exiting public plans, a successful state exchange and a Medi-Cal delivery system that is more than 80 percent managed care. These California-specific conditions need to be the starting point for exploring public options and will directly impact the advisability and the feasibility of specific policies.

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Insure the Uninsured Project (ITUP) is an independent 501(c)(3) nonprofit organization and health policy institute that for more than two decades has offered expert analysis and facilitated convenings of California health leaders on emerging issues affecting health and health policy in the state. The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad-based stakeholder engagement.

For more information on this report, contact ITUP Executive Director Deborah Kelch, at 916-226-3899.

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APPENDIX A

Bringing Medi-Cal Managed Care Plans into the Exchange: The Bridge Plan Demonstration Project

California has experience in evaluating strategies to more fully engage Medi-Cal managed care (MCMC) plans in offering exchange coverage. Prior to the implementation of the Affordable Care Act (ACA) in 2014, California considered but chose not to implement the "Bridge Plan Demonstration Project" (Bridge Plan).

On July 11, 2013 Governor Brown signed legislation authorizing Covered California to develop a three-year demonstration project, contingent on federal approval, that would "bridge" coverage between Medi-Cal and Covered California for eligible low-income families transitioning between the two programs. Although Covered California did develop and evaluate a Bridge Plan approach, the project was not implemented.

Proposed Program. The Bridge plan was intended to achieve the following objectives: promote continuity of coverage, reduce consumer disruptions in care associated with changes in health plans, and create access to more affordable coverage. The proposal involved existing MCMC plans (both public plans and non-governmental plans), certified as Qualified Health Plans (QHPs) by Covered California, offering coverage for exchange-eligible individuals with incomes under 250 percent of the federal poverty level in the following groups:

- New Covered California enrollees previously enrolled in a MCMC Plan who opt to participate in the Project,
- Family members eligible for Covered California seeking coverage in the same Medi-Cal plan as other family members, and
- Parents or caretaker relatives of a Medi-Cal enrolled child.

The Bridge Plan proposal required MCMC plans to guarantee coverage to eligible individuals but not to other applicants for exchange or individual coverage, providing the MCMC plan could demonstrate, consistent with federal requirements and the Covered California proposal, that the plan's provider network was only adequate to serve Bridge Plan enrollees.

Covered California hoped to negotiate Bridge Plan rates low enough to serve as the lowest cost silver plan in affected regions. The proposal also included specific suggestions for a streamlined QHP certification process for participating MCMC plans, such as streamlining regulatory approval by DMHC and limiting required product offerings to those required in federal law, silver and gold level coverage.

Challenges. An analysis conducted by Milliman for Covered California determined that providers would likely have been paid 5-15 percent less under the Bridge Plan than under typical commercial contracts, raising network adequacy concerns. Consumer advocates were concerned, among other things, that the

Bridge Plan would not be fully operational by the first ACA open enrollment, provider networks might not sufficiently overlap with MCMC networks and premium levels might not be low enough to maximize federal premium tax credits available to participants. Moreover, not all MCMC plans had the capacity to perform all the functions and meet the statutory requirements to become a certified QHP. Given the financial uncertainty, administrative and regulatory complexity, and potential challenges in gaining federal approval, the proposal did not seem viable at the time.

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APPENDIX B

A Basic Health Plan in California?

Under the ACA, California expanded Medi-Cal eligibility to include citizen and lawfully present individuals up to 138 percent of the federal poverty level (FPL). Individuals between 138-400 percent FPL are eligible for premium and cost sharing subsidies through Covered California.

The ACA Basic Health Plan (BHP) is an option for states to establish a separate program for individuals not eligible for other government coverage, or without access to affordable employer coverage, up to 200 percent FPL. In the lead up to ACA implementation, California considered but chose not to implement the BHP.

In 2012, the UCLA Center for Health Policy Research/UC Berkeley Labor Center estimated that 829,000 individuals would be eligible for the BHP in California (mid-range estimate) – 783,000 because they have family incomes 138-200 percent FPL and an additional 46,000 lawfully present immigrants with incomes below 138 percent FPL ineligible for federal Medicaid, currently covered through state-only Medi-Cal.

Under ACA rules, state BHP programs receive federal funds equal to 95 percent of the amount the federal government would have paid for premium and cost sharing subsidies in the exchange. Premiums for the BHP must not exceed premiums for the second lowest cost silver plan in the exchange and monthly premiums and out-of-pocket costs for individuals in the BHP must not exceed what they would have paid if they had exchange coverage.

In 2011 and 2012, California researchers and stakeholders explored the potential for a BHP in California. One concern was the extent to which individuals signing up for a BHP would reduce the number available to enroll in the California exchange, still yet to be implemented, and unknown impacts on the overall risk mix and costs for exchange coverage. Also, given the approach to calculating the federal share, also still in development, experts determined that the state fiscal impact was hard to estimate and could be significant. Additional information about the process and analyses during the earlier debate can be found on the California Health Care Foundation website.

To date, two states have implemented the BHP, Minnesota and New York. The two programs are very different, as illustrated by Kaiser Family Foundation's comparison across a variety of program measures.

Importantly for consideration of a BHP in California, changes at the federal level also create some uncertainty about the BHP going forward. With the President's elimination of federal payments for cost sharing reductions (CSRs), both states are likely to experience reductions in federal funding for the BHP; New York could potentially lose $1 billion in federal funds, and Minnesota could lose $65 million in the 2018 budget year, approximately 25 percent of current federal funding for the BHP, MinnesotaCare. In addition, as part of the process of Minnesota seeking a federal ACA Section 1332 waiver to implement a state-based reinsurance program in the state exchange, CMS approved the waiver, but also reduced

funding for the BHP to reflect anticipated reductions in exchange premiums resulting from the reinsurance program.

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APPENDIX C
Basic Health Plan Features in Minnesota and New York
(Kaiser Family Foundation)

	Minnesota (MinnesotaCare)	New York (Essential Plan)
Program Structure	▪ Single product, regardless of income or immigration status ▪ Premiums and cost sharing above 35% FPL, with exceptions	▪ 4 products: EP 1 and 2 for 138-200% FPL; EP 3 and 4 for immigrants at or below 138% FPL ▪ Benefits, premium, and cost-sharing requirements vary between EP programs, but within each program are the same for all health plans
Premiums	▪ Premiums on a sliding scale, 35-200% FPL: $4/month to $80/month ▪ No premiums for those under age 21, American Indians and family members, military members completing a tour of active duty within last 24 months	▪ No premiums at or below 150% FPL ▪ $20/month premium for between 151% and 200% FPL
Cost-sharing	▪ No deductible; (statutory $2.95 monthly deductible waived by all insurers) ▪ Modest co-payments ▪ No copays for those under age 21 and American Indians	▪ No deductibles ▪ Modest co-payments above 100% FPL
Benefits	▪ Essential health benefits ▪ Dental care, vision, and enhanced behavioral health services covered	▪ EP 1 and 2: Essential health benefits covered ▪ Enrollees in EP 1 and 2 can purchase dental and vision coverage at full cost ▪ EP 3 and 4: Additional benefits approximate Medicaid coverage
Enrollment Policy	▪ Enrollment open year round ▪ Enrollees must report changes in circumstance within 30 days	▪ Enrollment open year round ▪ Enrollees must report changes in circumstance
Grace Period	▪ 30-day grace period; can avoid coverage gap by paying past-due and current premiums by the end of the grace month ▪ 90-day lock-out period if enrollees fail to pay past-due and current premiums; after 90 days, can re-enroll without penalty	▪ 30-day grace period; can avoid coverage gap by paying past-due and current premiums by the end of the grace month

APPENDIX C
Basic Health Plan Features in Minnesota and New York
(Kaiser Family Foundation)

	Minnesota (MinnesotaCare)	New York (Essential Plan)
Health Plan Contracting		
Approach to contracting	▪ Joint procurement with Medicaid	▪ Marketplace issues Invitation to Participate to insurers; rates set by Medicaid agency (>Medicaid rates)
Health plan overlap	▪ Plans must serve both Medicaid and MNCare ▪ At least one Medicaid/MNCare plan in each county also participates in the marketplace	▪ 11 of 13 plans offering EP coverage also participate in Medicaid and the marketplace
Provider networks	▪ Provider networks broader in MNCare compared to QHPs	▪ Generally, 85% overlap between EP and QHP provider networks. ▪ In some areas, EP provider networks narrower than Medicaid
Program Administration		
Administration	▪ Administered by Medicaid agency; some responsibilities shared with marketplace	▪ Program operations shared between Medicaid and the marketplace
Financing		
Costs	▪ Projected FY2017 costs: $608 million	▪ Projected FY2017 costs: $2,461 million
Source of funding	▪ Federal BHP payments: 68%; State funds: 26%; Consumer premiums: 6%	▪ Federal BHP payments: 85%; State funds: 15%

Source: Kaiser Family Foundation

APPENDIX D

Public Option Approaches in Other States

Public Option Approaches in Other States

In 2017, with federal threats to the Affordable Care Act (ACA) mounting, public option proposals gained renewed attention in several state legislatures and in Congress. The public option bills considered by other state legislatures in 2017 are barebones, providing a general framework with few specifics.

The first table in this appendix compares the Medicaid programs of the four other states with Medi-Cal. Medicaid in the four states considering a public option are a fraction of the size of the Medi-Cal program and rely less on managed care in Medicaid than California. For example, in fiscal year 2016, total Medi-Cal spending was $82 billion. State Medicaid spending for the other states in fiscal year 2016 ranged from $3.4-17.1 billion.

As the second table illustrates, most of the states considering a public option intend to offer this product in state marketplaces to individuals with incomes above existing Medicaid income eligibility levels in their respective states. The states propose to finance the public option primarily through premium payments and cost sharing from enrollees. To address affordability, states propose securing federal approval to capture ACA premium assistance and cost sharing reduction subsidies that enrollees would have received in the marketplaces. A federal waiver is necessary to capture ACA premium assistance and cost sharing reductions for a Medicaid buy-in because this public option operates outside the ACA marketplaces.

Characteristics of State Medicaid Programs

Program Characteristics	California	Massachusetts	Minnesota	Nevada	Wisconsin
2015 Medicaid Enrollment	12.3 million	1.6 million	1.0 million	631,000	1.0 million
Percent of Population Enrolled in Medicaid, 2015	26%	23%	14%	17%	17%
Percent of Medicaid Population in Risk-Based Managed Care, 2016*	84.6%	53.5%	75.0%	77.0%	67.0%
Eligible Populations	Medi-Cal covers: ▪ Children to 266% of the federal poverty level (FPL) ▪ Pregnant women to 322% FPL ▪ Parents and childless adults to 138% FPL ▪ Seniors and People with Disabilities (SPDs) to 100% FPL	Medicaid covers: ▪ Children to 305% FPL ▪ Pregnant women to 205% FPL ▪ Parents and childless adults to 138% FPL ▪ SPDs to 100% FPL	Medicaid covers: ▪ Children to 288% FPL ▪ Pregnant women to 283% FPL ▪ Parents and childless adults to 138% FPL ▪ SPDs to 100% FPL	Medicaid covers: ▪ Children to 205% FPL ▪ Pregnant women to 165% FPL ▪ Parents and childless adults to 138% FPL ▪ SPDs to 73% FPL	Medicaid covers: ▪ Children to 306% FPL ▪ Pregnant women to 306% FPL ▪ Parents and childless adults to 100% FPL ▪ SPDs to 83% FPL
Total Medicaid Spending, Fiscal Year 2016	$82.0 billion	$17.1 billion	$11.2 billion	$3.4 billion	$7.7 billion
Percent of State General Fund spent on Medicaid	19%	24%	22%	17%	17%

Source: Insure the Uninsured Project; Medicaid State Fact Sheets, Kaiser Family Foundation, June 2017, https://www.kff.org/interactive/medicaid-state-fact-sheets/.
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Proposed Public Option Legislation in 2017
Other States and Federal

Characteristics	Massachusetts MassHealth S.2202/S.2211 *(Passed by Senate 11/9/17)*	Minnesota MinnesotaCare Option S.F. No.58 *(Failed to Pass)*	Nevada Nevada Care Plan A.B. 374 *(Vetoed by Governor)*	Wisconsin BadgerCare Plus A.B. 449 *(Introduced 7/25/17)*	FEDERAL LEGISLATION State Public Option Act S.2001 *(Introduced 10/24/17)*
Exchange or Medicaid Buy-In Public Option	Medicaid Buy-In Public Option ▪ Authorizes, but does not require the State Health Department to implement a Medicaid Buy-In Public Option ▪ In addition to individuals buying into Medicaid, employers can also purchase state Medicaid coverage for employees as an employer-sponsored insurance (ESI) plan	Exchange Public Option* ▪ Offered on the marketplace, subject to federal approval	Medicaid Buy- In/ Exchange Public Option* ▪ Offered by contracted insurers inside or outside the exchange, subject to federal approval ▪ Designates the public option as a qualified health plan (QHP)	Medicaid Buy-In/ Exchange Public Option* ▪ Individuals buy into state Medicaid coverage ▪ Exchange public option offered in state Small Business Health Options Program, subject to federal approval	Optional State Exchange Public Option* ▪ State product modeled after Medicaid offered on the state's marketplace
Eligibility	▪ State sets eligibility standards and can condition participation	▪ Individuals above the state Medicaid income eligibility level, but otherwise eligible	▪ Any person who is not otherwise eligible for state Medicaid	▪ Individuals above the state Medicaid income eligibility level, but otherwise eligible	▪ Uninsured residents of the state

Proposed Public Option Legislation in 2017

Other States and Federal

Characteristics	Massachusetts MassHealth S.2202/S.2211 *(Passed by Senate 11/9/17)*	Minnesota MinnesotaCare Option S.F. No.58 *(Failed to Pass)*	Nevada Nevada Care Plan A.B. 374 *(Vetoed by Governor)*	Wisconsin BadgerCare Plus A.B. 449 *(Introduced 7/25/17)*	FEDERAL LEGISLATION State Public Option Act S.2001 *(Introduced 10/24/17)*
Benefits	▪ State can adjust Medicaid benefits, subject to limitations ▪ Enrolled employees otherwise eligible for state Medicaid/CHIP coverage receive state Medicaid/CHIP benefits	▪ Benefits modeled after state Medicaid benefits ▪ State can adjust actuarial value of the benefits package to no lower than 87%	▪ Benefits modeled after state Medicaid benefits for non-managed care participants, except transportation services can be excluded	▪ Benefits modeled after state Medicaid benefits ▪ State ability to adjust actuarial value of the benefits package to no lower than 87%	▪ Modeled after the benchmark or benchmark equivalent benefits (or the state Medicaid benefits developed for the ACA adult expansion population)
Cost for Enrollees	▪ State establishes premiums or enrollee cost-sharing requirements based on per-member/per-month expenditures for coverage ▪ Enrolled employees otherwise eligible for state Medicaid/CHIP coverage receive state Medicaid/CHIP cost-sharing	▪ State determines premiums based on the average rate paid by the state to Medicaid managed care plan contractors	▪ State determines premiums	▪ State determines premiums based on the average rate paid by the state to Medicaid managed care plan contractors ✓ Estimated to be $605/month for an adult and $248/month for a child	▪ State determines premiums and cost sharing that are actuarially fair and can vary based on factors permitted under the ACA ▪ Total annual premium amount capped at 9.5% of a family's household income ▪ Other ACA cost-sharing limitations apply
Subsidies	▪ Seeks to secure federal waiver to capture ACA premium assistance and cost sharing reduction	▪ Seeks to secure federal waiver to capture ACA premium assistance and cost sharing reduction	▪ Seeks to secure federal waiver to capture ACA premium assistance and cost sharing reduction	▪ Seeks to secure federal waiver to capture ACA premium assistance and cost	▪ State receives payment to provide enrollees with premium assistance available to a similarly

Proposed Public Option Legislation in 2017
Other States and Federal

Characteristics	Massachusetts MassHealth S.2202/S.2211 *(Passed by Senate 11/9/17)*	Minnesota MinnesotaCare Option S.F. No.58 *(Failed to Pass)*	Nevada Nevada Care Plan A.B. 374 *(Vetoed by Governor)*	Wisconsin BadgerCare Plus A.B. 449 *(Introduced 7/25/17)*	FEDERAL LEGISLATION State Public Option Act S.2001 *(Introduced 10/24/17)*
	subsidies to offset enrollee costs	subsidies to offset enrollee costs	subsidies to offset enrollee costs	sharing reduction subsidies to offset enrollee costs	situated, marketplace enrollees ▪ State receives payment to provide enrollees with cost-sharing reduction subsidies available to similarly situated, ACA silver-level plan enrollees
Financing	▪ Employers purchasing the Medicaid public option as ESI are required to pay not less than 50% of the projected costs ▪ State is permitted to seek contributions from employers purchasing the Medicaid public option as ESI for employees that otherwise meet state Medicaid/CHIP eligibility	▪ State financial contribution is contingent on future state legislative action ▪ State to implement mechanisms to minimize adverse selection, state financial risk, state contributions, and the negative impact to the individual and group markets	▪ Allocates state funds for state administrative expenses only ▪ Intend public option to be self-funded	▪ Requires federal approval to secure federal financial participation ▪ State to implement mechanisms to minimize adverse selection, state financial risk, state contributions, and the negative impact to the individual and group markets	▪ Enhanced federal match (90%) for administrative expenses ▪ States receive the advance payment for premium assistance and cost sharing reduction subsidies that would have been available to enrollees under the ACA

Source: Insure the Uninsured Project. March 2018.
**Language in the legislation does not specifically limit participation to publicly operated plans, but most of these state Medicaid programs (except Nevada) rely heavily on publicly operated plans in their Medicaid programs.*

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A PATH TO UNIVERSAL COVERAGE AND UNIFIED HEALTH CARE FINANCING IN CALIFORNIA

MARCH 12, 2018

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This report reflects the authors' attempts to explain information that emerged from the six Select Committee hearings and to assemble the findings from the hearings into a coherent set of possible recommendations for the California Assembly. This report reflects the views and opinions of the authors and should not be interpreted as the official policy of the University of California or members of the Select Committee.

The authors wish to thank Juliana Fung for her assistance in preparing this report, and the large number of experts who provided the testimony on which this report is based.

Copies of this report may be found at http://healthcare.assembly.ca.gov/reports

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Executive Summary

In March 2017, California Assembly Speaker Anthony Rendon appointed a Select Committee on Health Care Delivery Systems and Universal Coverage to identify the best and quickest path to universal coverage for California and to explore strategies for improving our health care system. This summary and the accompanying report document and synthesize Select Committee hearings held between October 2017 and February 2018.

Health coverage and care in California today

Under the Affordable Care Act (ACA), the number of Californians without health insurance fell dramatically from nearly 7 million in 2013 to about 3 million today. The majority of the remaining uninsured population, about 1.8 million, is not eligible for public coverage programs due to immigration status. Various factors including affordability and awareness contribute to others remaining uninsured.

Health care spending across California from all sources totals about $400 billion. Of this total, more than half comes from public sources of which the largest are Medi-Cal (more than $100 billion) and Medicare ($75 billion). Employer-sponsored coverage remains the dominant source of coverage in the state and accounts for the largest share of private health care spending (between $100 and $150 billion). In addition to the portion of the $100 billion to $150 billion in employer-sponsored insurance premiums that is paid by employees, consumers pay $10 billion for premiums for individual insurance and $25 billion to $35 billion in out-of-pocket spending.

The health insurance market in California is relatively competitive and includes multiple national, state-based and local health plans. Health plans are responsible for health care provider contracting and payment and, to varying extents, plan contracts establish rules and incentives for providers to meet quality standards and achieve positive health outcomes. California has a long history of managed care arrangements within both private and public health plans. The settings in which Californians receive health care vary depending on their source of coverage (employer-sponsored, Covered California or remaining individual market, Medi-Cal or Medicare).

Challenges under the status quo

Despite California's substantial progress in increasing coverage, a number of challenges remain. Even among people with coverage, some are underinsured, facing substantial financial barriers to access. Access to care also varies with coverage sponsor, geographic location and health plan. People with coverage through the individual market and Medi-Cal report better access to care than the uninsured, but more difficulty than those with employer-sponsored coverage. Access to care in rural areas is a particular challenge, regardless of coverage source. When individuals' health insurance status changes, they often must switch plans and physicians which can disrupt care and increase consumer confusion.

Even as health care financing arrangements create access barriers and inefficiency, a substantial share of health care services is low-value, potentially unnecessary and possibly harmful. Many factors contribute to sub-par outcomes, including payment systems that reward volume rather than good health outcomes and a heavy dependence on specialists rather than primary care health care providers.

In California and across the U.S., prices for health care services are higher than in other developed nations and vary by type of coverage. Medi-Cal payments are substantially lower than those paid via employer-sponsored insurance (ESI) and contribute to barriers to care for Medi-Cal enrollees. High hospital prices paid by ESI reflect a lack of competition among hospitals in most parts of the state and the ability of some hospitals to command "must-have" status within health plan networks. Billing and insurance-related costs borne by providers as they collect money from private insurers contribute to high prices.

Improving health care and coverage under today's financing structure

As a part of the Select Committee hearings, presenters described a variety of policy approaches to achieve universal coverage, make health care more affordable and improve access and make our multi-payer system less fragmented and more transparent.

Address remaining coverage gaps and reduce affordability barriers, for example:

- Expand Medi-Cal eligibility and Covered California financial assistance to people currently ineligible due to immigration status
- Provide enhanced affordability assistance for Covered California beyond that available under the ACA
- Address underlying premium trends by limiting out-of-network hospital prices
- Impose penalties for those who don't maintain coverage (to replace the federal ACA individual mandate penalties that will be eliminated in 2019)

Improve access and continuity of care, for example:

- Stabilize or expand health plan competition via a "public option"
- Develop a comprehensive strategy to address health care workforce needs that better develops and sustains the primary care workforce and addresses gaps in rural areas
- Address regulatory and reimbursement issues related to the use of telehealth

Reduce fragmentation and increase transparency, for example*:*

- Make health insurance products more uniform between Covered California and ESI
- Require that health care providers make information available on average negotiated prices for ESI as a percentage of prices paid by Medicare
- Establish an all-payer claims database

Improving California's health care system via a unified. publicly financed approach

An alternative to our current patchwork financing approach would be to establish a unified, publicly financed approach that assures coverage for all state residents; pools funds for health coverage across Medicare, Medi-Cal and other major financing sources and dramatically reduces or eliminates variations in eligibility, benefits and payments. A unified, publicly financed system would increase equity, be simpler for patients and

providers and reduce administrative costs. It would likely increase efficiency and produce better health outcomes, although these results would depend on how well the system was managed and on mechanisms of accountability. To accomplish such a sweeping transition would require substantial and unprecedented changes in federal and state law as well as decisions regarding many design parameters.

Considerations related to integrating multiple payers: The public and private funding streams that support health care and coverage today are accompanied by many requirements not readily eliminated or easily reconciled. The federal government is the largest source of funds for health care in California today. Redirecting those funds would require federal permissions and actions such as statutory changes to redirect Medicare funds to a state-based pool. Similarly, either statutory changes in federal Medicaid law or an agreement on a means to track eligibility and expenditures for Medicaid-eligible populations that enables California to claim federal matching yet preserves simplicity and equity goals, would be needed. Further, Congressional action would be required if revenues linked to federal ESI tax exclusion were to be redirected to state control.

Because direct state intervention in plans that must comply with the Employee Retirement Income Security Act of 1974 (ERISA) is impermissible, either federal ERISA statute would need to be amended or California would need to devise financing approaches that do not run afoul of ERISA legal challenges and associated delays. This might involve a broad state-based payroll tax to finance health care on all employers, whether or not they currently have or maintain an ERISA plan.

Considerations related to state financial oversight: Provisions of the State Constitution require California to enact a balanced budget each year and strictly limit the state's ability to engage in deficit spending. Many forces and factors could introduce volatility into revenue streams and expenses associated with state-managed universal coverage. It will be important to establish and finance reserves upon which the health fund can draw in periods when costs are unexpectedly high or revenues fall short of projections. Provisions of the State Constitution also constrain the Legislature's ability to substantially raise taxes and dedicate the proceeds exclusively to universal health coverage. These provisions render it prudent to seek explicit ballot initiative approval to dedicate new funds to health care.

Design and implementation considerations: In moving from diverse benefit, payment and delivery arrangements under today's fragmented financing and coverage programs to a more uniform set of expectations, tradeoffs would arise. In the course of establishing and implementing a statewide universal coverage program, it would be important to consider matters such as:

- The extent to which integrated managed care arrangements would be encouraged and the role, if any, for health plans;
- How provider payment levels would be set and adjusted;
- Whether and how payments and delivery system arrangements might be allowed to vary based on regional differences, local preferences and needs;

- How quality and access to care would be assured;
- The extent to which the needs of special populations would be prioritized;
- What governance structures and management tools would be put in place to assure accountability and effective oversight

A host of transition issues, including job dislocation for people currently involved in billing and insurance-related activities would also need to be addressed.

Potential paths forward

California has made great progress in reducing the number of uninsured but has not yet achieved universal coverage. In high-performing health care systems around the globe, universal coverage is essential for ensuring access to care, improving outcomes and controlling costs. A strong primary care system, a comprehensive basic benefit package, provider payments that reward better health outcomes, a strong social safety net and administrative simplicity are other important ingredients for high performance. California could take short-term steps and establish a longer term roadmap for system transformation.

Short-term steps

Working within California's current fragmented financing system, various approaches are available. California could:

- *Improve coverage* by using state funds to:
  - Expand Medi-Cal coverage to income-eligible undocumented adults
  - Extend Covered California premium tax credit assistance to undocumented individuals
- *Improve affordability*:
  - Address affordability and participation for those already eligible for Medi-Cal and Covered California
  - Limit out-of-network prices for hospitals benchmarked to a specified ratio of the price paid by Medicare for similar services
- *Improve access*:
  - Increase the amount of Medi-Cal payment rates
  - Explore a Medicaid Public Option
- *Simplify the consumer choice process* by requiring each fully insured product in the large group market to be either a bronze, silver, gold or platinum plan as defined by Covered California
- *Increase transparency*:
  - Require hospitals and larger medical groups to post information on the average prices received from people covered by ESI, Covered California, Medicare and Medi-Cal
  - Establish an all-payer claims database

Short-term approaches can be evaluated against several criteria: their potential benefits for consumers and the delivery system, state fiscal cost, potential to preserve gains under the ACA, and the extent to which they either lay a foundation for, or undermine, potential future heath reforms.

A roadmap for a broader transformation of California's health care system
California could embrace a goal of guaranteed access to health care for all through unified public financing that improves health outcomes and keeps costs for the state and its residents in check. To achieve that goal, several preconditions would need to be satisfied:

- Diverse stakeholders must develop a sense of shared purpose and mutual responsibility to advance a health system that works well for all Californians
- Data must be collected and analyzed to better understand the status quo and to explore how a new system could be monitored and managed
- State budgetary implications must be modeled; financial risks must be assessed and mitigated
- A detailed proposal would need to be developed and the Legislature would need to enact enabling legislation
- State constitutional amendments would need to be approved by the voters
- Federal statutory changes and waivers would need to be obtained

The California Legislature could demonstrate leadership by establishing a planning commission responsible for advancing progress toward universal coverage and unified health care financing. The Legislature would establish the governance structure of the planning commission, provide its charge and appropriate funding. The commission would:

- Convene a stakeholder engagement and analytic process by which key design features are refined and vetted
- Establish data collection and reporting efforts to support management, evaluation, transparency and public accountability
- Model state budgetary implications and assess options for raising and managing funds
- Make recommendations to the Legislature on the design of a system of unified public financing and work with the Legislature to draft necessary state enabling legislation and any necessary ballot propositions.
- Ready the state to seek federal waivers and statutory changes by which funds managed by the federal government but used on behalf of Californians can be consolidated with other funds
- Explore operational requirements related to information technology and financial management
- Establish partnerships to coordinate activities with nongovernment entities

Conclusion
California has established itself as a leader in using the opportunities created by the ACA to increase insurance coverage. Testimony at hearings identified many ways to build on that foundation, both short-term and over coming years. Short-term efforts to expand coverage, improve access, reduce fragmentation and improve transparency, coupled with development of a longer term path toward unified public financing, would help secure a future in which all Californians have access to the health care they need and deserve.

Background

In March 2017, California Assembly Speaker Anthony Rendon appointed a Select Committee on Health Care Delivery Systems and Universal Coverage (Committee) to identify the best and quickest path to universal health coverage for California and explore strategies for improving our health care delivery system. Co-chaired by Dr. Joaquin Arambula (D-Fresno) and Dr. Jim Wood (D-Santa Rosa) with members Autumn Burke (D-Inglewood), David Chiu (D-San Francisco), Laura Friedman (D-Glendale), Tom Lackey (R-Palmdale) and Marie Waldron (R-Escondido), the Committee held a series of public hearings in late 2017 and early 2018. The Committee engaged a University of California team to capture themes from the hearings (but not recapitulate details available elsewhere), describe policy options that could work well within the California context and identify issues likely to arise within that context.

This report describes health coverage and care in California and identifies remaining challenges related to access, coordination, and cost. It presents a range of options to expand coverage, address issues of fragmentation and cost under our current mixed public-private financing system, followed by options and considerations should the state move toward a state-based publicly financed approach. It concludes with a discussion of potential paths forward in the near future and over the longer term.

1. Health coverage and care in California today

Insurance status and sources of coverage

California experienced dramatic expansions of coverage under the Affordable Care Act (ACA). Prior to the ACA, the number of uninsured residents approached 7 million, or about 17% of the non-elderly population; post-ACA, it has fallen to around to 3 million (about 7%).[1] California embraced the Medicaid expansion available under the ACA. In addition, in 2016, California expanded Medi-Cal to all children, regardless of immigration status, using state funds. As a result of these and other policy and administrative actions, Medi-Cal enrollment is now approaching 14 million.[2]

Coverage through employment continues to be the dominant source of coverage for Californians, accounting for about 17.5 million people. About 6 million Californians with employer-sponsored coverage are in self-insured arrangements subject to the federal Employee Retirement Income Security Act of 1974 (ERISA) and over which the state has

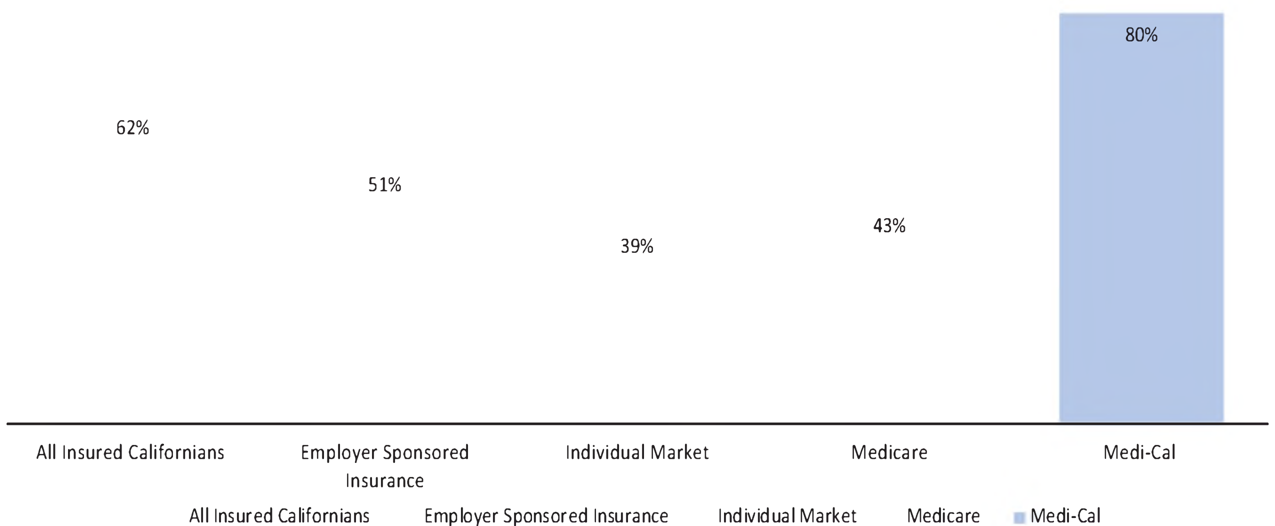
[1] Kelch, Deborah, "Overview of Coverage and Care in California," Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, October 23, 2017

[2] Ibid.

limited regulatory oversight.[3] ERISA prevents states from directly regulating private employer health insurance arrangements. In particular, ERISA prevents states from imposing a mandate that private employers offer or pay for health insurance. ERISA also prevents states from imposing taxes on private employer-sponsored plans.[4]

California has a long history of heavy reliance on managed care arrangements -- including incentives or restrictions related to provider network -- in both public and private health plans. More than 60 % of insured Californians are enrolled in Health Maintenance Organization (HMO) plans, a higher share than most other states. Among California Medicare enrollees, 41% are in Medicare Advantage managed care plans, and approximately 80% of Medi-Cal enrollees are in managed care plans.[5]

Percentage of Insured Californians Enrolled in HMOs, by Source of Insurance, 2016



Source: CHCF statewide CA Health Insurers Enrollment Database, combines figures from DMHC Enrollment Summary Reports and CDI Covered Lives Reports.

Note: Employer-sponsored insurance includes 5.7 million people in Administrative Services Only (ASO) coverage. The underlying CDI reports do not separate ASO coverage into HMO and non-HMO coverage. The statistic here assumes that ASO coverage is not HMO. The count of Medicare enrollees in HMOs may include some Medicare beneficiaries in Medicare Advantage PPOs.

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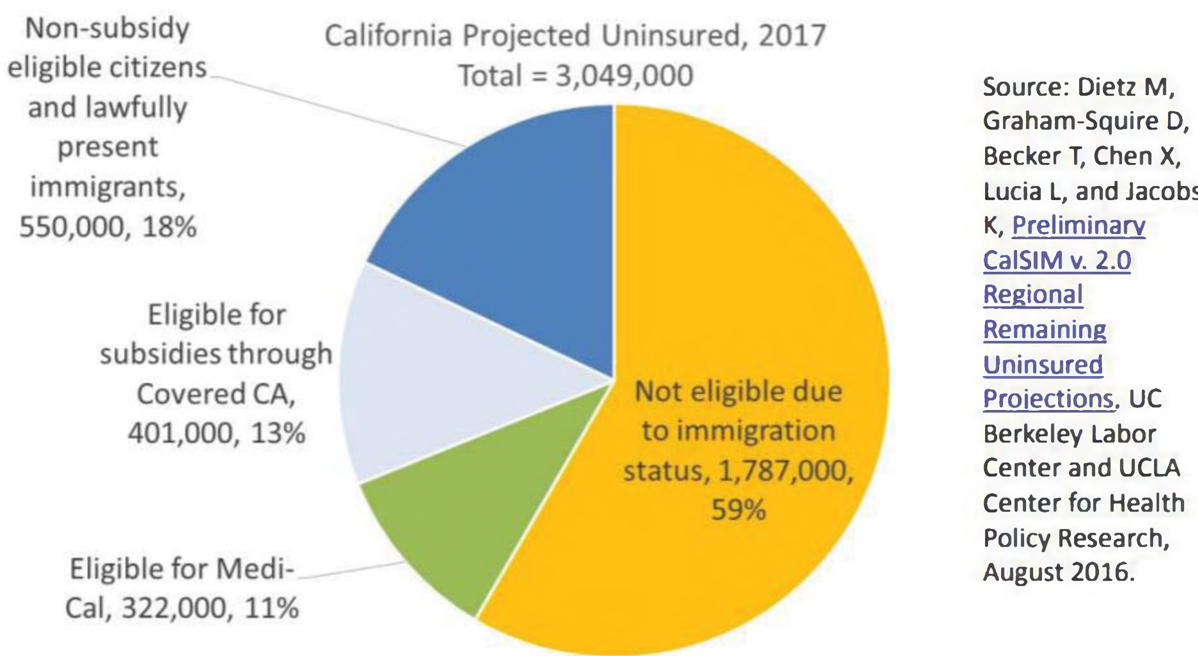
[3] Wilson, Katherine B., California Health Insurance Enrollment, 2016, (California Health Care Foundation: February 12, 2018) available at https://www.chcf.org/publication/california-health-insurance-enrollment-2016/

[4] Marciarille, Ann Marie, "Implementation Considerations for Universal Coverage: ERISA," Testimony before California Select Committee on Health Delivery System and Universal Coverage, February 5, 2018.

[5] Based on Department of Health Care Services data, in October 2017 10.7 million people were enrolled in Medi-Cal managed care. This represents about 80% of Medi-Cal total enrollment of 13.3 million.

Despite gains in coverage under the ACA, 3 million Californians remain uninsured.[6] The majority of California's remaining uninsured, about 1.8 million, are not eligible for coverage programs due to immigration status; characteristics of other subsets are shown in the chart below.



Even among the 93% of Californians who have health coverage, many continue to face challenges in affording health care and may curtail health service use as a result. Underinsurance, defined as having high cost burden or exposure to high health cost sharing, affects 21% of insured Californians using Commonwealth Fund criteria.[7] Although state-specific data are unavailable, the subpopulations most affected by underinsurance across the U.S. are those enrolled in Medicare (47%) and the individual market (44%).[8]

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[6] Lucia, Laurel, "Health Coverage Gaps in California," Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, October 23, 2017

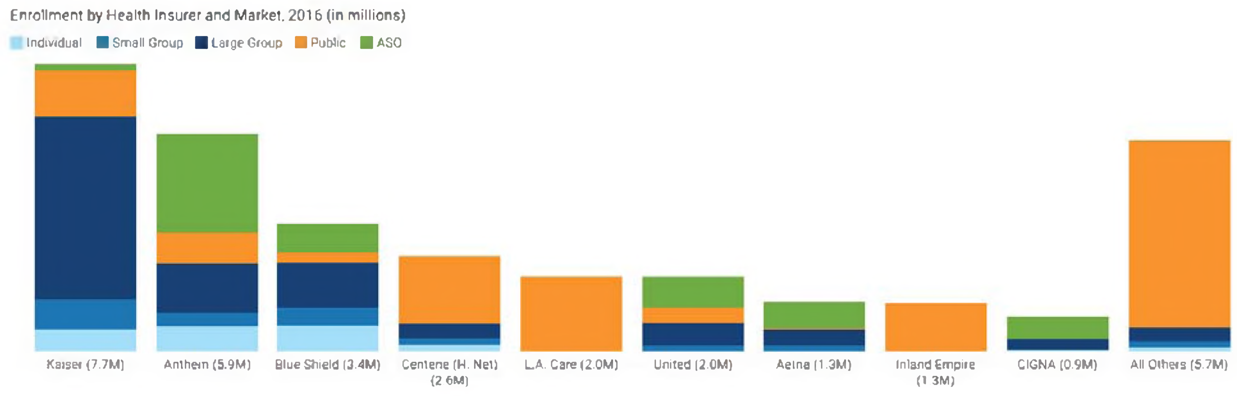
[7] The Commonwealth Fund defines underinsurance as either 1) incurring out-of-pocket health expenses (excluding premiums) of ≥5% of income in households at or below 200% of the Federal Poverty Level (FPL) or ≥10% of income in households over 200% FPL or 2) having coverage with a deductible of 5% or more of household income, regardless how much is actually spent.

[8] Lucia, Ibid.

Spending and sources of payment
Total health care spending across the state of California, from all sources, totals about $400 billion. Of this total, more than half comes from public sources of which the largest shares are Medicare ($75 billion); Medi-Cal (more than $100 billion); and federal ACA subsidies through Covered California ($6 billion). Private spending is primarily through employer-sponsored insurance premiums (ESI) ($100 billion to $150 billion). In addition to the portion of the $100 billion to $150 billion in employer-sponsored insurance premiums that is paid by employees, consumers pay $10 billion for premiums for individual insurance and $25 billion to $35 billion in out-of-pocket spending.[9]

Federal and state tax law allows payments toward employer-sponsored insurance to be excluded from employees' taxable income. In California, this exclusion accounts for foregone revenues between $40 billion and $50 billion. About 75% of this indirect tax benefit comes from the federal government. [10]

Health plans and provider networks
Compared to many states in the country, California's health insurance market is relatively competitive. The state's three largest insurance carriers by total enrollment are Kaiser, Anthem and Blue Shield of California. Other plans, including Medi-Cal managed care plans in many California counties, also provide coverage for millions of Californians. The share of enrollment by market segment (individual, small group, large group, Medi-Cal and Medicare and Administrative Services Only (ASO) for self-insured arrangements) varies considerably across insurers.



[9] Legislative Analyst's Office, "Financing Considerations for Potential State Healthy Policy Changes," Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, February 5, 2018.

[10] Legislative Analyst's Office, Ibid.

Source: Wilson, Katherine B., "California Health Insurance Enrollment 2016, California Health Care Foundation: February 12, 2018

Health insurers collect premiums from purchasers and establish contracts with providers to deliver care to enrollees. Plans differ in the composition of provider networks: Kaiser contracts exclusively with Permanente physicians and offers the same providers to all enrollees. Other plans develop networks that vary by product and market segment. People purchasing in the individual market, including Covered California, appear to be more price-sensitive with respect to health plan premiums than people covered by employer-sponsored insurance. To keep premiums lower and attract enrollment, plans in the individual market tend to have narrower networks than typical plans in the ESI market.

Health insurers perform a variety of functions, and the functions vary significantly across channels of coverage – that is, health plan functions in the individual and small group market are different from their functions in the large group market, and different again from their functions in the Medicare and Medi-Cal markets. For individuals and small groups, a key function is the aggregation of risk. For large groups, the main functions of health plans are provider contracting and payment, member services, and working with (and sometimes against) providers to reduce the provision of low value care and increase quality and efficiency.

Some California health insurance carriers reimburse providers via full or partial capitation arrangements that reduce or eliminate provider incentives to increase the volume of services. Although fee-for-service remains the most common method of paying providers, California health plans are increasingly tying providers' financial risk more explicitly to accountability for quality and outcomes.

Unlike small- and medium-sized employers, there is no reason that publicly financed programs would necessarily need to contract with risk-bearing health insurers. Medicare and Medi-Cal can perform all of the functions listed above without using health insurers -– these programs can either hire government personnel to perform these functions, or contract with independent entities (third party administrators) to perform them. It is notable, then, that Medicare and Medi-Cal, which once functioned as 'single payers,' have turned to health insurers as risk-bearing intermediaries. One rationale for involving health insurers is that they can work more flexibly with providers than can the government in reducing the delivery of low value care, potentially yielding more appropriate use of health care services.[11]

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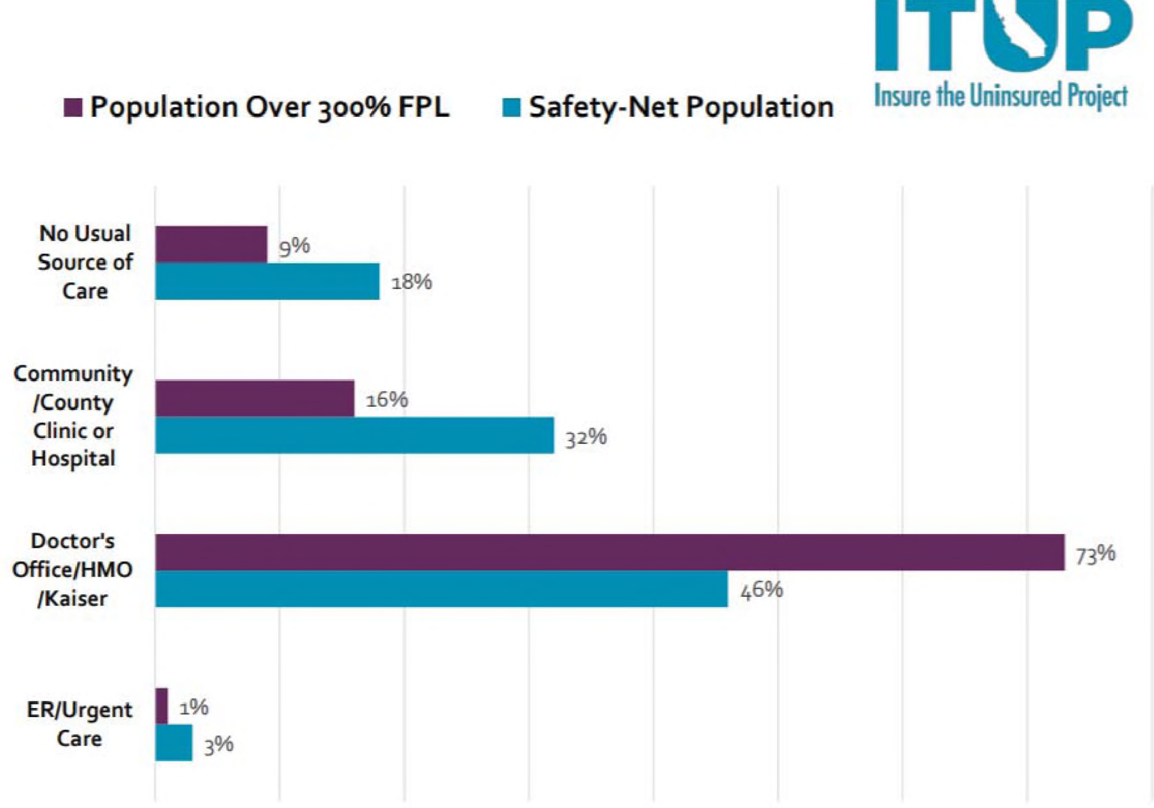
[11] Landon, Bruce, et al. Analysis of Medicare Advantage HMOs Compared with Traditional Medicare Shows Lower Use of Many Services During 2003-09. Health Affairs 31, NO. 12 (2012): 2609–2617.

Sources of care
Californians receive their health care in an array of settings. Sources of coverage influence where Californians obtain health care, as do plan contracting requirements and provider payment arrangements. In particular California's safety net population – those who are uninsured, enrolled in a public coverage program, and with incomes under 300% of Federal Poverty Level -- is more likely to rely on a community or county health clinic, or to lack a usual source of care than are people with household incomes above 300% FPL.[12]



Source: Kelch, Deborah, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, October 23, 2017

2. CHALLENGES UNDER THE STATUS QUO

Despite California's substantial coverage expansions under the ACA, a number of problems related to health care delivery and finance remain. These include problems with access to care; fragmentation and inefficiency in care delivery; and issues related to high prices and administrative costs.

[12] Gallardo, Elia, "Safety Net Programs, Populations, and Providers," Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, October 23, 2017.

Remaining uninsured and coverage gaps

People who are uninsured are more likely to forego care and experience worse health outcomes than those with health insurance. In addition, being without health insurance increases the likelihood that households will experience health care-related financial burden. Because the remaining insured are more likely to be low-income and people of color, coverage gaps contribute to disparities in health outcomes and household financial stability across California.[13]

Subgroups of the remaining uninsured face different obstacles to getting and keeping coverage:

- Those ineligible for coverage programs due to immigration status (about 1.8 million Californians) cannot access low-cost options such as Medi-Cal or subsidized coverage through Covered California. Most do not have access to ESI and would find individual coverage outside Covered California unaffordable.
- Those whose family earnings exceed criteria for subsidy eligibility through Covered California (about 550,000 Californians) may nevertheless struggle with affordability when annual premiums cost many thousands of dollars and annual deductibles are as high as $6,300.[14]
- Those eligible for Covered California subsidies but unenrolled (401,000) and may be unaware of their eligibility or may have decided that even subsidized premiums do not fit within their household budgets. Those eligible for Medi-Cal but unenrolled (322,000) may be unaware of their eligibility or may have encountered administrative obstacles. Enrollment requires multiple steps; some people, particularly those who view their lack of coverage as temporary, may not complete the process.

Access challenges

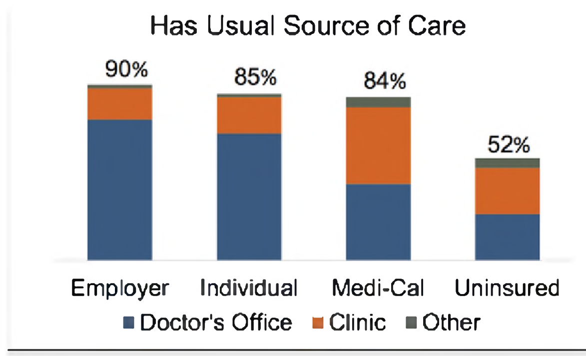
Fragmented health care financing results in variability in individuals' access to health care services. The lack of health insurance coverage is the single largest barrier to care, but even among those with coverage, access varies by an individual's sponsor of coverage, geographic location and health plan.

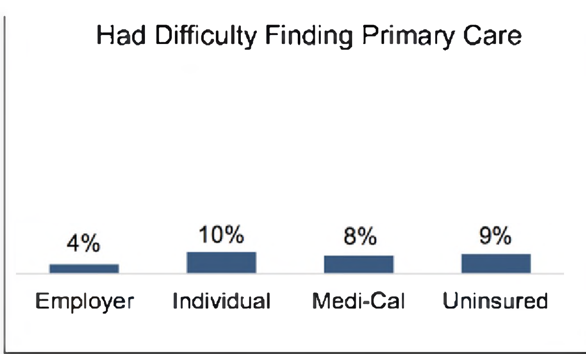
In general, Californians with employer-sponsored coverage report the fewest barriers to care. Physicians in California are not required to participate in the Medi-Cal program and many do not for the main reason that the payment rate is lower than the payment from Medicare and commercial insurers. Growth of physicians participating in the Medi-Cal program has not kept pace with the growth in the number of beneficiaries following the implementation of the ACA. Nonetheless, those covered by Medi-Cal report similar rates of having a regular source of care as those with coverage in the individual market. In each

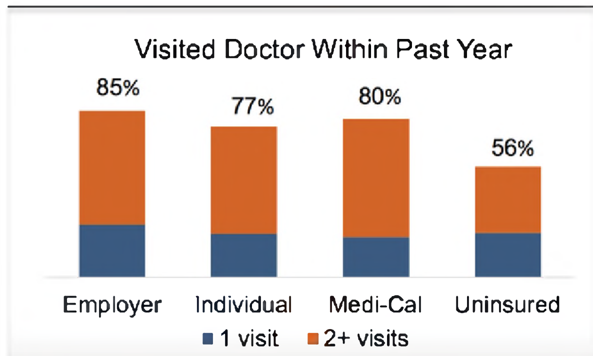
[13] Lucia, Laurel, "Health Coverage Gaps in California," Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, October 23, 2017

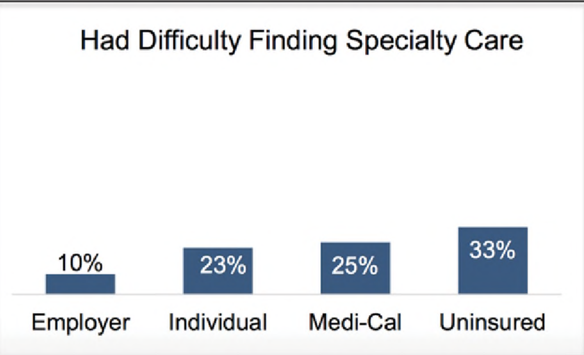
[14] 2018 Covered California Patient-Centered Benefit Designs and Medical Cost Shares available at https://www.coveredca.com/PDFs/2018-Health-Benefits-table.pdf

case, this is substantially better than for those who are uninsured, but somewhat lower than for those in employer-sponsored coverage. Medi-Cal beneficiaries and those covered in the individual market are more likely than those with employer-sponsored coverage to report difficulties finding primary care and specialist physicians.









Source: Perrone, Chris, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018

Even among Californians with the same source of coverage, individuals may experience marked differences in their ability to access medical care. Some of the disparity is related to the availability of physicians who are not distributed equally throughout the state. Rural areas, particularly those in the Central Valley and in the northern part of the state are particularly challenged, with physician-to-population ratios below established federal benchmarks.

The parsing of physicians into health plan networks can also amplify workforce shortages as beneficiaries of plans will typically only have financial coverage for physicians who are within the plan's network.

Statewide, Covered California offers more health plan choice than is available in most states through the federal exchange. Yet within some parts of the state, particularly in more rural areas, Californians may have a choice of only one or two plans through Covered California. In 2018, 66,000 Californians had only one plan option and another 216,000 lived in areas with two plan options. As compared to 2017, the number of Californians with limited (one or two) health plan choices grew over time. This reflects a decision by insurers to leave markets where they are concerned about their ability to be profitable.

	Number of Choices							
	1	2	3	4	5	6	7	Total
Thousands of Enrollees								
2017	0	120	158	189	332	470	203	1,473
2018	66	216	135	382	302	371	0	1473
Distribution of Enrollment		Monterey, Santa Barbara, San Luis Obispo counties account for ¾'s of all single choice enrollment. San Benito, Mono, Inyo counties are also universally single choice .			Los Angeles county (Regions 15 & 16)			
2017	0%	8%	11%	13%	23%	32%	14%	100%
2018	5%	15%	9%	26%	21%	25%	0%	100%

Source: Corlette, Sabrina, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018

Health insurance is also not uniform. Rules -- regarding covered benefits and services, the procedures that need to be followed to access particular services, and the out-of-pocket costs for beneficiaries -- vary widely across payers and plans. Navigating this variation can be timely and frustrating for patients and physicians.

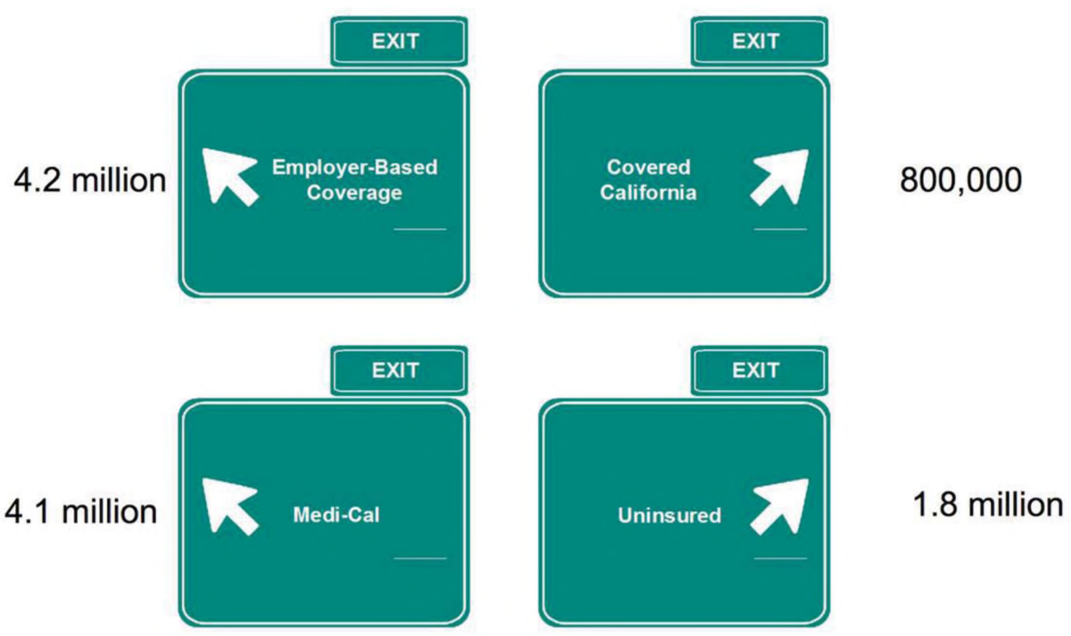
Many health plans restrict access or create financial incentives for patients to use "in network" providers. However, accurate information on which providers are "in network" can be difficult for individuals to determine, when enrolling in a plan or when seeking services. And although California law now limits patients' risk from many surprise bills from out-of-network providers for services delivered at in-network facilities, services delivered in emergency departments are not covered, and employees in self-insured plans regulated by ERISA are not protected.

Physicians and hospitals typically contract with many different insurers, and typically serve patients from multiple channels of coverage (that is, Medicare, Medicare Advantage, employer sponsored insurance, Covered California, and Medi-Cal). As a result, physicians and hospitals must invest substantial resources in personnel to provide the necessary documentation for billing, gaining prior approval, and reporting on quality all of which vary substantially across payers and plans. This administrative burden has not decreased with the growing availability of electronic health records and can be a source of frustration for patients as well as providers.

Further complicating the situation is the upheaval referred to as churn which occurs when individuals have a change in their health insurance status. For example, this may occur due to a change in job status or financial eligibility for public programs. A change in health

insurance coverage can result in a change in health plan, which due to physician network and service differences across plans can disrupt care and relationships between patients and providers. The ACA has not changed the rate of churn but it has shortened the duration of time individuals who lose coverage go without health insurance.

It is estimated that 11 million Californians will change their insurance status in the next two years. The figure below reflects the source of coverage these individuals are expected to exit during that time.



Source: Graves, John, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018

Churn is associated with a subsequent increase in the use and cost of health care services including a greater number of emergency department visits. Transitions may contribute to a heightened degree of consumer confusion about how to identify in-network providers, the services that are covered, the procedures which need prior approval, and how to fill prescriptions.

Problems associated with care delivery

At the same time that the U.S. health care financing system creates access barriers and administrative inefficiency, there is also ample evidence to suggest that a substantial fraction of the health care we receive is low value, potentially unnecessary and possibly harmful. The National Academy of Medicine estimates that 30% to 40% of care delivered

nationwide may be unnecessary.[15] Unnecessary care not only contributes to increased health care costs for payers and patients but can place patients at risk for complications, which can result in significant morbidity and mortality.

Many factors contribute to quality and safety problems in the delivery system, and unfortunately there are no magic wands that can simply be waved to make these problems disappear. Some analysts point to the influence of for-profit institutions and the entrepreneurial ethos that characterizes much of health care. These are certainly contributing factors, but the hospital industry in the U.S. is dominated by non-profit organizations yet quality and safety problems are nevertheless widespread.

Another contributing factor is a system primarily based on fee-for-service payment. Even when care is delivered by a managed care plan, the plan often pays physicians using fee-for-service. Fee-for-service payment rewards volume of care rather than good health outcomes. The fee schedules used in fee-for-service payment systems also undervalue cognitive services relative to procedural services. In the U.S., approximately two-thirds of physicians are specialists and approximately one-third in primary care, a ratio that is reversed in many Western European countries. The difference between the U.S. and other countries mirrors differences across countries in relative incomes of primary care and specialist physicians. Further, in the U.S. as in other countries, the payment system was designed at a time when caring for acute episodes of illness was the dominant need, and is ill-adapted to an emphasis either on prevention or on the coordinated care needed by people with chronic illnesses.

High prices and administrative costs

In California, as in the rest of the U.S., average prices for most health care services are much higher than in other developed nations. Further, prices vary substantially by type of coverage. Nationally, the prices paid for hospital services for people covered by ESI are approximately 75% higher than the prices paid by Medicare, and Medicaid pays hospitals substantially less than Medicare. The same is true in California, where Medi-Cal's hospital payment rates are similar to the national average.[16]

We note three implications of the wide price differentials. First, if hospitals were paid Medicare rates for all their patients, as has been suggested in some reform proposals, total hospital revenue would decline substantially, causing significant disruption in the hospital industry, with substantial and detrimental effects on access to care. Second, if the prices paid to hospitals for patients covered by employer sponsored insurance were brought somewhat closer to the prices paid by Medicare, there would be substantial opportunities for savings. Hospitals would no doubt be concerned about how they would maintain high

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[15] Institute of Medicine, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. September 2012.

[16] Trish, Erin, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 19, 2018.

quality in the face of a reduction in the rate of growth of revenue, but the limited evidence that exists suggests that hospitals that are heavily dependent on Medicare provide high quality care. Third the substantially lower prices paid by Medi-Cal have contributed to beneficiaries experiencing barriers to care and have inhibited the achievement of one of the original goals of the Medicaid program – namely, the mainstreaming of care for low income people into the same care settings as patients with other forms of coverage.

Price differentials between Medicare and private payers for physician services are smaller than for hospital services. Nationwide, private insurers pay approximately 18% more than Medicare for physician services[17], and there is some evidence to suggest that the differential is smaller in California.[18] Thus, while a proposal to pay Medicare rates for all hospital services would lead to substantial revenue declines and disruption for hospitals, a similar proposal for physician services would not be as disruptive because the differential between private payers and Medicare rates is much smaller for physicians than it is for hospitals.

In sharp contrast, while the Medicare to private payer differential for physician services is substantially smaller than it is for hospital services, the Medicare to Medi-Cal differential for physician services is much larger than it is for hospital services. The Medi-Cal fee schedule pays physicians approximately 40% less for the same services paid by Medicare. Medi-Cal's physician payment rates are among the very lowest among all Medicaid programs nationwide. The relatively low Medi-Cal payment rates contribute to California having one of the lowest rates of participation by physicians in Medicaid programs nationwide.[19] In California, approximately 60% of physicians participate in the program.[20] As a result in many California communities Federally Qualified Health Centers and 'look alike clinics' [21] furnish a high proportion of primary care services to Medi-Cal beneficiaries.

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[17] Biener, Adam and Selden, Thomas. "Public and Private Payments for Physician Office Visits." Health Affairs, December, 2017 available at (https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0749).

[18] Ginsburg, Paul. "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power," Health Systems Change Research Brief, #16, November, 2010 available at (http://www.hschange.org/CONTENT/1162/).

[19] Decker, Sandra, "Acceptance of New Medicaid Patients by Primary Care Physicians and Experiences with Physician Availability among Children on Medicaid or the Children's Health Insurance Program." Health Serv Res. 2015 Oct; 50(5): 1508–1527.

[20] Coffman, Janet, "Physician Participation in Medi-Cal: Is Supply Meeting Demand?" California Health Care Foundation, June 28, 2017 available at https://www.chcf.org/publication/physician-participation-in-medi-cal-is-supply-meeting-demand/

[21] Federally Qualified Health Centers (FQHCs) and some other county operated ambulatory care sites designated by Medi-Cal as "look alike clinics" receive a higher rate of Med-Cal reimbursement than what is paid to office-based physicians. When these FQHCs and look alike clinics furnish services as a part of a Medi-Cal managed care contract, they receive additional payments ("wrap around") from the state Medi-Cal program that maintain a substantially higher payment rate than what is provided for similar services when

High prices paid to hospitals for patients covered by ESI reflect the lack of a competitive market for hospital services in most areas of the state. Consolidation in the hospital industry has contributed to a lack of competition – in some areas of the state one or two large hospital systems account for a large fraction of the available hospital beds, and these hospital systems are in a very strong bargaining position when negotiating with private insurers. Using the Herfindal-Hirschman Index (HHI), an index measuring market concentration that is used by the Federal Trade Commission and the Department of Justice in evaluating market competition, virtually all hospital market areas in California are highly concentrated, and most markets have become more concentrated over time.

But concentration in the hospital industry is not the only factor leading to relatively high prices. Unlike many other industries, where the goods being traded are commodities with little differentiation in competing products across firms, many hospitals and some medical groups have been able to establish themselves as 'must have' providers. An insurer that did not include a well-regarded teaching hospital in its network might have a very hard time selling its product, and this knowledge gives the hospital substantial negotiating leverage, even in a market with multiple competing hospitals.

Relatively high prices reflect, in part, relatively high costs of producing care, and part of those high costs reflect the high costs borne by providers in collecting money from private insurers, Medicare, and Medi-Cal.[22] Billing and insurance related costs in California have been estimated at 13.9% of the total costs of physician practices and at 6.6%-10.8% of the cost of hospital services.[23] In a simplified system in which hospitals and physicians could employ fewer people whose job it was to collect money from third party payers, prices could be lower without any reduction in the bottom line for hospitals, or in the net income of physicians. In addition, the cost of health insurance includes the administrative costs and profits of health insurers, estimated to average approximately 7.9% of premium costs.[24]

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furnished through physicians' offices. See Wunsch, Bobbie and Reilly, Tim, "Medi-Cal Managed Care Plans and Safety Net Clinics Under the ACA." December 2015 available at https://www.chcf.org/wp-content/uploads/2017/12/PDF-MediCalMgdCarePlansSafetyNet.pdf

[22] Larry Levitt, "The Cost of Administering Health Care" Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018

[23] Kahn James et al. The cost of health insurance administration in California: estimates for insurers, physicians, and hospitals. Health Aff (Millwood). 2005 Nov-Dec;24(6):1629-39.

[24] Kamal Rabah and Cox Cynthia. "How Has U.S. Spending on Healthcare Changed Over Time." Peterson-Kaiser Health System Tracker available at https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/?post_types=chart_collection#item-per-capita-basis-health-spending-grown-substantially_2017

In sum, health care in California relies on a diverse patchwork of funding sources and delivery arrangements. Consumers face challenges regarding access to care, navigation of coverage, and affordability. Accountability is diffuse. Health outcomes and system costs are neither well-understood nor well-managed.

3. Improving Health Care and Coverage Under Today's Financing Structure

As a part of the Select Committee hearings, presenters described a variety of policy approaches that have been tried or considered in other countries, in other states, and in California to address challenges in achieving universal coverage, making health care more affordable and improving access to care, while also making our multi-payer system less fragmented and more transparent. This section describes these approaches and the rationale for them as a part of an incremental process of improvement. Section 4 will address ways to achieve these goals via a more fundamental change to today's fragmented financing and patchwork methods which could result in a more equitable and less complex health care system.

Address remaining coverage gaps
California embraced and effectively implemented new coverage opportunities under the Affordable Care Act, reducing the state's uninsured population to about 3 million. People are uninsured for a variety of reasons: ineligibility for public financial assistance due to immigration status; inability to afford coverage; uncertainty about the value of obtaining health insurance, particularly if insurance products have high deductibles or other cost-sharing requirements; and the complexity of getting and keeping coverage, particularly across changes in life circumstances. These causes are not mutually exclusive. Policy solutions to expand coverage to California's remaining uninsured aim to address one or more of these challenges.

Nearly 60% of California's remaining uninsured population is undocumented, so expanding eligibility for Medi-Cal and premium subsidies to this population would likely make substantial inroads toward universal coverage. Undocumented residents are specifically excluded from eligibility for Medicaid and for federal premium subsidies and cost-sharing assistance under the ACA. Therefore, a state proposal to extend Medi-Cal eligibility to undocumented residents, or to provide subsidies to assist this population in affording coverage, would need to be financed solely with state funds.[25] Implementing this proposal would be relatively straightforward because it would build on California's recent experience expanding coverage to undocumented children through the "Health4AllKids" campaign.

[25] Legislative Analyst's Office, "Financing Considerations for Potential State Healthy Policy Changes," Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, February 5, 2018.

Reduce affordability barriers
Difficulty affording premiums and concerns about coverage comprehensiveness are factors for many Californians who remain uninsured. Some population segments face particular affordability challenges. For example, people affected by the ACA's so-called "family glitch" are eligible for employer-sponsored health insurance that falls under the ACA affordability threshold for them, yet their employers contribute little or nothing toward family premiums. Under the ACA, no premium subsidies are available for anyone in the family, thus dependents face high premiums and may remain uninsured. For others, health status, age, or residence within a region with especially high health care costs may leave consumers responsible for costs that make up a substantial portion of their income. Under the ACA, people over 400% of the federal poverty level (FPL) receive no affordability assistance; one proposal would be to provide state-funded subsidies to assure that people in such households need spend no more than 10% of their income on premiums. People between 138% and 400% FPL are eligible for ACA subsidies but some still find premiums and out-of-pocket costs a burden and may forego coverage as a result. The state could fund additional subsidies to reduce the share of income people are expected to pay toward subsidies across the entire sliding scale range.

Affordability could also be tackled by moderating underlying premiums. For example, the state could seek to moderate the cost of health care inputs or the prices charged for health care services. One approach to this would be to limit out-of-network hospital prices. As discussed above, many hospitals have negotiated much higher prices for people covered by employer-sponsored insurance than the prices paid by Medicare for similar services. The nationwide average mark-up over Medicare prices in 2012 was 72%, and it seems likely that the differential in some markets in California is considerably larger. For a variety of reasons, insurers have not had enough leverage in their negotiations with many hospitals to limit the prices they pay to anything close to the prices that Medicare pays.

One option that was raised at the hearings to improve the bargaining leverage of insurers is to limit the prices that hospitals could receive for out-of-network services to some percentage (e.g., 150%) of the amount that would be paid by Medicare for similar services. [26] If the California Legislature enacted such a proposal, it is unlikely that hospitals would be able to negotiate in-network rates that were higher than the out-of-network cap.

If the upper limit were set quite high the proposal would only affect hospitals that have been able to negotiate extremely high prices. A much lower cap would result in steep declines in hospital revenues, and be quite disruptive to the industry. Regardless of where the cap was set, regulations would be needed to specify how the comparison of private prices to Medicare prices was to be calculated, and phase-in periods should be considered.

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[26] Laurence Baker "Price Variations and Consolidation" Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018.

A somewhat similar proposal was enacted for physician services by the California Legislature in 2016.[27] However, the legislation on physician services was primarily intended to limit 'surprise billing' from out-of-network providers at in-network hospitals. Legislation on hospital services would be intended to indirectly limit the prices that hospitals could negotiate for in-network services.

Another policy option that could help to make health insurance coverage affordable is the use of a mandate for coverage. The federal health insurance mandate as a part of the ACA was intended to encourage healthy, not just sick individuals, to pursue coverage. Having healthy individuals in the insurance pool lowers premiums relative to what they would be if just sick individuals were enrolled. With the 2019 elimination of federal penalties for not maintaining creditable coverage, the state may want to consider imposing its own penalties on people who go without health insurance. The state could consider a variant of a proposal being discussed in Maryland, in which penalty payments made by uninsured individuals are essentially put in escrow for them, to be made available for the purchase of insurance in the coming year.[28]

Improve access and continuity of care

One way insurers control costs is by limiting the network of providers, hospitals and physicians, available to the members of their health plan. By limiting the providers who can be a part of their plans, the insurers have leverage to negotiate lower rates of payment to these providers. Health plans then compete for consumers within different segments of the market – employer based coverage, Medicare, Medicaid and the individual market- in part related to differences in their networks. An insurer may or may not use the same physician network across all payers.

Insurers may avoid competing in certain communities if they perceive that the number or the way the physicians or hospitals are organized will limit their ability to negotiate payment rates which will allow them to be profitable. This issue has garnered significant attention in the individual market where certain parts of the country, particularly rural areas which typically have fewer physicians per population and fewer competing hospitals, have struggled to create competition among health plans. Most Californians enjoy choice of

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[27] AB 72, effective 7/1/17, requires that if a patient receives non-emergency services at an in-network hospital, the payment received by any out-of-network physicians providing services to that patient is limited to 125% of the Medicare rate. The rationale for that legislation is to avoid surprise billing, in which a patient chooses an in-network hospital, but is confronted by high priced out-of-network bills. The effect, however, is likely to be similar to the effect of the hospital pricing proposal discussed above. It seems unlikely that physicians would be able to negotiate prices much higher than 125% of Medicare for services delivered to hospital inpatients if they are limited to 125% of Medicare if they are out-of-network.

[28] McDaniels, Andrea, "General Assembly weighs bill to require Marylanders to buy health insurance," Baltimore Sun, February 20, 2018 available at http://www.baltimoresun.com/health/bs-hs-individual-mandate-20180216-story.html.

two or more plans, but in some parts of the central coast and in some rural areas in northern California and the southern central valley there is only one choice.[29]

One proposed solution to the problem of limited health plan competition in the individual market is the establishment of a "public option" as an alternative to existing private health plans. A public option could be a plan or a set of plans across the state. Many details regarding its structure, financing and governance remain to be resolved.[30] Offering a public option through Covered California would enable eligible consumers to use federal subsidies to support its purchase, but to do so, a public option would have to meet ACA Qualified Health Plan (QHP) requirements.

A public option offers several potential benefits to consumers. First, it guarantees that consumers will have a choice of at least one plan in an area even if private insurers choose not to enter the market. Second, a public plan may be less expensive to consumers than private insurance offerings since a public plan does not need to generate a profit and may be able to contract providers at lower reimbursement rates. Third, to the extent a public option includes providers who are not available through other insurers, it can broaden the physicians and hospitals available to consumers.

In Medi-Cal, health plan public options were created at the county level beginning in the 1990s using "local initiatives" which relied to a greater extent than private plans do on safety-net providers. Creating a public option in the individual market might similarly be able to expand the availability of providers by making access to safety net providers a choice for consumers via Covered California. If the public option utilized the same or a similar network of physicians for Medi-Cal beneficiaries as it did through a Covered California product, people who churn between Covered California and Medi-Cal would be less likely to experience a disruption in patient-provider relationships.

Medicaid as a public option is distinct from a Medicaid expansion. A Medicaid expansion or what is sometimes referred to as a "buy in" enables individuals to gain access to coverage through the Medicaid program but it does not expand the choice of plans for those in the individual market. No state has used its Medicaid program to create a public option but a few, including Nevada and Minnesota, are exploring this policy approach.
The regulatory and financial requirements imposed on QHPs in Covered California differ from those required for Medi-Cal participation. This creates a barrier to entry for public Medi-Cal plans interested and able to expand into the individual market. Medi-Cal contracts with a public plan in 36 of California's 58 counties, but currently only one, LA Care, is available as a choice through Covered California and it is only available in Los Angeles.

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[29] Semanskee, Ashley, et al., "Insurer Participation on ACA Marketplaces. 2014-2018." Kaiser Family Foundation: November 10, 2017; Corlette, Sabrina, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018.

[30] Insure the Uninsured Project, "Exploring Public Options in California: Key Issues and Considerations," February 2018.

Helping Medi-Cal's public plans to expand their mission to serve as a public option in the individual market could potentially expand competition and access to care in some parts of California. But there are risks to this strategy as well. Policymakers would need to carefully consider how best to assist Medi-Cal plans to compete in Covered California in a way that does not undermine healthy competition among other insurers in the exchange. Furthermore, policymakers would want to ensure that if Medi-Cal plans were used in this expanded role, their ability to serve the ongoing needs of Medi-Cal beneficiaries would not be undermined.

Even if California were to expand health plan competition through a public option in the individual market, additional steps would be needed to overcome physician workforce shortages in underserved areas. Some of this might be addressed by producing more physicians, but this is a lengthy and expensive process. There is also no guarantee at the end of that training that these newly minted clinicians would enter primary care or work in a rural area. Nurse practitioners and other mid-level clinicians may be a part of the solution but the same issues arise in terms of a long training period and a disincentive to enter into primary care or to work in rural areas.

To overcome workforce shortages California needs a comprehensive strategy, utilizing incentives to overcome the market forces that discourage physicians and other clinicians from specializing in primary care and practicing in underserved areas. Such an approach could include incentives (1) to ensure that the physician training pipeline includes individuals who are interested and prepared for these roles, (2) to reduce the financial and practice barriers for individuals to enter in these roles, and (3) through physician payment policies which can sustain them in these roles over time.[31]

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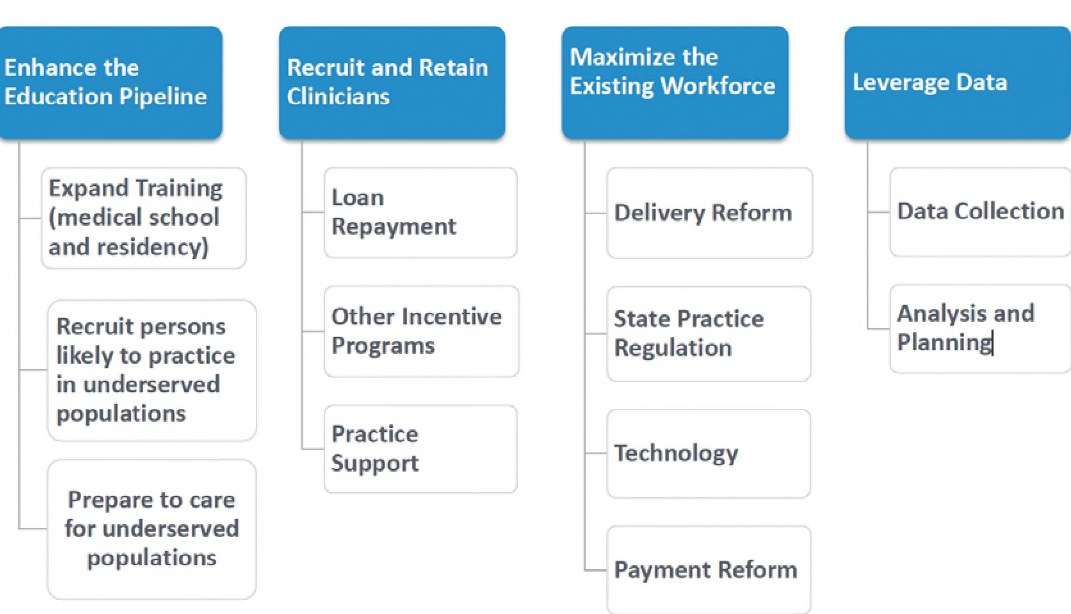
[31] Coffman, Janet, "Access to Physicians in California" Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018.



Source: Coffman, Janet, Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018

California should consider additional investments in each of these areas to address access barriers in underserved areas, but the most glaring shortcoming is in its Medi-Cal physician payment policy. Medi-Cal is the most significant payer in underserved communities, especially in rural areas where Medi-Cal is an even more prevalent payer than in urban areas.[32]

The state sets physician payment rates in Medi-Cal using a fee schedule. California is among the very lowest payers in the nation. Medi-Cal managed care plans are not bound by the fee schedule. Data are lacking on physician payment rates in Medi-Cal managed care. They are assumed to reflect what is paid in Medi-Cal fee-for-service but greater transparency of what is paid would inform future policy decision-making.

As with other Medi-Cal expenditures, increases in physician payments are paid in part by the federal government. With approval through a state plan amendment, the federal government provides 50% of the cost of any physician payment increase for services provided to beneficiary groups who were eligible for Medi-Cal prior to the passage of the

[32] Foutz, Julia et al. The Role of Medicaid in Rural America available at https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/

ACA and a minimum of 90% for physician services for those who became eligible under the ACA (e.g., childless adults).

In January of this year, California received approval from the federal government for a state plan to implement a one-year supplemental payment increase for a limited number of physician services including office visits and psychiatric visits. The supplemental payments range from $5 to $50 per claim and are being paid retrospectively dating back to July 1, 2017. The state plans to assess the impact of the supplemental payments on access to care to determine if additional payment changes are warranted.[33] As a part of the ACA, a provision of two years' duration (2013-2014) required states to increase primary care physician payment rates in Medicaid to at least those of Medicare. A study in ten states (not including California) found that this policy was associated with increases in Medicaid beneficiaries' access to care but that delays in its implementation blunted its impact.[34]

Given the size and scale of California's health care workforce challenges, the state should also utilize technology to leverage available personnel. Telehealth is a rapidly developing area which holds much promise as a means to quickly and efficiently address workforce shortages. It includes a wide range of digital communication strategies such as text messaging, email, audio-video interactions from home or a health care setting between patients and practitioners, and consultative services between primary care and specialty practitioners on behalf of a patient. There are structural resources needed to make this type of non-face-to-face communication possible, but the growing presence of computers and mobile devices with all of these communication capabilities makes this a diminishing component of what limits the use of telehealth as a strategy to improve access to care in underserved areas. Regulatory and payment policies are what are needed to accelerate this service approach.

Regulatory policies are also needed to ensure that the communication is secure to protect the privacy of the patient in a way which does not also make it overly cumbersome for either the patient or the practitioner to use telehealth. There are also more nuanced issues having to do with how care delivered via telehealth is counted toward network adequacy standards. Plans might be more likely to accelerate the use of telehealth if they were able to receive credit for its use in how the state regulatory agencies judge the adequacy of their network. California can encourage greater use of telehealth by reimbursing for virtual visits and including them in assessments made of network adequacy, but it should do this in a way which does not undermine the ability of patients to see practitioners when that is appropriate.

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[33] California Hospital Association. Medi-Cal Supplemental Payments for Selected Physician Services Approved available at https://www.calhospital.org/cha-news-article/medi-cal-supplemental-payments-selected-physician-services-approved

[34] Polsky Daniel et al. Appointment Availability after Increases in Payments for Primary Care N Engl J Med 2015; 372:537-545

Many clinicians have been slow to embrace telehealth in part because most services delivered through these methods are not directly reimbursed. Payers have been cautious in establishing payment codes for non-face-to-face delivery of services through telehealth due to concern that it could substantially increase total spending. In settings where clinicians are paid either a salary or based on capitation there has been more rapid adoption of telehealth. This suggests that policies which encourage the use of alternative payment methods could encourage widespread adoption of telehealth into clinical care.

Reduce fragmentation and increase transparency
In a scenario in which Medicare, Medi-Cal, employer sponsored insurance, and Covered California continue as the primary channels through which Californians obtain health insurance, testimony presented at the hearings provided suggestions about how California could streamline consumer experience and improve market performance. A brief synopsis of some of these suggestions follows.

Reduce fragmentation: The multiplicity of coverage channels adds costs and confusion for consumers, providers, and insurers. One proposal to attempt to reduce costs and confusion would be to require all insured products sold in California in the employer sponsored insurance market to offer the cost sharing parameters and covered benefits of one of the plans offered in Covered California.[35] Under this proposal, all fully insured products sold in the ESI market in California would be required to be either a bronze, silver, gold, or platinum plan, and the cost-sharing parameters at each metal level would be required to be the cost-sharing parameters for the applicable metal level as determined by Covered California. For example, silver plans have a deductible of $2,500, and a primary care visit office copayment of $35, with the first three visits not subject to the deductible. This approach is similar to the approaches taken in the Netherlands, Germany, and most other countries that rely on private health insurers to deliver benefits, and was mentioned as a possibility for California in testimony to the committee.[36]

One advantage of this proposal is that it would simplify the choice process for consumers – when comparing among insured products, consumers would not need to pay attention to teasing out differences in copayment and deductible structures offered by competing insurers. As a result, competition on price and quality would be strengthened – insurers would be prevented from competing by trying to design a benefit package that would be unattractive to high risk members. Administrative costs for insurers should decrease at

[35] Although it might in principle be useful to standardize products in all market segments, a change in federal law would be required to apply this principle to Medicare offerings. Further, the low-income people who are covered by Medi-Cal would find even the relatively low copayments required under platinum plans a substantial financial barrier to accessing care.

[36] Robin Osborn "Where the US Health Care System Stands Compared to Other Industrialized Countries" Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, October 24, 2017.

least marginally, since the number of benefit packages they would need to administer would be greatly reduced.

This proposal also has disadvantages. Some employers may think that there are benefits to the particular configuration of copayments and deductibles they are purchasing, and that being forced into one (or more) of the standard bronze, silver, gold, platinum offerings will reduce the value of their offerings to employees. Other employers may have implemented, or be planning to implement, innovative benefit structures such as reference pricing, and be concerned that there will be less beneficial innovation in copayment structures under the proposed standardization than there would be under the status quo. However, there is little evidence that the variation among employers in copayment and deductible structures has resulted in gains to consumers, and similarly, limited evidence that innovations in benefit packages in ESI have led to meaningful improvements in cost or quality. Further, Covered California has created a robust process for updating its benefit package, gathering input from a wide variety of stakeholders, and, ultimately, requiring approval from the publicly appointed Covered California board.

A significant limitation of this proposal is its limited scope. The standard Covered California benefit packages are already required in the individual and small group (< 100 employees) market. The proposal would extend the standardization requirement to the fully insured segment of the large group market, but federal ERISA statute would prevent California from imposing a similar requirement on self-insured plans. However, many large employers offer both fully insured and self-insured plans, and some attempt to offer the same cost sharing in both types of plans. If forced to offer standardized bronze, silver, gold, or platinum cost sharing in their fully insured plans, some of these employers might move to standardization in their self-insured plans as well, potentially extending the effect of the requirement beyond fully insured plans.

Increase transparency: Lack of price transparency differentiates health care from most other goods and services in our economy. As noted by one of the Committee co-chairs, when he takes his dog to a veterinarian, he is presented with a price list, but similar price lists in health care generally do not exist. As discussed at the January 17, 2018 hearing, the Legislature could potentially require providers to post price lists of some sort.[37] A provision requiring price lists to be posted was included in the ACA, although the Department of Health and Human Services did not issue regulations to implement the requirement.

However, it is not clear how meaningful or helpful price lists would be. If the posted prices simply reflected list prices that are charged, as opposed to the contracted prices negotiated by insurers that are actually paid, they would not be of much use to patients because they would not reflect the prices that insured patients would be required to pay. If the prices reflected average contracted prices, they would be somewhat more helpful, but still would

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[37] Laurence Baker "Price Variations and Consolidation" Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, January 17, 2018.

not reflect the amount that any individual patient could expect to pay, since contracted rates typically vary across insurers.

More importantly, it is not clear that price information, in the absence of useful quality information, would either encourage patients to choose lower price providers or result in downward pressure on prices. Some patients will assume that higher prices are associated with better quality, and may gravitate towards higher priced providers. Further, if prices are publicly available, providers who have negotiated prices on the lower end of the spectrum may, after observing the higher prices that their competitors have negotiated, attempt to hold out for higher prices in the next round of negotiations.

One proposal that might put some downward pressure on negotiated prices would be a requirement that hospitals and medium to large-sized physician groups (e.g., groups with at least 25 physicians) make information available on their average negotiated prices for patients covered by employer sponsored insurance, expressed as a percentage of the prices paid by Medicare. As discussed above, it appears that the mark-up above Medicare prices for inpatient hospital services is quite large for some hospitals in the state. Public scrutiny of very high prices might lead to community-wide pressure on outlier hospitals and medical groups to extract less of a premium above Medicare prices in subsequent negotiations (although might also, as discussed above, encourage relatively low-priced providers to hold out for higher prices). If this proposal were adopted, regulations would be needed to specify how the price comparisons were to be calculated.

An additional means to increase transparency would be to establish an All-Payer Claims Data Base (APCD). The Massachusetts Health Policy Commission (HPC) makes extensive use of the information collected by the Massachusetts All-Payer Claims Database (APCD) to monitor changes in utilization and price at the health system level. The HPC uses the data from the APCD to determine whether each health system in the state is adhering to spending targets. Similarly, an APCD in California would provide useful information to support a variety of efforts at improving the quality and efficiency of care, and would be a useful building block in improving the ability to successfully implement a system based on unified public financing. An APCD in California would expand on the hospital discharge data that is currently collected by OSHPD. However, the OSHPD data are limited to inpatient hospital discharges, and do not contain information on allowed or paid amounts.[38]

Additional approaches

<u>More closely scrutinize proposed mergers and acquisitions:</u> Consolidation has increased hospitals' negotiating leverage, and contributed to high prices. Increased oversight of

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[38] In 2016 the Supreme Court ruled that a Vermont requirement on self-insured plans to submit data to the Vermont APCD was preempted by the ERISA statute. Any proposal to establish an APCD in California would need to work within the restrictions created by that decision.

proposed hospital mergers would likely have at least a small effect in restraining future price growth. As described in the December 11 hearing, the Massachusetts Health Policy Commission analyzes proposed mergers and acquisitions in Massachusetts, and the Massachusetts Attorney General seriously considers the HPC's evaluation of the likely effects of proposed consolidation when deciding whether to challenge a proposed action. California could consider a similar model.

Greater scrutiny of proposed mergers and acquisitions would likely be helpful, but would likely also be of limited utility. The market for hospital care in most regions of California is already highly concentrated – the horse is already out of the barn. Further, as discussed above, concentration is only one factor that gives hospitals the leverage to negotiate high prices.

All-Payer Rate Setting: An alternative approach to limiting prices would be to implement some version of all-payer rate setting. Testimony at the December 11 hearing described the all-payer hospital rate setting system used in Maryland in detail, and a number of other people who testified at the hearings suggested that an option like this could be considered for California. Under the Maryland model, Medicare, Medicaid, and ESI all pay the same rate for hospital services. An important component of generating support for this system within the state is that Medicare payments to hospitals are higher, on a per-admission basis, than would be paid under the Diagnosis Related Group (DRG) system which Medicare uses to determine hospital payments in the rest of the country.

It seems unlikely that the Maryland all-payer model would be feasible in California. First, the federal government is unlikely to increase the amount that Medicare pays for hospital services, and, as discussed above, if ESI rates were to be reduced to Medicare rates, the revenue loss to hospitals would be catastrophic. Further, Medi-Cal rates are substantially lower than Medicare rates, and the state is not likely to be interested in increasing Medi-Cal hospital rates to Medicare levels. A variant of the Maryland model, in which all payers use the same unit of payment (e.g., DRGs) but payers pay different multiples of a base rate, could be considered for California. However, this model would work at cross purposes with the emphasis in California, both from Medi-Cal and private insurers, on selective contracting with hospitals, and it is not clear that it would bring benefits that outweigh the disruption it would entail. Proposals to extend Maryland-style all-payer rate setting to the California context need more development before they could be fully vetted.

California could also consider a global budgeting approach limited to hospitals in rural areas of the state, similar to the demonstration waiver obtained by the Commonwealth of Pennsylvania in an attempt to shore up the financing of rural hospitals and to provide incentives for them to invest in moving care out of the inpatient setting.[39]

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[39] Sule Calikoglu Gerovich "A New Hospital's Payment Model: Maryland's Global Budgeting System" Testimony before the Assembly Select Committee on Health Care Delivery and Universal Coverage, December 11, 2017. Additional information on the Pennsylvania Rural Health Model, as described by CMS available at https://innovation.cms.gov/initiatives/pa-rural-health-model/.

Consolidated public program purchasing: Consolidated purchasing for pharmaceuticals or other services, particularly across Medi-Cal, CalPERS, and Covered California, was mentioned at one hearing as a potential approach to attempt to reduce prices and spending. Given the very large number of people covered by Medi-Cal, it seems unlikely that adding the relatively smaller number of CalPERS and Covered California members to the Medi-Cal purchasing pool would provide much by way of benefits to Medi-Cal. And while such an approach might, in theory, provide some benefit to CalPERS or Covered California, the legal, technical, and political difficulties in attempting to consolidate purchasing across these agencies seem likely to outweigh any potential benefits that such consolidation might create.[40]

Reduce health plan administrative costs and profits

A variety of proposals have been suggested to limit the amount of money that health insurers can spend on administrative costs, including further restricting the fraction of premium revenue that insurers can spend on activities other than medical care (that is, tightening the Medical Loss Ratio (MLR) requirements, regulation of health plan profits, and limiting the compensation that can be earned by health plan executives. Any such proposals would need further development before they could be meaningfully evaluated.

In sum, a wide array of approaches could be pursued to address various shortcoming and opportunities within California's existing health care system. These approaches are incremental by design and differ in terms of the policy goals they aim to advance. Each brings associated tradeoffs and uncertainties.

4. IMPROVING CALIFORNIA'S HEALTH CARE SYSTEM VIA A UNIFIED PUBLICLY FINANCED APPROACH

The current patchwork approach to financing health insurance and health care is accompanied by uneven access and, in many cases, inefficient delivery of services. Under the status quo, funds follow individuals and are constrained by disparate rules based on the payer or program from which they originate. Highly fragmented funding adds administrative burden and potential confusion for consumer and providers throughout the system.

An alternative would be to establish a unified, publicly financed approach that

- Assures coverage for all state residents;

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[40] Bailit M and Burns M. "All Together Now: Coordinating California's Public Sector Health Care Purchasing" available at https://www.chcf.org/publication/all-together-now-coordinating-californias-public-sector-health-care-purchasing/

- Pools funds for health coverage across Medicare, Medi-Cal, and other major sources of financing;
- Dramatically reduces or eliminates variations in eligibility, benefits and payments.

A unified publicly financed approach to health care coverage would eliminate the differences between Medicare, Medi-Cal, and employer sponsored insurance in consumer cost-sharing and benefits. A unified publicly financed approach would reduce the considerable administrative burden that today's financing arrangements impose on purchasers, consumers and providers. Taken together, these changes would create a more equitable health care system. It would likely increase efficiency and produce better health outcomes, although these results would depend on how well the system was managed and on mechanisms of accountability. To accomplish such a sweeping transition would require substantial and unprecedented changes in federal and state law as well as decisions regarding many design parameters.

One such proposal would create the Healthy California Program to "provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state." Necessary waivers and permissions would be sought; financing provisions are not spelled out in the bill but would be developed. The legislation would not take effect until the California Secretary of Health and Human Services notifies the Senate and the Assembly that the Healthy California Trust Fund has the revenues to fund implementation costs.[41]

Other states have sought to establish a single payer system. Vermont pursued a single payer approach that went further than most yet was never implemented. Vermont's exploratory effort began in 2010, followed by 2011 legislation to establish Green Mountain Care, a government-financed system to replace most health insurance in Vermont.[42] As planning efforts evolved, it became clear that Medicare, Medicaid, health plans for veterans and military personnel, and plans serving workers at out-of-state companies would continue to operate in Vermont even after the implementation of Green Mountain Care.[43] In 2014, after serious planning efforts, Governor Peter Shumlin withdrew the plan citing "the limitations of state-based financing, the limitations of federal law, the limitations of our tax capacity, and the sensitivity of our economy."[44]

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[41] SB 562, The Healthy California Act (2017-18), described at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB562

[42] VerValin, Joe, "The Rise and Fall of Vermont's Single Payer Plan," Cornell Policy Review, July 13, 2017.

[43] Ollove, Michael, "Vermont Is 'Single-Payer' Trailblazer," Pew Charitable Trusts: Stateline, August 7, 2014.

[44] McDonough, John, "The Demise of Vermont's Single Payer Plan," N Engl J Med 372: 1584-1585 (April 23, 2015).

The history of California health reform and single payer proposals is described elsewhere.[45] Questions and issues that would confront California in any comprehensive re-organization of health care financing have also been explored.[46] The purpose of this discussion is to review, within the current context, California's opportunities and challenges with respect to consolidated financing for health care.

Considerations related to integrating multiple payers
The public and private funding streams that support health care and coverage today are accompanied by many requirements not readily eliminated nor easily reconciled. Pooling funds to pay for health care for all residents depends on navigating those requirements and either renegotiating their terms or working around them.

Federal funding and permissions: The federal government is the largest source of funds for health care in California today.[47] Federal funds flow via:

- Medicare, the federal program that serves most people aged 65 and over and certain people with disabilities;
- Medi-Cal -- California's Medicaid program-- the jointly funded state-federal program available to people who meet income eligibility criteria;
- The provision of subsidies under the Affordable Care Act for income-eligible individuals and families who obtain insurance through Covered California;
- The exclusion from federal taxable income of employer and employee premiums for employer-sponsored health insurance; and
- A variety of additional federally funded coverage programs such as Tricare (for the dependents of active duty military and military retirees).

To redirect funds from these sources to a unified state-based pool would require federal action. For example:

- Because existing federal law does not grant the federal Secretary of Health and Human Services authority to redirect Medicare's funding streams or trust fund dollars to states, bringing Medicare funds into a unified state-based public financing pool would require federal statutory changes.[48]

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[45] Dimmitt, Michael, "Ninety Years of Health Insurance Reform Efforts in California," *California Agencies* Paper 316 (California State Library: 2007).

[46] Philip, Susan and Mulkey, Marian, "Key Questions When Considering a State-Based, Single-Payer System in California," available at https://www.chcf.org/publication/key-questions-when-considering-a-state-based-single-payer-system-in-california/

[47] Sorensen, Andrea et al. "Public Funds Account for Over 70 Percent of Health Care Spending in California," (UCLA Center of Health Policy Research, August 2016) available at http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/PublicSharePB_FINAL_8-31-16.pdf

[48] Cubanski, Juliette, "Federal Law Considerations and Medicare," Testimony before California Select Committee on Health Delivery Systems and Universal Coverage, February 5, 2018.

- Federal Medicaid requirements tie federal matching funds to the services provided to Medicaid-enrolled individuals. To claim federal Medicaid funds for use through a unified financing pool, California would either need a change in federal law, or would have to continue to track eligibility and expenditures related to individuals who meet complex eligibility criteria. Some steps required for continued compliance with federal Medicaid rules might well be in conflict with the simplicity and equity principles of unified public health care finance in California.[49]
- Subsidies through Covered California might be redirected to a unified financing pool under existing Section 1332 waiver authority, if ACA statutory guardrails including federal deficit neutrality are met.[50]
- If California moved away from employer-based financing of health insurance, and wages were increased in California to compensate for the elimination of employer contributions to health care, federal income tax revenues would increase. To capture the resources associated with the current federal tax subsidy for employer sponsored insurance, Congress would need to pass legislation providing for a direct payment to California in the amount of the estimated increase in federal tax revenues.
- To redirect federal funds that currently support special populations such as CHAMPUS enrollees and veterans would involve revisiting long-standing expectations regarding benefits.

Employer-sponsored coverage and ERISA: Employer-sponsored health insurance covers about 17.5 million Californians and is another major source of health care funding. Today, employers choose health plans with which to contract and decide what coverage to offer based on business needs and employee preferences and in some cases through collective bargaining. As a consequence, employer-sponsored health insurance products vary greatly, including variation in provider networks, benefits, and cost-sharing arrangements. As previously described, about 6 million Californians are in self-insured private employer plans subject to ERISA.

Although direct state intervention in ERISA plans is impermissible, either federal ERISA statute would need to be amended or California would need to devise financing approaches that do not run afoul of ERISA legal challenges and associated delays. California could impose a broad state-based payroll tax to finance health care on all employers, whether or not they currently have (or continue to maintain) an ERISA plan. Given the amount of money and number of people and firms involved, some degree of resistance in the political or legal sphere is likely. A "pay or play" financing approach might also be considered, but

[49] Manatt Health, "Understanding the Rules: Federal Legal Considerations for State-Based Approaches to Expand Coverage in California," available at https://www.manatt.com/getattachment/6c6ebd95-d8da-40be-9529-04cbbb7b8142/attachment.aspx

[50] Brooks-LaSure, Chiquita, "Medicaid (1115) and Marketplace (1332) Waiver Authority," Testimony before California Select Committee on Health Delivery Systems and Universal Coverage, February 5, 2018.

would have also have to be carefully constructed to withstand ERISA legal challenge and deviates from the spirit of fully integrated financing.[51]

In sum, self-insured plans represent a large share of covered lives and an important financing source for a unified state program. However, efforts to integrate them within a state coverage program would have to navigate potential legal challenges and could be subject to associated delays and uncertainty.

Considerations related to state financial oversight
Across all sources and programs, about $400 billion will be spent on health care in California in 2017-18.[52] A program based on unified public financing with a guarantee of access to care for all residents would likely need to raise, manage and spend approximately that sum on an annual basis. State fiscal realities and California constitutional provisions would influence California's ability to effectively execute those responsibilities.

For years, in both California and nationally, health care spending has risen more rapidly than spending throughout the economy as a whole.[53] A unified financing approach might alter these trends, but the magnitude of any savings as well as the timeline over which savings would be achieved is unclear. On one hand, unified financing would clarify how funds are being used and would introduce new spending discipline. Some administrative savings would be achieved by virtue of simplified administrative processes, but many of these would be one-time. On the other hand, bringing everyone into a system of guaranteed access with minimal cost-sharing will increase expectations and reduce cost-sharing considerations that today exert downward pressure on spending. One forecast asserts a net 5% per year reduction in health care spending under SB 562 due to reductions in low value care.[54] In the view of these authors, that estimate is highly speculative and depends to a great extent on program design and implementation decisions that are as yet unknown.

Provisions of the State Constitution require California to enact a balanced budget each year and strictly limit the state's ability to engage in deficit spending. Many forces and factors could introduce volatility into revenue streams and expenses associated with state-managed universal coverage. It will be important to establish and finance reserves upon

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[51] Manatt Health, "Understanding the Rules: Federal Legal Considerations for State-Based Approaches to Expand Coverage in California," available at https://www.manatt.com/getattachment/6c6ebd95-d8da-40be-9529-04cbbb7b8142/attachment.aspx

[52] Legislative Analyst's Office, "Current Healthcare Coverage and Spending Landscape," Testimony before California Select Committee on Health Delivery Systems and Universal Coverage, February 5, 2018.

[53] "California Personal Health Care Spending," California Health Care Foundation: September 2017 and Wilson, Katherine B., "Health Care Costs 101: Spending Growth Slowed," California Health Care Foundation: September 2017.

[54] Pollin, Robert, et al., "Economic Analysis of the Healthy California Single-Payer Health Care Proposal (SB-562)," University of Massachusetts Amherst Political Economy Research Institute: May 31, 2017.

which the health fund can draw in periods when costs are unexpectedly high or revenues fall short of projections.

Provisions of the State Constitution also constrain the Legislature's ability to substantially raise taxes and dedicate the proceeds exclusively to universal health coverage. Proposition 98 of 1988, as amended by Prop. 111 of 1990, guarantees a minimum funding level for K-12 schools and community colleges. Prop. 4 of 1979 (the "Gann limit"), as amended by both Prop. 98 and Prop. 111, sets limits on certain state appropriations. The scope and cost of a program to finance all health care throughout the state would trigger both provisions, rendering it prudent to seek explicit ballot initiative approval to dedicate new funds to health care.[55]

Design, Implementation and Transition Considerations

Consolidating financing for health care within a single statewide pool would bring new opportunities for financial oversight, more transparent and accountable decisions regarding covered services and providers, and greater consistency and equity in how health care providers and consumers were treated. In moving from diverse benefit, payment and delivery arrangements under today's fragmented financing and coverage program features to a more uniform set of expectations, a number of tradeoffs and tensions would likely arise.[56] For example, the following topics would invite serious deliberation and careful monitoring in the course of establishing and implementing a statewide universal coverage program:

- The extent to which integrated managed care arrangements would be encouraged, and the role, if any, for health plans;
- How provider payment levels would be set and adjusted;
- Whether and how payments and delivery system arrangements might be allowed to vary based on regional differences, local preferences and needs;
- How quality and access to care would be assured;
- The extent to which the needs of special populations would be prioritized; and
- What governance structures and management tools would be put in place to assure accountability and effective oversight.

In addition to these significant design choices, many thorny transition issues would arise. For example, it may be prudent to begin to accumulate funds in a reserve fund prior to program launch. Managing and explaining how new revenues would be collected in parallel with current financing arrangements would be challenging. Jobs in billing and insurance related functions in hospitals, physician offices, and health plans may disappear when

[55] Graves, Scott, "Constitutional Constraints on Moving Toward Universal Coverage in California," Testimony before California Select Committee on Health Delivery Systems and Universal Coverage, February 5, 2018.

[56] Philip, Susan and Mulkey, Marian, "Key Questions When Considering a State-Based, Single-Payer System in California," available at https://www.chcf.org/publication/key-questions-when-considering-a-state-based-single-payer-system-in-california/

administrative costs are reduced; a program of transitional assistance or retraining for people in those roles would merit consideration.

In a broad reorganization of financing and delivery of health care in California, existing financial and care delivery relationships would need to be reimagined and restructured. Some degree of disruption is inevitable. Clear articulation of priorities and program goals, along with a systematic planning effort, would be helpful in navigating the transition to universal coverage and more effective care delivery systems.

5. POTENTIAL PATHS FORWARD

California has made great progress in reducing the number of uninsured, but has not yet achieved universal coverage. Studies of high performing health care systems around the globe suggest that universal coverage is essential for ensuring access to care, improving outcomes, and controlling costs. A strong primary care system, a comprehensive basic benefit package, provider payments that reward better health outcomes, a strong social safety net in addition to universal health care, and administrative simplicity are other important ingredients for high performance.[57] There are many pathways to achieving universal coverage and a more efficient health care system. Western European countries have taken a variety of paths to universal coverage, varying in their use of public and private sources of funds to provide universal coverage as well as in the degree to which they rely on the government to pay for services directly, versus relying on residents to make a choice among available health plans.

A unified publicly financed health care system offers a means to a less complex health care system, but the process of transitioning to it would be a substantially more disruptive path of expanding coverage in the state than building upon the foundation of the current system. Californians and their elected representatives will need to assess whether the financial risks and disruption of transitioning from the current multi-payer system to a publicly financed system is in the best interests of the state; make a judgment about the likelihood of obtaining necessary federal statutory changes and waiver approvals; and, if they believe that moving forward on this path makes sense, what timing and practical steps are needed to make it possible. Even if California were to decide today that it was prepared to transition to a publicly financed universal health care system for its residents, it would take years to accomplish the necessary steps at the state and federal level to make that possible. In the meantime, there are steps California can take in the near term to improve coverage, affordability and access to care while also building its capacity to pursue a broader change agenda.

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[57] Schneider EC et al." Mirror, Mirror 2017: International Comparison Reflects flaws and Opportunitiies for Better U.S. Health Care" available at http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/

To evaluate policy approaches that build on California's current multi-payer approach, policymakers may wish to consider the following criteria:

- Extent and immediacy of benefit for Californian consumers and the health care delivery system
- State fiscal cost
- Potential to preserve gains achieved under the ACA
- Extent to which incremental approaches either lay a foundation for, or undermine, potential future reforms

Below we consider short-term approaches within the context of these criteria.

SHORT-TERM STEPS TO IMPROVE COVERAGE, AFFORDABILITY, ACCESS, FRAGMENTATION AND TRANSPARENCY

IMPROVE COVERAGE

Expand Medi-Cal coverage to income-eligible undocumented adults: California could choose to build upon what it has already done to provide full scope Medi-Cal using state funds to low-income undocumented children by expanding the age range of eligibility.

- The proposal targets the largest group of individuals who remain uninsured in California. More than 1 million residents are estimated to be in an income group that would allow them to qualify for Medi-Cal but for their immigration status. California would be required to take some administrative actions to execute on this strategy but it would have a relatively immediate impact on expanding coverage in the state.
- The costs of this approach would depend on the eligible age range, and it could perhaps become more feasible by expanding the age range over time. The state could also anticipate substantial offsetting savings from spending currently associated with providing restricted scope Medi-Cal benefits (for care related to pregnancies and emergencies) to these same individuals. Much of the additional cost would allow these individuals to obtain primary care services which could contribute to reduced emergency care needs.
- Expanding coverage to undocumented adults in the near term would indicate that these individuals would also be included in coverage were California at a later time to transition to a universal coverage system supported by unified public financing.

Extend Covered California premium tax credit assistance to undocumented individuals using state funds

- The proposal targets the majority of the uninsured undocumented individuals whose income is too high to qualify for Medi-Cal. These individuals would be eligible for federal insurance subsidies in Covered California but for their immigration status. Similar to the approach using Medi-Cal, California could choose to use state funds to provide these subsidies, substantially lowering financial barriers for these individuals to purchase coverage.

- This strategy would have a relatively immediate impact on expanding coverage in the state.
- The costs of this approach would depend on whether California chose to target the full income range (e.g., 138% FPL to 400% FPL) reflected in the federal approach or to limit financial support to those at lower income levels (e.g., 138% to 200% FPL). California could also choose a smaller subsidy than what is provided by the federal government but this would reduce the impact of the policy as it would most likely not provide sufficient cost relief to consumers to encourage them to purchase coverage in Covered California.
- Similar to the proposal to use Medi-Cal to expand coverage to low-income undocumented adults, this approach would be an indication that this group of individuals would also be included in coverage were California at a later time to transition to a universal coverage system supported by unified public financing.

IMPROVE AFFORDABILITY

Address consumer affordability and participation for those already eligible for Medi-Cal and Covered California

- The LAO estimates that there are 1 million uninsured in California who are citizens or legal residents and that more than two-thirds of them are already eligible for Medi-Cal or subsidies to purchase insurance in Covered California. These numbers are likely to grow beginning in 2019 with the repeal of the federal tax penalty associated with the individual mandate.[58]

- California could undertake one or several steps with a relatively immediate impact on expanding coverage and preventing erosion of coverage gains achieved under the ACA:
  - Build upon the state's extensive outreach efforts to ensure individuals who are eligible for Medi-Cal and federal subsidy support to purchase coverage through Covered California are aware of their options.
  - Enhance coordination between Medi-Cal and Covered California so as to minimize disruptions in coverage for those who are required, due to changes in their income, to churn between these two programs.
  - Use state funds to reduce financial barriers to coverage by further subsidizing insurance premiums and/or cost-sharing for those who qualify for federal subsidies and/or to create subsidy support for those whose incomes are above the 400% federal poverty limits for federal subsidies.
  - Implement a state individual mandate with a tax penalty to replace the federal ACA individual mandate penalties that will be eliminated in 2019. Such a policy would be likely to generate state revenue and more importantly it would provide an incentive for young, healthy adults to obtain coverage. This not only

[58] Congressional Budget Office. Repealing the Individual Health Insurance Mandate: An Updated Estimate available at https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf

provides financial protection to them, but would have the impact of lowering health care costs for everyone purchasing insurance through Covered California.

- The costs of subsidy-oriented approaches would vary based on the size of the subsidy and the income ranges to which subsidies were provided. The impact and administrative burden associated with each approach also vary, depending on how policies are designed and implemented.

Limit out-of-network prices for hospitals to a specified ratio of the price that would be paid by Medicare for similar services

- Some hospitals have been able to negotiate much higher prices than the prices paid by Medicare. Hospitals heavily dependent on Medicare appear to be able to provide high quality care. If the prices that hospitals could receive for out-of-network services were limited, it seems likely that in-network prices would be reduced at those outlier hospitals that currently have negotiated prices above the specified ratio. This would result in lower premiums for employers and employees, and, potentially, for members in Covered California. The adjustment at hospitals whose prices were limited would be difficult, and phase-in options should be considered.

- Reducing price differentials across payers would, arguably, ease a potential transition to a system of unified public financing.

IMPROVE ACCESS

Increase Medi-Cal payment rates: The number of physicians available to care for Medi-Cal beneficiaries has not kept pace with the program's rapid expansion following the implementation of the ACA. Physicians cite low reimbursement rates as the main reason they do not participate in the program. As California looks to translate its gains in coverage into improved access and considers additional expansion of the Medi-Cal program to incorporate undocumented adults, it will need to take steps to improve the program's capacity to provide medical services. Medi-Cal has recently undertaken a step toward increasing physician payment rates but it is time-limited. Additional time and larger increases may be needed to more effectively address barriers to care in Medi-Cal. Medi-Cal might explore requiring its health plans to be more transparent regarding physician payment rates so that the state could use this information to guide evaluations of access to inform future payment policy.

- The proposal would improve access to care for California's many Medi-Cal enrollees.
- The state budgetary impact could be significant. However, state commitments to any physician payment increases can be scaled in amount and targeted to selected services. For example, primary care may be a priority. Evaluations of a primary care physician payment increase to make Medi-Cal payments equivalent to those in Medicare suggests the impact on access can occur within a 1- to 2-year period. State commitments will be

matched with federal support so long as Medi-Cal receives federal approval of a state plan amendment.

- Bringing Medi-Cal payment rates nearer to those of other payers would reduce disincentives to care for Medi-Cal enrollees and help pave the way to uniform payment rates under a future unified financing system.

Explore a Medicaid Public Option

- California has health plan competition in the individual market throughout most areas of the state and there are no areas where there is not at least one option. A Public Option in the individual market in parts or all of the state could protect the state against erosion in coverage if insurers choose to leave any of the regional markets.
- While a Public Option using Medi-Cal's public plans might provide consumers with a lower cost option, there are many questions which would need to be answered about the provider network, provider payment rates, and provider capacity. Before embarking on this effort, California should pursue a planning process with Medi-Cal, Medi-Cal's public plans, Covered California, and key stakeholder groups to assess the costs and benefits, as well as any barriers, legal or otherwise, which could impact the feasibility and timing of this policy approach.

SIMPLIFY THE CONSUMER CHOICE PROCESS

Require each fully-insured product in the large group market to be either a bronze, silver, gold, or platinum plan as defined by Covered California

- Bringing greater uniformity to the plans available to employees and their dependents would focus competition among insurers on price and quality, and eliminate the ability of insurers to fashion benefit packages in an attempt to avoid high cost enrollees. However, greater uniformity would also eliminate the ability of employers to experiment with innovative coverage options and copayment and deductible structures. The ERISA preemption would likely prevent this proposal from directly affecting the offerings of self-insured employers.
- Greater uniformity of benefit packages in the status quo would arguably ease a potential transition to a uniform benefit package under unified public financing.

INCREASE TRANSPARENCY

Require hospitals and larger medical groups (e.g., > 25 physicians) to post information on average prices received from people covered by ESI, as well as average prices received from people covered by Covered California, by Medicare, and by Medi-Cal

- Greater transparency on pricing might lead to community pressure on high-priced hospitals and medical groups to limit their prices (although also might encourage low-priced providers to negotiate harder). The information would be useful employers and purchasers in understanding differences across providers in pricing.
- Better information on status quo pricing would facilitate a potential transition to uniform pricing under unified public financing.
- Regulations would be needed to specify how average prices were to be computed in order to make them comparable across providers and across payers.

- If an APCD were successfully established, average prices could be calculated from the data in the APCD. However, we assume that it will take quite a few years before an APCD is fully operational, and the posting of average prices could be accomplished more expeditiously. Further, ERISA preemption might limit the ability of an APCD to obtain data from self-insured plans, but would not appear to apply to the ability to require hospitals and medical groups to provide data on average prices.

Establish an All-Payer Claims Database (APCD)

- As demonstrated by the work of the Health Policy Commission in Massachusetts, the data in an APCD is extremely valuable to monitoring the cost and quality of care produced by the state's health systems, and to working with those systems to improve cost and quality, as well as potentially sanctioning systems in which per capita costs increase more quickly than the state benchmark.
- A system of unified public financing could be more effectively managed if APCD data were available than if it were not.
- Establishing an APCD would require resources from the state, and resources from the health insurers required to contribute data, and would be a multi-year process. Privacy protections would need to be established. Legal analysis would be needed to determine the extent to which the 2016 Supreme Court ruling on the Vermont APCD would limit the ability to obtain data from self-insured plans.

A Roadmap for a Broader Transformation of California's Health Care System

As suggested by the former Governor of Vermont, Peter Shumlin, the California Legislature could declare that California embraces a goal of guaranteed access to health care for all its residents via a system of unified public financing that improves health outcomes and keeps costs for the state and its residents in check. Under a system of unified public financing, the differences in financing and coverage among Medicare, Medi-Cal, employer-sponsored insurance, and the individual market would be largely eliminated.

To achieve this goal, several preconditions would need to be satisfied:

- Diverse stakeholders must develop a sense of shared purpose and mutual responsibility to advance a health system that works well for all Californians
- Data must be collected and analyzed to better understand the status quo, and to explore how a new system could be monitored and managed
- State budgetary implications must be modeled; financial risks must be assessed and mitigated
- A detailed proposal would need to be developed, and the Legislature would need to enact enabling legislation.
- State constitutional amendments would need to be approved by the voters to assure that the new system did not run afoul of Propositions 4 and 98, and would be desirable to assure broad-based support for the sweeping state revenue changes that such a system would require.

- Federal statutory changes and waivers would need to be obtained.

A system based on unified public financing would have far-reaching effects on how Californians obtain insurance coverage and on health care delivery. The existing channels through which Californians obtain coverage – primarily, Medicare, Medi-Cal, employer sponsored insurance, and Covered California (and the individual market outside of Covered California) – would be replaced with a unified public financing mechanism.

To implement such a system, the federal government would need to agree to write checks to the California unified public financing authority to replace the money that would otherwise be spent to pay for Medicare, Medi-Cal, and subsidized Covered California enrollees. Such agreement would require federal statutory change, most notably in Medicare law, as well as cooperation in obtaining waivers from the federal executive branch. A sensible principle would be that the federal government would write a check to California to replace the money that would otherwise have been spent on Medicare, Medi-Cal, and Covered California subsidies (as well, presumably, for funds that would have been spent on CHAMPUS beneficiaries), in exchange for California's assurances that people who would have been beneficiaries of these federal programs would now be entitled to state benefits. Moving from a sensible principle to an operational and sustainable program would require extensive planning and negotiation. In addition to establishing an initial set of assurances about benefits and payments, agreements would be needed about how to determine the rate at which the federal payment to California would grow over time.

California can increase the chances of favorable federal action if it designs a system of unified public financing that generates broad-based support within the state. Demonstration of that broad-based support could be shown through a favorable vote on a statewide ballot proposition that established the basic building blocks for a system of unified public financing, and cleared away any legal obstacles to such a system created by Propositions 4 and 98. With a favorable vote on enabling legislation, the California congressional delegation would be in a strong position to argue for the required federal statutory changes and waiver approvals.

And even if, somehow, the federal statutory changes and waiver approvals could be obtained tomorrow, it would take at least two years, and more likely three to four, to develop the policies and operational systems needed to implement a system of unified public financing. The period 2018-2020 affords an opportunity to build a firm foundation for unified public financing that could then be implemented following potential federal action in 2021.

The Legislature could demonstrate leadership and advance progress via a Roadmap to Universal Coverage and Unified Financing by establishing a public entity responsible for advancing progress toward universal coverage and unified health care financing. The Legislature would establish the governance structure of the planning commission, provide its charge, and appropriate funding. The commission would engage in activities such as the following:

1. Convene a stakeholder engagement and analytic process by which key design features are refined and vetted.
    - Coverage and Benefit Packages: Develop proposals for covered services, and patient cost-sharing, if any. If cost sharing is lower for lower income people (or if covered benefits are broader (e.g., lower income people receive coverage for dental and vision, but upper income do not), develop proposals for what the income-cost sharing relationship should be, and how income would be determined.
    - Eligibility rules: Develop proposals for how to determine whether someone is a resident of California entitled to health care coverage. For example, rules will need to be developed about coverage for undocumented Californians as well as those who are either travelling temporarily outside of California, or who have temporarily relocated. Similarly, rules will be needed about out of state dependents (e.g., college students) of Californian residents.
    - Provider payment rules: Develop methodologies for paying hospitals, physicians, laboratories, pharmaceuticals, and other providers. If there is a role for health plans, develop methodology for paying health plans, including method for risk adjustment of payments. If hospitals are paid based on a budget, develop method for budgeting. If major capital investments will require approval by a public authority, develop rules/process to do so.
    - Quality assurance and improvement: Develop quality standards, a process for maintaining and updating them over time, and a system of incentives that promotes quality improvement over time.
    - Role, if any, for county government or other sub-state decision making or advisory bodies: Particularly if hospitals are paid based on a budget or if capital investments require approval, but also as other decisions are made that affect the configuration of the delivery system, consideration is needed for how local input into these decisions would be obtained, and whether any decision-making authority can or should be devolved to local governments or other organizations.

2. Establish data collection and reporting efforts to support management, evaluation, transparency, and public accountability.
    - Leverage existing and develop new data systems such as an All Payer Claims Data Base that can be used to establish an accurate baseline for California's health care system and be used to monitor and support informed decisions as California implements changes over time.
    - Develop reporting systems that minimize burden on providers but provide an accurate and comprehensive assessment of performance at the population level as well as among important subgroups of individuals throughout the state.

3. Model state budgetary implications and assess options for raising and managing funds
    - *Revenues:* Tax-based financing would be needed to replace most of the money currently paid by employers and employees for employer sponsored insurance. There are a variety of options to raise these funds, including an increase in

the state sales tax, an increase in the state income tax, a gross receipts tax, or a state payroll tax. Each of these options, as well as others, has advantages and disadvantages.

- We note here that while an increase in the income tax would be more progressive than a payroll tax, given current federal tax law, an increase in the state income tax would likely result in a significant increase (in the tens of billions of dollars) in Californian's federal income tax payments.[59] Further, one advantage of a payroll tax relative to an increase in the income tax (or other sources of financing) is that there will be fewer winners and losers among employers and employees relative to the status quo. Winners and losers could be even further minimized if the payroll tax were firm-specific -- that is, if each firm paid a percentage of payroll that was similar to (perhaps slightly less than) the percent it paid in recent years.[60]
- *Costs:* Benefit design and payment approaches have significant implications, both direct and via the incentives they establish, for total spending. The financial (and other) implications of different designs would need to be explored not only through actuarial modeling and stakeholder input but also by engaging representative members of the public in a structured deliberative process to understand and evaluate trade-offs. Further, it makes sense to be concerned that California could become a magnet for sick people -- if health care coverage is much better in California than in other states, it is possible that people in need of care will move to California. The design of the revenue and financing system (and perhaps eligibility rules) would need to be able to accommodate this possibility.

4. Make recommendations to the Legislature on the design of a system of unified public financing, and work with the Legislature to draft necessary state enabling legislation and any necessary ballot propositions.

5. Ready the state to seek federal waivers and statutory change by which funds currently managed by the federal government but used on behalf of Californians can be consolidated with other funding sources
   - Prepare waiver requests and draft changes in federal law as needed. Coordinate with Department of Health Care Services to explore and manage implications for existing

[59] The implication on federal taxes is based on the assumption that if employers are no longer contributing to health care then employees will receive compensating raises. However, increased income to employees will result in increased federal tax payments. In contrast, if employer paid a payroll tax, and if that tax were approximately equal to the amount that would have been paid for employer sponsored insurance, then there would be minimal effects on federal income tax liability.

[60] If a firm-specific payroll tax were contemplated, methods would be needed to calculate the rate for each firm, and rules would be needed for new firms as well as firms that previously did not make any payments for health care or made very small payments. Further, consideration would be needed about whether differences across firms in these percentages should be narrowed over time.

programs such as Medi-Cal. Support state efforts to negotiate with the Executive branch and Congress.

6. Operational requirements
   - Information technology: Develop an initial scope and recommendations to build (or contract for) an IT system capable of administering the system – determining residency, making provider and health plan payments, measuring utilization, spending, and quality
   - Financial management systems: develop an initial scope and budget to support a system capable of receiving checks from the Federal government for Medicare, Medicaid, and Premium Tax Credit funds, as well as from the state for tax revenue to replace current employer and employee payments for health insurance. Develop a financial control system capable of assuring that money is collected and spent as intended. The agency will be managing somewhere in the neighborhood of $300 billion to $400 billion of funds annually, and clearly many safeguards are needed. Develop estimates of reserves needed, and methods of funding and managing reserves.

7. Coordination

It is anticipated that non-government entities (foundations, nonprofits, consumer advocacy organizations and faculty at the University of California) would be enthusiastic partners in educating the public about cost, access and quality under the status quo as well as opportunities for improvement under a unified public financing approach. Coordinating such activities among public and private partners would be encouraged as the Roadmap is refined and implemented.

8. Roadmap

Many tasks will need to be successfully completed by the executive and legislative branches to achieve unified public financing in California. Given the complexity of tasks, this might best be done by enacting legislation to establish and fund a planning commission to work on behalf of the Legislature and Governor to pursue the necessary steps.

Among the early tasks, the planning commission could engage with stakeholders to resolve design features, including coverage and benefits, eligibility, provider payment rates, and quality metrics. The planning commission could oversee analysis of options to inform the financing of a unified public financing approach. A planning commission could also recommend a management plan with realistic estimates of the information technology needs as well as the operating costs for running the program overall.

After the planning commission had helped policymakers better define the parameters of a system of unified public financing, it could partner with stakeholders to educate the public regarding proposed changes. The planning commission could also assist in the drafting of state legislation and ballot propositions necessary to implement recommendations.

Assuming that policymakers and the public endorsed the unified public financing approach, the planning commission could assist state policymakers in drafting needed federal

statutory changes, developing federal waiver requests, and negotiating with the federal executive branch and Congress.

While it is difficult to estimate exactly how quickly these tasks can be accomplished, at a minimum it would require a multi-year process.

Conclusion

California has established itself as a leader in using the opportunities created by the Affordable Care Act to increase insurance coverage. Building on that foundation, as discussed during the hearings and summarized in this report, state leaders can take steps now to make coverage more widely available, increasing coverage from its current level of 93% to very close to 100%. Further, state leaders can take steps to reduce financial barriers to care for people who are insured. Something close to universal coverage can be achieved even with continuation of the current fragmented system in which Medicare, Medi-Cal, employer-sponsored insurance and the individual market continue to be the main channels through which Californians obtain coverage.

Testimony during the hearings also suggested a number of options for mitigating the deleterious effects of fragmentation and reducing the rate of growth of health spending within the context of a fragmented financing system. This report has summarized many of those suggestions and provided an assessment of the some of their major advantages and disadvantages.

Many people who testified during the hearings also voiced the opinion that the surest way to achieve universal coverage and the most likely way to substantially improve equity, quality and efficiency would be to implement a system of unified public financing. Under such a system, all Californians would have health insurance coverage by virtue of living in the state, and the separate coverage systems of Medicare, Medi-Cal, employer sponsored insurance and the individual market would be eliminated.

However, testimony also made clear that there are substantial legal, political and technical obstacles to implementing such a system. Substantial changes in federal law and federal waivers would be required to transform Medicare, Medi-Cal and the funds used for premium tax credits for Covered California enrollees into a system of unified public financing, and to allow the federal government to transfer funds to California in lieu of continuing to pay for Medicare, the federal portion of Medi-Cal and premium tax credits. In addition, the state would need to raise new revenue to replace most of the money currently spent by employers and employees for employer-sponsored insurance.

While there are obvious shortcomings in the design and implementation of the Medicare program, the Medi-Cal program, employer-sponsored insurance, and Covered California, 93% of Californians currently have insurance through one of these channels. Transitioning the vast majority of Californians into a new system of coverage, which does not have an established track record in the state, involves uncertainty and some risk. Policymakers

have a responsibility to educate the public about the benefits and risks of various options to provide health care coverage and to incorporate the public's values and priorities into their decision-making.

Short-term changes to increase coverage and improve equity, quality, and efficiency make sense given uncertain prospects and a multi-year timeline for achieving unified public financing. This is particularly true if short term changes are pursued in ways that facilitate rather than impede a potential future transition to unified public financing. Short-term efforts to expand coverage, improve access, reduce fragmentation, and improve transparency, coupled with development of a longer-term path toward unified public financing, would help secure a future in which all Californians have access to the health care they need and deserve.

Towards Universal Health Coverage:

California Policy Options for Improving Individual Market Affordability and Enrollment

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Executive Summary

California has made historic progress under the Affordable Care Act (ACA) by cutting the uninsurance rate by more than half, resulting in approximately 93% of Californians now having health insurance. Health coverage affordability has improved for many, especially for those who became newly eligible for Medi-Cal or subsidized coverage through Covered California. For those who purchase coverage individually, the ACA has not only provided financial assistance to help eligible low- and middle-income individuals afford premiums and out-of-pocket costs, but has also provided crucial protections to individual market enrollees of all income levels. These protections include requiring insurers to offer insurance to all without charging higher premiums for those with pre-existing conditions, setting a floor for the share of costs that insurers cover, and establishing a ceiling on enrollees' out-of-pocket costs.

However, many Californians continue to face difficulties in affording premium and out-of-pocket costs. Affordability challenges can deter enrollment in and retention of coverage, cause financial difficulties for those struggling to pay premiums or medical bills, and decrease access to care. In this report, we focus specifically on the affordability challenges for the 2.3 million Californians who purchase private insurance individually and for many of the 1.2 million Californians who are eligible to purchase insurance through Covered California but remain uninsured.

We also explore state policy options for improving affordability of individual market premiums and out-of-pocket costs, and consequently helping move the state closer to universal coverage. This set of policy options was developed based on analysis of the available evidence on affordability concerns in California's individual market, as well as on a review of policies used by other states and localities to improve affordability. The options include:

- Adding state premium subsidies to the federal ACA subsidies to further reduce enrollees' premium contributions;
- Providing financial assistance to further reduce deductibles, co-payments, and other cost sharing for some Californians already receiving ACA cost sharing subsidies, and making more Californians eligible for this assistance;
- Capping the percentage of income spent on premiums by Californians who earn too much for ACA premium assistance by providing state-funded premium subsidies;
- Establishing a state reinsurance program to lower premiums for unsubsidized individual market enrollees; and
- Extending eligibility for state-funded premium and cost sharing subsidies to children and spouses affected by the ACA "family glitch."

These policy options assume Covered California and its partners will continue the state's strong outreach and marketing efforts to increase awareness of the financial assistance available.

State policies to improve individual market affordability can help counteract the loss of insurance projected to occur beginning in 2019 as a result of the elimination of the ACA individual mandate penalty. Survey data indicates that subsidies are an even bigger driver of enrollment than penalties. Improved affordability would help to ensure strong enrollment by a broad population and help to minimize the growth in premiums that could occur if healthier people leave the market. Combining improve affordability with a state-level insurance requirement would further secure the stability of the insurance market.

These policy options could help Californians afford health coverage in the near-term in our existing health care system with its current cost structure. High and rapidly growing health care costs are a major driver of the affordability challenges facing Americans with all types of health coverage. Policies to reign in underlying medical costs, which are not the focus of this report, are also necessary.

* * *

The evidence on the extent and nature of Californians' affordability concerns underscores the need for state policy interventions. Based on our examination of survey data, analysis of Covered California enrollment data and premiums, and synthesis of the existing research on affordability, we found that:

Affordability concerns are a barrier to individual market enrollment and renewal of coverage

- Affordability is the top reason that those eligible for Covered California lack insurance, regardless of income level.
- Californians who were potentially eligible for ACA premium subsidies based on income were more likely to be uninsured and more likely to have paid the federal tax penalty for lacking insurance in 2015, compared to those with higher income.
- Many Californians enrolled in the individual market report difficulties affording premiums and out-of-pocket costs.

High out-of-pocket costs can be a barrier to care, cause financial problems, and potentially dissuade enrollment

- Even with ACA subsidies, combined premium and out-of-pocket spending in the individual market can exceed 10% of income for some Californians with median out-of-pocket spending, and can reach 20% to 30% of income for some with very high medical use.
- More than one-third of Covered California enrollees with incomes between $24,120 and $48,240 for a single individual are enrolled in Bronze plans with a $6,300 individual annual deductible.

- The vast majority of Americans eligible for ACA premium subsidies based on income do not have liquid assets sufficient to cover a $6,300 deductible.
- Research has shown that high out-of-pocket costs can be a barrier to care and cause financial problems. Out-of-pocket costs are a major consideration in individuals' enrollment decisions.

The high cost of living in California and broader financial insecurity may exacerbate health insurance affordability concerns for some individuals

- ACA premium subsidies are based on the Federal Poverty Level, but the higher cost of living in California may squeeze some families' ability to afford healthcare.
- The upper income limit for premium subsidies under the ACA—four times the Federal Poverty Level—is equivalent to five times that level in California and six times that level in San Francisco.
- In all California counties, some individuals face an affordability gap in that they earn too much to qualify for Medi-Cal with no premiums or cost sharing, but do not earn enough to afford Covered California insurance even with subsidies, based on a household budget analysis.

Some citizens and lawfully present immigrants lack access to coverage that meets ACA affordability standards

- Affordability can be a challenge for people who earn too much to be eligible for premium subsidies, especially for those age 50 or older and those who have family income between $48,240 and $72,360 for a single individual. In every region of California, premiums for some of these individuals exceed the standard of affordability under the ACA individual mandate.
- Some Californians have access to neither affordable employer-sponsored insurance nor affordable individual market coverage. Under the ACA "family glitch," they are ineligible for subsidies through Covered California because they have an offer of employer-sponsored coverage through a parent or spouse, but that employer-sponsored dependent coverage is unaffordable.

Concerns about affording health insurance and care are common among Americans with all types of health insurance, but affordability challenges are especially prevalent among those who rely on the individual insurance market. California's high cost of living makes affording health care even more challenging for some. California has substantially narrowed its coverage gaps as a result of the state's effective implementation of the ACA. Building on that momentum, California policymakers could take additional steps to make individual market insurance more affordable in the near-term, moving the state closer to universal and affordable coverage.

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Background

California has made substantial gains in individual market enrollment and affordability under ACA

The percentage of Californians with health insurance has grown dramatically under the Affordable Care Act (ACA), from 83% in 2013 to 93% in 2016, the largest increase in coverage of any state.[1] These coverage gains were due in part to substantial growth in the state's individual market, in which individuals without job-based coverage purchase private insurance either through the state's health insurance Marketplace, called Covered California, or directly from an insurer.

Enrollment in the individual market grew from 1.5 million in 2013 to 2.3 million in 2016[2] due to several provisions in the ACA as well as California's extensive and effective implementation of the law. Particularly important were:

- Federal premium subsidies and financial assistance to reduce deductibles, co-payments, and other cost sharing, depending on income;
- The requirement that insurers cannot deny coverage or charge higher premiums for applicants with pre-existing conditions;
- Improved ability of consumers to shop for coverage and compare plans owing to the creation of the state marketplace and the standardization of plan benefit designs;
- Strong state-level investment in outreach, advertising, and enrollment assistance to help individuals understand their options and apply for coverage; and
- The requirement that individuals have insurance or pay a penalty.

Improved affordability is likely one of the biggest factors explaining the net enrollment gain of 800,000 Californians in the individual market. A survey conducted for Covered California found that 70% of respondents receiving premium subsidies in 2015 said that the availability of subsidies was a very or extremely important factor in their decision to purchase a plan. In fact, subsidies were a bigger driver of enrollment than the ACA individual mandate penalty, which was cited by 44% of subsidized respondents as a very or extremely important motivator.[3]

In addition to providing financial assistance with premiums and out-of-pocket costs, the ACA also established new consumer protections that help to limit out-of-pocket liability for individuals of all income levels:

- The ACA set a floor for the share of medical costs that individual market plans must cover —60% of costs across an average population.[4] Before the ACA floor was implemented, half of Americans with individual market coverage were in plans that paid less than 60% of costs.[5] The higher share of costs paid by individual market insurers in California under the ACA[6] improves financial protection for families and reduces barriers to care due to cost.
- The ACA set a ceiling on out-of-pocket costs paid by households ($7,350 for individuals and $14,700 for families in 2018).[7] While many of the households that incur high

healthcare expenses likely struggle to pay out-of-pocket costs even with these maximum limits, no limits existed before passage of the ACA, and some families with individual market coverage spent as much as $27,000 on out-of-pocket costs in 2010.[8]

- The ACA banned insurers from limiting the amount of medical benefits covered for an enrollee over a lifetime or during any given year.

As a result of the financial assistance and consumer protections established by the ACA, enrollees reported improved affordability. A longitudinal study by the Kaiser Family Foundation followed a panel of Californians who were uninsured prior to the first ACA open enrollment period. Respondents who had gained private insurance or Medi-Cal by the time of the second ACA open enrollment period in 2015 were far less likely to report difficulty for their family in affording health insurance (49%) than they had been prior to the ACA (86%). These respondents were about half as likely report problems paying medical bills (23%) as they had been prior to the ACA (45%), and more than half (53%) reported that having health insurance made them feel more financially secure.[9]

Additionally, the share of Californians in the individual market who reported spending more than 10% of their family income on premiums and out-of-pocket costs fell from 43% in 2013 to 34% in 2015, according to analysis of Current Population Survey data by the State Health Access Data Assistance Center.[10]

Affordability is the main reason that those eligible for Covered California remain uninsured

However, there are at least 1.2 million Californians who remain uninsured despite being eligible to purchase insurance through Covered California, with or without subsidies (Exhibit 2, page 9). This is the second largest group of uninsured residents in the state, after undocumented residents who are excluded from the ACA and Medicaid under federal law.[11]

In 2014 through 2016, cost was identified as the top reason for lacking insurance among uninsured citizens in California, regardless of income level, according to the California Health Interview Survey. The vast majority of citizens who tried to purchase insurance through Covered California but ultimately remained uninsured said they found it difficult to find an affordable plan.[12]

Affordability is more of a challenge for those with individual market coverage than for most other insurance types

Among California citizens with individual market coverage, nearly half (45%) reported finding it very or somewhat difficult to find an affordable plan through Covered California in 2014 through 2016.[13]

Individuals with all types of health insurance can face difficulties affording insurance and care, but the challenges are greatest for those with individual market coverage, and, by some measures, Medicare. A national study by the State Health Access Data Assistance Center found that in 2015, 39% of those with individual market insurance spent in excess of 10% of family income on premiums and out-of-pocket costs, compared to 26% of those with Medicare, 20% of those with employer-sponsored insurance, and 16% of those with Medicaid.[14] National analysis by the

In discussing affordability concerns and potential state policy solutions, this report references various levels of income as they relate to the Federal Poverty Level (FPL). For reference, Exhibit 1 shows the FPL thresholds most frequently discussed in this report for the most common household sizes.

:

Annual Income as a Percentage of the Federal Poverty Level (FPL), 2017

FPL	Household size			
	1	2	3	4
139%	$ 16,760	$ 22,570	$ 28,380	$ 34,190
150%	$ 18,090	$ 24,360	$ 30,630	$ 36,900
200%	$ 24,120	$ 32,480	$ 40,840	$ 49,200
250%	$ 30,150	$ 40,600	$ 51,050	$ 61,500
267%	$ 32,200	$ 43,360	$ 54,520	$ 65,680
300%	$ 36,180	$ 48,720	$ 61,260	$ 73,800
400%	$ 48,240	$ 64,960	$ 81,680	$ 98,400
500%	$ 60,300	$ 81,200	$ 102,100	$ 123,000
600%	$ 72,360	$ 97,440	$ 122,520	$ 147,600

Notes: Under the ACA, 2017 FPLs are used to determine eligibility for premium and cost sharing subsidies in plan year 2018. Income amounts in this exhibit are rounded to the nearest $10.

Commonwealth Fund found that the rate of "underinsurance," the term for the situation in which insured individuals face out-of-pocket costs that are high relative to income, was higher for those with coverage in the individual market (44%) and for the non-elderly disabled enrolled in Medicare (47%) than for those with employer-sponsored insurance (24%) and Medicaid (26%) in 2016.[15]

Ensuring affordable individual market coverage is one potential state response to the elimination of the ACA individual mandate penalty

The enrollment and uninsurance estimates in this report reflect current policy, but trends could change starting in 2019, when the ACA penalty for lacking insurance will be eliminated. Under this federal policy change, the number of uninsured Americans is projected to grow and the number enrolled in individual market coverage, Medicaid, and employer-sponsored insurance is projected to decline. Individual market premiums are expected to increase as healthier people become less likely to purchase insurance, and the resulting premium increases would cause even more people to not purchase insurance.[16] The amount by which individual market enrollment will decline in California is uncertain. Some estimates indicate that several hundred thousand fewer Californians could enroll in the individual market in the initial year of the penalty elimination.[17] Most of the enrollment reduction is likely to occur among subsidized enrollees.[18] The coverage losses are expected to grow over the first few years without a penalty, then level off, according to Congressional Budget Office estimates.[19]

California could take steps to mitigate the coverage losses by enacting its own individual mandate, continuing and expanding its strong outreach efforts, and adopting policies that improve affordability, like those described in this report. Implementing all of these policies in combination

Defining "affordable"

Affordable health insurance is difficult to define using a one-size-fits-all standard. The amount that is "affordable" to an individual or family for the purchase and use health insurance depends on a constellation of factors including income, age, family size, medical use, cost of living, and the family's budget for other household expenses or outstanding debts. However, several different approaches have been developed and can be useful in evaluating health insurance affordability. Affordability can be evaluated using a household budget approach—at each level of income, are sufficient funds available to pay for healthcare after accounting for spending on other essentials like housing, food, transportation, and childcare? Another approach is to examine how much households currently spend on health care as an indicator of the level of spending that is feasible. Finally, benchmarks from public programs, such as Medicaid premium and cost sharing limits, could be used.

Each of these approaches to measuring affordability has advantages and limitations.[20] This report does not rely on a single standard of affordability, but instead presents evidence that reveals the concerns and challenges with affordability in the individual market in California, and outlines state-level policy options for improving affordability of coverage for those at all income levels without necessarily meeting one standard definition of affordability.

The ACA set various standards of affordability; these provide useful context for understanding the progress made under the law toward making affordable health coverage available, as well as the gaps that remain:

- Premium affordability standards are implied for individuals who are eligible for subsidies to purchase insurance through the Marketplaces. Enrollee premium contributions vary on a sliding scale from 3.38% of household income at 139% of the Federal Poverty Level to 9.56% of household income at 300% to 400% of the FPL.[21]
- Out-of-pocket affordability standards are implied by the level of cost sharing assistance for those under 250% FPL, which is based on a sliding scale. For low-income enrollees, insurers must cover between 73% and 94% of medical costs, on average, depending on the exact income level. When insurers pay a higher share of costs, families pay less in deductibles, copayments and other cost sharing.
- Individuals are exempt from the ACA individual mandate if they lack access to affordable coverage, defined as costing less than 8.16% of household income in 2018.
- Employer-sponsored insurance is considered affordable if a household's premium contributions to cover only the worker cost less than 9.56% of household income and if the insurer covers at least 60% of medical costs, on average. (See page 17 for further details.)

Affordability remains a concern for many Californians with access to individual market insurance that meets these ACA standards of affordability, but understanding these standards is important for understanding the affordability gaps discussed in this report.

would have the strongest impact in counteracting the loss of individual market coverage and increase in individual market premiums expected to occur without a federal mandate.

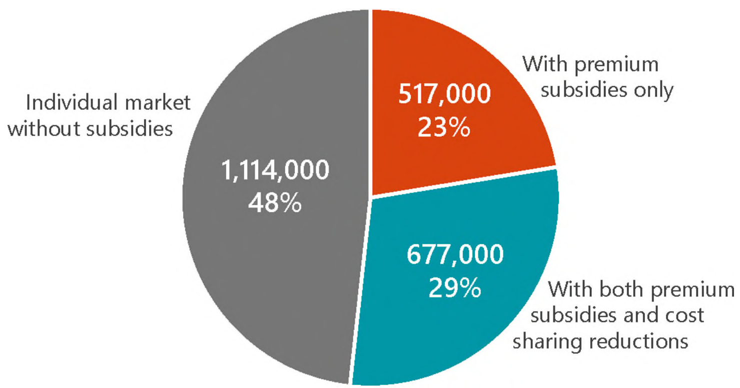
Affordability concerns among Californians eligible for or enrolled in the individual market

When premiums are affordable, individuals are more likely to enroll in and retain coverage over time. Younger individuals' and low-income individuals' decisions to enroll in Covered California are especially sensitive to the price of health insurance.[22] When health insurance is affordable, a broader population enrolls, supporting a balanced risk mix, a more stable market, and lower premiums.

This section summarizes the existing evidence on the extent and nature of affordability concerns among the 2.3 million Californians already enrolled in the individual market (Exhibit 2) and the approximately 1.2 million uninsured Californians who are likely eligible to enroll in Covered California (Exhibit 3).[23]

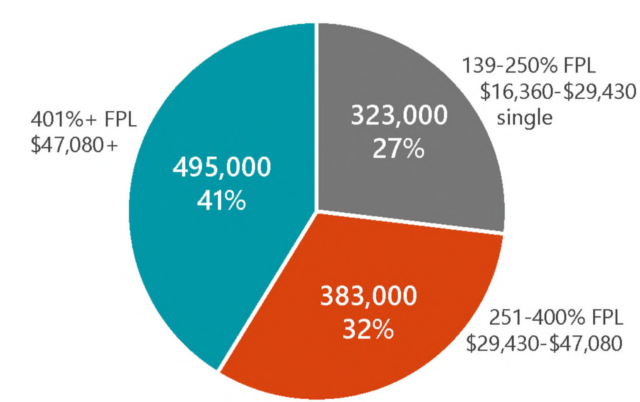
We consider first the affordability concerns of Californians with household incomes at or below 400% FPL, the upper eligibility threshold for premium subsidies under the ACA. Then, the affordability concerns of Californians not eligible for subsidies based on income are discussed. This section will last explore the health insurance affordability concerns of Californians caught in the ACA "family glitch," in which they are ineligible for subsidies through Covered California because they have an offer of employer-sponsored family coverage through a parent or spouse, but that employer-sponsored dependent coverage is unaffordable.

Exhibit 2:
Individual market enrollment, California, 2016



Source: Katherine Wilson, California Health Insurers Hold on to Previous ACA Gains, California Health Care Foundation Blog, July 13, 2017, https://www.chcf.org/blog/california-health-insurers-hold-on-to-previous-aca-gains/. Covered California, Active Member Profile, June 2016, http://hbex.coveredca.com/data-research/library/active-member-profiles/12-13-17/CC_Membership_Profile_2016_06.xlsx

Exhibit 3:
Uninsured citizens ages 0-64 with household income above Medi-Cal eligibility threshold, California, 2016



Note: Due to data limitations, this chart does not include lawfully present immigrants, though they are also eligible to enroll in Covered California and receive subsidies if eligible based on income.[24] This chart excludes uninsured citizen adults ages 19-64 in households with income below 139% FPL and uninsured citizen children ages 0-18 in households with income below 267% FPL because they are eligible for Medi-Cal.

Source: 2016 California Health Interview Survey

Affordability concerns for Californians currently eligible for subsidies

Approximately half of individual market enrollees in California, or nearly 1.2 million, receive ACA subsidies (Exhibit 2, page 9). Of those who are eligible for Covered California but remain uninsured,[25] six out of ten, or more than 700,000, may be eligible for subsidies based on income. Approximately half of this uninsured subsidy-eligible group may be eligible for premium subsidies and the other half may be eligible for both premium and cost sharing subsidies (Exhibit 3, page 9). Not every individual with income at or below 400% FPL is necessarily eligible for subsidies: they may have an offer of employer-sponsored insurance that disqualifies them from subsidies, or they may have an unsubsidized premium that falls below the maximum required premium contribution under
the ACA.

Premium affordability concerns remain in spite of ACA subsidies

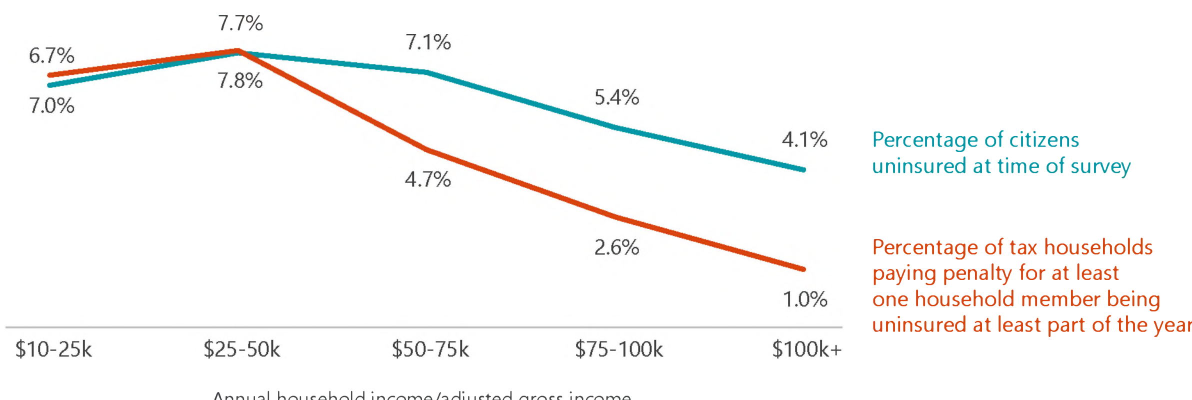
Under the ACA, citizens and lawfully present immigrants are eligible for premium subsidies if their household income is at or below 400% FPL, which is $48,240 annually for a single individual or $98,400 for a family of four. Premium subsidies are calculated on a sliding scale such that households pay between 2.01% and 9.56% of income (further details are shown in Appendix Exhibit A1). For individuals who receive premium subsidies, in 2017 the federal government paid on average 71% of premium costs, reducing average annual premium contributions per subsidized California household by over $6,000.[26] In 2018, monthly premium payments for Covered California enrollees receiving premium subsidies are between $47 and $384 for a single individual, depending on income, and up to $784 for a family of four.[27] By contrast, Californians with employer-sponsored insurance paid on average $85 per month for single coverage and $410 per month for family coverage in 2016.[28]

In 2015, Californians with incomes in the subsidy-eligible range were more likely to be uninsured and more likely to have paid the tax penalty for lacking insurance than those with higher income (Exhibit 4, page 11).[29] As a result, uninsured households in the subsidy-eligible income range comprised at least three-quarters of Californian households paying the tax penalty for not having insurance in 2015.[30] The higher rates at which Californians in this income range are uninsured and paying the tax penalty, coupled with survey data showing that affordability is the top reason for uninsurance among citizens at all income levels, indicates that significant affordability challenges remain for Californians with incomes in the subsidy-eligible range.

Non-elderly adults potentially eligible for Covered California subsidies are more likely to remain unenrolled than adults eligible for Medi-Cal. More than 1.1 million adults ages 19 to 64 with incomes at or below 400% FPL were enrolled in Covered California with subsidies in 2016,[31] compared to 671,000 uninsured working age citizens with incomes between 139% and 400% FPL,[32] some of whom may not have been eligible for subsidies due to an offer of employer-sponsored insurance.[33] By contrast, nearly 5.7 million adults ages 21 to 64 were enrolled in comprehensive Medi-Cal benefits,[34] compared to 379,000 uninsured working age citizens with incomes below 139% FPL in 2016.[35] Given that Medi-Cal has no premiums or cost sharing for adults, the higher level of enrollment in Medi-Cal is another indicator that affordability is a barrier to enrollment for some who lack insurance and are eligible for Covered California with subsidies.

Exhibit 4:

Uninsurance rate among citizens and percentage of households paying penalty for lacking insurance, by household income, California, 2015



Note: $50,000 in annual income is equivalent to approximately 410% FPL for a single individual and approximately 200% FPL for a family of four. $75,000 in annual income is equivalent to approximately 620% FPL for a single individual and approximately 300% FPL for a family of four. Graph excludes households with income below $10,000 because they are likely eligible for Medi-Cal, as well as often exempt from the individual mandate due to their income being below the tax filing threshold.

Sources: UC Berkeley analysis of American Community Survey (ACS) 2015 data; U.S. Internal Revenue Service (IRS), California Individual Income Tax Returns: Selected Income and Tax Items by State, County, and Size of Adjusted Gross Income, Tax Year 2015.

One survey found that affordability concerns are common even among Californians enrolled in the individual market. At least four out of ten surveyed non-elderly adults enrolled in the California individual market had some or a lot of difficulty paying their premiums in 2014, and a similar share had difficulty affording out-of-pocket costs. The prevalence of affordability concerns was relatively similar between individuals with incomes below 250% FPL and those with incomes between 250% and 400% FPL. The study found that premium affordability difficulties were worse for those who purchased insurance through the off-Exchange market where federal subsidies are not available.[36]

Premium affordability may be especially concerning to the lowest-income Covered California enrollees. Approximately 25,000 lawfully present immigrants enrolled in Covered California have incomes below 139% FPL.[37, 38] Additionally, some Medi-Cal enrollees experiencing an increase in income may face challenges transitioning from zero premiums in Medi-Cal to monthly premium contributions of at least $46 in Covered California, given the low income of those who earn a little too much to qualify for Medi-Cal (approximately $1,400 per month for a single individual or $2,850 for a family of four).

A number of studies have shown how premiums can hamper enrollment and retention of coverage for low-income individuals.[39] One recent study found that “near poor” non-elderly adults who were eligible for Marketplace coverage because they lived in a state that did not expand Medicaid were more likely to be uninsured than their counterparts in expansion states.[40] Medicaid generally requires no premiums while single Marketplace enrollees with incomes between 100% and 138% FPL pay between $20 and $46 on monthly premiums after subsidies. In many states, including California, Medicaid requires no cost sharing.

High out-of-pocket costs can hinder access to care, cause financial problems, and potentially deter enrollment

Research has also shown that high deductibles and other cost sharing can create barriers to care. Insured Americans with deductibles and out-of-pocket costs that meet the Commonwealth Fund's standard for "underinsurance" are more likely to: forgo seeing a doctor when they have a medical problem; leave a prescription unfilled, skip a medical test, and decline doctor-recommended treatment or follow-up; and forgo seeing a specialist despite a doctor's recommendation.[41] According to the California Health Interview Survey, in 2014 through 2016, two-thirds (67%) of non-elderly Californians in the individual market reported delaying care due to cost, a lower rate than among the uninsured (81%) but a higher rate than among those with employer-sponsored insurance (35%). For the subset of Californians with incomes at or below 400% FPL, the relative rates of delaying access to care due to cost by coverage type were similar.[42]

Underinsurance does not just impede access to care; it also increases the prevalence of difficulties paying medical bills and the likelihood of related financial problems such as taking on credit card debt or using up savings.[43]

Out-of-pocket costs that are high relative to income "will likely dissuade many individuals from enrolling or re-enrolling" in coverage, according to Linda Blumberg and John Holahan of the Urban Institute.[44] According to one national survey that asked uninsured individuals who tried to purchase insurance why they decided not to enroll, out-of-pocket costs were the second most important factor named after premiums. As a decision-making consideration, out-of-pocket costs ranked higher in importance than covered benefits, the individual mandate penalty, and the availability of doctors in the plan network.[45]

Under the ACA, eligible individuals with incomes at or below 250% FPL ($30,150 for a single individual or $61,500 for a family of four) are offered cost sharing reductions, which provide federal financial assistance to reduce deductibles, co-payments, and other costs, on top of premium subsidies. Cost sharing subsidies had an average value of nearly $1,500 annually per subsidized California household in 2016.[46] Eligible Californians continue to receive this financial assistance in spite of President Trump's decision in October 2017 to discontinue federal payments to insurers for cost sharing reductions[47] because insurers are still legally required to provide cost sharing reductions and California insurers have raised the premiums for certain Silver plans to reflect the reduction in federal payments.

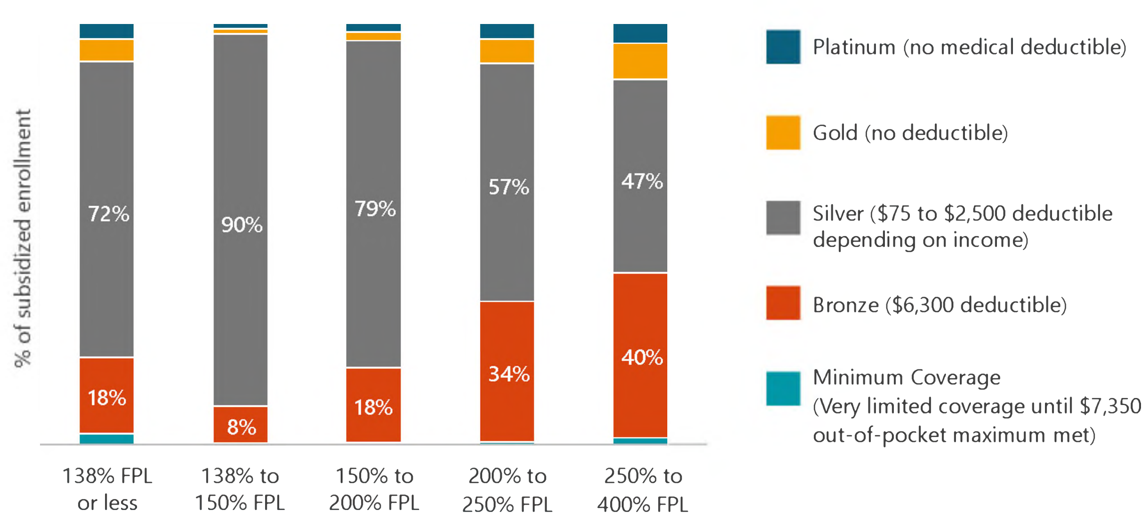
Cost sharing reductions have greatly improved out-of-pocket affordability for many Californians. Those in the individual market have also benefited from the state's decision to standardize benefit designs for plans offered through Covered California, and the subsequent efforts by Covered California, in partnership with stakeholders, to design benefits to maximize value and access to care. In Silver plans offered through Covered California, doctor visits, emergency room care, lab tests, x-rays, and imaging are not subject to medical deductibles. The annual medical deductible of $2,500 in the Silver plan only applies to hospital care. (See Appendix Exhibit A2 for further details on Covered California standardized benefit designs, including the deductibles, co-payments, and other cost sharing under each plan type.)

Nonetheless, one-quarter of Covered California enrollees with incomes at or below 400% FPL were enrolled in Bronze plans in 2017, which offer the least financial protection of the plans offered through Covered California. The rate of Bronze enrollment was even higher (37%) among Covered California enrollees with incomes between 200% and 400% FPL.[48] These rates of Bronze enrollment for low- and middle-income Covered California enrollees are significantly higher than those for Californians with employer-sponsored insurance: 11% of Californians with insurance through a small employer and only 1% of those with insurance through a large employer had coverage equivalent to or somewhat better than a Bronze plan in 2016.[49] Individuals who have difficulty affording premiums for Silver plans may opt to enroll in a Bronze plan because of the lower premiums. Covered California estimated that while 60% of subsidized enrollees could purchase a Silver plan for less than $100 per month in plan year 2018, nearly three-quarters (74%) could purchase a Bronze plan for less than $10 a month.[50]

While Bronze premiums are lower than Silver premiums, individuals who enroll in Bronze plans are at significant risk of out-of-pocket costs due to the plans' $7,000 out-of-pocket maximum and $6,300 individual medical deductible, which applies to all services except the first three doctor visits. Individuals eligible for cost sharing reductions only receive that financial assistance if they enroll in a Silver plan, and the level of financial assistance provided is most substantial for people with incomes below 200% FPL (Appendix Exhibit A2). This may be one explanation for lower Bronze enrollment among those in the lower income range compared to enrollment among those with incomes between 200% and 400% FPL (Exhibit 5).

Although some middle-income individuals who enroll in Bronze plans may feel confident that they can afford the deductible and out-of-pocket limit if they were to incur high health care

Exhibit 5:
Covered California enrollment distribution by metal tier and income level under 400% FPL, June 2017



Source: Covered California Active Member Profile, June 2017

costs, this sentiment is likely shared by only a minority of enrollees. Research by the Kaiser Family Foundation found that American non-elderly households with incomes between 150% and 400% FPL had median liquid assets of $1,902 for single-person households and $2,811 for multi-person households in 2016. These numbers reflect the potential for severe affordability challenges for those enrolled in Bronze plans, given their deductible of $6,300 for all care other than the first three doctor visits. Liquid assets sufficient to cover a Bronze deductible were found to be available to fewer than one out of three American households with incomes between 150% and 400% FPL. The affordability risk associated with the Bronze deductible was even higher for U.S. households with incomes at or below 150% FPL, which had median liquid assets of approximately $500 in 2016. Only approximately one in ten of these low-income households had liquid assets sufficient to cover a Bronze deductible.[51]

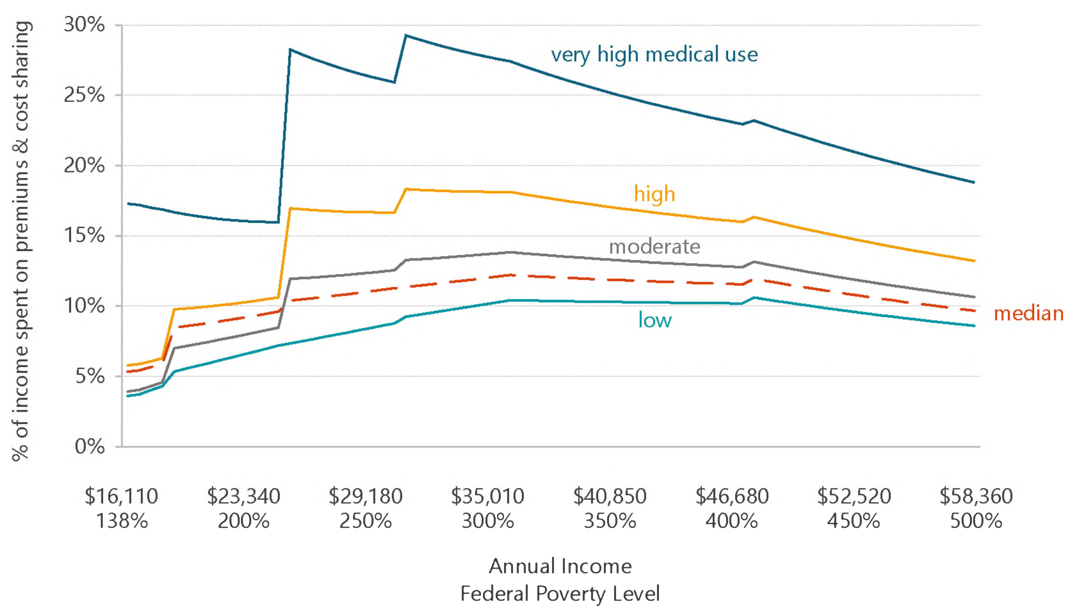
Combined premium and out-of-pocket spending can reach 10% to 30% of income for some Californians

The affordability problem is compounded when premium and out-of-pocket costs are considered in combination. As shown in Exhibit 6, a single 40-year old in San Francisco with median health care use and with an income level between approximately 200% and 485% FPL would have spent more than 10% of income on Silver plan premiums and out-of-pocket costs in 2015 after subsidies. San Franciscans with similar demographics but very high medical use would have spent more than 20% percent of annual income at income levels between approximately 200% and 470% FPL, with some individuals spending nearly 30% of their income on health insurance and care.[52]

Exhibit 6:

Total expected health spending for single 40-year old, San Francisco, 2015

Premium & out-of-pocket spending after subsidies for second lowest cost Silver plan through Covered California



Source: UC Berkeley analysis excerpted from Health Management Associates, Addressing Affordability of Health Insurance in San Francisco, Technical Report Presented to San Francisco Department of Public Health, June 2015, https://www.sfdph.org/dph/files/uhc/HMA-FinalReport-SFDPH-PublicBenefitProgram-June2015.pdf.

While the range of health spending is relatively similar across all regions in the state (more than 10% of income for some with median health use and as much as 20% to 30% of income for some with high medical use), the specific spending levels at each income level may vary slightly by region. This is especially the case for individuals who earn too much to receive premium subsidies and who therefore are not shielded from regional premium differences.[53]

High cost of living and general financial insecurity exacerbate affordability concerns

Concerns about health insurance affordability do not necessarily stem solely from premium and out-of-pocket costs. For many, these concerns may also reflect broader financial insecurity related to living expenses and other factors. The high cost of living in certain regions of California undoubtedly leave little room in some families' budgets for health insurance.

ACA premium subsidies are set on a sliding scale based on the Federal Poverty Level, but the cost of living in much of California is higher than in most other parts of the U.S., primarily due to high housing costs. Using the California Poverty Measure, an unofficial measure that accounts for cost of living and a range of family needs and resources, the 400% FPL upper limit for eligibility for ACA premium subsidies is equivalent to approximately 500% FPL statewide in California, and up to 600% FPL in a high-cost region like San Francisco.[54]

Previous analysis by the UC Berkeley Labor Center estimated the minimum household income needed to pay Covered California premiums for a Silver plan and out-of-pocket costs after federal subsidies, while also meeting other basic needs. The analysis found that in every California county there is an affordability gap for some residents who earn too much to qualify for zero-premium Medi-Cal, but not enough to be able to afford Covered California insurance and care while also covering their other basic needs.

The income level at which health care costs could be considered affordable varied by county based on cost of living. A typical family of four in the highest-cost region, Marin County, might be able to afford premiums and out-of-pocket costs with earnings of $110,300, or 455% FPL, in 2016. This is compared to a typical family of four in the California county with the lowest cost of living, Modoc, where $54,600 in annual income, or 225% FPL, might be sufficient for a family of four to afford healthcare costs through Covered California. These estimates were conservative in that they assumed low medical use by all household members and a minimal household budget for other expenses, based in part on the California Budget & Policy Center's "Making Ends Meet" household budget estimates by county. (An interactive map with estimates for all 58 California counties and further information about this analysis is available on the California Health Care Foundation website.[55])

More than one-third (36%) of California non-elderly adults newly insured through Covered California in 2014 reported feeling financially insecure in general, according to a survey conducted by the Kaiser Family Foundation. Four out of ten (41%) reported that it was somewhat or very difficult to pay for necessities, two-thirds (66%) reported that it was somewhat or very difficult to save money, and more than half (54%) reported that it was somewhat or very difficult to pay off debt.[56] A national survey of uninsured adults in 2015 found that more than half (58%) had $100 or less left over each month after paying bills, and more than half (56%) had less than $100 in

CASE STUDY:

High Housing Costs in Certain Regions Squeeze Household Budgets, Exacerbating Heath Insurance Affordability

A single 40-year old man with income of $3,015 per month (300% FPL) living in San Mateo, California, where the median rent for a studio apartment is over $2,000 a month[58] would have approximately $1,000 left each month after paying rent to cover food, transportation, utilities, taxes, other expenses, and health care. In 2018, he would face the following health coverage choices if he were not offered affordable insurance through his job.

- He could pay $280 per month in premiums, after subsidies, for the lowest cost Silver plan, leaving a little over $700 per month after housing for all other expenses including taxes. This might cause difficulty affording other basic needs.
- He could pay $95 per month, after subsidies, for the lowest cost Bronze plan, which may be more manageable than Silver premiums but would put him at greater risk of high out-of-pocket costs. He has $2,000 in savings, which would only partially cover the $6,300 deductible if he incurred high medical expenses. If he were to select this plan, he might forgo needed care due to cost.
- He could remain uninsured and pay approximately $58 per month in penalties for the 2018 tax year.[59] In 2019, he would not owe a penalty for lacking insurance unless the state enacts its own mandate.

The evidence shows that Californians in situations like this are making all three of these choices, depending on their individual circumstances.

savings.[57] This broader financial insecurity may make it difficult for some Californians to afford health insurance even with subsidies.

Affordability concerns for Californians not eligible for subsidies based on income

Affordability is also a challenge for people who earn too much to qualify for premium subsidies: more than $48,240 for a single individual or $98,400 for a family of four. Covered California estimates that nationally the median household income of off-Marketplace individual market enrollees was approximately $75,000 in 2016.[60] While the typical unsubsidized Marketplace enrollee is not poor, they are also generally not high-income individuals.

The ACA exempts uninsured individuals from paying a penalty if the lowest cost Bronze plan available to them costs more than 8.16% of income, but no financial assistance is available to individuals with incomes above 400% FPL to make insurance more affordable for them. Many of the approximately 1 million California individual market enrollees in households earning more than 400% FPL[61] face Bronze premiums that cost more than 8.16% of income. Some individuals face premiums for a Bronze plan that are equal to more than 20% of their income.[62]

Affordability challenges for those seeking unsubsidized coverage are most likely to affect those age 50 or older.[63] The ACA limited the allowable variation in premiums based on age so that older individuals pay no more than three times the amount younger individuals pay—but this still results in older people facing significantly higher premiums than younger people. Even so, Bronze plans can fail to meet the individual mandate affordability exemption standard (8.16% of income) for single individuals as young as age 36 in San Mateo County, the pricing region with the highest 2018 Bronze premium. In the lowest premium region of California, Los Angeles, only older single individuals—those at least 51 years old— may be subject to Bronze premiums that cost more than 8.16% of income (Appendix Exhibit A3).

All other things equal, premiums constitute a higher share of income for married couples than for single individuals of the same age; this is because unsubsidized premiums for a couple are double those for a single individual, while the Federal Poverty Level for a couple is only 35% higher than for a single individual. As shown in Appendix Exhibit A4, in some parts of Northern California, couples as young as age 18 would pay Bronze premiums that fail to meet the individual mandate affordability standard. As a percentage of income, unsubsidized Bronze premium spending for families with children (not shown) generally falls in between spending by single individuals and married couples without children.

Among unsubsidized enrollees, individuals with incomes between 400% and 600% FPL (between $48,240 and $72,360 for a single individual) are the most likely to pay a higher percentage of income on premiums,[64] but even higher-income individuals sometimes face premiums that fail to meet the individual mandate affordability standard. Bronze premiums exceed the individual mandate affordability exemption standard for single 64-year olds with incomes up to 652% FPL in Los Angeles (Region 15) and up to 982% FPL in San Mateo (Appendix Exhibit A3). The problem of high premium spending relative to income extends higher up the income scale for married 64-year old couples: 968% FPL in Los Angeles (Region 15) and 1,458% FPL in San Mateo (Appendix Exhibit A4).

Appendix Exhibits A3 and A4 show the results of our analysis on the full range of ages and income levels for which Bronze premiums may be unaffordable for individuals with incomes above 400% FPL. Our analysis found that while it is possible for some Californians as young as 18 or with incomes well above 1000% FPL to face unaffordable Bronze premiums, it is older and middle-income Californians who are the most likely to face these affordability challenges.

Californians lacking access to affordable employer-sponsored and individual market coverage due to the “family glitch”

In order to curb “crowd out,” or the reduction of enrollment in employer-sponsored insurance as a result of the expansion of publicly-subsidized coverage options, the ACA requires large employers to offer coverage to full-time employees and their dependent children or pay a penalty. No penalty is owed for not offering coverage to spouses. Large employers that offer unaffordable coverage to full-time employees may owe a penalty, but the ACA imposes no penalty for offering unaffordable coverage to dependent children and spouses.[65]

To maintain the primary role of employer-sponsored insurance in the U.S. health coverage system, the ACA also prohibits individuals with an offer of affordable employer-sponsored insurance from receiving subsidies to purchase coverage through the Marketplaces. Because of this provision,

CASE STUDY:

Older Individuals Ineligible for Subsidies based on Income

A married couple, both age 55 and self-employed, living in San Mateo, California, and earning $73,080 annually (450% FPL) would pay $1,200 per month total for the lowest cost Bronze plan offered in that region. Premium spending would equal nearly 20% of the couple’s income, before any out-of-pocket spending on health care costs under the plan’s $6,300 deductible.

CASE STUDY:
"Family Glitch" Affected Households

A married California couple with two children earns $66,420 (270% FPL), a little too much for the children to be eligible for Medi-Cal. One spouse works full time and the other spouse is the primary caregiver for the family's young kids. The worker's employer offers health insurance requiring an employee premium contribution of $140 per month for worker-only coverage and $810 per month for coverage for the whole family. This family would pay 2.5% of income to enroll the worker and 14.7% of income to enroll the entire family in employer-sponsored insurance. The worker's spouse and children are not eligible for premium subsidies through Covered California because the worker-only premiums are affordable under the ACA definition for the purposes of determining premium subsidy eligibility. Some families in this scenario may struggle to pay the employer-sponsored premiums for the whole family, while other families may be unable to do so, leaving some family members uninsured.

In a second example, a married couple without children earns $24,360 (150% FPL). One spouse is offered employer-sponsored insurance requiring an employee premium contribution of $140 per month for worker-only coverage and $400 per month for the couple. This household would pay 6.9% of income to enroll the worker in employer-sponsored insurance and 19.7% of income to enroll the couple.

workers with an offer of insurance coverage that costs less than 9.56% of household income cannot receive subsidies through the Marketplaces. The ACA statute was unclear, however, on the affordability standard for coverage offered to dependents and spouses of a worker.[66] In 2013, the Internal Revenue Service (IRS) decided to define affordability using the cost of worker-only coverage, meaning dependent children and spouses of workers with affordable worker-only coverage would also be ineligible for subsidies, regardless of the cost of family coverage.[67]

The IRS's decision was significant because, in many cases, worker-only coverage through an employer may be affordable while family coverage is not. Premiums for employer-sponsored family coverage are much higher than premiums for worker-only coverage, and the share of premiums that employees are required to contribute for family coverage is often higher than for worker-only coverage.[68] Some employers that cover a significant portion of their employees' premiums allow the employees to include their dependent children and spouses on the plan but do not cover any of their premiums.

For "family glitch" affected households, purchasing individual market coverage without subsidies is an option under current policy. However, in those circumstances when a spouse requires coverage, this option may be particularly formidable since the cost of coverage for spouses, which varies by age, is higher than for children.

If children and spouses caught in the family glitch choose not to enroll in a health insurance plan, most are exempt from the individual mandate and do not face a penalty for not having coverage.[69] Despite the exemption from the individual mandate penalty, many individuals affected by the family glitch maintain unaffordable insurance.

State policy options to improve individual market affordability

States can play a role in further improving affordability of individual market coverage beyond the standards set by the ACA. Several states and localities have already enacted policies that reduce premium and/or out-of-pocket costs for some residents. Massachusetts provides additional premium and cost sharing subsidies to eligible individuals with incomes at or below 300% FPL who enroll in Commonwealth Care, a program that began under the state's health reform efforts enacted in 2006 and was modified under the ACA. The Vermont Premium Assistance program provides premium and cost sharing assistance to eligible individuals with incomes at or below 300% FPL. Under the San Francisco Health Care Security Ordinance, some San Franciscans with incomes at or below 500% FPL receive premium and cost sharing subsidies through the Covered San Francisco MRA program if they have an employer that fulfills the law's health care spending requirement by contributing to the City Option program.[70] Finally, three states—Alaska, Minnesota, and Oregon—have received federal approval for state reinsurance programs that will reduce premiums for unsubsidized enrollees, most of whom have incomes above 400% FPL.

These programs serve as examples for some of the five state policy options explored in this report:

1. Adding state premium subsidies for those who are already eligible for federal ACA subsidies;
2. Increasing the level of financial assistance to reduce deductibles, co-payments, and other cost sharing, and expanding eligibility for this assistance;
3. Limiting premium contributions for individuals not eligible for ACA premium subsidies based on income;
4. Establishing a state reinsurance program that would reduce premiums for unsubsidized individual market enrollees; and
5. Extending eligibility for state-funded premium and cost sharing subsidies to children and spouses affected by the ACA "family glitch."

These policy proposals are discussed as separate options, but implementing them in combination would likely produce effects that are greater than the sum of the effects of each policy in isolation. Implementing these policies in concert would increase enrollment in the individual market to an extent exceeding the pooled effect of each individual policy. Correspondingly, the state cost to implement these policies in combination could be higher than the sum of the cost of each policy on its own. The potential for these policies to result in lower premiums due to the enrollment of a healthier population would be greater if these policies were implemented in combination,[71] thereby further improving affordability for unsubsidized enrollees, further reducing federal spending on premium subsidies, and helping to limit some of the state cost associated with any new premium subsidies provided. Implementing a package of these policies in combination may also potentially "crowd out" enrollment in employer-sponsored insurance beyond the sum of the effects of each policy.[72]

Enhance premium subsidies for those already eligible

California could consider using state funds to increase premium subsidies for eligible individuals with incomes at or below 400% FPL in order to improve affordability and increase enrollment.

Policy design considerations:

The state could increase premium subsidies for Californians under 400% FPL in a variety of ways. Premium contributions could be reduced proportionally for all enrollees in this income range, or premium contributions could be reduced by differing amount at various income levels. For example, California could add state premium subsidies that result in households with incomes under 139% FPL paying zero premiums, households with incomes between 300% and 400% FPL paying no more than 8% of income on premiums, and improved affordability scaled to income for households in between. This could improve premium affordability both for those who currently receive subsidies through Covered California as well as for those eligible but not enrolled.

Programs in Massachusetts, Vermont, and San Francisco provide examples of various standards for premium affordability that California policymakers could consider. (See Appendix Exhibit A5 for details.)

One potential element of a policy to improve premium affordability for those already eligible would be to eliminate premium contributions for the 25,000 lawfully present immigrants in Covered California who have incomes below 139% FPL but are not eligible for Medi-Cal.[73] As described earlier in this report, these individuals, who earn less than $1,400 per month if single, face premiums of up to $46 per month for a single individual. Eliminating premiums for this population, as Massachusetts has done (for those with incomes at or below 150% FPL), would improve affordability and create parity with the other Californians in this income range who are eligible for Medi-Cal and pay no premiums.

Number of Californians affected:

If state premium subsidies were provided to all Californians currently eligible for ACA premium subsidies, affordability would improve for the 1.2 million Californians already enrolled in subsidized coverage (Exhibit 2, page 9). The projected increase in enrollment would depend on the size of the reductions in premium contributions. A 15% decrease in net premium contributions would be estimated to increase individual market enrollment by tens of thousands, and a 50% decrease in net premiums would result in an increase in enrollment that is in the low hundreds of thousands.[74] These estimates do not take into account the elimination of the ACA individual mandate penalty, which is expected to reduce enrollment. Providing state premium subsidies would help to counteract the reduction in individual market enrollment that would occur when the ACA individual mandate penalty is eliminated, but we have not quantified how many Californians would retain coverage if the state provides premium subsidies in the absence of a penalty for lacking insurance.

Impact on premiums:

Under this policy option, the new enrollees in the individual market would likely be somewhat healthier on average than existing enrollees, which could slightly reduce premiums across the whole market. This, in turn, would result in unsubsidized enrollees paying less than they otherwise

would have, and the federal government spending less on premium tax credits for subsidized enrollees. RAND estimated that reducing subsidized premium contributions by 15% under a federal policy would decrease Silver premiums by 0.2% in 2020.[75] A larger reduction in premium contributions for subsidized enrollees, or enhancing premium subsidies in combination with other policies to improve affordability, would likely yield higher premium reductions across the market.

Funding considerations:
California would likely need to rely solely on state funding to further improve premium subsidies beyond ACA standards. If this policy were pursued under a 1332 State Innovation Waiver, federal deficit neutrality calculations would be unlikely to result in federal pass-through savings to the state, though the exact impact would depend on the specifics of the proposal and projections of how much enrollment and premiums would change as a result. Although federal spending on premium subsidies per enrollee could be reduced by enrollment of a broader, healthier population, those federal savings might be offset by an increase in federal spending resulting from higher enrollment with improved affordability.[76]

Impact on employer-sponsored insurance:
In determining the level of state premium subsidies to provide, policymakers might consider the impact that improving the affordability of coverage offered to individuals without employer-sponsored insurance would have on the offer of and enrollment in employer-sponsored insurance. A national analysis by RAND indicated that 1,000 fewer people would be enrolled in employer-sponsored insurance for every 2,800 more people enrolled in individual market coverage, under a federal policy scenario in which net enrollee premium contributions would be 15% lower than under the ACA.[77]

Enhance cost sharing subsidies and expand eligibility

California policymakers could consider improving financial assistance for out-of-pocket costs (cost sharing reductions) to lower deductibles, co-payments, and other costs in order to improve access to care, reduce financial problems related to medical bills, and potentially increase enrollment.

Policy design approach:
Improving affordability of co-pays, deductibles, and other costs could involve providing additional financial assistance to those currently eligible for ACA out-of-pocket assistance as well as providing financial assistance to those with incomes above 250% FPL. Massachusetts and Vermont have reduced out-of-pocket costs for eligible individuals with incomes at or below 300% FPL and San Francisco provides financial assistance to reduce out-of-pocket costs to certain residents with incomes at or below 500% FPL in recognition of the city's high cost of living. Further details about these programs are provided in Appendix Exhibit A6.

Number of Californians affected:
This policy option would improve out-of-pocket affordability for some of the 680,000 Californians already receiving cost sharing reductions (Exhibit 2, page 9), depending on the income levels for which additional financial assistance is provided. If California used state funds to extend eligibility for cost sharing reductions to Covered California enrollees with incomes up to 400% FPL, as many

as 320,000 additional individuals could benefit from increased out-of-pocket affordability, based on the current number of Covered California enrollees in that income range.[78]

Under this policy option, all individuals receiving state-funded cost sharing subsidies would pay lower co-payments, which could improve access to care and reduce financial burdens. This policy would especially improve affordability for Californians with the highest health care use because it could reduce their deductibles and out-of-pocket maximums by hundreds or thousands of dollars annually, depending on the specific policy design. State spending on such a policy would be most concentrated on the Californians who need the most care.

Enhanced cost sharing could also potentially increase enrollment among the uninsured, for whom out-of-pocket costs are one of the most important considerations in their enrollment decisions. It is not known how many Californians would be likely to become newly insured if out-of-pocket costs were reduced. This policy option also could also potentially improve retention of coverage, which is particularly important in the context of the elimination of the ACA individual mandate penalty.

Impact on premiums:
The impact of state-funded enhanced on premiums would depend on the extent to which reducing out-of-pocket costs changes the amount and mix of health services used by enrollees, and whether the average risk mix in the market would change as a result of any new enrollment under this policy. No existing research was found that could be used to predict these impacts.

Funding considerations:
This policy would likely need to be completely funded using state funds.

Impact on employer-sponsored insurance:
In determining the level of state financial assistance to provide for enhanced cost sharing subsidies, policymakers might consider the impact that reducing out-of-pocket costs for individuals without employer-sponsored insurance would have on the offer of and enrollment in employer-sponsored insurance. For Californians who have insurance through a small employer, insurers paid 79% of medical costs, on average, and enrollees paid the other 21% in 2016. For Californians with insurance through a large employer, insurers paid between 86% and 90% of costs, on average, in 2016.[79] Marketplace Silver plans for individuals with incomes above 200% FPL pay a lower share of costs, on average, compared to the amount paid by employer-sponsored plans.

Cap premium contributions for individuals not currently eligible for subsidies

State policymakers could consider limiting premium contributions for all individuals eligible for Covered California to a certain percentage of income and providing a state tax credit for the amount by which premiums exceed this standard.

Policy approach:

Under the ACA, individuals are exempt from paying a penalty for lacking insurance if they have no offer of affordable coverage, defined as premiums costing no more than 8.16% of income, but premium subsidies are only provided to households with annual income equivalent to or below 400% FPL, or $48,240 for a single person. To make coverage more affordable to Californians with incomes above 400% FPL, premiums could be capped at 8.16% of income for the lowest cost Bronze plan. The ACA individual mandate affordability standard is just one example of a standard that policymakers could consider in making coverage more affordable for Californians in this income range. Policymakers could design the policy using a different affordability standard, tying the affordability standard to a different benchmark plan, or applying the policy to a more limited income range, such as 400% to 600% FPL or 400% to 800% FPL. Assistance could be provided through a refundable income tax credit or through another mechanism.

One consideration in developing a mechanism for financial assistance with premiums for those over 400% FPL is that some individuals in this income range may lack the liquid assets to pay premiums upfront and then receive a tax credit when they file their taxes. The ability to pay premiums upfront will also depend on how much financial assistance a particular individual needs to make coverage affordable. A Kaiser Family Foundation analysis indicated that in 2016, the vast majority (93%) of U.S. households with incomes between 400% and 800% FPL had liquid assets of at least $1,000, while more than two-thirds (68% to 73% depending on household size) had at least $5,000, and over half (53% to 54%) had at least $10,000.[80]

Number of Californians affected:

A policy capping premiums for Californians with incomes above 400% FPL at 8.16% of income for the lowest cost Bronze plan would improve affordability for those who are already enrolled in individual market coverage that exceeds this affordability standard. Out of the approximately 1 million California individual market enrollees with incomes at or above 400% FPL, the number currently enrolled in coverage that is unaffordable by this standard is estimated to be in the low hundreds of thousands.[81] This policy would be especially likely to improve affordability for Californians ages 50 and older who have incomes between 400% and 600% FPL, or $48,240 to $72,360 for a single individual.[82] Improved affordability for those already enrolled could lead to greater retention of coverage.

In addition, individual market enrollment could increase by tens of thousands as a result of such a policy, as some Californians would likely become newly insured as a result of the more affordable options that this policy would yield.[83] This estimate does not take into account the elimination of the ACA individual mandate penalty.

Impact on premiums:

RAND estimated that capping premium contributions at 9.95% of income based on the second-lowest cost Silver plan would be projected to reduce Silver premiums across the individual market by 2.5% for a 40-year old in 2020 as a result of enrollment by individuals who are healthier, on average, than existing enrollees.[84]

Funding considerations:

State policymakers could consider applying for a 1332 State Innovation Waiver in order to try to obtain federal pass-through funding to help offset a fraction of state costs for this proposal. This policy has the potential to reduce federal spending on premium tax credits as a result of new enrollment by healthier individuals who are not eligible for ACA subsidies, which would reduce premiums across the market. The policy is unlikely to substantially increase enrollment among those eligible for ACA premium subsidies and therefore would likely not result in increased federal spending on premium tax credits.

Impact on employer-sponsored insurance:

In evaluating the impacts of this policy, policymakers might consider how it could affect the role of employer-sponsored insurance. Under one federal policy scenario that would cap premium contributions for individuals with incomes above 400% FPL, RAND estimated that 1,000 fewer people would be enrolled in employer-sponsored insurance for every 4,000 more people enrolled in individual market coverage.[85]

Reduce premiums for unsubsidized enrollees via state reinsurance

Another approach to improving affordability for individuals not currently eligible for premium subsidies based on income would be to establish a state-level reinsurance program to help insurers pay for high-cost claims or high-cost enrollees. This would result in reduced premiums across the individual market and improved affordability for unsubsidized enrollees, most of whom have incomes above 400% FPL. Premium contributions paid by subsidized enrollees would generally remain constant because they are based on a percentage of income, but federal spending on premium tax credits for subsidized enrollees would be reduced. Reinsurance programs also help to maintain a stable market and increase insurer participation.

Policy approach:

The ACA established a temporary reinsurance program from 2014 through 2016. Under this program, insurance plans received payments when the costs for a particular enrollee exceeded a certain initial amount (the "attachment point") and payments continued until the costs for that enrollee exceeded a higher amount (the "cap"). Specifically, federal funding covered 100% of individual market insurers' costs between $45,000 and $250,000 in claims in the first year of the program, approximately half of claims between those claims amounts in the second year, and approximately half of insurers' costs between $90,000 and $250,000 in claims in the last year.[86] The ACA reinsurance program reduced premiums by an estimated to 10% to 14% in the first year.[87] The Medicare Part D program also has a reinsurance program.

In 2017, three states—Alaska, Minnesota, and Oregon—received federal approval for 1332 State Innovation Waivers for their reinsurance programs. The Minnesota and Oregon programs will provide payments to insurers to cover a percentage of costs for claims within a certain dollar range, while Alaska covers all claims costs for enrollees that have one of 33 designated health conditions.

Number of Californians affected:

This policy option has the potential to reduce premiums for the approximately 1.1 million Californians enrolled in the individual market without subsidies (Exhibit 2, page 9). It could also increase enrollment among the uninsured who are eligible for Covered California without subsidies. A 7% premium reduction (see discussion of premium impact below) would be estimated to result in an increase in unsubsidized enrollment that is in the low tens of thousands.[88] This estimate does not take into account the elimination of the ACA individual mandate penalty.

Impact on premiums:

For every $1 billion in gross reinsurance payments in California, individual market premiums would be reduced by approximately 7%, on average, in 2019.[89] Alaska and Minnesota each aim to reduce premiums by 20%, on average, while Oregon is targeting a premium reduction of approximately 7%.[90] Premium reductions may vary by issuer and region depending on the risk mix of each plan, but premium reductions would not vary based on how much financial assistance each enrollee needs to make premiums affordable. As a result, this policy option is less targeted to the unsubsidized Californians with the greatest affordability challenges than the policy option that would cap premium contributions as a percentage of income.

Funding considerations:

Ongoing state funding would be required for a state reinsurance program. The three states with 1332 Waiver approval will receive federal pass-through funding to offset a share of the state payments to insurers for reinsurance. The most dominant factor in the calculation of federal pass-through funding under a Waiver is the estimated reduction in federal spending on premium tax credits as a result of lower premiums. Federal funding will offset an estimated 80% of the gross reinsurance spending in Alaska, 51% in Minnesota, and 33% in Oregon. The states remain responsible for the remainder of the cost.

The share of state reinsurance payments that would be offset by federal funding in California would be dependent on actuarial analysis and the state's negotiations with the U.S. Department of Health and Human Services on the calculations of federal deficit neutrality. One key driver of the level of federal pass-through funding is the state's share of the individual market enrollment that is subsidized. A higher share of the market receiving premium subsidies yields greater opportunity for federal savings to offset the state's costs. In California, approximately 52% of individual market enrollees received premium subsidies in 2016 (Exhibit 2, page 9), compared to 23% in Minnesota,[91] 39% in Oregon,[92] and 66% in Alaska in 2016.[93]

Impact on employer-sponsored insurance:

In evaluating the impacts of this policy, policymakers might consider how it could affect the role of employer-sponsored insurance. Under two federal reinsurance scenarios with varying levels of funding, RAND estimated that 1,000 fewer people would be enrolled in employer-sponsored insurance for every 2,350 to 3,000 more people enrolled in individual market coverage.[94]

Extend ACA affordability standards to Californians with unaffordable employer-sponsored insurance for dependents

California policymakers could consider offering state-funded premium and cost sharing subsidies to Californians in households with incomes at or below 400% FPL who have an offer of unaffordable employer-sponsored insurance through a parent or spouse. These individuals are currently excluded from subsidy eligibility under the ACA "family glitch."

Policy approach:

Our analysis focuses on a policy option under which children and spouses caught in the family glitch would become eligible for subsidies through Covered California and workers with an affordable offer of employer-sponsored insurance would continue to be ineligible for subsidized coverage. An alternate option for fixing the family glitch, which would affect more Californians and would require greater state funding, would allow the workers to enroll in subsidized coverage through Covered California, along with their dependents, even if the worker has an offer of affordable worker-only coverage.

Number of Californians affected:

This proposal would improve affordability for an estimated 110,000 Californians who would be expected to switch from employer-sponsored insurance to more affordable subsidized insurance through Covered California, according to estimates by the UC Berkeley Labor Center and UCLA Center for Health Policy Research in 2011.[95] National estimates by the Urban Institute also suggest that, if the family glitch were fixed in this way, most new enrollees in subsidized coverage would have already been insured through unaffordable employer-sponsored insurance.[96] RAND estimates that most who would newly enroll in subsidized coverage under this policy would have had employer-sponsored insurance or unsubsidized individual market coverage.[97] Families purchasing unaffordable private or employer-sponsored insurance have less room in their budgets for other essentials, and some go into debt to pay their premiums.[98]

According to national analysis by the Urban Institute, employer-sponsored insurance costs for households that fall into the family glitch average 15.8% of household income. If these households became eligible for subsidized marketplace coverage, their average premiums could fall to a more affordable 9.3% of income in combined costs for subsidized marketplace coverage and employer-sponsored insurance.[99]

In addition, an estimated 30,000 Californians would become newly insured under this proposal, according to the 2011 UC Berkeley–UCLA estimates. Approximately half of the 140,000 Californians who would be projected to newly enroll in Covered California under this proposal are children and half are adult dependents, primarily spouses but also adult children.[100]

Impact on premiums:

The Californians who would be projected to enroll under this proposal would be younger and healthier than existing enrollees, which could slightly reduce average premiums across the market, with the potential to slightly improve affordability for unsubsidized enrollees.[101] RAND estimates that allowing dependents with unaffordable employer-sponsored insurance offers to be eligible

for ACA subsidies would result in Silver premiums for a 40-year old that are approximately 1% lower than they otherwise would be, due to the shift in enrollment of some relatively healthy workers from employer-sponsored coverage to Marketplace coverage.[102]

Funding considerations:
This policy option would rely completely on the use of state funds.

Impact on employer-sponsored insurance: Approximately 110,000 fewer Californians would be expected to have employer-sponsored insurance under this policy option because they would switch to subsidized insurance through Covered California, according to estimates by the UC Berkeley Labor Center and UCLA Center for Health Policy Research in 2011.[103]

Continue strong outreach and marketing efforts to improve awareness of financial assistance available

The policy options discussed above, individually and collectively, would reduce the amount that Californians struggling to afford coverage and care would spend, but perceived unaffordability can also be a barrier to enrollment in the individual market. A recent survey conducted for Covered California by Greenberg Strategy found that nearly three-quarters of uninsured Californians eligible for subsidized coverage either did not know they were eligible for subsidies or falsely believed they were ineligible. This finding is important because the same survey also found that uninsured people who expected to be eligible for subsidies were twice as likely to plan to enroll.[104] While California has been a leader among states in conducting strategic outreach campaigns and investing in marketing and enrollment assistance to help individuals understand their coverage options, more work is needed to ensure that people understand their eligibility and shop for coverage at the time that they are eligible. These efforts are not a focus of this report, but will always be needed as people churn in and out of needing individual market coverage as their income fluctuates, as their access to job-based coverage changes, or as they undergo other life transitions. Ensuring awareness of the financial assistance available would become even more important if California enacted policies to make coverage more affordable.

Conclusion

The ACA has significantly improved the affordability of and enrollment in coverage among Covered California-eligible individuals who lack access to employer-sponsored insurance or Medi-Cal. However, at least 1.2 million Californians eligible for Covered California, with or without subsidies, remain uninsured, with affordability concerns being the leading reason for lacking insurance. Many of the 2.3 million Californians enrolled in individual market coverage struggle to afford premiums, causing financial problems and putting retention of coverage at risk. Many Californians also face high out-of-pocket costs, which can cause financial hardship, result in delay or avoidance of necessary care, and potentially serve as a deterrent to enrollment. The evidence from California indicates that affordability is a concern for both those already eligible for ACA premium subsidies and those who earn too much to qualify.

Policies to improve affordability of individual market coverage are an important and necessary component to making health coverage more universal and affordable in this state. Affordability concerns are one of the biggest drivers of uninsurance in California, second only to the exclusion of undocumented immigrants from coverage options.

California policymakers could consider improving premium subsidies and cost sharing assistance for those already eligible under the ACA, and expanding cost sharing assistance to individuals who are not currently eligible based on income. Massachusetts, Vermont, and San Francisco have implemented policies that could serve as models. These policies have the potential, especially if implemented in combination, to improve affordability, enrollment, and access to care, while reducing premiums for unsubsidized enrollees if a broader and healthier population enrolls.

California could also limit premium spending as a share of income for individuals who earn too much to be eligible for ACA premium subsidies. A state reinsurance program would be another way to reduce premiums for unsubsidized enrollees. Both of these options would improve affordability for individuals who are ineligible for ACA premium subsidies based on income, though the affordability help provided under a cap on premium spending as a share of income would be more targeted to those with affordability concerns than would be the case under a reinsurance program. Both of these options also have the potential to increase enrollment, leading to a broader and healthier enrollment population that would consequently result in lower premiums.

Providing state-funded premium and cost sharing subsidies mirroring the ACA subsidies would benefit Californians caught in the ACA "family glitch"—in which children and spouses have an offer of family coverage through a parent's or spouse's job, rendering them ineligible for ACA subsidies, but whose family coverage offer is unaffordable. This policy option would reduce spending on health care by families caught up in this glitch by allowing them to switch from unaffordable employer-sponsored coverage to subsidized coverage through Covered California. It would also result in new enrollment in subsidized coverage among some who remain uninsured due to this eligibility gap in the ACA.

Consideration and adoption of policy options to increase health care affordability takes on greater importance with the elimination of the federal individual mandate penalty starting in 2019, which threatens to reduce individual market enrollment and increase individual market premiums. However, survey data indicate that affordability considerations are a bigger driver of the enrollment decision than concern over the penalty for not having insurance.

With these improvements to individual market affordability, California could continue to build upon the progress it has made under the ACA by bringing the state even closer to universal coverage. The state has already served as a national model for successful implementation of the ACA. Implementation of these policies could further expand the state's role as a model for how states can go beyond the ACA.

Appendix

Exhibit A1:

Premium contributions under ACA by income level, 2018

Income as a percent of the federal poverty level (FPL)	Maximum premium contributions for second-lowest cost silver plan		
	As percentage of income	Monthly $ (single)	Monthly $ (family of 4)
Less than 139% FPL	2.01% – 3.32%	$ 0 – 47	$ 0 – 96
At least 139% but less than 150%	3.38% – 4.03%	$ 47 – 61	$ 96 – 124
At least 150% but less than 200%	4.03% – 6.34%	$ 61 – 127	$ 124 – 260
At least 200% but less than 250%	6.34% – 8.10%	$ 127 – 204	$ 260 – 415
At least 250% but less than 300%	8.10% – 9.56%	$ 204 – 288	$ 415 – 588
At least 300% but less than 350%	9.56%	$ 288 – 336	$ 588 – 686
At least 350% but not more than 400%	9.56%	$ 336 – 384	$ 686 – 784

Exhibit A2:

Excerpts from Covered California Standardized Benefit Designs, 2018

Benefits in blue are not subject to a deductible

Coverage category	Bronze	Silver	Enhanced Silver 73 200–250% FPL	Enhanced Silver 87 150–200% FPL	Enhanced Silver 94 100–150% FPL	Gold	Platinum
Primary care visit	$75*	$35	$30	$10	$5	$25	$15
Specialist visit	$105*	$75	$75	$25	$8	$55	$30
Generic drugs	Full cost until drug deduct-ible is met	$15 after drug deductible is met	$15 after drug deductible is met	$5 or less	$3 or less	$15 or less	$5 or less
Emergency room	Full cost until deductible is met	$350	$350	$100	$50	$325	$150
Hospital facility fee	100% coinsurance	20% coinsurance	20% coinsurance	15% coinsurance	10% coinsurance	$600 per day up to 5 days	$250 per day up to 5 days
Individual Medical deductible	$6,300	$2,500	$2,200	$650	$75	N/A	N/A
Individual Pharmacy deductible	$500	$130	$130	$50	N/A	N/A	N/A
Individual Out-of-pocket maximum	$7,000	$7,000	$5,850	$2,450	$1,000	$6,000	$3,350

** 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.*

For a fuller description of cost sharing by metal tier and service see Covered California's Standardized Benefit Design chart here https://www.coveredca.com/PDFs/2018-Health-Benefits-table.pdf. More details are available from Covered California at http://hbex.coveredca.com/stakeholders/plan-management/PDFs/2018-Covered-California-Patient-Centered-Benefit-Plan-Designs.pdf?v=2.0.

Exhibit A3:

Characteristics of **single individuals** in California with incomes above 400% FPL for whom lowest cost Bronze premium exceeds ACA individual mandate affordability standard, by Covered California pricing region, 2018

Covered California Pricing Region	Lowest cost Bronze premium exceeds ACA individual mandate affordability standard (8.16% of income), 2018	
	For this age range, depending on income	For this income range as a percentage of the Federal Poverty Level, depending on age
1 – Northern Counties	Age 43+	401% – 888% FPL
2 – North Bay Area	41+	401% – 935%
3 – Greater Sacramento	43+	401% – 888%
4 – San Francisco County	38+	401% – 969%
5 – Contra Costa County	43+	401% – 888%
6 – Alameda County	42+	401% – 912%
7 – Santa Clara County	47+	401% – 795%
8 – San Mateo County	36+	401% – 982%
9 – Santa Cruz, Benito, Monterey	42+	401% – 912%
10 – Central Valley	47+	401% – 795%
11 – Fresno, Kings, Madera Counties	48+	401% – 758%
12 – Central Coast	44+	401% – 874%
13 – Eastern Counties	46+	401% – 829%
14 – Kern County	47+	401% – 794%
15 – Los Angeles County (partial)	51+	401% – 652%
16 – Los Angeles County (partial)	48+	401% – 738%
17 – Inland Empire	49+	401% – 708%
18 – Orange County	49+	401% – 731%
19 – San Diego County	47+	401% – 788%

Source: Authors' analysis of Covered California rates, 2018.

Exhibit A4:

Characteristics of **married couples** in California with incomes above 400% FPL for whom lowest cost Bronze premium exceeds ACA individual mandate affordability standard, by Covered California pricing region, 2018

Note: Examples assume spouses are the same age for simplicity.

Covered California Pricing Region	Lowest cost Bronze premium exceeds ACA individual mandate affordability standard (8.16% of income), 2018	
	For this age range, depending on income	For this income range as a percentage of the Federal Poverty Level, depending on age
1 – Northern Counties	Age 18+	401% – 1320% FPL
2 – North Bay Area	18+	401% – 1389%
3 – Greater Sacramento	18+	401% – 1320%
4 – San Francisco County	18+	401% – 1439%
5 – Contra Costa County	18+	401% – 1320%
6 – Alameda County	18+	401% – 1354%
7 – Santa Clara County	26+	401% – 1181%
8 – San Mateo County	18+	401% – 1458%
9 – Santa Cruz, Benito, Monterey	18+	401% – 1354%
10 – Central Valley	26+	401% – 1181%
11 – Fresno, Kings, Madera Counties	28+	401% – 1125%
12 – Central Coast	19+	401% – 1298%
13 – Eastern Counties	21+	401% – 1232%
14 – Kern County	26+	401% – 1179%
15 – Los Angeles County (partial)	38+	401% – 968%
16 – Los Angeles County (partial)	29+	401% – 1096%
17 – Inland Empire	31+	401% – 1052%
18 – Orange County	29+	401% – 1085%
19 – San Diego County	27+	401% – 1171%

Source: Authors' analysis of Covered California rates, 2018.

Exhibit A5:
Premium Affordability Programs in Other States and Localities

Program	Eligibility	Premium Contributions for second-lowest cost Silver plan	Reduction in premiums compared to under ACA
Commonwealth Care (Massachusetts)	Eligible for ACA premium subsidies and income at or below 300% FPL	No premiums for those at or below 150% FPL, premium contributions of between 2.90% and 7.45% of income between 150% and 300% FPL, compared to between 4.03% and 9.56% of income under the ACA	100% reduction for those with incomes at or below 150% FPL Varies from 0% to 54% reduction for those with incomes 150-300% FPL
Vermont Premium Assistance	Eligible for ACA premium subsidies and income at or below 300% FPL	Reduces premiums by 1.5% of income on top of ACA subsidies (e.g., maximum required contribution under ACA is 4.03% at 150% FPL and in Vermont it is 2.53%)	Sliding scale from 75% reduction below 133% FPL to 16% reduction at 300% FPL
Covered San Francisco MRA	Adult residing in San Francisco with income at or below 500% FPL, enrolled in Covered California, not eligible for Medi-Cal or Medicare, employer meets City health spending requirement by contributing to City Option	For individuals with subsidized coverage, enrollee pays 40% of net premium after ACA subsidies For individuals with unsubsidized coverage, enrollee pays 40% of total premium	60% reduction

Sources: Massachusetts Health Connector, Final Affordability Schedule for Calendar Year 2018, Board of Directors Meeting, April 13, 2017, https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2017/04-13-2017/CY2018-Final-Affordability-Schedule-VOTE-041317.pdf. Correspondence with Department of Vermont Health Access, January 2018. Ken Jacobs (UC Berkeley Labor Center), Universal Access to Care: Lessons from San Francisco, Testimony to the California Assembly Select Committee on Health Care Delivery Systems and Universal Coverage, December 11, 2017, http://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/Ken%20Jacobs%20powerpoint%20presentation%20Lessons%20from%20San%20Francisco.pdf.

Exhibit A6:

Actuarial value of plans offered to eligible individuals by household income level under ACA and programs in states and localities that provide additional financial assistance with out-of-pocket costs

Note: Actuarial value is a measure of the percentage of claims an insurer pays, on average, across a population, with enrollees paying the remainder of costs. Deductibles and other cost sharing amounts can vary even among plans with the same actuarial value.

	Household income as a percentage of the Federal Poverty Level (FPL)					
Program	**At or below 100% FPL**	**100–150% FPL**	**150–200% FPL**	**200–250% FPL**	**250–300% FPL**	**300–500% FPL**
Affordable Care Act	94%	94%	87%	73%	70%	70% if enrolled in benchmark plan
Commonwealth Care (Massachusetts)	99%	97%	97%	95%	95%	
Vermont Premium Assistance	94%	94%	87%	77%	73%	
Covered San Francisco MRA	Financial assistance is not directly tied to actuarial value: cost sharing assistance is provided to keep deductible below 5% of income (after ACA cost sharing reductions when applicable)					

Sources: Suzanne Curry, Maintaining Affordable Health Coverage in Massachusetts, Presentation to Families USA Health Action 2015, January 2015, http://slideplayer.com/slide/4103559/. Correspondence with Department of Vermont Health Access, January 2018. Ken Jacobs (UC Berkeley Labor Center), Universal Access to Care: Lessons from San Francisco, Testimony to the California Assembly Select Committee on Health Care Delivery Systems and Universal Coverage, December 11, 2017, http://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/Ken%20Jacobs%20powerpoint%20presentation%20Lessons%20from%20San%20Francisco.pdf.

Endnotes

[1] U.S. Census Bureau, American Community Survey, 2013 and 2016.

[2] Wilson K. July 13, 2017. California Insurers Hold on to Previous Gains. California Health Care Foundation Blog. https://www.chcf.org/blog/california-health-insurers-hold-on-to-previous-aca-gains/.

[3] NORC at the University of Chicago. October 22, 2015. Covered California Overview of Findings from the Third California Affordable Care Act Consumer Tracking Survey. http://hbex.coveredca.com/data-research/library/2015CA-Affordable-Care-Act%20Consumer-Tracking-Survey.pdf.

[4] Individuals under age 30 also have the option of a "Minimum Coverage" that offers limited coverage before the deductible is reached. Approximately 12,000 Covered Californians were enrolled in these plans in June 2017. (Covered California. September 1, 2017. Active Member Profile June 2017. http://hbex.coveredca.com/data-research/library/active-member-profiles/12-13-17/CC_Membership_Profile_2017_06.xlsx.)

[5] Gabel JR, Lore R, McDevitt RD, et al. June 2012. More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges As Of 2014. *Health Affairs* 31(6): 1339-1348.

[6] In California prior to the ACA, many individual market plans covered less than 60% of costs and some plans paid as little as 32% of medical costs. (McDevitt R. October 2008. Actuarial Value: A Method for Comparing Health Plan Benefits. Prepared for California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2017/12/PDF-HealthPlanActuarialValue.pdf.) After the ACA, insurers paid 78% of medical costs for subsidized enrollees in Covered California, on average, and 71% for unsubsidized enrollees in 2016. (UC Berkeley analysis of data from: Covered California. March 14, 2017b. Bringing Financial Assistance Within Reach. http://hbex.coveredca.com/data-research/library/Bringing_Health_Care_Coverage_Within_Reach_Data_Sheet_2016.xlsx.) Data is not available for the individual market outside of Covered California.

[7] In Covered California, maximum out-of-pocket spending is limited to $7,000 for an individual and $14,000 for a family in 2018, with lower spending limits for individuals receiving financial assistance to reduce out-of-pocket costs and for those enrolled in Gold or Platinum plans. After this out-of-pocket limit is reached, insurers must pay for all covered care without any enrollee contributions. Most families do not use enough care to reach this out-of-pocket spending limit.

[8] Gabel et al. 2012.

[9] DiJulio B, Firth J, and Brodie M. July 2015. California's Previously Uninsured after the ACA's Second Enrollment Period, Kaiser Family Foundation. Kaiser Family Foundation. https://www.kff.org/health-reform/report/californias-previously-uninsured-after-the-acas-second-open-enrollment-period/.

[10] Planalp C and Hartman L. April 2017. Financial Burden and Cost-related Barriers to Care: Changes Since Implementation of the ACA. State Health Access Data Assistance Center. http://www.shadac.org/sites/default/files/publications/CHCF_financial_impacts_brief.pdf.

[11] Dietz M, Graham-Squire D, Becker T, Chen X, Lucia L, and Jacobs K. August 2016. Preliminary CalSIM 2.0 Regional Remaining Uninsured Projections. UC Berkeley Center for Labor Research and

Education, and UCLA Center for Health Policy Research. http://laborcenter.berkeley.edu/pdf/2016/Preliminary-CalSIM-20-Regional-Remaining-Uninsured-2017.pdf.

[12] California Health Interview Survey, pooled 2014-2016 data.

[13] California Health Interview Survey, pooled 2014-2016 data.

[14] Planalp and Hartman 2017.

[15] Collins SR, Gunja MZ, Doty MM. October 2017. How Well Does Insurance Coverage Protect Consumers from Health Care Costs? Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016. Commonwealth Fund. http://www.commonwealthfund.org/publications/issue-briefs/2017/oct/insurance-coverage-consumers-health-care-costs.

[16] Congressional Budget Office. November 8, 2017. Repealing the Individual Health Insurance Mandate: An Updated Estimate. https://www.cbo.gov/publication/53300.

[17] Approximately 378,000 fewer Californians would be estimated to enroll in the individual market without an individual mandate, based on a survey in which 18% of respondents enrolled in the California individual market reported that they would not have purchased insurance in 2017 if the penalty had not existed. (Hsu J, Fung V, Chernew ME, et al. March 1, 2018. Eliminating the Individual Mandate Penalty in California: Harmful but Non-Fatal Changes in Enrollment and Premiums. *Health Affairs Blog*. https://www.healthaffairs.org/do/10.1377/hblog20180223.551552/full/.) Using the Congressional Budget Office's national estimates of individual market coverage losses in 2019 (Congressional Budget Office 2017), and assuming that the coverage loss in California would be proportionate to California's share of the national individual market enrollment in 2016, we estimate that 440,000 fewer Californians would be enrolled in the individual market in 2019.

[18] Prior estimates by Covered California, with PricewaterhouseCoopers, projected that if the individual mandate was not enforced, 280,000 fewer Californians would be enrolled in subsidized individual market insurance and 60,000 fewer Californians would be enrolled in unsubsidized individual market coverage in 2018. (Bertko J and Hunt S. April 27, 2017. Analysis of Impact to California's Individual Market if Federal Policy Changes are Implemented. http://hbex.coveredca.com/data-research/library/CoveredCA_Impact_to_CA_ind_market_4-27-17%20(1).pdf.) This is consistent with the more recent estimate that of the approximately 378,000 fewer Californians expected to enroll in individual market coverage due to the elimination of the individual mandate penalty (Hsu et al. 2018), 250,000 are currently insured through Covered California. Given that the vast majority of Covered California enrollees are subsidized, most of the enrollment loss would also be likely to be among subsidized enrollees. These projections are also consistent with research by Evan Saltzman. He concluded from his analysis of data from Covered California that "individuals with income above 400 percent of FPL are not sensitive to the existence of the mandate, compared to those with income below 400 percent of FPL." (Saltzman E. 2017. Demand for Health Insurance, Evidence from the California and Washington ACA Marketplaces. Wharton Health Care Management. https://repository.upenn.edu/cgi/viewcontent.cgi?article=1140&context=hcmg_papers.)

[19] Congressional Budget Office 2017.

[20] Blumberg LJ, Holahan J, Hadley J, and Nordahl K. 2007. Setting a Standard of Affordability for Health Insurance Coverage. *Health Affairs* 26(4): w463-473.

[21] Individuals with incomes at or below 133% FPL pay 2.01% of income on premiums under the ACA. This applies to a subset of lawfully present immigrants who are not eligible for Medi-Cal.

[22] Saltzman 2017.

[23] Throughout this report, due to data limitations, data on uninsured citizens is referenced as a proxy for those eligible for Covered California but lawfully present immigrants are also eligible to enroll in Covered California and receive subsidies. Undocumented Californians are not eligible to purchase insurance through Covered California under federal law, but are eligible to purchase private insurance directly from insurers in the individual market.

[24] Non-citizens made up approximately 15% of enrollees with individual market coverage through Covered California in 2015 through 2016, according to the California Health Interview Survey. However, it is not known how many uninsured Californians with incomes at or above 139% FPL are lawfully present immigrants.

[25] Adults with household incomes below 139% FPL are covered by Medi-Cal, with zero premiums and zero cost sharing. Children are also eligible for Medi-Cal if they are in households with incomes below 267% FPL. Depending on income, some children have zero premiums and no cost sharing, while others have modest premiums and co-pays.

[26] Covered California, Active Member Profile June 2017.

[27] These are premium contributions for the benchmark plan, the second-lowest cost Silver plan. Premium contributions are lower for individuals purchasing the lowest cost Silver plan or a Bronze plan.

[28] Whitmore H and Gabel J. March 14, 2017. California Employer Health Benefits: Prices Up, Coverage Down. California Health Care Foundation. https://www.chcf.org/publication/california-employer-health-benefits-prices-up-coverage-down/.

[29] 2015 is the most recent tax data available for California at the time of this report's publication. The number of California households paying the penalty may have been lower in 2016 as uninsurance rates in the state continued to decline. Nationally, the number of households paying the penalty declined 26.8% between tax year 2015 and tax year 2016. (U.S. Treasury Inspector General for Tax Administration. January 31, 2018. Results of the 2017 Filing Season. https://www.treasury.gov/tigta/auditreports/2018reports/201840012fr.pdf.)

[30] 76% of Californians paying the tax penalty for not having insurance in 2015 had household income between $10,000 and $50,000, which in most cases would make them eligible for subsidies through Covered California. Another 14% of Californians paying the tax penalty had income between $50,000 and $75,000 and in some cases could have been eligible for subsidies based on income, depending on household size. (Internal Revenue Service (n.d.). Individual Income Tax Returns: Selected Income and Tax Items by State, County, and Size of Adjusted Gross Income, Tax Year 2015. https://www.irs.gov/pub/irs-soi/15incyca.xls.)

[31] Covered California. September 1, 2017b. Active Member Profile June 2016. http://hbex.coveredca.com/data-research/library/active-member-profiles/12-13-17/CC_Membership_Profile_2016_06.xlsx.

[32] California Health Interview Survey 2016.

[33] In 2014, fewer than one in five (18%) of uninsured citizen adults in the subsidy-eligible income range had an offer of employer-sponsored insurance that they declined. It is not known to what extent these offers of employer-sponsored insurance met the ACA affordability standards for the purpose of determining subsidy eligibility. (California Health Interview Survey 2014.)

[34] Excludes nearly 1 million undocumented enrollees who had coverage for emergency and pregnancy-related services only. (California Department of Health Care Services, Research and Analytic Studies Division. December 2016. Medi-Cal Monthly, Enrollment Fast Facts September 2016. http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_Sept_16_ADA.pdf.)

[35] California Health Interview Survey 2016.

[36] Fung V, Liang CY, Donelan K, et al. January 2017. Nearly One-Third of Enrollees in California's Individual Market Missed Opportunities to Receive Financial Assistance. *Health Affairs* 36(1): 21-31.

[37] Covered California, Active Member Profile June 2017.

[38] Under federal law, only a subset of lawfully present immigrants are considered "qualified" immigrants eligible for Medi-Cal. Certain other immigrants are eligible for Medi-Cal using state funds, such as Lawful Permanent Residents who are subject to the federal "five-year bar." Lawfully present immigrants who are not eligible for Medi-Cal under federal or state law— such as those with Temporary Protective Status (TPS), individuals with work visas, student visas, or certain other visas, or individuals applying for certain statuses —are eligible for Marketplace coverage and subsidies (depending on income). (National Immigration Law Center, Center on Budget and Policy Priorities, and the Georgetown Center for Children and Families. September 19, 2014. Overview of Immigrant Eligibility Policies for Health Insurance Affordability Programs. https://www.nilc.org/wp-content/uploads/2015/12/CMS-Immigrant-Eligibilty-Presentation-2014-09-19.pdf.)

[39] Snyder L and Rudowitz R. February 2013. Premiums and Cost Sharing in Medicaid: A Review of the Research Findings. Kaiser Commission on Medicaid and the Uninsured. https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417-premiums-and-cost-sharing-in-medicaid.pdf.

[40] Blavin F, Karpman M, Kenney GM, and Sommers BD. January 2018. Medicaid versus Marketplace Coverage for Near-Poor Adults: Effects on Out-of-Pocket Spending and Coverage. *Health Affairs* 37(2): 299–307.

[41] The Commonwealth Fund considers an individual underinsured if actual spending on out-of-pocket costs, not including premiums, exceeds 10% of income (or 5% of income for those with household incomes below 200% FPL) or if one's deductible exceeds 5% of income, regardless of how much is actually spent on healthcare. (Collins et al. 2017).

[42] California Health Interview Survey, pooled 2014-2016 data.

[43] Collins et al. 2017.

[44] Blumberg LJ and Holahan J. August 2015. After King v. Burwell: Next Steps for the Affordable Care Act. Urban Institute. https://www.urban.org/research/publication/after-king-v-burwell-next-steps-affordable-care-act.

[45] Robert Wood Johnson Foundation, PerryUndem, and GMMB. June 2015. Understanding the Uninsured Now. https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2015/rwjf420854/subassets/rwjf420854_4.

[46] Covered California 2017b.

[47] U.S. Department of Health and Human Services. October 12, 2017. Press Release: Trump Administration Takes Action to Abide by the Law and Constitution, Discontinue CSR Payments.

https://www.hhs.gov/about/news/2017/10/12/trump-administration-takes-action-abide-law-constitution-discontinue-csr-payments.html.

[48] Covered California, Active Member Profile June 2017.

[49] These estimates include employer-sponsored insurance plans with an actuarial value of between 60% and 69%. The large group plans in this estimate include only those that are fully insured. Large group estimates based on analysis of California SB 546 filings. (California Labor Federation (n.d.). California's Fully Insured Large Group Market: Findings from the First Year of SB 546 Filings. http://calaborfed.org/californias-fully-insured-large-group-market-findings-from-the-first-year-of-sb-546-filings/.) Small group enrollment distribution by actuarial value is based on the PricewaterhouseCoopers (PWC) analysis for California Health Benefits Review Program (CHBRP) of the 2016 distribution of enrollees by benefit plan type obtained through PWC surveys of health plans, CHBRP's estimate of the 2018 population split by market and broad plan type, and the calculated weighted average actuarial values.

[50] Covered California. October 11, 2017. Press Release: Covered California Keeps Premiums Stable by Adding Cost-Sharing Reduction Surcharge Only to Silver Plans to Limit Consumer Impact.

[51] Liquid assets sufficient to cover a Bronze deductible are available for between 27% and 29% of American households with incomes between 150% and 400% FPL, and between 7% and 11% of households with incomes under 150% FPL, depending on household size. (Rae M, Claxton G, and Levitt L. November 2017. Do Health Plan Enrollees have Enough Money to Pay Cost Sharing? Kaiser Family Foundation Issue Brief. https://www.kff.org/report-section/do-health-plan-enrollees-have-enough-money-to-pay-cost-sharing-issue-brief/.)

[52] These estimates for San Francisco are consistent with a national analysis by the Urban Institute, which estimated that individual market enrollees with incomes between 200% and 500% FPL and median health use spent more than 10% of income on premiums and out-of-pocket costs, on average, in 2016. Combined premium and out-of-pocket spending exceeded 20% of income for individuals in the same income range with health spending at the 90th percentile. The Urban Institute concluded that under the ACA the burden of premium and out-of-pocket costs in the individual market is highest among individuals with incomes between 200% and 500% FPL. (Blumberg LJ, Holahan J, and Buettgens M. December 2015. How Much Do Marketplace and Other Nongroup Enrollees Spend on Health Care Relative to Their Income? Urban Institute. https://www.urban.org/sites/default/files/publication/76446/2000559-How-Much-Do-Marketplace-and-Other-Nongroup-Enrollees-Spend-on-Health-Care-Relative-to-Their-Incomes.pdf.)

[53] An individual living in Los Angeles with the same demographics as the individual in the Exhibit 6 example would have spent the same percentage of income as someone in San Francisco through approximately 285% FPL. Between 286% and 500% FPL, a single 40-year old in Los Angeles would have spent 6.9% to 11.9% of income on combined premium and out-of-pocket spending in 2015 with median health use, and 16.0% to 27.6% of income with very high health use. These ranges are slightly lower than in San Francisco, where combined health spending for an individual with these demographics would have been 9.7% to 12.0% of income with median health use and 18.8% to 27.7% with very high health use.

[54] Authors' analysis extrapolating from the California Poverty Measure (CPM), produced by Public Policy Institute of California and the Stanford Center on Poverty and Inequality, https://inequality.stanford.edu/publications/research-reports/california-poverty-measure. These estimates are based specifically on CPM data, which are averaged over 2013 to 2015 and show the resources required by

county for a family of four to live out of poverty assuming they do not own their home. (Public Policy Institute of California and Stanford Center on Poverty and Inequality (n.d.). California Poverty by County, 2013-2015. http://www.ppic.org/data-set/california-poverty-by-county-and-legislative-district/.)

[55] Lucia L. June 2016. How Affordable is Health Insurance through Covered California When Local Cost of Living is Taken into Account? California Health Care Foundation Publication. https://www.chcf.org/publication/balancing-the-books-how-affordable-is-health-insurance-through-covered-california-when-local-cost-of-living-is-taken-into-account/.

[56] Garfield R, Majerol M, and Young K. May 2015. Coverage expansions and the remaining uninsured: A look at California during year one of ACA implementation, Kaiser Family Foundation. https://www.kff.org/health-reform/report/coverage-expansions-and-the-remaining-uninsured-a-look-at-california-during-year-one-of-aca-implementation/.

[57] Robert Wood Johnson Foundation et al. 2015.

[58] U.S. Department of Housing and Urban Development. Fiscal Year 2018 Fair Market Rents. https://www.huduser.gov/portal/datasets/fmr.html.

[59] Kaiser Family Foundation. November 7, 2017. Individual Mandate Penalty Calculator. https://www.kff.org/interactive/penalty-calculator/.

[60] This is only somewhat higher than the overall U.S. median income of $66,000 for all Americans ages 19 through 64. (Covered California. January 18, 2018. The Roller Coaster Continues—The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies. http://board.coveredca.com/meetings/2018/01-18/CoveredCA-Roller_Coaster_Continues_1-18-18.pdf.)

[61] Over 1.0 million individual market enrollees were in households with incomes above 400% FPL in 2016, according to the California Health Interview Survey.

[62] UC Berkeley Labor Center analysis using Covered California 2018 rates by age.

[63] UC Berkeley Labor Center analysis using Covered California 2018 rates by age. These findings are consistent with national analysis by RAND. (Eibner C and Liu J. October 2017. Options to Expand Health Insurance Enrollment in the Individual Market. Commonwealth Fund. http://www.commonwealthfund.org/publications/fund-reports/2017/oct/expand-insurance-enrollment-individual-market.)

[64] Ibid.

[65] The ACA requires employers with an average of 50 or more full-time employees to offer these full-time employees affordable health insurance, with "affordability" defined as not costing the employee more than 9.56% of his or her income. The plan must also meet a minimum value standard under which it covers 60% of medical costs, on average. Coverage must also be offered to employees' children under age 26. If employers do not make such an offer, employers may owe a penalty to the IRS. See the IRS's website for more information about Employer Shared Responsibility Provisions, https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions.

[66] Interpretations of the text of the ACA varied on whether the cost of worker-only coverage or family coverage should be compared against household incomes to determine eligibility for subsidies. The Joint Committee on Taxation (JCT) interpreted the statute to define affordability using the cost of worker-only coverage, but some experts argued that there was a strong legal basis for interpreting

the statute to define affordability using the cost of family coverage for determining eligibility for dependents. (Internal Revenue Service. November 17, 2011. Public Hearing on Proposed Regulations 26 CFR Part 1. http://www.taxhistory.org/www/features.nsf/Articles/1C04199B199E24678525794C00541F-D8?OpenDocument.)

[67] IRS Code Title 26, Chapter 1, Subchapter A, Part 1 §1.36b-3.

[68] In 2016, the average monthly premium for worker-only coverage was $597 in California while the average premium for a family of four was $1,634. Employers in California contributed 86% of premiums for worker-only coverage, on average, and 75% for family coverage. (Whitmore and Gabel 2017.)

[69] These dependents are exempt from the individual mandate if the cost of purchasing overage for all family members would exceed 8.13% of household income.

[70] For more information about San Francisco's City Option program see: http://sfcityoption.org/whatiscityoption/.

[71] For example, a national analysis by RAND estimated that a particular federal policy option to improve premium subsidies for those with incomes at or below 400% FPL would decrease Silver premiums for a 40-year old by 0.2%, another policy option to extend premium subsidies to those with incomes above 400% FPL would decrease premiums by 2.5%, but in combination the policies would decrease premiums by 4.8%. (Eibner and Liu, October 2017.)

[72] The term "crowd-out" describes when enrollment in private coverage decreases because of the expansion of publicly-subsidized coverage options. This can occur in a variety of ways, including employers no longer offering coverage or workers and/or their dependents no longer enrolling in employer-sponsored insurance in response to the availability of publicly subsidized programs.

[73] Covered California, Active Member Profile June 2017.

[74] These are order-of-magnitude estimates by the authors based on a working paper by Evan Saltzman of the University of Pennsylvania Wharton School estimating changes in demand for health insurance based on changes in price, using Covered California data from 2014–2015. The price elasticities of demand are applied to estimates of uninsured Californians not offered or eligible for employer-sponsored insurance, by income level, using 2016 California Health Interview Survey. All estimates assume that take-up rates will not exceed 90% under any scenario. (Saltzman 2017.)

[75] Eibner and Liu, October 2017.

[76] Manatt Health. February 2018. Understanding the Rules: Federal Legal Considerations for State-Based Approaches to Expand Coverage in California. California Health Care Foundation Publication. https://www.chcf.org/wp-content/uploads/2018/02/UnderstandingTheRules-FederalLegalConsiderations.pdf.

[77] Eibner and Liu, October 2017.

[78] Covered California, Active Member Profile June 2017.

[79] The large group plans in this estimate include only those that are fully insured. Large group estimates based on analysis of California SB 546 filings. (California Labor Federation (n.d.).) Small group enrollment distribution by actuarial value is based on the PricewaterhouseCoopers (PWC) analysis for the California Health Benefits Review Program (CHBRP) of the 2016 distribution of enrollees by benefit

plan type obtained through PWC surveys of health plans, CHBRP's estimate of the 2018 population split by market and broad plan type, and the calculated weighted average actuarial values.

[80] Correspondence with Matthew Rae, Kaiser Family Foundation, October 2017.

[81] UC Berkeley analysis of Covered California 2018 rates by age and region, compared to analysis of individual market enrollment by age, income, and region using data from the California Health Interview Survey, 2016.

[82] RAND also estimated that people age 50 and over and people with incomes between 400% and 600% FPL would disproportionately benefit from a similar policy option at the federal level. (Eibner C and Liu J. July 2017. Extending Marketplace Tax Credits Would Make Coverage More Affordable for Middle-Income Adults. Commonwealth Fund. http://www.commonwealthfund.org/publications/issue-briefs/2017/jul/marketplace-tax-credit-extension.)

[83] These are order-of-magnitude estimates by the authors in part based on a working paper by Evan Saltzman, The Wharton School, estimating changes in demand for health insurance based on changes in price, using Covered California data from 2014–2015. The price elasticities of demand are applied to estimates of uninsured Californians with demographics that would make them potentially eligible for this state policy option, using 2016 California Health Interview Survey. All estimates assume that take-up rates will not exceed 90% under any scenario. (Saltzman 2017.) RAND projected that a potential federal policy that would cap premiums for individuals with incomes at or above 400% FPL at 9.95% of income based on the second-lowest cost Silver plan (a more affordable standard than 8.16% of income based on lower-cost Bronze) in 2020 would result in 1.6 million additional individual market enrollees. (Eibner and Liu, October 2017.)

[84] Eibner and Liu, October 2017.

[85] The federal policy scenario would cap premium contributions for the second-lowest cost Silver plan at 9.95% of income in 2020. (Eibner and Liu, October 2017)

[86] Harrington SE. September 11, 2017. Stabilizing Individual Health Insurance Markets with Subsidized Reinsurance. University of Pennsylvania Leonard Davis Institute of Health Economics Issue Brief. https://ldi.upenn.edu/brief/stabilizing-individual-health-insurance-markets-subsidized-reinsurance.

[87] Volk J. September 2017. The ABCs of State Reinsurance Programs. Presentation for Community Catalyst Learning Community Webinar.

[88] These are order-of-magnitude estimates by the authors based on a working paper by Evan Saltzman, The Wharton School, estimating changes in demand for health insurance based on changes in price, using Covered California data from 2014–2015. The price elasticities of demand are applied to estimates of uninsured Californians not offered or eligible for employer-sponsored insurance, by income level, using 2016 California Health Interview Survey. All estimates assume that take-up rates will not exceed 90% under any scenario. (Saltzman 2017.)

[89] Gross reinsurance spending of $1 billion in 2019 would be approximately 7% of estimated aggregate individual market premiums in that year, using 2015 actual aggregate premiums from Milliman adjusted up by 7% annually to estimate premium growth. (Milliman. April 2017. Individual Health Insurance Market Profile: State of California, 2015. http://www.milliman.com/uploadedFiles/insight/2017/state-profiles/CA-summary-april-17.pdf.)

[90] State Health Value Strategies. January 4, 2018. State Options for Responding to Changes in the Individual Market. https://www.shvs.org/wp-content/uploads/2018/01/Consolidated-Tax-Bill-Slide-Deck_20180104.pdf.

[91] Minnesota Department of Commerce, Division of Insurance. May 20, 2017. Minnesota Section 1332 Waiver Application. http://mn.gov/commerce-stat/pdfs/mn-1332-actuarial-analysis.pdf.

[92] Oregon Department of Consumer and Business Services. August 31, 2017. Oregon 1332 Draft Waiver Application. http://healthcare.oregon.gov/DocResources/1332-application.pdf.

[93] Tomczyk T, Mueller R, and Kaczmarek P (n.d.). Alaska 1332 Waiver Application: Oliver Wyman Actuarial Analyses and Certification. https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=105951.

[94] Both federal policy options analyzed would pay a share of claims up to $250,000. Under one of the options, reinsurance would pay 100% of claims starting at an attachment point of $45,000, while under the other option reinsurance would pay 50% of claims starting at $90,000. (Eibner and Liu, October 2017.)

[95] Jacobs K, Graham-Squire D, Roby DH, et al. December 2011. Proposed Regulations Could Limit Access to Affordable Health Coverage for Workers' Children and Family Members. UC Berkeley Center for Labor Research and Education, and UCLA Center for Health Policy Research. http://laborcenter.berkeley.edu/pdf/2011/Proposed_Regulations11.pdf.

[96] Buettgens M, Dubay L, and Kenney GM. 2016. Marketplace Subsidies: Changing The 'Family Glitch' Reduces Family Health, Spending But Increases Government Costs. *Health Affairs* 35(7): 1167-1175.

[97] Nowak SA, Saltzman E, and Cordova A. 2015. Alternatives to the ACA's Affordability Firewall. RAND Corporation. https://www.rand.org/content/dam/rand/pubs/research_reports/RR1200/RR1296/RAND_RR1296.pdf.

[98] Pollitz K, Cox C, Lucia K, and Keith K. January 7, 2014. Medical Debt Among People with Health Insurance. Kaiser Family Foundation. https://www.kff.org/private-insurance/report/medical-debt-among-people-with-health-insurance/.

[99] Buettgens et al. 2016.

[100] Jacobs et al. 2011.

[101] Jacobs et al. 2011.

[102] Nowak et al. 2016.

[103] Jacobs et al. 2011.

[104] Greenberg Strategy. October 5, 2017. Covered California Sentiment Research, Wave 2: A Quantitative Study on Current Attitudes of Uninsured and Select Insured Californians Toward Health Insurance Coverage. https://www.coveredca.com/PDFs/October_2017_Covered_California_Sentiment_Survey_FINAL.pdf.

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United States Government Accountability Office

Report to Congressional Requesters

March 2018

CMS INNOVATION CENTER

Model Implementation and Center Performance

This Report Is Temporarily Restricted Pending Official Public Release.

GAO-18-302

Highlights of GAO-18-302, a report to congressional requesters

March 2018

CMS INNOVATION CENTER

Model Implementation and Center Performance

Why GAO Did This Study

The Patient Protection and Affordable Care Act created the Innovation Center within CMS to test new approaches to health care delivery and payment—known as models—for use in Medicare, Medicaid, or CHIP. The Innovation Center became operational in November 2010. In 2012, GAO reported on the early implementation of the Innovation Center. GAO found that, during the first 16 months of operations, the Innovation Center focused on implementing 17 new models and developed preliminary plans for evaluating the effects of each model and for assessing the center's overall performance.

GAO was asked to update its previous work. In this report, GAO: (1) describes the status of payment and delivery models implemented and the resources used; (2) describes the center's use of model evaluations; and (3) examines the center's assessment of its own performance. GAO reviewed available documentation, such as model fact sheets and frequently asked questions, and evaluation reports for models that have been implemented. GAO reviewed obligation data and performance information for the time period for which complete data or information were available. GAO also interviewed officials from the Innovation Center and CMS's Office of the Actuary.

The Department of Health and Human Services provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View GAO-18-302. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

As of March 1, 2018, the Center for Medicare and Medicaid Innovation (Innovation Center) had implemented 37 models that test new approaches for delivering and paying for health care with the goal of reducing spending and improving quality of care. These models varied based on several characteristics, including the program covered—Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or some combination of the three—and the nature of provider participation—voluntary or mandatory. Going forward, the Innovation Center indicated that the center plans to continue focusing on the use of voluntary participation models and to develop models in new areas, including prescription drugs, Medicare Advantage, mental and behavioral health, and program integrity. Through fiscal year 2016, the Innovation Center obligated $5.6 billion of its $10 billion appropriation for fiscal years 2011 through 2019.

The Innovation Center has used evaluations of models (1) to inform the development of additional models, (2) to make changes to models as they are implemented, and (3) to recommend models for expansion. For example, Innovation Center officials noted that, for some instances where evaluations have shown reduced spending with maintained or improved quality of care, the center has developed new models that build upon the approaches of earlier models, but with adjustments intended to address reported limitations. In addition, the Innovation Center used evaluations to recommend two models to the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary for certification for expansion. According to CMS officials, a model evaluation and a certification for expansion differ in that a model evaluation assesses the impact of a delivery and payment approach for model participants only, while a certification for expansion assesses the future impact on program spending more broadly across all beneficiaries, payers, and providers who would be affected by the expanded model. As a result, the Office of the Actuary used the results of the evaluation and other information, such as Medicare claims data and published studies, to certify the expansion of both models.

To assess the center's overall performance, the Innovation Center established performance goals and related measures and reported meeting its targets for some goals in 2015, the latest year for which data were available (see table below).

Center for Medicare and Medicaid Innovation Reported Results for 2015 Performance Goals

Performance goal	Performance targets met
Reducing the growth of health care costs while promoting better health and healthcare quality through delivery system reform	Partially met
Identifying, testing, and improving payment and delivery models	Met
Accelerating the spread of successful practices and models	Partially met

Source: Center for Medicare & Medicaid Services. | GAO-18-302

Innovation Center officials told GAO that the center also recently developed a methodology to estimate a forecasted return on investment for its model portfolio. The center is in the early stages of refining the methodology and applying it broadly across its models.

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Abbreviations

ACO	Accountable Care Organization
APRN	Advanced Practice Registered Nurse
BPCI	Bundled Payments for Care Improvement
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CJR	Comprehensive Care for Joint Replacement
Diabetes Prevention Program	YMCA of the USA Diabetes Prevention Program
FQHC	Federally Qualified Health Center
HHS	Department of Health and Human Services
ICIP	Innovation Center Investment Proposal
OMB	Office of Management and Budget
Innovation Center	Center for Medicare and Medicaid Innovation
PPACA	Patient Protection and Affordable Care Act

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441 G St. N.W.
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March 26, 2018

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Michael C. Burgess
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

Federal spending on health care in the United States—driven primarily by Medicare and Medicaid expenditures—is expected to reach over $1 trillion in 2018 and to continue increasing and exerting pressure on the federal budget.[1] At the same time, studies have found that higher levels of spending do not reliably lead to enhanced quality of care.[2] The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), has sought to both reduce spending and improve quality of care for beneficiaries enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) by testing new ways

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[1]Medicare is the federal health insurance program for persons aged 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicaid is a joint federal-state health care financing program for certain low-income individuals and medically needy individuals.

[2]See for example, Sirovich, Brenda E., Daniel J. Gottlieb, H. Gilbert Welch, and Elliott S. Fisher. "Regional Variations in Health Care Intensity and Physician Perceptions of Quality of Care." *Annals of Internal Medicine,* vol. 144, no. 9 (2006); Landrum, M. B., Meara, E. R., Chandra, A., Guadagnoli, E., & Keating, N. L. "Is Spending More Always Wasteful? The Appropriateness Of Care And Outcomes Among Colorectal Cancer Patients." *Health Affairs, vol*. 27, no. 1 (2008); Yasaitis, L., Fisher, E. S., Skinner, J. S., & Chandra, A. "Hospital Quality And Intensity Of Spending: Is There An Association?" *Health Affairs, vol. 28, no.4*, (2009); and Rothberg MB, Cohen J, Lindenauer P, Maselli J, Auerbach A. "Little Evidence Of Correlation Between Growth In Health Care Spending And Reduced Mortality." *Health Affairs*, vol. 29, no.8 (2010).

for delivering and paying for health care services.[3] To further such testing, the Patient Protection and Affordable Care Act (PPACA) established the Center for Medicare and Medicaid Innovation (Innovation Center) within CMS under section 1115A of the Social Security Act.[4]

In establishing the Innovation Center, the law provided CMS with additional authority when testing new health care delivery and payment approaches, known as models.[5] For example, CMS may expand the duration and scope of models tested by the Innovation Center through rulemaking instead of needing the enactment of legislation, which was required to expand the demonstrations that CMS frequently conducted in the past. In addition, the law provided a dedicated appropriation for testing models—$10 billion for the Innovation Center's activities for the period of fiscal years 2011 through 2019 and $10 billion per decade beginning in fiscal year 2020.

In November 2012, we reported on the early activities of the Innovation Center. We found that, during the first 16 months of operations, the Innovation Center focused on implementing 17 new models while assuming responsibility for 20 demonstrations that CMS began before the start of the center. We also reported that the Innovation Center developed preliminary plans for evaluating the effects of each model on spending and quality of care and assessing the center's overall performance.[6]

At the time of our 2012 report, however, it was too early to consider certain questions raised by members of Congress about Innovation

[3]CHIP is a federal-state program that provides health care coverage to children 18 years of age and younger living in low-income families whose incomes exceed the eligibility requirement for Medicaid.

[4]The Innovation Center was established by section 1115A of the Social Security Act, as added by section 3021 of PPACA. See Pub. L. No. 111-148, §§ 3021, 10306. 124 Stat. 119, 389, 939 (Mar. 23, 2010) (codified at 42 U.S.C. § 1315a).

[5]Historically, CMS's efforts to test new approaches to health care delivery and payment have been referred to as "demonstrations." In this report, we will use the term "models" when discussing approaches initiated by the Innovation Center, and "demonstrations" when discussing approaches that were initiated prior to the establishment of the center.

[6]We also found that the Innovation Center had initiated implementation of a process to review and eliminate unnecessary duplication in the contracts awarded in one of its models. We recommended completing the implementation expeditiously. Implementation was completed in August 2013. See GAO, *CMS Innovation Center: Early Implementation Efforts Suggest Need for Additional Actions to Help Ensure Coordination with Other CMS Offices*, GAO-13-12 (Washington, D.C.: November 15, 2012).

Center operations, including the use of its dedicated funding, the impact of the models tested, and the center's overall performance. Given the amount of time that has passed—the Innovation Center has been in operation for over 7 years—you asked us to update our previous work to provide information on the activities of the center and to report on any results of the testing. This report examines

1. the status of the Innovation Center's testing of models and the resources used for such activities;
2. the use of model evaluations; and
3. the Innovation Center's assessment of its performance.

To determine the status of model testing and the resources used by the Innovation Center for such activities, we reviewed Innovation Center documentation, including information on models the center was implementing or had announced, as well as web pages, model fact sheets, and frequently asked questions. We obtained and analyzed Innovation Center data on the amounts of the Innovation Center's appropriations obligated. We also interviewed and obtained written responses from Innovation Center officials. Our work focused on models tested and funded through appropriations under section 1115A of the Social Security Act, as enacted by PPACA, which established the center and provided its dedicated appropriations. In general, our work covered the period during which the Innovation Center first became operational (fiscal year 2011) through the most recent time period for which complete information was available. For the status of model testing, we considered information through March 1, 2018. For the resources used, we analyzed data on the amounts of the Innovation Center's appropriations obligated through fiscal year 2016. We assessed the reliability of the obligation data by comparing it to publicly reported amounts and discussing the data with center officials. We determined these data were sufficiently reliable for the purposes of our objectives.

To determine how the Innovation Center used evaluations of models, we interviewed officials from the center, CMS's Office of the Actuary, evaluation contractors, and subject matter experts to discuss the use of

evaluations, in general, as well as for five selected models specifically.[7] We selected models based on a nonprobability sample that included both Medicare and Medicaid models; ongoing and completed models; models that fell under the responsibility of different Innovation Center staffing groups; and one model evaluated for expansion. Because we used a nonprobability sample, our results are not generalizable beyond the models we reviewed; however, they provide insight into how CMS uses the evaluations of its models. We also analyzed publicly available evaluation reports and other model documentation publicly available from the Innovation Center and the Office of the Actuary.

To describe the Innovation Center's assessment of its performance, we reviewed information reported on the center's targeted and actual performance available in CMS's Congressional Budget Justifications for fiscal years 2012 through 2018. Information on the center's targets was available for performance years 2014 through 2018. Complete information on the center's actual performance was available for 2015. Partial information was available for 2014 and 2016, and no information was available for 2017 and 2018. We also interviewed Innovation Center officials regarding the assessment of performance.

We conducted this performance audit from February 2017 to March 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[7]The five models selected were the Bundled Payments for Care Improvement Model 2; the Comprehensive Primary Care Initiative; the Health Care Innovation Awards; the Pioneer Accountable Care Organization model; and the Strong Start for Mothers and Newborns Initiative: Enhanced Prenatal Care model.

Background

Requirements for Innovation Center Models Implemented under Section 1115A

Section 1115A establishes certain requirements for the Innovation Center that relate to the selection of models, use of resources, and evaluation of models. These requirements include:

- consulting with representatives of relevant federal agencies, as well as clinical and analytical experts in medicine or health care management, when carrying out its duties as described in the law;
- ensuring models address deficits in care that have led to poor clinical outcomes or potentially avoidable spending;
- making no less than $25 million of the Innovation Center's dedicated funding available for model design, implementation, and evaluation each fiscal year starting in 2011;
- evaluating each model to analyze its effects on spending and quality of care, and making these evaluations public; and
- modifying or terminating a model any time after testing and evaluation has begun unless it determines that the model either improves quality of care without increasing spending levels, reduces spending without reducing quality, or both.

Under section 1115A, certain requirements applicable to previous CMS demonstrations are inapplicable to models tested under the Innovation Center. For example, while prior demonstrations generally required congressional approval in order to be expanded, section 1115A allows CMS to expand Innovation Center models—including on a nationwide basis—through the rulemaking process if the following conditions are met: (1) the agency determines that the expansion is expected to reduce spending without reducing the quality of care, or improve quality without increasing spending; (2) CMS's Office of the Actuary certifies that the expansion will reduce or not increase net program spending; and (3) the agency determines that the expansion would not deny or limit coverage or benefits for beneficiaries.[8] In addition, certain requirements previously cited by the Medicare Payment Advisory Commission as administrative

[8]In addition, the law provides that demonstrations conducted under 42 U.S.C. § 1395cc-3, Medicare's Health Care Quality Demonstration Program, may also be expanded under the same conditions. 42 U.S.C. § 1315a(c).

barriers to the timely completion of demonstrations are inapplicable.[9] Specifically, section 1115A provides the following:

- HHS cannot require that an Innovation Center model initially be budget neutral—that is, designed so that estimated federal expenditures under the model are expected to be no more than they would have been without the model—prior to approving a model for testing.
- Certain CMS actions in testing and expanding Innovation Center models cannot be subject to administrative or judicial review.
- The Paperwork Reduction Act—which generally requires agencies to submit all proposed information collection efforts to the Office of Management and Budget (OMB) for approval and provide a 60-day period for public comment when they want to collect data on 10 or more individuals—does not apply to Innovation Center models.[10]

Innovation Center Staffing and Organization

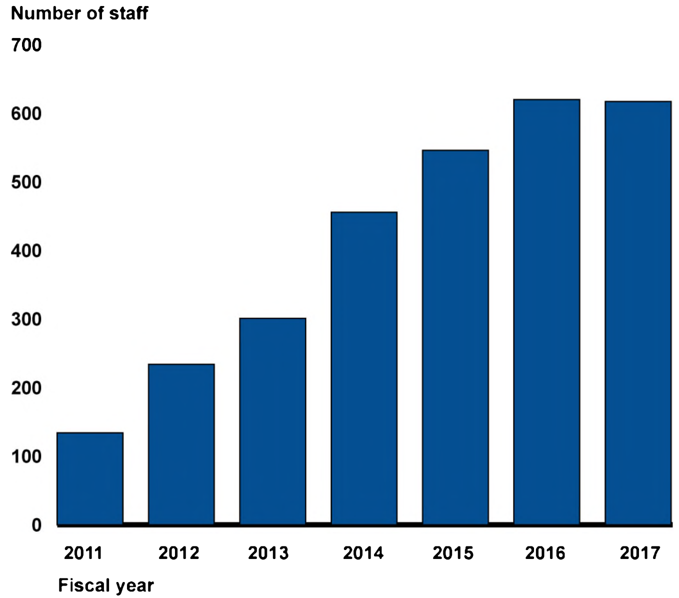
The Innovation Center uses a combination of staff and contractors to test models. Since the center became operational in November 2010, the number of staff increased steadily through the end of fiscal year 2016.[11] (See fig. 1.) As of September 30, 2017, there were 617 staff—a slight decrease in the number of staff from the end of the prior fiscal year. Officials indicated that, in the future, changes in the model portfolio may require additional staff to manage and support model development and implementation. However, officials do not anticipate needing to increase staffing levels at the same pace as they did between fiscal years 2011 and 2016. Additionally, the Innovation Center uses third-party contactors to perform functions related to the implementation of models and to perform evaluations of the changes in the quality of care furnished and program spending under a model.

[9]See Medicare Payment Advisory Commission, *Report to Congress: Aligning Incentives in Medicare*, (Washington, D.C.: 2010).

[10]44 U.S.C. §§ 3501-3520. OMB assists the President in overseeing the preparation of the federal budget and in supervising its administration in executive branch agencies. OMB also oversees and coordinates the administration's procurement, financial management, information, and regulatory policies.

[11]We previously reported that, as of March 31, 2012, the Innovation had 184 staff. See GAO-13-12. Staff are primarily funded through appropriations under section 1115A of the Social Security Act.

Figure 1: Center for Medicare and Medicaid Innovation Staffing Levels, Fiscal Years 2011-2017



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-302

The Innovation Center has organized its 617 staff members primarily into eight groups and the Office of the Director. Four of the eight groups are responsible for coordinating the development and implementation of models.[12] Staff in these four groups primarily lead efforts in developing model designs and obtaining approval for their models from CMS and HHS. Once a model is approved, staff coordinate the remaining implementation steps, including soliciting and selecting participants and overseeing the model during the testing and evaluation period. The other four groups perform key functions that support model development and implementation, such as reviewing ideas submitted for consideration as possible models, overseeing the evaluations of models, providing feedback to model participants about their performance, disseminating

[12]We previously reported that as of March 31, 2012, the groups that implement models included the Medicare Demonstration Group, which was responsible for implementing models required by authorities other than section 1115A of the Social Security Act and CMS demonstrations that existed prior to the establishment of the Innovation Center. See GAO-13-12. According to Innovation Center officials, the responsibility for these models and demonstrations was reassigned to other model groups.

lessons learned across models, and monitoring budget resources.[13] The Office of the Director, in general, has oversight responsibilities for the models led by these groups. Table 1 provides information on the staffing groups within the Innovation Center.

Table 1: Description of Center for Medicare and Medicaid Innovation (Innovation Center) Staffing Groups

Group	Purpose
Groups that coordinate model development and implementation	
Patient Care Models Group	Develop and coordinate the implementation of models designed to improve care for clinical groups of patients, such as patients needing heart bypass surgery
Prevention and Population Health Group	Develop and coordinate the implementation of models designed to improve the health of different populations of beneficiaries.
Seamless Care Models Group	Develop and coordinate the implementation of models designed to improve coordination of care for a general patient population across care settings.
State Innovations Group	Develop and coordinate the implementation of models designed to use states' policy and regulatory levers to accelerate health care transformation in multi-payer environments.
Groups that support model development and implementation	
Business Services Group	Provide administrative support to the Innovation Center in areas such as budgeting, contracting, project management, information technology support and maintenance.
Learning and Diffusion Group	Facilitate learning within models and disseminate the lessons learned across models so that participants can benefit from the experiences of other models.
Policy and Programs Group	Manage ideas for consideration as possible models and seek to ensure a balanced portfolio of different types of models and manage stakeholder engagement for the Innovation Center.[a]
Research and Rapid Cycle Evaluation Group	Coordinate the evaluation of models and provide ongoing feedback to participants.

Source: GAO analysis of Centers for Medicare & Medicaid Services information. | GAO-18-302

Notes: We previously reported that the groups under which the Innovation Center organized staff included the Medicare Demonstration Group and the Stakeholder Engagement Group. See GAO-13-12. The Medicare Demonstration Group, which previously was responsible for implementing

[13]We previously reported that as of March 31, 2012, the groups that support model implementation included the Stakeholder Engagement Group, which conducted outreach to potential stakeholders, to gain support and solicit ideas for innovative models, and to potential participants—such as physician groups and hospitals—to inform them of the opportunity to participate in models. See GAO-13-12. According to Innovation Center officials, this group was incorporated into the Policy and Programs Group in 2016. The Policy and Programs Group is also responsible for developing and implementing a portion of the Quality Payment Program—a new payment framework for Medicare intended to reward providers for efficient, high-quality care, instead of a higher volume of services. This program includes two tracks: (1) the Merit-based Incentive Payment System and (2) Advanced Alternative Payment Models.

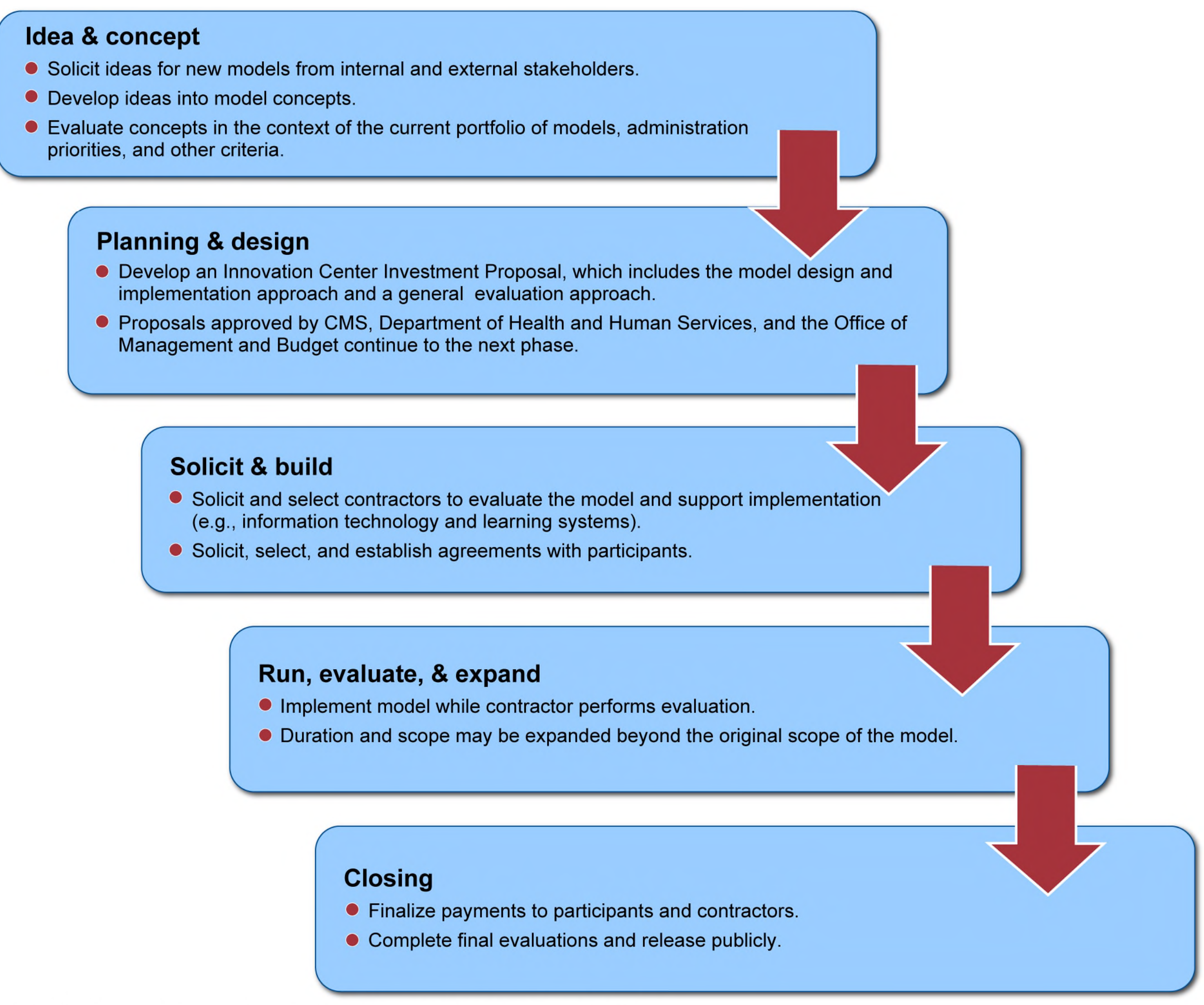
certain models and demonstrations, was eliminated, and its responsibilities were reassigned to other groups. The Stakeholder Engagement Group was incorporated into the Policy and Programs Group.

[a]The Policy and Programs Group is also responsible for developing and implementing a portion of the Quality Payment Program—a new payment framework for Medicare intended to reward health care providers for efficient, high-quality care, instead of a higher volume of services. This program includes two tracks: (1) the Merit-based Incentive Payment System and (2) Advanced Alternative Payment Models.

Innovation Center Process for Model Development and Implementation

The Innovation Center has developed internal agency guidance that outlines a general process used by the four model groups for developing and implementing models. (See fig. 2.) Appendix I provides additional information about the general process for implementing models.

Figure 2: Center for Medicare and Medicaid Innovation (Innovation Center) Process for Model Development and Implementation



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-18-302

Innovation Center Categories for Models

The Innovation Center has organized its models into seven categories based on delivery and payment approaches tested and program beneficiaries covered. The seven categories are as follows:

- **Accountable Care.** This category includes models built around accountable care organizations (ACOs)—groups of coordinated health care providers who are held responsible for the care of a group of patients. The models are designed to encourage ACOs to invest in infrastructure and care processes for improving coordination, efficiency, and quality of care for Medicare beneficiaries.
- **Episode-based payment initiatives.** This category includes models in which providers are held accountable for the Medicare spending and quality of care received by beneficiaries during an "episode of care," which begins with a health care event (e.g., hospitalization) and continues for a limited time after.
- **Initiatives Focused on Medicare-Medicaid Beneficiaries.** This category includes models focused on better serving individuals eligible for both Medicaid and Medicare in a cost-effective manner.
- **Initiatives Focused on Medicaid and CHIP Populations.** This category includes models administered by participating states to lower spending and improve quality of care for Medicaid and CHIP beneficiaries.
- **Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models.** This category includes models where the Innovation Center works with participants to test state-based and locally developed models, covering Medicare beneficiaries, Medicaid beneficiaries, or both.
- **Initiatives to Speed the Adoption of Best Practices.** This category includes models in which the Innovation Center collaborates with health care providers, federal agencies, and other stakeholders to test ways of disseminating evidence-based best practices that improve Medicare spending and quality of care for beneficiaries.
- **Primary Care Transformation.** This category includes models that use advanced primary care practices—also called "medical homes"—to emphasize prevention, health information technology, care coordination, and shared decision-making among patients and their providers.

For certain categories, the Innovation Center assigns primary responsibility for developing and implementing models to a single model group; for some other categories, the responsibility is shared across different groups. For example, the center assigned responsibility for models in the ACO and the Primary Care Transformation categories to the Seamless Care Model Group, whereas the responsibility for models in the Initiatives to Accelerate the Development and Testing of New

Payment and Service Delivery Models categories were assigned across all four model groups. Appendix II provides a summary of the number of models organized under each category and a description of each model.

The Innovation Center Implemented 37 Models That Test Varying Delivery and Payment Approaches, and Obligated over $5.6 Billion

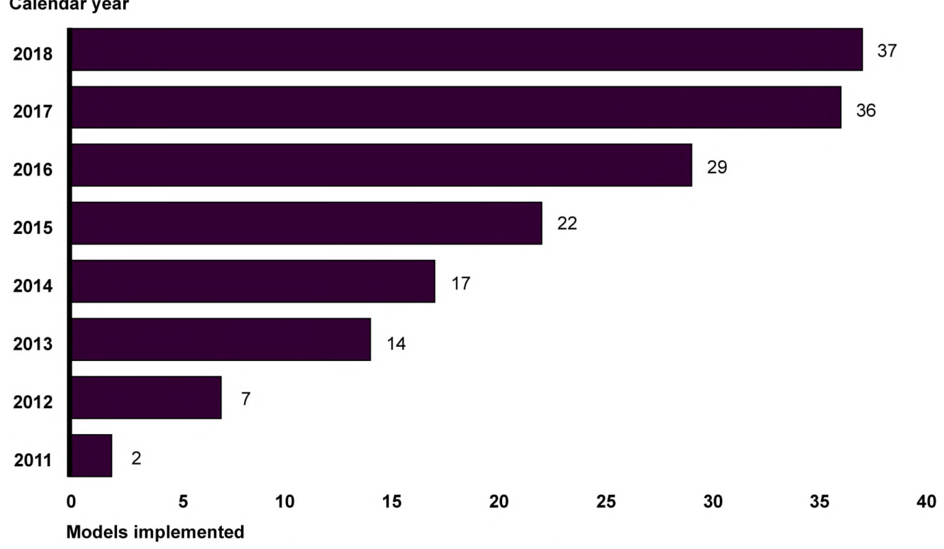
The Innovation Center Implemented 37 Models and Announced an Additional 2; Models Varied by Delivery and Payment Approaches Tested, Beneficiaries Covered, and Other Characteristics

As of March 1, 2018, the Innovation Center had implemented 37 models under section 1115A of the Social Security Act.[14] (See fig. 3.) Of those 37 models, the testing period has concluded for 10 of them.[15] In addition, the Innovation Center has announced two models to begin testing in 2018.

[14]In addition to these models, we previously reported that the Innovation Center was responsible for implementing 6 models required by other provisions of PPACA, as well as 20 CMS demonstrations that existed prior to the establishment of the Innovation Center. See GAO-13-12. The testing periods for 4 of the 6 models required by other provisions of PPACA and 19 of 20 demonstrations have ended. See appendix III for more information on the 6 models required by other provisions of PPACA.

[15]These ten models are the Advance Payment ACO Model, the Bundled Payments for Care Improvement Model 1 (Retrospective Acute Care Hospital Stay Only), the Comprehensive Primary Care Initiative, the Federally Qualified Health Center Advanced Primary Care Practice Demonstration, the Health Care Innovation Awards Round 1, the Health Care Innovation Awards Round 2, the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: Phase One, Pioneer ACO, Partnership for Patients, and State Innovation Models Initiative: Round One.

Figure 3: Cumulative Number of Models Implemented by the Center for Medicare and Medicaid Innovation, 2011-2018



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-302

Note: Models were implemented between January 1, 2011 and March 1, 2018. Of the 37 models, the testing period ended in calendar year 2017 or before for 10 models.

Innovation Center models varied based on several characteristics, including delivery and payment approaches tested and program(s) covered. Delivery and payment approaches varied across all implemented and announced models—even models organized by the Innovation Center under the same model category. For example, the six models that tested an episode-based payment approach varied in terms of how episodes were defined, including the clinical and surgical episodes to which models applied. In addition, some models included multiple approaches for achieving changes in health care delivery or payment. Models also differed in terms of the programs covered, with 22 models covering Medicare only, 9 models covering Medicare and Medicaid, one model covering Medicaid and CHIP, and 7 models covering all three programs. Other characteristics by which models varied include the nature of model participation for providers (voluntary or mandatory) and the source of innovation (i.e., federal, state, or local initiatives). See table 2 for a breakdown of models across selected characteristics. Appendix II provides a full description of all models implemented and announced by the Innovation Center.

Table 2: Selected Characteristics of the Center for Medicare and Medicaid Innovation Implemented and Announced Models, as of March 1, 2018

Model characteristic	Description of models implemented or announced
Program covered	• Twenty-two models covered Medicare only—one of which specifically focused on Medicare Advantage. • Nine models covered Medicare and Medicaid. • One model covered Medicaid and the Children's Health Insurance Program (CHIP). • Seven models covered Medicare, Medicaid, and CHIP.
Nature of provider participation	• Thirty-seven models had voluntary participation. • One model had a combination of mandatory and voluntary participation.[a] • One model had mandatory participation.
Innovation source	• Thirty-one models tested a delivery and payment approach designed by the Innovation Center. • Six models tested approaches designed and implemented by or in partnership with states. • Two models tested a variety of delivery and payment approaches designed and implemented by individual cooperative agreement awardees.
Other	• Eight models were considered advanced alternative payment models—payment approaches that gave incentive payments to provide high-quality and cost-efficient care allowing providers to earn more for taking on some risk related to patient outcomes. • Two models tested delivery and payment approaches designed to prevent the development of specific diseases in at-risk beneficiaries. • Two models focused on specialty care services— orthopedic surgeries and chemotherapy—to test payment arrangements in which hospitals received additional payments or made recoupment payments if total spending for Medicare services provided during an "episode of care" was over or under a predetermined target price.

Source: GAO analysis of Centers for Medicare & Medicaid Services information. | GAO-18-302

[a]On December 1, 2017, a final rule was issued making provider participation in select geographic areas voluntary for this model, effective January 1, 2018. Prior to the final rule, provider participation was mandatory in all geographic areas included in this model.

In September 2017, the Innovation Center provided some insight into its future plans when it issued an informal "request for information" that identified guiding principles under which models will be designed going forward, described focus areas for new models, and requested feedback from stakeholders. One of the guiding principles focused on voluntary models—a principle consistent with a final rule published in December 2017 canceling four mandatory participation models in development and making participation in a fifth mandatory model voluntary for some

geographic areas.[16] Other guiding principles included promoting competition based on quality, outcomes, and costs; empowering beneficiaries, their families, and caregivers to take ownership of their health; and using data-driven insights to ensure cost-effective care that also leads to improvements in beneficiary outcomes. In addition, the Innovation Center indicated the following focus areas for new model development: additional advanced alternative payment models; consumer-directed care and market-based innovation models; physician specialty models; prescription drug models; Medicare Advantage innovation models; state-based and local innovation, including Medicaid-focused models; mental and behavioral health models; and program integrity.

The Innovation Center Obligated over 55 Percent of Its Initial Multiyear Appropriation through Fiscal Year 2016

According to Innovation Center documentation, through September 30, 2016, the center obligated over $5.6 billion of the $10 billion appropriated for fiscal years 2011 through 2019 under section 1115A of the Social Security Act.[17] The obligated amounts for individual models during this period ranged from $8.4 million to over $967 million, and varied based on model scope and design.[18] For example, a model where the Innovation Center used its waiver authority to provide additional flexibility to participants (rather than additional funding) required only $8.4 million in obligations for the evaluation of the model and implementation activities. In contrast, a model where the Innovation Center awarded funding to a

[16]See 82 Fed. Reg. 57,066 (Dec. 1, 2017). The final rule canceled the Episode Payment Models—the Surgical Hip/Femur Fracture Treatment Model, the Acute Myocardial Infarction Model, and the Coronary Artery Bypass Graft Model—and the Cardiac Rehabilitation Incentive Payment Model, all of which were scheduled to begin on January 1, 2018. The Comprehensive Joint Replacement model was implemented in April 2016 in 67 geographic areas. When implemented, participation was mandatory in all areas. The final rule made participation voluntary in 33 of the 67 geographic areas and for all low volume and rural hospitals.

[17]An obligation is a definite commitment that creates a legal liability of the government for the payment of goods and services ordered or received, or a legal duty on the part of the United States that could mature into a legal liability by virtue of actions on the part of the other party beyond the control of the United States. Payment may be made immediately or in the future.

[18]Obligated amounts for individual models reflect payments made to model participants (including health care providers, states, and others) as well as other payments to support model development and testing. Amounts do not include Medicare, Medicaid, and CHIP payments that health care providers or others receive for services provided to the beneficiaries. For models selected by the Innovation Center for development and implementation, the center obtains approval from CMS, HHS, and OMB for the amount it expects will be required to test and evaluate models.

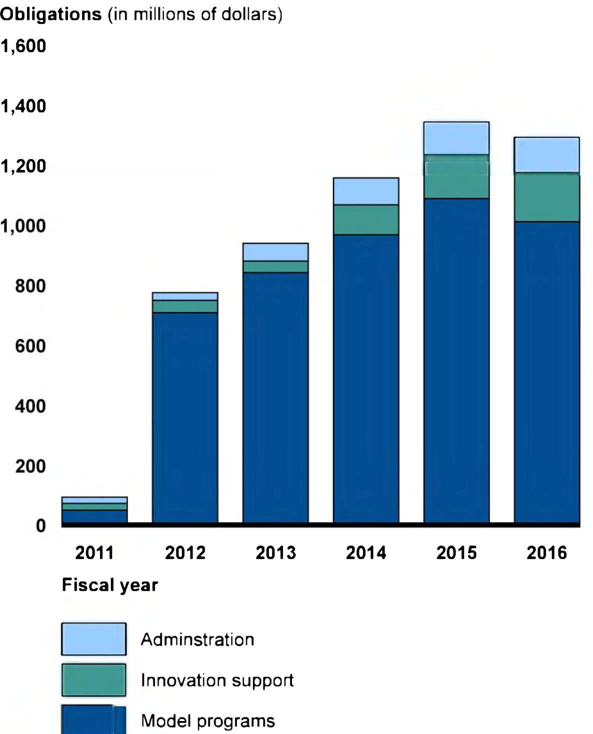
broad set of partners, including providers, local government, and public-private partnerships, to test their own care delivery and payment models required more than $870 million in obligations for payments to awardees and used over $95 million for contractor evaluations and other activities that supported model development and implementation.

Innovation Center spending falls into three categories: model programs, innovation support, and administration.

- Model programs include obligations that directly support individual models and delivery system reform initiatives.
- Innovation support includes center-wide operational expenses that are not directly attributable to a single model.
- Administration includes permanent federal full-time equivalent payroll expenses, administrative contracts, administrative interagency agreements, and general administrative expenses.

As the Innovation Center implemented additional models each year, total annual obligations increased steadily from approximately $95 million in fiscal year 2011 to more than $1.3 billion in fiscal year 2015, but decreased slightly in fiscal year 2016. (See fig. 4) Most of these total obligations were for model programs, which followed a similar pattern, increasing from $51 million in 2011 to about $1.1 billion in fiscal year 2015, with a slight decrease in fiscal year 2016. According to officials, the 2016 decrease in obligations for model programs was due in part to some of the earlier, expensive models ending and to newer models being less costly than the older models. Officials noted, for example, that a number of newer models incorporated basic program infrastructure used in previously implemented models, which allowed for reduced model costs. Officials also indicated that the decrease in obligations may be due to newer models using payment approaches that are funded by the Medicare Trust Fund, rather than funded by the Innovation Center's dedicated appropriation. The center's obligations for both innovation support and administration increased from around $20 million for each category in fiscal year 2011 to about $163 million for innovation support and $119 million for administration in fiscal year 2016. Officials told us that as obligations for model programs grew, so did obligations for innovation support and administration, which includes indirect costs and contractor assistance.

Figure 4: Center for Medicare and Medicaid Innovation Annual Obligations, Fiscal years 2011-2016



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-302

Evaluations Inform the Development of Models and Decisions to Certify Certain Models for Expansion

The Innovation Center Has Used the Results from Evaluations to Inform the Development of Additional Models and to Make Changes to Implemented Models

The Innovation Center has used the results from model evaluations to generate ideas for new models. For some of the early implemented models, evaluation results showed reduced spending and maintained or improved quality of care, but also identified model design limitations that could affect those results. According to officials, in some of these instances, the Innovation Center has developed new models that build upon the approaches of earlier models, but include adjustments intended to address identified limitations (see text box).

Evaluations of Implemented Models

The evaluation of each model is performed by a third-party contractor, who generally determines the effect of a model on quality of care and program spending by comparing data for model participants to those of a comparison group of providers and beneficiaries with characteristics similar to model participants. For purposes of the evaluation, the Innovation Center has the authority to require the collection and submission of necessary data by model participants. Accordingly, the third-party contractor collects both quantitative and qualitative data. The quantitative data are used to assess program spending and quality of care and the qualitative data are used to provide the context needed to understand the quantitative results.

Source: GAO | GAO-18-302

Example of A Model That Tests the Same General Delivery and Payment Approach of a Previously Implemented Model While Addressing Limitations

Bundled Payment for Care Improvement (BPCI) Model 2 tested an episode-based delivery and payment approach in which the Innovation Center set a benchmark, or target, price for all Medicare services a beneficiary might receive during a clinical episode—defined by BPCI Model 2 as the initial hospital stay and all services received up to 90 days after discharge. If the total spending for Medicare services during an episode was lower than the target price, participating hospitals would receive payments in addition to the normal fee-for-service payments. If the total spending for Medicare services during an episode was higher than the target price, participating hospitals would have to reimburse Medicare. Participants could select up to 48 different clinical episodes under the model.

The evaluation of BPCI Model 2 found that orthopedic surgery episodes—of which approximately 90 percent were hip and knee joint replacement surgeries—may have resulted in reduced program spending and improved quality of care. However, the evaluation also identified limitations affecting those results. For example, the target prices for hip and knee replacement surgeries did not account for potential differences in Medicare spending between elective surgeries and surgeries required after a fracture. As a result of this limitation, hospitals could attempt to control spending by limiting the number of episodes associated with higher cost beneficiaries (i.e., those requiring surgery due to a fracture).

In part to address the design issue identified under BPCI Model 2, Innovation Center officials told us they developed the Comprehensive Care for Joint Replacement (CJR) model. Implemented in April 2016, the CJR model tests the same general delivery and payment approach used in BPCI Model 2, but focuses specifically on hip and knee joint replacement surgical episodes and adjusts the target price to account for the higher spending related to hip and knee joint replacement surgeries following a fracture. As of March 1, 2018, no evaluations of the CJR model have been publicly released.

Source: GAO. | GAO-18-302

The Innovation Center has also used the results from evaluations as one way to improve the operational and participant support for new models. According to officials, evaluations have helped them identify lessons learned regarding support systems, such as which types of systems work well with which types of models, and then the center incorporated those lessons when designing the systems for new models. For example, officials noted that the experience with the learning system from the Bundled Payments for Care Improvement (BPCI) models informed the learning system for the Comprehensive Care for Joint Replacement (CJR) model.[19] The lessons learned helped the Innovation Center better identify where participants would need additional support and the learning activities—such as webinars and implementation guides—to provide the needed support during the early stages of model implementation. Innovation Center officials told us that these lessons from evaluations helped ensure that each successive model built upon the collective experience of models implemented by the center.[20]

The Innovation Center also has used evaluation results to make periodic changes to models during the testing period. According to officials, these changes include adjustments to the delivery and payment approaches tested, such as refining the target population, broadening the geographic focus, and refinements of spending calculations. Innovation Center officials noted that, in general, such changes were limited to minimize their effects on the evaluation of program spending and quality of care. Officials also identified changes to operational and participant support systems, which have included changes to the timing of participant data reporting, revisions to how data are collected from participants, and changes to the way learning materials are delivered to participants. According to officials, these types of changes are generally intended to help improve the experience of participants.

[19]The Innovation Center uses learning systems to help participants achieve success under its models by articulating the aim and drivers of success, providing technical assistance and feedback, and facilitating peer-to-peer exchange of ideas, among other functions.

[20]Another way in which the evaluations inform the development of additional models relates specifically to primary care redesign models. The Innovation Center initiated a systematic review of the evaluation results for six primary care redesign models implemented by the center. The review, in part, identified common themes to consider when developing new models. See https://innovation.cms.gov/Files/reports/primarycare-finalevalrpt.pdf (accessed March 7, 2018).

According to Innovation Center officials, evaluation results may also be used in making a decision to terminate a model prior to the end of its planned testing period. However, officials stated that the Innovation Center has not terminated any models prior to the conclusion of their testing periods, either based on the results of an evaluation or for other reasons.[21]

Evaluations Informed Innovation Center Decisions to Recommend Two Models be Certified for Expansion

The Innovation Center used evaluation results in recommending two models be certified for expansion. According to Innovation Center officials, the evaluation of each model adequately demonstrated that the delivery and payment approach tested reduced Medicare spending while maintaining or improving quality of care. Based on these results, the Innovation Center formally requested that CMS's Office of the Actuary analyze the financial impact of a potential expansion of each model. The two models were:

- **Pioneer ACO.** Pioneer ACO tested an ACO delivery and payment approach that gave providers an opportunity to be paid a relatively greater share of savings generated, compared to participants in other ACO models, in exchange for accepting financial responsibility for any losses. In year 3 of the model, ACOs that met certain levels of savings in the first two years could elect to receive a portion of their Medicare fee-for-service payments in the form of predetermined, per beneficiary per month payments.
- **YMCA of the USA Diabetes Prevention Program (Diabetes Prevention Program).** The Diabetes Prevention Program applied a lifestyle change program recognized by the Centers for Disease Control and Prevention to reduce to the risk of Type 2 diabetes for at-risk Medicare beneficiaries. The Diabetes Prevention Program was a part of the Health Care Innovation Awards Round One model.

When assessing the Pioneer ACO and Diabetes Prevention Program models for expansion, the officials from the Office of the Actuary considered the model evaluation results that were available and information from other sources.[22] For example, the assessment of Pioneer ACO used historical shared savings calculations and beneficiary

[21]Innovation Center officials told us that some models have been canceled prior to the start of testing due to lack of interest in participation.

[22]The Office of the Actuary conducted its assessments prior to the availability of final evaluations for both models.

attribution data from ACOs in the Medicare Shared Saving Program and Pioneer ACO; Medicare claims and enrollment data; and published studies. According to CMS officials, a model evaluation and a certification for expansion differ in that a model evaluation assesses the historical impact of a delivery and payment approach for model participants only, while a certification for expansion assesses the future impact on program spending across all beneficiaries, payers, and providers who would be affected by the expanded model.

Based on its assessments, the Office of the Actuary certified both models for expansion and steps have been taken to expand them. In certifying Pioneer ACO, the Office of the Actuary concluded that because ACOs, in general, have been shown to produce savings relative to Medicare fee-for-service, an expansion of Pioneer ACO would generate further savings to the Medicare program.[23] According to officials, CMS expanded Pioneer ACO by incorporating elements of the model—through rulemaking—as one of the options that providers may choose under the Medicare Shared Savings Program.[24] For the Diabetes Prevention Program, the Office of the Actuary concluded that certain changes considered as part of the expansion would, in the near term, improve upon the original savings achieved as part of the Health Care Innovation Awards as well as savings achieved in similar diabetes prevention programs. The Innovation Center has expanded—through rulemaking—the Diabetes Prevention Program under a new, nationwide model to be implemented in April 2018.

In addition, officials from the Innovation Center and the Office of the Actuary discussed potentially assessing whether Partnership for Patients should be certified for expansion. Partnership for Patients is a model that leveraged federal, state, local, and private programs to spread proven practices for reducing preventable hospital-acquired conditions and readmissions across acute care hospitals. According to officials, the Innovation Center shared the results for Partnership for Patients—which showed improved quality of care in the form of reduced preventable hospital-acquired conditions and readmissions—with the officials from the

[23]In order for the requirements for expansion to be met, the Secretary must also determine that expansion is expected to reduce spending without reducing the quality of care or improve the quality of care without increasing spending and that expansion would not deny or limit the coverage or provisions of benefits.

[24]The Medicare Shared Savings Program is a permanent Medicare ACO program. The program includes different participation options that allow ACOs to assume various levels of risk.

Office of the Actuary. After discussing these issues, Innovation Center officials decided not to request a formal analysis for certification of expansion.[25]

The Innovation Center Established Performance Goals and Related Performance Measures and Reported Meeting Its Targets for Some Goals

To assess is own performance, the Innovation Center established three center-wide performance goals and related measures.[26]

Goal 1: Reduce the growth of healthcare costs while promoting better health and health care quality through delivery system reform. This goal has three performance measures that focus on ACOs. As shown in table 3, the Innovation Center has reported mixed results in achieving the targets set. According to agency reported data, the Innovation Center met the targets for 2 of its 3 Goal 1 performance measures for 2015. For the remaining measure—the percentage of ACOs that shared in savings—the center did not meet its target during either of the two years for which data were available. According to officials, when results fall short of targets, they examine the causes and make appropriate adjustments to the program. Officials stated that the missed target was driven by the high growth in the number of ACOs that were new—and therefore would not yet be expected to achieve a level of savings in which they could share—and not by ACO performance deficits. As a result, officials decided that no adjustments were required to the Medicare Shared Savings Program or other ACO Models to help improve performance. However, as shown in table 3, the Innovation Center set a target for 2016 that was lower than the 2015 target. For 2017, the Innovation Center lowered the expectation for growth compared to previous years, setting a target that was 1 percent higher than the 2016 target. Moving forward, CMS believes that as more ACOs gain experience, more will share in savings. Additionally, the agency expects that with additional performance years, the targets for the measure will become more refined.

[25]According to Innovation Center officials, the evidence of improvements under the model was sufficient for the model approach to be incorporated in the Quality Improvement Organization program—a program under which CMS contracts with organizations to improve quality of care of Medicare beneficiaries in nursing homes and other settings.

[26]We previously reported that the Innovation Center's initial plans for evaluating its own performance included aggregating data on cost and quality measures developed for individual models, in conjunction with its third-party contractors. See GAO-13-12. According to center officials these measures could not be aggregated because of differences in the target populations and participating providers across models.

Table 3: Reported Results of the Center for Medicare and Medicaid Innovation's Performance Measures for Its Goal to Reduce the Growth of Health Care Costs While Promoting Better Health and Health Care Quality through Delivery System Reform

Performance measure	Performance year				
	2014	2015	2016[a]	2017[a]	2018[a]
Increase the number of Medicare beneficiaries who have been aligned with accountable care organizations (ACOs)	✔ (Target: 5,425,000) (Actual: 5,954,342)	✔ (Target: 7,090,000) (Actual: 7,731,655)	n/a (Target: 8,710,000) (Actual: n/a)	n/a (Target: 9,920,000) (Actual: n/a)	n/a (Target: 11,245,000) (Actual: n/a)
Increase the number of physicians participating in an ACOs	✘ (Target: 150,000) (Actual: 132,148)	✔ (Target: 178,000) (Actual: 195,212)	n/a (Target: 266,600) (Actual: n/a)	n/a (Target: 275,200) (Actual: n/a)	n/a (Target: 331,200) (Actual: n/a)
Increase the percentage of ACOs that share in savings	✘ (Target: 35 percent) (Actual: 34 percent)	✘ (Target: 37 percent) (Actual: 34 percent)	n/a (Target: 36 percent) (Actual: n/a)	n/a (Target: 37 percent) (Actual: n/a)	n/a (Target: n/a) (Actual: n/a)

Legend: ✔– met or exceeded performance target; ✘ – did not meet performance target; n/a – data not available

Source: Centers for Medicare & Medicaid Services (CMS). | GAO-18-302

[a]CMS has not released performance data for 2016 through 2018 for this performance measure.

Goal 2: Identify, test, and improve payment and service delivery models. This goal has one performance measure, which identifies the number of models that currently indicate (1) cost savings while maintaining or improving quality or (2) improving quality while maintaining or reducing cost. As of September 30, 2016, the Innovation Center reported that four section 1115A model tests have met these criteria (see table 4). [27]

[27]The four models that have met the criteria of the Innovation Center's goal 2 are: Pioneer ACO, the Diabetes Prevention Program, the Initiative to Prevent Avoidable Hospitalizations among Nursing Facilities Residents Phase 1, and lower-extremity joint replacement under the BPCI.

Table 4: Reported Results of the Center for Medicare and Medicaid Innovation's Performance Measures for Its Goal to Identify, Test, and Improve Payment and Service Delivery Models

Performance measure	Performance year				
	2014	2015	2016	2017[a]	2018[a]
Increase the number of model tests that currently indicate (1) cost savings while maintaining or improving quality, and/or (2) improving quality while maintaining or reducing cost	n/a	✔ (Target: 3 models) (Actual: 3 models)	✔ (Target: 4 models) (Actual: 4 models)	n/a (Target: 5 models) (Actual: n/a)	n/a (Target: 6 models) (Actual: n/a)

Legend: ✔ – met or exceeded performance target; ✘ – did not meet performance target; n/a – data not available

Source: Centers for Medicare & Medicaid Services (CMS). | GAO-18-302

Note: The goal and related performance measure were established in 2014. A target for performance was established in 2015.

[a]CMS has not released performance data for fiscal year 2017 or 2018 for this performance measure.

Goal 3: Accelerate the spread of successful practices and models. For this goal, the first performance measure focuses on the number of states developing and implementing a health system transformation and payment reform plan.[28] The second measure focuses on increasing the percentage of active model participants who are involved in Innovation Center or related learning activities. As shown in table 5, the Innovation Center reported meeting its target for the first measure for both fiscal years 2015 and 2016, but not meeting its target for the second measure. For the second measure, the Innovation Center noted in its report to Congress that although the results for fiscal year 2016 showed a slight decrease in overall participation in Innovation Center or related learning activities, the majority of models performed higher than their individual targets. Several models underperformed, however, bringing down the overall percentage rate.

[28]The Innovation Center provides funding and technical assistance to states to design or to test new payment and service delivery models that have the potential to reduce health care costs in Medicare, Medicaid, and CHIP.

Table 5: Reported Results of the Center for Medicare and Medicaid Innovation's Performance Measures for Its Goal to Accelerate the Spread of Successful Practices and Models

Performance measure	Performance year				
	2014	2015	2016	2017[a]	2018[a]
Number of States developing and implementing a health system transformation and payment reform plan	n/a	✔ (Target: 38 states) (Actual: 38 states)	✔ (Target: 38 states) (Actual: 38 states)	n/a (Target: 17 states) (Actual: n/a)	n/a (Target: 12 states) (Actual: n/a)
Increase the percentage of active model participants who are engaged in Innovation Center or related learning activities	n/a	✘ (Target: 61 percent) (Actual: 58.6 percent)	✘ (Target: 64.5 percent) (Actual: 56.9 percent)	n/a (Target: 59.7 percent) (Actual: n/a)	n/a (Target: 60 percent) (Actual: n/a)

Legend: ✔ – met or exceeded performance target; ✘ – did not meet performance target; n/a – data not available

Source: Centers for Medicare & Medicaid Services (CMS). | GAO-18-302

Note: The goal and related performance measure were established in 2014. A target for performance was established in 2015.

[a]CMS has not released performance data for fiscal year 2017 or 2018 for this performance measure.

In addition to the Goal 3 performance measures, the Innovation Center identifies two related contextual indicators—which according to officials are measures that provide supporting information to help understand trends or other information related to the goal. The first contextual indicator provides a snapshot of Medicare beneficiary participation at a given point in time for all models operational for more than 6 months. In fiscal year 2016, CMS reported that over 3.6 million Medicare fee-for-service beneficiaries participated in models, representing approximately 9 percent of Medicare fee-for-service beneficiaries. The second contextual indicator provides information to help understand the level of interest and participation among providers in the Innovation Center's model portfolio. In fiscal year 2016, the Center estimates that 103,291 providers participated in Innovation Center payment and service delivery models.

In addition to the three goals established by the Innovation Center, CMS has established an agency-wide goal related to the center's performance. In 2015, CMS announced goals to help drive Medicare, and the health care system at large, toward rewarding the quality of care instead of the quantity of care provided to beneficiaries. One of these goals was to shift Medicare health care payments from volume to value using alternative payment models established under the Innovation Center. This agency-wide goal has one performance measure, which is to increase the

percentage of Medicare fee-for-service payments tied to alternative payment models, such as ACOs or bundled payment arrangements. As shown in table 6, CMS reported meeting its target for 2015 and 2016.

Table 6: Reported Results of Center for Medicare & Medicaid Services' Performance Measures for Its Goal to Shift Medicare Health Care Payments from Volume to Value

Performance measure	Performance year				
	2014	2015	2016	2017[a]	2018[a]
Increase the percentage of Medicare Fee-for-Service Payments Tied to Alternative Payment Models	n/a	✔ (Target: 26 percent) (Actual: 26 percent)	✔ (Target: 30 percent) (Actual: 30 percent)	n/a (Target: 40 percent) (Actual: n/a)	n/a (Target: 50 percent) (Actual: n/a)

Legend: ✔ – met or exceeded performance target; ✘ – did not meet performance target; n/a – data not available

Source: Centers for Medicare & Medicaid Services (CMS). | GAO-18-302

Note: The goal and related performance measure were established in 2014. A target for performance was established in 2015.

[a]CMS has not released performance data for 2017 or 2018 for this performance measure.

Looking forward, officials told us that the Innovation Center has developed a methodology to estimate a forecasted return on investment for the model portfolio, and is in the early stages of refining the methodology and applying it broadly across the portfolio in 2018. As part of the development efforts, the Innovation Center expects to utilize standard investment measures used in the public and private sectors.

Agency Comments

We provided a draft of this report to HHS for comment. The Department provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

Kathleen M. King
Director, Health Care

Appendix I: Center for Medicare and Medicaid Innovation's General Process for Implementing Models

Table 7: Description of the Center for Medicare and Medicaid Innovation's (Innovation Center) General Process for Model Implementation

Idea & concept	
Identify ideas for new models	• Internally, the Innovation Center receives ideas for different payment and care delivery approaches from the administration and leadership of the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS). • Externally, the Innovation Center solicits and receives ideas for different payment and care delivery approaches through listening sessions, its web-based idea-submission tool, informal requests for information inviting the public to provide information to CMS for information and planning purposes, and other mechanisms.[a] • As part of this step, the Innovation Center considers model types suggested in its authorizing law, and seeks input from across CMS; HHS; other federal partners, including the Physician-Focused Payment Model Technical Advisory Committee (PTAC); and an array of external stakeholders.[b]
Develop promising ideas into concepts for new models	• The Innovation Center reviews details of the ideas that have been submitted—such as the health care services addressed; providers, beneficiaries, and stakeholders involved; and the resources needed— to assess the potential for developing the idea into a working model. • A small collaboration team is formed from across the Innovation Center to further develop promising model concepts. A model concept includes preliminary model design, evaluation plans, budget information, and estimates of potential savings to be achieved. • The Innovation Center evaluates concepts in the context of the current portfolio of models, administration priorities, and other criteria such as the potential impact on Medicare and Medicaid beneficiaries, the concept's ability to improve how care is delivered nationally, and the degree to which the concept would meet the needs of the most vulnerable beneficiaries.
Planning & design	

Develop an Innovation Center Investment Proposal (ICIP)	• Once the Innovation Center decides to move forward with a concept, it develops an ICIP, which typically includes
	   • a proposed design for the model, including the size and scope of testing, the population and programs involved, and duration;
	   • a summary of prior evidence and supporting research;
	   • a preliminary evaluation plan, including research questions, proposed measures related to spending and quality, and discussion of the model's expected impact; and
	   • an implementation plan, including the application and selection process, an analysis of whether the model overlaps or complements other initiatives, and an analysis of the potential for expansion of the model.
	• The Innovation Center prepares separate documents for approval that are related to funding requests and solicitations associated with the model.

Obtain approval from CMS, HHS, and the Office of Management and Budget (OMB) and announce model	• The Innovation Center seeks approval for the model. This includes separate approval processes for the ICIP, model funding, and any solicitations that would be issued to potential participants. • The approval process includes a sequence of reviews within CMS, within HHS, and finally within OMB. During these reviews, revisions may be made on the basis of input from individuals in other CMS centers and offices, in other related HHS programs, and from OMB. • Once the ICIP is approved, the Innovation Center issues an announcement and other information about the model to the public.
Solicit & build	
Solicit and select contractors for evaluating and implementing model	• The Innovation Center solicits and hires contractors to evaluate the model. Applicants are asked to propose specific evaluation approaches to the preliminary evaluation plans that the Innovation Center has identified. Contractors are selected through a competitive process. Once a contractor is selected, it works with the Innovation Center to complete a design phase and reach agreement on the final evaluation plan for the model. • The Innovation Center also engages contractors for other purposes that are part of implementation, such as data collection and provider recruitment.
Solicit, select, and establish agreements with participants	• The Innovation Center issues information about how to apply for participation in the model, including information about which types of providers or organizations are eligible to participate, the process for submitting applications, and the selection process. The Innovation Center may also organize webinars or learning sessions open to the public and interested participants to share information and answer questions. • Innovation Center models vary by the type of participant that is involved—for example, physician group practices, health plans, and state Medicaid programs. • Models also vary in terms of the type of agreement that is established with participants—for example, whether it is a grant, a cooperative agreement, a contract, or a provider agreement. • The selection process for participants is generally competitive. The criteria used in the selection process may vary by model. For example, selection criteria may include such factors as organizational capabilities and plans for ensuring quality of care. In other cases, eligible participants may be selected in order to achieve a mix and balance of certain characteristics for evaluation purposes, for example geographic location (urban, rural) and whether the participant uses electronic health records

Build operational and participant support	• The Innovation Center and contractors create systems or plans that support the implementation of each model, including: • information technology systems that collect, maintain, and provide access to data; • a learning system that consists of a combination of educational approaches that focus on collaboration and group-based activities, as well as known improvement strategies that support participants in achieving the goals of the model's learning activities; • a communication plan that establishes communication channels between participants and the Innovation Center, as well as for information released to the general public; • a monitoring system that establishes requirements for participant reporting and, if applicable, corrective action plans; and • an operational plan that establishes steps—including training—to help ensure the Innovation Center and participants understand how the model will operate once it is implemented.
Run, evaluate, & expand	
Run model implementation	• The innovations that models are testing—changes to health care delivery or payment—are put into effect by CMS and by participants. • The testing period for Innovation Center models is typically set for 3 to 5 years. However, monitoring may indicate that the model should be modified, terminated, or expanded before this period ends (see below). The Innovation Center may choose to shorten the test period for a model for such reasons.
Conduct evaluation of model to assess its impact on cost and quality	• Data are collected for cost and quality measures. Using a variety of statistical techniques, these data are generally compared to data for a comparison group representing patients or providers that are not participating in the model to determine the model's impact on cost and quality. When comparison groups are not possible, data for model participants are compared to "baseline" data that represent a period prior to the test period. Qualitative information on the different strategies participants may use to deliver care under each model is also collected and analyzed. • During the testing period information collected is shared on a regular basis with participants. The purpose of this "rapid cycle" feedback is to provide timely information so that participants can make improvements during the testing period.

Determine whether to terminate, modify, or recommend expanding model	• The Innovation Center regularly reviews each model's impact on the quality and cost of care to determine whether the payment or delivery approach is successful and should be recommended for expansion. • The Secretary is required to terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary certifies with respect to program spending), after testing has begun, that the model is expected to improve the quality of care without increasing spending, reduce spending without reducing the quality of care, or improve the quality of care and reduce spending. • The Secretary may expand the duration and scope of a model if (1) the CMS Chief Actuary certifies that expansion would reduce or not result in any increase in net program spending, (2) the Secretary determines that expansion is expected to reduce spending without reducing the quality of care or improve the quality of patient care without increasing spending, and (3) the Secretary determines that expansion would not deny or limit the coverage or provision of benefits.
Closing	
Participant, contract, and administrative closeout	• The Innovation Center makes final payments to participants and contractors, final evaluations are completed and publicly released, lessons learned are documented and, if applicable, continuity of model operations is coordinated with CMS.

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

[a]An agency may issue a request for information for planning purposes.

[b]PTAC was chartered by the Secretary of HHS in January 2016. PTAC evaluates stakeholder proposals for physician-focused payment models, and submits comments and makes recommendations on the models to the Secretary of HHS, who is required to respond to PTAC's recommendations.

Appendix II: Models Implemented or Announced by the Center for Medicare and Medicaid Innovation under Section 1115A

As of March 1, 2018, the Center for Medicare and Medicaid Innovation (Innovation Center) organized its models into seven categories based on delivery and payment approaches tested and program beneficiaries covered. Table 8 provides the number of models implemented and announced, organized under each category.

Table 8: Number of Section 1115A Center for Medicare and Medicaid Innovation Models Implemented and Announced by Category, as of March 1, 2018

Model category	Models implemented	Models announced	Total
Accountable Care	7	0	**7**
Episode-based Payment Initiatives	6	1	**7**
Initiatives Focused on Medicare-Medicaid Enrollees	3	0	**3**
Initiatives Focused on the Medicaid and Children's Health Insurance Program Population	1	0	**1**
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	14	0	**14**
Initiatives to Speed the Adoption of Best Practices	2	1	**3**
Primary Care Transformation	4	0	**4**
Total	**37**	**2**	**39**

Source: GAO analysis of Centers for Medicare & Medicaid Services information. | GAO-18-302

The Innovation Center organized seven of its models under the Accountable Care category. (See table 9.)

Table 9: Descriptions and Other Information for Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Accountable Care

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Advance Payment Accountable Care Organization (ACO) Model – Tested the effectiveness of providing physician-based and rural Medicare Shared Savings Program ACOs with upfront and monthly payments that they could use to invest in care coordination activities.[c]	Implemented - testing period ended (2012-2015)	35 ACOs	$73.8 million ($110.1 million)
Pioneer ACO – Tested the effectiveness of allowing experienced ACOs to take on greater financial risk than ACOs that participated in the Medicare Shared Savings Program.[d] In exchange, participating ACOs are eligible for a greater percentage of any savings achieved. In year 3 of the model, providers that met certain levels of savings in the first two years were eligible to receive prospective per beneficiary per month payments.	Implemented - testing period ended (2012-2016)	Began with 32 ACOs and concluded with eight.	$96.9 million ($244.3 million)
Comprehensive End-Stage Renal Disease Care Model – Tests the effectiveness of an ACO delivery and payment approach for providing care to end-stage renal disease beneficiaries.	Implemented (2015-2020)	37 end-stage renal disease seamless care organizations	$56.5 million (n/a)
ACO Investment Model – Tests the effectiveness of pre-paid shared savings in encouraging new Medicare Shared Savings Program ACOs to form in rural and underserved areas and in encouraging current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk.[d]	Implemented (2016-tbd)	45 ACOs	$62.0 million ($10.9 million)
Next Generation ACO Model – Tests the impact of strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management. ACOs participating in the Next Generation ACO Model must assume greater risk and can earn greater rewards than in other Centers for Medicare & Medicaid Services' (CMS) ACO initiatives.	Implemented (2016-2020)	44 ACOs	$44.5 million ($11.8 million)

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Vermont All-Payer ACO Model – Tests a model in which Medicare, Medicaid, and commercial health care payers in Vermont will coordinate to have similar design requirements for ACOs. Under the arrangement, Vermont commits to meeting statewide quality of care and financial targets. CMS will also provide funding to Vermont to support care coordination and improve collaboration between providers.	Implemented (2017-2022)	1 state	n/a (n/a)
ACO Track 1 Plus – Tests the effectiveness of offering an advanced alternative payment model with a more limited risk track than currently available in the Medicare Shared Savings Program to encourage more Medicare Shared Savings Program ACOs, especially ACOs composed solely of small physician practices and small rural hospitals, to take on financial risk.	Implemented[e] (2018-tbd)	n/a	n/a (n/a)

Legend: n/a – not applicable; tbd – to be determined

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Note: Information in this table is as of December 1, 2017 with the exception of the status for ACO Track 1 Plus, which was updated as of March 1, 2018.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security Act. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reported reflect obligations through fiscal year 2016.

[c]An ACO refers to a group of providers and suppliers of services, such as hospitals and physicians, that work together to coordinate care for the patients they serve.

[d]The Medicare Shared Savings Program is an ACO program enacted as an ongoing part of the Medicare program and not an Innovation Center model. See 42 U.S.C. § 1395jjj. The program includes different participation options that allowed ACOs to assume various levels of risk.

[e]ACO Track 1 Plus was implemented on January 1, 2018.

The Innovation Center organized seven of its models under the Episode-Based Payment Initiatives category. (See table 10.)

Table 10: Descriptions and Other Information for Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Episode-Based Payment Initiatives

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Bundled Payments for Care Improvement (BPCI) Model 1, Retrospective Acute Care Hospital Stay Only – Tested the effectiveness of a payment arrangement in which hospitals received discounted payments for Medicare services provided during an inpatient hospital stay and in which physicians who provided services during the inpatient stay were paid their standard rates under the physician fee schedule. Hospitals were able to share cost-savings they generated under the model with physicians as a means of encouraging them to participate in redesigning the care process to become more efficient. Hospitals were also held financially responsible for the cost of all Medicare services provided 30 days after discharge that exceeded historical trends.	Implemented – testing period ended (2013-2016)	Began with 24 hospitals and concluded with nine.	$75.7 million, includes BPCI Models 1-4 (n/a)
BPCI Model 2, Retrospective Acute & Post-Acute Care Episode – Tests the effectiveness of a payment arrangement in which acute care hospitals and physician group practices receive additional payments or make recoupment payments if the total costs for Medicare services provided during an inpatient hospital stay and up to 90 days after discharge are over or under a pre-determined target price.	Implemented (2013-2018)	335 hospitals and 204 physician group practices	See BPCI Model 1
BPCI Model 3, Retrospective Post-Acute Care Only – Tests the effectiveness of a payment arrangement in which post-acute care providers—such as a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency—or physician group practices receive payments or make recoupment payments if total costs for certain Medicare services are over or under a predetermined target price. These services are those provided during a clinical episode that begins with post-acute care services and include all services up to 90 days after the hospital discharge that preceded the post-acute care services.	Implemented (2013-2018)	620 skilled nursing facilities, 81 home health agencies, 9 inpatient rehab facilities, and 48 physician group practices	See BPCI Model 1

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
BPCI Model 4, Prospective Acute Care Hospital Stay Only – Tests the effectiveness of making a single, predetermined payment in advance for all Medicare services furnished by a hospital, physicians, and other practitioners during an inpatient stay in an acute care hospital. Physicians and other practitioners submit "no-pay" claims to Medicare and are paid by the hospital out of the advance, bundled payment.	Implemented (2013-2018)	2 hospitals	See BPCI Model 1
Comprehensive Care for Joint Replacement Model – Tests the effectiveness of a payment arrangement in which acute care hospitals receive additional payments or make recoupment payments if the total costs for certain Medicare services are over or under a predetermined target price. These services are those provided during a clinical episode that includes an inpatient hospital stay related to a hip or knee replacement surgery and all services up to 90 days after discharge.	Implemented (2016-2020)	Participation required for about 800 hospitals in 67 randomly selected geographic areas[c]	$25.7 million (n/a)
Oncology Care Model – Tests the effectiveness of a payment arrangement in which providers receive a monthly payment for each Medicare beneficiary during a 6-month episode of care following the administration of chemotherapy and can earn additional performance-based payments if the total costs for Medicare services provided during the episode are under a predetermined target price. Starting in 2017, practices could receive higher performance-based payments by taking on risk for costs that exceed the target price.	Implemented (2016-2021)	192 practices and 14 payers	$58.3 million (n/a)
BPCI Advanced[d] – Will test the effectiveness of a payment arrangement in which acute care hospitals and physician group practices receive additional payments if the total costs for Medicare services provided are under a pre-determined target price and performance is maintained or improved on specific quality measures. Services are those to be provided during a clinical episode that will include either an inpatient hospital stay or outpatient procedure and all services for 90 days after discharge or the procedure. This model will qualify as an advanced alternative payment model.	Announced (2018-2023)	tbd	n/a (n/a)

Legend: n/a – not applicable; tbd – to be determined

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Note: Information in this table is as of December 1, 2017 with the exception of information for BPCI Advanced, which was updated as of March 1, 2018.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security Act. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reflect obligations made through fiscal year 2016.

[c]On December 1, 2017, a final rule was issued making provider participation in 33 geographic areas voluntary for this model, effective January 1, 2018. Participation will remain mandatory for 34 geographic areas.

[d]BPCI Advanced was announced on January 9, 2018.

The Innovation Center organized three of its models under the Initiatives Focused on Medicare-Medicaid Enrollees category. (See table 11.)

Table 11: Descriptions and Other Information for the Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Initiatives Focused on Medicare-Medicaid Enrollees

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Phase One – Tested effectiveness of partnerships between independent organizations and long-term care facilities to enhance on-site services to reduce hospitalizations for Medicare-Medicaid beneficiaries.	Implemented – testing period ended (2012-2016)	Seven Enhanced Care and Coordination Provider organizations and 143 long-term care facilities	$124.7 million (n/a)
Financial Alignment Initiative for Medicare-Medicaid Enrollees – Tests two models to integrate primary, acute, behavioral health and long-term services and supports for Medicare-Medicaid enrollees and better aligns the financing of the Medicare and Medicaid programs.	Implemented (2013-2020)	Model tests are operating in 13 states, with two demonstrations operating in New York.	$234.2 million ($7.2 million)
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Phase Two – Tests whether a new payment model for a new set of long-term care facilities, as well as long-term care facilities that participated in the initial phase of the model and continue to offer enhanced on-site services, will improve quality of care by reducing avoidable hospitalizations, while also lowering combined Medicare and Medicaid spending.	Implemented (2016-2020)	Six Enhanced Care and Coordination Provider organizations	$18.8 million (n/a)

Legend: n/a – not applicable

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Note: Information in this table is as of December 1, 2017.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security Act. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reflect obligations made through fiscal year 2016.

The Innovation Center organized one of its models under the category, Initiatives Focused on the Medicaid and Children's Health Insurance Program Population. (See table 12.)

Table 12: Descriptions and Other Information for the Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Initiatives Focused on the Medicaid and Children's Health Insurance Program Population

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Strong Start for Mothers and Newborns Initiative: Enhanced Prenatal Care Models - Tests three approaches to enhance the current care delivery and address the medical, behavioral and psychosocial factors that may be present during pregnancy and contribute to preterm-related poor birth outcomes.	Implemented (2013-2018)	27 awardees with more than 200 sites including hospitals, health plans, community-based providers, Federally Qualified Health Centers, nationally-certified birth centers, Indian Health services clinics, local health departments, and physician groups	$96.2 million (n/a)

Legend: n/a – not applicable

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Note: Information in this table is as of December 1, 2017.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security Act. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reflect obligations made through fiscal year 2016.

The Innovation Center organized 14 of its models under the category, Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models. (See table 13.)

Table 13: Descriptions and Other Information for the Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Partnership for Patients – Tested whether a coordinated, goal-directed, national collaborative approach for systematically spreading known best practices in patient safety could make acute care hospitals safer, more reliable, and less costly by reducing hospital acquired conditions and readmissions.	Implemented – testing period ended (2011-2016)	3,700 short stay acute care hospitals	$559.4 million (n/a)
Health Care Innovation Awards Round One – Tested the effectiveness of providing funding to a broad set of partners, including providers, local government, and public-private partnerships, to test new care delivery and payment models for beneficiaries enrolled in Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).	Implemented – testing period ended (2012-2015)	108 awardees including academic medical centers, not-for-profit organizations, provider organizations, managed care organizations, integrated health systems, health clinics, hospitals, and local and state agencies.	$967.4 million (n/a)
State Innovation Models Initiative: Round One – Tested the effectiveness of financial, technical, and other support to states that were either prepared to test or were committed to design and test new payment and service delivery models for beneficiaries enrolled in Medicare, Medicaid, or CHIP.	Implemented – testing period ended (2013-2016)	Six test states, 16 design states	$326.7 million (n/a)
Health Care Innovation Awards Round Two – Tested the effectiveness of providing funding to awardees to test new care delivery and payment models for beneficiaries enrolled in Medicare, Medicaid, or CHIP.	Implemented – testing period ended (2014-2017)	39 awardees including academic medical centers, not-for-profit organizations, provider organizations, managed care organizations, integrated health systems, health clinics, hospitals, and local and state agencies.	$397.7 million (n/a)
Maryland All-Payer Model – Tests the effectiveness of an all-payer system for hospital payment on quality of care and cost.	Implemented (2014-2019)	One state	$12.6 million (n/a)
Repetitive Scheduled Non-Emergent Ambulance Transport Model (Prior Authorization) – Tests the effectiveness of prior authorization of repetitive scheduled non-emergent ambulance transport.	Implemented (2014-2018)	Nine states	$28.9 million (n/a)

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
State Innovation Models Initiative: Round Two – Tests the effectiveness of financial, technical, and other support to states that are either prepared to test or are committed to designing and testing new payment and service delivery models for beneficiaries enrolled in Medicare, Medicaid, or CHIP.	Implemented (2015-2018)	11 test states, 17 design states, plus America Samoa, District of Columbia, Commonwealth of the Northern Mariana Island, and Puerto Rico	$373.7 million (n/a)
Hyperbaric Oxygen Therapy Model (Prior Authorization) – Tests the effectiveness of prior authorization of non-emergent hyperbaric oxygen therapy.	Implemented (2015-2018)	Three states	$5.7 million (n/a)
Home Health Value-Based Purchasing Model – Tests the effectiveness of tying payments for Medicare-certified home health agencies to the quality of care provided.	Implemented (2016-2022)	Nine states	$18.0 million (n/a)
Medicare Care Choices Model – Tests the effectiveness of providing Medicare, Medicaid, or dual-eligible beneficiaries the option to receive hospice-like support services from certain hospice providers while concurrently receiving curative services.	Implemented (2016-2020)	141 hospices	$16.5 million (n/a)
Part D Enhanced Medication Therapy Management Model – Tests the effectiveness of providing basic, stand-alone prescription drug plans with the regulatory flexibility to design and implement innovative medication therapy management programs with the goal of optimizing medication use.	Implemented (2017-2021)	Six Part D sponsors	$10.7 million (n/a)
Pennsylvania Rural Health Model – Tests whether multi-payer global budgets will enable participating rural hospitals to invest in quality and preventive care and to tailor the services they deliver to better meet the needs of their local communities.	Implemented (2017-2023)	One state	n/a (n/a)
Medicare Advantage Value-Based Insurance Design Model – Tests the effectiveness of offering Medicare Advantage plans the flexibility to design and offer reduced cost-sharing and/or additional supplemental benefits to enrollees with chronic conditions with the goal of incentivizing beneficiaries to use high-value services. Eligible Medicare Advantage plans in seven states, upon approval from the Centers for Medicare & Medicaid Services (CMS), can offer varied plan benefit designs for enrollees who fall into certain clinical categories identified and defined by CMS.	Implemented (2017-2021)	11 Medicare Advantage and Medicare Advantage prescription drug plans[c]	$8.4 million (n/a)

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Accountable Health Communities Model – Tests the effectiveness of systematically identifying and addressing the health-related social needs of beneficiaries through improved clinical-community linkages.	Implemented (2017-2022)	32 organizations including hospitals, university health systems, and local health departments	n/a (n/a)

Legend: n/a – not applicable

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Note: Information in this table is as of December 1, 2017.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security Act. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reflect obligations made through fiscal year 2016.

[c]In 2017, participation was limited to eligible plans in 7 states. CMS expanded the model into 3 additional states in 2018 and will expand into 15 more in 2019. The Bipartisan Budget Act of 2018 requires that the model covers all states effective no later than January 1, 2020.

The Innovation Center organized three of its models under the category, Initiatives to Speed the Adoption of Best Practices. (See table 14.)

Table 14: Descriptions and Other Information for the Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Initiatives to Speed the Adoption of Best Practices

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Health Care Payment Learning and Action Network – Facilitates the national learning collaborative to accelerate the adoption of advanced payment models that include private payers, purchasers, health care providers, consumers, and states.	Implemented (2015-tbd)	Over 600 organizations	$11.7 million (n/a)
Million Hearts®: Cardiovascular Disease Risk Reduction Model – Tests the effectiveness of providing financial incentives for health care providers to reduce the patients' risk of heart attack and stroke on outcomes and accountability for costs among Medicare beneficiaries.	Implemented (2017-2022)	516 organizations	$13.8 million (n/a)
Medicare Diabetes Prevention Program Expanded Model – Will test the effectiveness of an evidence-based intervention targeted to prevent the onset of type 2 diabetes among Medicare beneficiaries with an indication of prediabetes.	Announced (2018-tbd)	tbd	n/a (n/a)

Legend: n/a – not applicable; tbd – to be determined

Source: Centers for Medicare & Medicaid Services (CMS). | GAO-18-302

Note: Information in this table is as of December 1, 2017 with one exception. We excluded the Direct Decision Support model, which was cancelled by the Innovation Center on February 2, 2018, as of March 1, 2018.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reflect obligations made through fiscal year 2016.

The Innovation Center organized four of its models under the category, Primary Care Transformation. (See table 15.)

Table 15: Descriptions and Other Information for the Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Primary Care Transformation

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration – Tested the effectiveness of the advanced primary care practice model—referred to as a patient-centered medical home—for health centers that have received a FQHC designation from the Centers for Medicare & Medicaid Services. FQHCs provide comprehensive community-based primary and preventive care services in medically underserved areas or to medically underserved populations. As part of the model, FQHCs were paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services.	Implemented – testing period ended (2011-2014)	434 FQHC sites	$64.2 million (n/a)
Comprehensive Primary Care Initiative – Tested the impact of enhanced primary care services, including care coordination, prevention, and 24-hour access for Medicare and Medicaid beneficiaries. The initiative included multiple payers and participating providers received a monthly care management fee and an opportunity to share in any net savings to the Medicare program.	Implemented – testing period ended (2012-2016)	442 primary care practices	$397.0 million ($0.6 million)
Comprehensive Primary Care Plus – Tests the impact of multi-payer enhanced primary care services for Medicare and Medicaid beneficiaries, including care coordination, prevention, and 24-hour access for Medicare and Medicaid beneficiaries. This model includes greater financial resources and flexibility to make appropriate investments to improve quality and efficiency of care. The initiative included multiple payers and participating providers received a monthly care management fee, performance-based incentive payments, and payments under the Medicare physician fee schedule.	Implemented (2017-2022)	2,816 primary care practices	$66.7 million (n/a)
Transforming Clinical Practice Initiative – Tests the effectiveness of providing support to outpatient clinical practices to move from volume to value-based delivery systems within the Quality Payment Program by sharing, adapting, and developing comprehensive quality improvement strategies to facilitate large-scale practice transformation.	Implemented (2015-2019)	29 practice transformation networks and 12 support and alignment networks	$328.7 million (n/a)

Legend: n/a – not applicable

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Note: Information in this table is as of December 1, 2017.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security Act. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reflect obligations made through fiscal year 2016.

Appendix III: Models Required by Different Provisions of the Patient Protection and Affordable Care Act

In addition to models required by section 1115A of the Social Security Act, as added by the section 3021 of Patient Protection and Affordable Care Act, the Center for Medicare and Medicaid Innovation implemented six models under different provisions of the Patient Protection and Affordable Care Act. (See table 16.)

Table 16: Models Implemented by the Center for Medicare and Medicaid Innovation Required by Different Provisions of the Patient Protection and Affordable Care Act

Model Description	Status (Years tested)	Participants	Obligations through September 30, 2016
Incentives for Prevention of Chronic Diseases in Medicaid – Tested the impact of providing incentives to Medicaid beneficiaries to participate in prevention programs such as those that address tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and managing or avoiding the onset of diabetes. The final evaluation was unable to directly measure whether the programs prevented chronic diseases, but found programs focusing on tobacco cessation increased cessation rates.	Implemented – testing period ended (2011-2015)	10 states	$71.1 million
Medicaid Emergency Psychiatric Demonstration – Tested the extent to which reimbursing private psychiatric hospitals for inpatient services needed to stabilize psychiatric emergency medical conditions in adult Medicaid beneficiaries ages 21 to 64 (which is generally prohibited under Medicaid) improved access to and quality of care for these beneficiaries and reduced overall Medicaid spending and utilization. The final evaluation was unable to make definitive conclusions about whether the demonstration improved access to and quality of care while reducing spending and utilization.	Implemented – testing period ended (2012-2015)	27 private psychiatric hospitals in 11 states and the District of Columbia	$74.2 Million
Medicare Independence at Home Demonstration – Tests the effectiveness of delivering an expanded scope of primary care services in a home setting on improving care for Medicare beneficiaries with multiple chronic conditions.	Implemented (2012-2019)	14 primary care practices and consortia	$16.1 million

Model Description	Status (Years tested)	Participants	Obligations through September 30, 2016
Community Based Care Transitions Program – Tested approaches to reduce unnecessary hospital readmissions by improving the transition of Medicare beneficiaries from the inpatient hospital setting to home or other care settings. The final evaluation was unable to make definitive conclusions on the impact of the model, but found some evidence that suggested the potential for the program to reduce hospital readmissions.	Implemented – testing period ended (2012-2017)	Began with 101 community-based organizations and concluded with 44.	$291.5 million
Certain Complex Diagnostic Lab Tests – Tested the effect of making separate payments for certain complex diagnostic laboratory tests on access to care, quality of care, health outcomes, and expenditures. The final evaluation found that the Demonstration did not have a significant impact on the care received, health outcomes, or expenditures among the Medicare beneficiary population as a whole.	Implemented – testing period ended (2012-2014)	Not applicable	$400,000
Graduate Nurse Education – Tests the effect of offsetting the costs of clinical training for Advanced Practice Registered Nurses (APRN) on the availability of graduate nursing students enrolled in APRN training programs. The final evaluation found that the model had a positive impact on APRN student growth, and helped transform clinical education within participating schools of nursing.	Implemented (2012-2018)	5 hospitals partnering with 19 schools of nursing	$153 million

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Greg Giusto (Assistant Director), Aaron Holling (Analyst-in-Charge), Ashley Dixon, and Rachel Rhodes made key contributions to this report. Also contributing to the report were Sam Amrhein, Muriel Brown, and Emily Wilson.

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Cost-Sharing Reductions in CB...

Posted by Keith Hall on May 3, 2018

At hearings about the Congressional Budget Office's Budget and Economic Outlook on April 11 and April 12, I answered several questions asked by Members of Congress about how cost-sharing reductions (CSRs) have been incorporated in the agency's baseline budget projections. Time to answer questions during the hearings was limited, so this blog post provides additional information.

Background

The Affordable Care Act (ACA), in section 1402, requires insurers who participate in the marketplaces established under that act to offer CSRs to eligible people who purchase silver plans through the marketplaces. CBO views that requirement as establishing an entitlement for those eligible.

To qualify for CSRs, people must purchase a plan through a marketplace and generally have income between 100 percent and 250 percent of the federal poverty guidelines (also known as the federal poverty level, or FPL). The size of the subsidy varies with income.[1]

CSRs reduce deductibles and other out-of-pocket expenses like copayments. For example, in 2017, by CBO's estimates, the average deductible for a single policyholder (for medical and drug expenses combined) with a silver plan varied according to income in the following way:

Income as a Percentage of the FPL	Approximate Deductible (Dollars)
Above 250 (Without CSRs)	3,600
Between 200 and 250	2,900
Between 150 and 200	800
Between 100 and 150	300

Individuals with income generally between 100 percent and 400 percent of the FPL are also eligible for tax credits to help cover a portion of their premiums. The size of those premium tax credits varies with income and premiums.

Before October 12, 2017, the federal government reimbursed insurers for the cost of CSRs through a direct payment. However, on that date, the Administration announced that, without an appropriation for that purpose, it would no longer make such payments to insurers. Because insurers are still required to offer CSRs and to bear their costs even without a direct payment from the government, most have covered those costs by increasing premiums for silver plans offered through the marketplaces for the 2018 plan year. (For the most part, insurers did not increase premiums for other plans to cover the cost of CSRs because the CSR entitlement is not available for those plans.)

Budgetary Treatment

Section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985, which specifies rules for constructing CBO's baseline, requires that the agency assume full funding of entitlement authority.[2] CBO and the staff of the Joint Committee on Taxation (JCT) have long viewed the requirement that the federal government compensate insurers for CSRs as a form of entitlement authority. On that basis, CBO included the CSR payments as direct spending (that is, spending that does not require appropriation action) in the agency's June 2017 baseline.

For the spring 2018 baseline, CBO and JCT project that the entitlement for subsidies for CSRs is being funded through higher premiums and larger premium tax credit subsidies instead of a direct payment. The projection reflects the manner in which insurers are currently reimbursed for the cost of providing CSRs to eligible enrollees in light of the Administration's change in policy in October 2017. That approach complies with section 257 of the Deficit Control Act because

the CSR entitlement is assumed to be fully funded. The revised baseline treatment of CSRs' means of financing was made by CBO after consultation with the House and Senate Budget Committees.

On the basis of an analysis of insurers' rate filings, CBO and JCT estimate that gross premiums for silver plans offered through the marketplaces are, on average, about 10 percent higher in 2018 than they would have been if CSRs were funded through a direct payment. The agencies project that the amount will grow to roughly 20 percent by 2021.

Effect on the Baseline

The size of premium tax credits is linked to the premiums for the second-lowest-cost silver plans offered through the marketplaces: Out-of-pocket payments for premiums for enrollees who are eligible for subsidies are based on a percentage of their income, and the government pays the difference through the premium tax credits. As a result, in CBO's projections, higher gross premiums for silver plans increase the amount of tax credits paid by the federal government, thereby covering insurers' costs for CSRs. Higher gross premiums for silver plans do not significantly affect the out-of-pocket payments that subsidized enrollees pay for premiums for silver plans offered through the marketplaces because the structure of the premium tax credit largely insulates them from those increases.

For plans besides silver ones, insurers in most states have not increased gross premiums much, if at all, to cover the costs of CSRs. Because the premium tax credits are primarily based on the income levels of enrollees and not the nature of the plan they choose, enrollees could use those credits to cover a greater share of premiums for plans other than silver ones in those states. For example, more people are able to use their higher premium tax credits to obtain bronze plans, which cover a smaller share of benefits than silver plans, for free or for very low out-of-pocket premiums. Also, some people with income between 200 percent and 400 percent of the FPL can purchase gold plans, which cover a greater share of benefits than do silver plans, with similar or lower premiums after tax credits. As a result of those changes, in most years, between 2 million and 3 million more people are estimated to purchase subsidized plans in the marketplaces than would have if the federal government had directly reimbursed insurers for the costs of CSRs.

In CBO's projections, higher gross premiums for silver plans affect premiums for people who are not eligible for premium tax credits (most of whom have income above 400 percent of the FPL). However, many of those enrollees have options for purchasing other plans to avoid paying the premium increases resulting from the

Administration's policy change in October 2017. Just as insurers in most states have not increased premiums for plans other than silver ones much to cover the costs of CSRs, insurers in many states have not increased the premiums of silver plans sold outside the marketplaces to cover the costs of CSRs either. Therefore, many people who are not eligible for subsidies are able to select a plan besides a silver one or a silver plan sold outside the marketplaces and avoid paying the premium increases related to the lack of a direct appropriation for CSRs.

Future Cost Estimates

In recent cost estimates for legislation that would appropriate funding for the payment of CSRs, CBO and JCT estimated that the appropriation would not affect direct spending or revenues because such payments were already incorporated in CBO's baseline projections.[3] After consulting with the budget committees about the baseline and about cost estimates relative to that baseline, the agency will continue that practice.

For legislation that would change the means of funding the CSR entitlement, CBO will estimate that enactment would not affect the federal deficit—because the obligations stemming from the entitlement can be fully satisfied through either a direct payment or higher premiums and larger premium tax credit subsidies. However, if legislation was enacted that appropriated funds for direct payments for CSRs, the agency would update its baseline projections to incorporate those appropriations and to reflect lower premium tax credits and other effects—because insurers would no longer increase gross premiums for silver plans offered through the marketplaces to cover the costs of providing CSRs.

Keith Hall is CBO's Director.

[1] In most marketplaces, people can choose among plans—such as bronze, silver, and gold—for which the portion of covered medical expenses paid by the insurer differs. The average percentage of covered expenses paid by the insurer is called the actuarial value of the plan. Silver plans differ from other plans because they must provide CSRs to eligible enrollees. For people at most income levels, the actuarial value of a silver plan is 70 percent; however, people who qualify for CSRs are eligible for silver plans with higher actuarial values: 73 percent for people with income between 200 percent and 250 percent of the FPL; 87 percent for people with income between 150 percent and 200 percent of the FPL; and 94 percent for people with income between 100 percent and 150 percent of the FPL. The actuarial values of bronze and gold plans are 60 percent and 80 percent, respectively.

[2] 2 U.S.C. §907(b)(1) (2012). Entitlement authority is authority for federal agencies to incur obligations to make payments to entities that meet the eligibility criteria set in law.

[3] See Congressional Budget Office, cost estimate for the Bipartisan Health Care Stabilization Act of 2018 (March 19, 2018).

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Keith Hall, Director

March 19, 2018

Honorable Lamar Alexander
Chairman
Committee on Health,
Education, Labor and Pensions
United States Senate
Washington, DC 20510

Re: Appropriation of Cost-Sharing Reduction Subsidies

Dear Mr. Chairman:

On March 19, 2018, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) produced a cost estimate for the Bipartisan Health Care Stabilization Act of 2018 (BHCSA). The agencies estimated that enacting the BHCSA would increase the deficit by $19 billion over the 2018-2027 period relative to CBO's baseline, primarily because of the cost of subsidizing reinsurance or invisible high-risk pool programs in the nongroup health insurance market. The reduction in premiums associated with those programs would primarily benefit people with income greater than 400 percent of the federal poverty level (FPL).[1] This letter responds to your request for additional information about that estimate.

You requested an alternative estimate of section 602(b) of the bill, which would appropriate such sums as may be necessary for payments for cost-sharing reductions (CSRs) authorized by section 1402 of the Affordable Care Act (ACA).[2] Specifically, you asked that CBO and JCT provide an alternative estimate that reflects the fact that insurers are not being separately reimbursed through an appropriation for the costs of CSRs.[3] Under such a scenario, CBO and JCT estimate that enacting section 602(b)

1. Most people with incomes below 400 percent of the FPL purchasing nongroup insurance receive premium tax credits that largely insulate them from changes in gross premiums.

2. The ACA comprises the Patient Protection and Affordable Care Act (Public Law 111-148) and the provisions of the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) that are related to health care.

3. CSRs take the form of reduced deductibles, copayments, and other means of cost sharing for eligible individuals enrolled in silver plans through marketplaces.

of the BHCSA would result in a net reduction in the deficit of $29 billion over the 2018-2027 period, as opposed to having no effect when estimated relative to CBO's baseline.

That net deficit reduction of $29 billion would stem mainly from smaller federal subsidies for health insurance purchased through the marketplaces by people with income between 200 percent and 400 percent of the FPL.

Background

The ACA requires insurers to offer CSRs to eligible people who purchase silver plans through the marketplaces established by that legislation.[4] People must generally have income between 100 percent and 250 percent of the FPL to qualify for CSRs, and the size of that subsidy varies with income. Individuals with incomes generally between 100 percent and 400 percent of the FPL also are eligible for tax credits to help cover a portion of their premiums. The size of those premium tax credits varies with income and premiums.

Prior to October 2017, the federal government reimbursed insurers for the cost of CSRs through a direct payment. However, on October 12, 2017, the Administration announced that it would no longer make such payments to insurers absent an appropriation for that purpose. Because insurers are still required to offer CSRs and to bear their costs even without a direct payment from the government, most have covered those costs by increasing premiums for silver plans offered through the marketplaces for the 2018 plan year. (For the most part, insurers did not increase premiums for other plans to cover the cost of CSRs because the CSR entitlement is not available for those plans.)

Based on an analysis of insurers' rate filings, CBO and JCT estimate that gross premiums for silver plans offered through the marketplaces are, on average, about 10 percent higher in 2018 than they would have been if CSRs were funded through a direct payment. The agencies project that amount will grow to roughly 20 percent by 2021.

4. In most marketplaces, people can choose among plans—such as bronze, silver, and gold—for which the portion of covered medical expenses paid by the insurer differs. The average percentage of expenses paid by the insurer is considered the actuarial value of the plan. Silver plans differ from other plans because they must provide CSRs to eligible enrollees. For people at most income levels, the actuarial value of a silver plan is 70 percent; however, people who qualify for CSRs are eligible for silver plans with higher actuarial values.

The size of premium tax credits is linked to the premiums for the second-lowest-cost silver plans offered through the marketplaces: Out-of-pocket payments for premiums for enrollees who are eligible for subsidies are based on a percentage of their income, and the government pays the difference through the premium tax credit. As a result, higher gross premiums for silver plans are expected to increase the amount of tax credits paid by the federal government, thereby covering the costs to insurers of CSRs. However, higher gross premiums for silver plans are not expected to significantly affect the out-of-pocket payments that subsidized enrollees pay for premiums for silver plans offered through the marketplaces because the structure of the premium tax credit largely insulates them from those increases.

In addition, because insurers in the majority of states are not expected to increase gross premiums for non-silver plans much, if at all, to cover the costs of CSRs, the larger premium tax credits are expected to cover a greater share of premiums for non-silver plans in those states. For example, more people would be able to use their higher premium tax credits to obtain bronze plans, which cover a smaller share of benefits than silver plans, for free or for very low out-of-pocket premiums. Also, the agencies anticipate that some people with income between 200 percent and 400 percent of the FPL would be able to purchase plans that cover a greater share of benefits with similar or lower premiums, after tax credits, than do silver plans. As a result of those changes, the agencies estimate that more people would purchase subsidized plans in the marketplaces than would have if the federal government had directly reimbursed insurers for the cost of CSRs.[5]

Budgetary Treatment

Section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985, which specifies rules for constructing the baseline, requires that CBO assume full funding of entitlement authority.[6] CBO and JCT have long viewed the requirement that the federal government compensate insurers for CSRs as a form of entitlement authority. On that basis, in the most recent baseline projections (summer 2017), CBO included the CSR payments as direct spending (that is, spending that does not require appropriation action). After consulting with the Budget Committees, CBO

5. For related discussion, see Congressional Budget Office, *The Effects of Terminating Payments for Cost-Sharing Reductions* (August 2017), www.cbo.gov/publication/53009.

6. 2 U.S.C. §907(b)(1) (2012). Entitlement authority is authority for federal agencies to incur obligations to make payments to entities that meet the eligibility criteria set in law.

continued to assume in its baseline that CSRs would be funded even though the Administration announced on October 12, 2017, that it would stop making direct payments for CSRs.

Section 602(b) of the BHCSA would appropriate such sums as may be necessary for the federal government to make payments to insurers for CSRs for the last quarter of plan year 2017, for certain insurers for plan year 2018, and for all of plan years 2019, 2020, and 2021. Because such direct payments are already in CBO's baseline projections, CBO and JCT estimated that providing such an appropriation would not increase direct spending or revenues, relative to the baseline.

Alternate Estimate

Estimating the budgetary effects of section 602(b) of the BHCSA relative to a different benchmark—that the CSR entitlement is funded through adjustments to premiums and premium tax credits (not through direct federal payment)—would produce a different budgetary result. Specifically, CBO and JCT estimate that appropriating funds for CSR payments for part of 2017 and for 2018—years in which insurers have already set premiums—would increase the deficit. However, CBO and JCT estimate that appropriating funds for CSR payments for the 2019-2021 period would reduce the deficit, on net, because insurers would no longer increase gross premiums for silver plans offered through the marketplaces in those years to cover the costs of CSRs.

Appropriating Funds for CSR Payments for 2017. Section 602(b) would appropriate such sums as may be necessary for CSR payments in the last quarter of plan year 2017. Because such an appropriation would not affect premiums that have already been set, the agencies estimate that the provision would cost $1.8 billion in 2018 relative to the alternative benchmark.

Special Rules for 2018. Section 602(b) would appropriate such sums as may be necessary for the cost of CSR payments in plan year 2018 for certain insurers that did not increase premiums in response to the lack of direct funding for such subsidies. Based on an analysis of rate filings and information from states, CBO and JCT estimate that about 5 percent of individuals receiving CSRs are enrolled in such plans and that the provision would cost $320 million relative to the alternative benchmark.

Section 602(b) also would provide an additional appropriation to Minnesota's and New York's Basic Health Programs (BHPs) in 2018. Those programs provide an alternative form of health insurance for individuals with incomes below 200 percent of the FPL who would otherwise be eligible for subsidized coverage through the marketplaces. The federal government subsidizes those programs by providing a per-enrollee payment equal to 95 percent of the subsidy those individuals would have received if they had obtained insurance through their state's marketplace. The appropriation in section 602(b) would provide funding equal to 95 percent of the amount of those enrollees' cost-sharing subsidies for 2018. CBO estimates that this would cost $1.2 billion in 2018 relative to the alternative benchmark.

Appropriating Funds for CSR Payments for 2019-2021. If the estimate incorporated the assumption that insurers were currently compensated for CSRs through larger premium tax credits, CBO and JCT estimate that appropriating payments for CSRs in future years would decrease total federal subsidies (premium tax credits and CSRs combined) for health insurance in the nongroup market. That decrease would occur because the average amount of subsidy per person would be smaller, and because fewer people would receive subsidies.

CBO and JCT anticipate that if insurers were compensated for CSRs through an appropriation, they would no longer increase gross premiums for silver plans offered through the marketplaces to cover the cost of providing reduced deductibles, copayments, and other means of cost sharing as required by law. As premiums declined, so would premium tax credits. CBO and JCT estimate that premium tax credits would decrease by more than the cost of appropriating CSR payments mainly because the decrease in premium tax credits for those with income between 200 percent and 400 percent of the FPL would be substantially larger than the small increases in CSR payments for this group. According to CBO and JCT's estimates, the reduction in the average subsidy per person accounts for less than half of the projected net reduction in federal costs for coverage through the marketplaces.

In addition, the agencies estimate that fewer people would enroll in—and receive subsidies for—coverage through marketplaces if payments for CSRs were appropriated. Those declines in enrollment would occur mostly among people with incomes between 200 percent and 400 percent of the FPL. As discussed earlier, in the absence of direct CSR payments, premiums and premium tax credits rise, and the higher premium tax credits are expected to cover a greater share of premiums for non-silver plans. For example, some people in that income range may be able to pay a similar or lower premium after tax credits for a plan that covers a greater share of covered benefits than a silver plan does. Accordingly, if the federal government instead directly reimbursed insurers for the cost of CSRs, people with income between 200 percent and 400 percent of the FPL would no longer have that option. In addition, fewer people would have access to bronze plans at no or very low premium cost after tax credits. The projected reduction in subsidized enrollment accounts for more than half of the estimated net reduction in federal costs for coverage through the marketplaces.

CBO and JCT estimate that appropriating CSR payments for 2019 through 2021 would, on net, reduce the deficit by $32 billion over the 2019-2027 period relative to the alternative benchmark. In addition, CBO and JCT project that the number of uninsured people would increase by less than 500,000 in 2019 and by between 500,000 and 1 million in 2020 and 2021. Most of those uninsured people would have incomes between 200 percent and 400 percent of the FPL.

I hope that you find this information helpful; if you wish to have further information, we will be pleased to provide it. The primary staff contacts for this analysis are Kate Fritzsche and Kevin McNellis.

Sincerely,

Keith Hall
Director

cc: Honorable Patty Murray
Ranking Member

Identical letter sent to the Honorable Greg Walden

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

March 19, 2018

Bipartisan Health Care Stabilization Act of 2018

As provided to CBO on March 19, 2018 (version TAM18347)

SUMMARY

The Bipartisan Health Care Stabilization Act of 2018 (BHCSA) would make several changes to health care laws. It would:

- Change the state innovation waiver process established by the Affordable Care Act (ACA),
- Appropriate a total of $30.5 billion for reinsurance programs or invisible high-risk pools in the nongroup insurance market,
- Appropriate funds for the direct payment for cost-sharing reductions (CSRs) through 2021,
- Allow any enrollee in the nongroup market to purchase a catastrophic plan, and
- Require some existing funding for operations in the health insurance marketplaces to be used specifically for outreach and enrollment activities in 2019 and 2020.

On net, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting the legislation would increase the deficit by $19.1 billion over the 2018-2027 period relative to CBO's baseline. The agencies estimate that the legislation would increase the number of people with health insurance coverage, on net, by fewer than 500,000 people in each year from 2019 through 2022, compared with the baseline projection. Because enacting the legislation would affect direct spending and revenues, pay-as-you-go procedures apply.

CBO and JCT estimate that enacting the legislation would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

The BHCSA would impose intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that the costs of those mandates would fall below the annual thresholds established in UMRA for intergovernmental and private-sector mandates ($78 million and $156 million in 2017, respectively, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effects of the Bipartisan Health Care Stabilization Act of 2018 are shown in the following table. The costs of this legislation fall within budget function 550 (health).

BASIS OF ESTIMATE

For this estimate, CBO and JCT assume that the legislation will be enacted in the spring of 2018. The agencies have measured the budgetary effects relative to CBO's most recent baseline (June 2017), incorporating adjustments published in September 2017, as well as adjustments for enacted legislation.[1]

State Innovation Waivers

Under current law, states may apply for waivers from some of the rules governing insurance markets or the programs offering health insurance established by the ACA. Those "state innovation waivers" were established by section 1332 of the ACA. Under current law and this legislation, waivers are required to be budget neutral and to provide comparable levels of insurance coverage, measured in terms of covered benefits, per-enrollee costs, and the number of state residents with health insurance. However, in CBO and JCT's assessment, the actual net budgetary effects of the waiver process are unclear.

1. The most significant adjustment for enacted legislation incorporates the effects of P.L. 115-97, which repealed penalties related to the individual health insurance mandate beginning in 2019 and changed income tax rates.

	By Fiscal Year, in Millions of Dollars											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018-2022	2018-2027
INCREASES OR DECREASES (-) IN DIRECT SPENDING												
State Innovation Waivers[a]	*	*	*	*	*	*	*	*	*	*	*	*
Reinsurance and Invisible High-Risk Pools[a]	50	6,866	6,199	9,029	6,024	-1,620	0	0	0	0	28,168	26,548
Waiver Pass-through Recalculation	68	69	70	72	79	*	*	*	*	*	359	359
Funding for CSRs	0	0	0	0	0	0	0	0	0	0	0	0
Copper Plans[a]	0	-71	-99	-88	-85	-87	-91	-93	-94	-97	-343	-805
Total Changes	118	6,864	6,170	9,013	6,019	-1,707	-91	-93	-94	-97	28,184	26,102
INCREASES OR DECREASES (-) IN REVENUES[b]												
State Innovation Waivers[a]	*	*	*	*	*	*	*	*	*	*	*	*
Reinsurance and Invisible High-Risk Pools[a]	0	802	1,501	2,160	1,986	520	0	0	0	0	6,449	6,970
Funding for CSRs	0	0	0	0	0	0	0	0	0	0	0	0
Copper Plans[a]	0	3	4	5	5	5	5	5	6	7	17	44
Total Changes	*	805	1,505	2,165	1,991	525	5	5	6	7	6,466	7,014
On-Budget	*	665	1,234	1,777	1,632	432	5	5	6	7	5,308	5,763
Off-Budget[c]	*	140	271	388	359	94	*	*	*	*	1,158	1,251
NET INCREASE OR DECREASE (-) IN THE DEFICIT FROM INCREASES OR DECREASES (-) IN DIRECT SPENDING AND REVENUES												
Impact on Deficit	118	6,059	4,665	6,848	4,028	-2,232	-96	-98	-100	-104	21,718	19,088
On-Budget	118	6,199	4,936	7,236	4,387	-2,138	-96	-98	-100	-104	22,875	20,339
Off-Budget[c]	*	-140	-271	-388	-359	-94	*	*	*	*	-1,158	-1,251

Notes: Budget authority is equal to outlays; components may not add to totals because of rounding; * = an increase or decrease of less than $500,000; CSRs = cost-sharing reductions.

a. Policies affect both direct spending and revenues.
b. For revenues, a positive number indicates an increase (reducing the deficit) and a negative number indicates a decrease (adding to the deficit).
c. All off-budget effects would come from changes in Social Security revenues.

Under a waiver, states receive federal funding (known as “pass-through funds”) to implement the waiver in an amount equal to the Administration’s estimate of federal subsidies that would have otherwise been paid in the absence of the waiver.[2] If the amount of pass-through funding equaled the amount that otherwise would have been paid, then the waiver would have no net budgetary effect. In CBO and JCT’s assessment, the factors that tend to increase net costs are probably roughly offset by factors that tend to decrease them. However, that equality might not occur for several reasons. For example, approved waivers could increase net costs if states chose to implement waivers only when the Administration’s estimate of pass-through funding turned out to be too high and did not implement them when that estimate turned out to be too low. On the other hand, states could implement waivers that reduced net costs by more than the amounts that would be included in the calculation of pass-through funding; for example, federal tax revenues could increase if state waivers caused premiums for employment-based insurance to fall or fewer employers to offer employment-based coverage under a waiver.

The legislation would make several changes to the rules for state innovation waivers. For example, under the legislation, states would no longer need to enact legislation before submitting a waiver application, and the standards by which the Departments of Health and Human Services and the Treasury Department evaluate states’ applications would change. CBO and JCT estimate that those changes would increase the number of applications submitted by states and the likelihood that future waiver applications would be approved. However, the agencies do not expect that the changes made to the standards for evaluating new waivers would significantly alter the net budgetary effect relative to current law.

Reinsurance and Invisible High-Risk Pools

The legislation would appropriate $10 billion per year over the 2019-2021 period to be used for reinsurance programs or invisible high-risk pools in the nongroup insurance market, plus $500 million to be used for state administrative costs, for a total of $30.5 billion. Generally, in order to receive its share of the money, a state would have to apply for a state innovation waiver and establish a reinsurance program or an invisible high-risk pool. However, for 2019 only, the legislation would establish a federal reinsurance program in any state that did not have a waiver related to reinsurance or an invisible high-risk pool. CBO and JCT estimate that, together, those provisions of the legislation would increase the deficit by $19.6 billion over the 2018-2027 period. That increase in the deficit is composed of a spending increase of $26.5 billion, partly offset by an increase in revenues of $7.0 billion.

2. Under current law, those federal subsidies that a state may receive in pass-through funds include subsidies for coverage purchased through a marketplace established by the ACA.

How Reinsurance Programs and Invisible High-Risk Pools Would Work. Reinsurance programs or invisible high-risk pools protect insurers from the risk of high-cost enrollees. A reinsurance program would pay insurers when enrollees incurred particularly high costs for medical claims—that is, costs above a specified threshold and up to a certain maximum. An invisible high-risk pool would allow insurers to pay premiums for selected high-risk enrollees into a pool, which would then cover the claims for those enrollees using the premiums and the federal funding. CBO and JCT estimate that either type of program would result in lower premiums for coverage in the nongroup market because the risk to insurers from high-cost enrollees would be lower.

What Proportion of the Population Would Be Affected. Based on information provided by state governments, insurers, and other outside experts, CBO and JCT estimate that almost all of the U.S. population would live in a state that used the federal default reinsurance program for 2019. Three states already have waivers approved under section 1332 that relate to reinsurance, but the agencies expect that it would be difficult for other states to establish a state-based program in time to affect premiums for 2019. Beginning in 2020, a state would need to establish its own program through a waiver under section 1332 in order to receive federal funds for reinsurance. CBO and JCT expect that about 60 percent of the population would live in a state that received such a waiver for 2020 and that about 80 percent of the country would live in a state that received such a waiver for 2021. The remainder of the population in those years would be without a federally-funded reinsurance program or invisible high-risk pool.

Why the Federal Costs Differ from the Appropriated Amounts. Because the funding would be available until spent, CBO and JCT expect that the money allocated to states that did not obtain a waiver for reinsurance or an invisible high-risk pool in 2020 and 2021 would be available for use by other states in 2022.

In 2019, CBO and JCT estimate, about 60 percent of the federal cost for the default federal reinsurance program would be offset by other sources of savings, mainly by reductions in federal subsidies. The largest amount of offsetting savings would result from lower premiums in the nongroup market. Because premium tax credits for coverage purchased through the marketplaces established under the ACA are directly linked to those premiums, any reductions in nongroup premiums would result in lower federal subsidies.

States that instead established their own reinsurance program or invisible high-risk pool through a waiver under section 1332 would receive most of those offsetting savings as additional "pass-through funds" under the waiver, with the remainder accruing to the federal government. CBO and JCT project that states would use the pass-through funding they receive under a waiver to help finance their state reinsurance program or invisible high-risk pool. Therefore, the agencies estimate that the size of the reinsurance program or invisible high-risk pool, and therefore the magnitude of the premium reductions in the

nongroup market, would be larger in states with a waiver than in states using the federal default program.

How Premiums Would Be Affected. CBO and JCT estimate that premiums for nongroup insurance would be about 10 percent lower in 2019, on average, under the legislation than projected for that year under current law. They also estimate that, in 2020 and 2021, premiums for nongroup insurance would be about 20 percent lower, on average, than estimated for those years under current law in states that applied for a waiver to establish their own reinsurance program or invisible high-risk pool. The reduction in premiums would result in less federal spending on premium tax credits and more federal spending on waiver pass-through funding. In states that did not apply for a waiver, premiums would be the same under current law as under the legislation starting in 2020. The reduction in premiums would mainly affect people with income greater than 400 percent of the federal poverty level (FPL). Most people with lower incomes purchasing nongroup insurance receive premium tax credits and pay a percentage of their income toward the purchase of the plan in their area used for determining the tax credit (referred to here as a benchmark plan) regardless of the gross premium charged for that plan.

The agencies estimate that insurers would lower premiums for coverage in the nongroup market based on the amount of funding they expect to be available for reinsurance programs or invisible high-risk pools. However, insurers would tend to set premiums conservatively to hedge against uncertainty about how the reinsurance program or invisible high-risk pool would be implemented and what their enrollees' ultimate healthcare costs would be. As a result, the agencies expect that total premiums would not be reduced by the entire amount of available federal funding.

How Insurance Coverage Would Be Affected. CBO and JCT estimate that this provision would increase the number of people with health insurance coverage, on net, by fewer than 500,000 people in each year from 2019 through 2022, compared with CBO's baseline projections. The largest portion of that net increase in coverage would come from people with incomes above 400 percent of the FPL who would be uninsured under current law, but who would purchase unsubsidized coverage in the nongroup market under the legislation because the premiums for that coverage would be lower.[3] Because the increase in the number of people with health insurance coverage would primarily occur among the unsubsidized population, the additional federal cost of increased enrollment would be relatively small (and such costs would reduce the size of the pass-through funding that a state would receive).

3. People are generally eligible for subsidies for coverage purchased through the marketplaces if they have incomes between 100 percent and 400 percent of the FPL and do not have another affordable source of insurance coverage, such as employment-based insurance or Medicare.

Waiver Pass-through Recalculation

The legislation would allow states with waivers under section 1332 that were approved before the legislation's enactment to request a recalculation of the pass-through funding they would be owed. The legislation also would modify the methodology for calculating pass-through payments to include reductions in Basic Health Program (BHP) subsidies caused by the terms of a waiver. (The BHP allows states to offer subsidies to certain low-income people that are based on the subsidies available through the marketplaces.) Minnesota is the only state with an approved 1332 waiver and a BHP. Because Minnesota's reinsurance waiver reduces premiums in the nongroup market, BHP payments are lower because those payments are directly tied to the premiums in the nongroup market. This provision would allow a state to receive the amount of the reduction in BHP payments as pass-through funding for its 1332 waiver.

CBO and JCT expect that Minnesota would request a recalculation, and that it would receive $359 million more in pass-through funding between 2018 and 2022. CBO and JCT also expect that if other states with an already-approved 1332 waiver but no BHP requested a recalculation, the amount of pass-through funding would not change significantly.

Funding for Cost-Sharing Reductions

The legislation would appropriate such sums as may be necessary to make payments for CSRs for the fourth quarter of calendar year 2017, for certain insurers for plan year 2018, and for all of plan years 2019 through 2021.[4] Because such payments are already in CBO's baseline projections (totaling $25 billion for 2019 through 2021 and $76 billion over the 2018-2027 period), CBO and JCT estimate that the appropriation would not affect direct spending or revenues, relative to that baseline.

CBO and JCT have long viewed the requirement that the federal government compensate insurers for CSRs as a form of entitlement authority. The Balanced Budget and Emergency Deficit Control Act of 1985, which specifies rules for constructing the baseline, requires CBO to assume full funding of such entitlement authority.[5] On that basis, in the most recent baseline projections (summer 2017), CBO included the CSR payments as direct spending (that is, spending that does not require appropriation action). After consulting with the Budget Committees, CBO continued to assume in its baseline that CSRs would be funded, even though the Administration announced on October 12, 2017, that it would stop making direct payments for CSRs.

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4. CSRs take the form of reduced deductibles, copayments, and other means of cost sharing for eligible individuals enrolled in silver plans through marketplaces.

5. 2 U.S.C. §907(b)(1) (2012). Entitlement authority is authority for federal agencies to incur obligations to make payments to entities that meet the eligibility criteria set in law.

Because CBO's baseline incorporates the assumption that direct payments for CSRs will be made for 2019 through 2021, premiums for those years would not change under the provision, relative to that baseline. To the extent that there would be uncertainty in 2022 about whether CSRs will be directly funded, CBO and JCT expect that insurers would increase premiums in that year relative to the baseline projections. Because CBO's baseline incorporates the funding for CSRs, however, this cost estimate excludes any effects on premiums of uncertainty about future funding—consistent with the exclusion of effects of providing the funding itself.

This analysis of the effects of CSRs on health insurance coverage and federal costs differs from that which CBO published in August 2017 in various ways.[6] Most importantly, the August 2017 analysis considered the effects of hypothetical legislation that would terminate direct funding for CSRs, whereas this analysis addresses the effects of legislation that would provide direct funding for CSRs. In both cases, the legislation was compared to a baseline in which CSRs were directly appropriated.

Simply comparing outcomes with and without direct funding for CSRs, CBO and JCT expect that premiums for benchmark plans over the 2019-2021 period would be lower with funding for CSRs than without it, and federal costs would be lower as well. Such effects are explained in CBO's August 2017 report.

Copper Plans

Under current law, only certain people, most of whom are under the age of 30, may enroll in a catastrophic plan in the nongroup insurance market. Beginning in 2019, the legislation would allow any nongroup enrollee to choose a catastrophic plan (those plans would be called copper plans). As under current law, subsidies would not be available for that coverage. In addition, the legislation would require that catastrophic plans be included as part of the single risk pool for pricing premiums in the nongroup market, alongside most other plans. (Under current regulations, catastrophic plans are treated separately from other nongroup plans for purposes of the risk-adjustment program.)

CBO and JCT estimate that this provision would not substantially change the total number of people purchasing insurance through the nongroup market. However, the agencies estimate that making catastrophic plans part of the single risk pool would slightly lower premiums for other nongroup plans, because the people who enroll in catastrophic plans tend to be healthier, on average, than other nongroup market enrollees. As a result of the slightly lower estimated premiums, CBO and JCT expect that federal costs for subsidies for insurance purchased through a marketplace would be reduced by

6. For related discussion, see Congressional Budget Office, *The Effects of Terminating Payments for Cost-Sharing Reductions* (August 2017), www.cbo.gov/publication/53009.

$849 million over the 2019-2027 period. That decrease in the deficit is composed of a decrease in outlays of $805 million and an increase in revenues of $44 million.

Outreach and Assistance Funding

Under current law, insurers participating in the federally-facilitated health insurance marketplace must pay a user fee. Those user fees support operations of the marketplace such as conducting outreach and enrollment activities, building and maintaining information technology systems, determining eligibility for subsidies, ensuring proper payments of subsidies, operating a quality rating system, conducting plan certification and oversight, and educating and assisting consumers with the marketplace.

The legislation would require the Department of Health and Human Services to spend $105.8 million of those existing user fees for outreach and enrollment activities related to the federally-facilitated marketplace for each of plan years 2019 and 2020. That amount is larger than the amount the Administration has previously announced it plans to spend on those activities for the 2018 plan year.

The legislation would designate specific purposes for existing funding and would not appropriate additional funds. Funding for outreach and enrollment activities could increase enrollment, increasing the number of people receiving subsidies while potentially improving the average health of enrollees in marketplace plans (and thus lowering average premiums in marketplace plans). However, because CBO and JCT do not have a basis for comparing the effects on enrollment and subsidies of using the funding for newly specified activities rather than choices under current law (which also could affect enrollment and subsidies), the agencies do not have a basis for estimating a net effect on the deficit from enacting the provision.

PAY-AS-YOU-GO CONSIDERATIONS

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays and revenues that are subject to those pay-as-you-go procedures are shown in the following table. Only on-budget changes to outlays or revenues are subject to pay-as-you-go procedures.

CBO Estimate of Pay-As-You-Go Effects for the Bipartisan Health Care Stabilization Act of 2018

	By Fiscal Year, in Millions of Dollars											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018-2022	2018-2027
NET INCREASE OR DECREASE (-) IN THE ON-BUDGET DEFICIT												
Statutory Pay-As-You-Go Impact	118	6,199	4,936	7,236	4,387	-2,138	-96	-98	-100	-104	22,875	20,339
Memorandum:												
Changes in Outlays	118	6,864	6,170	9,013	6,019	-1,707	-91	-93	-94	-97	28,184	26,102
Changes in Revenues	0	665	1,234	1,777	1,632	432	5	5	6	7	5,308	5,763

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

MANDATES

The bill would impose two private-sector mandates as defined in UMRA. It would require insurers to consider catastrophic plans as part of the single risk pool. The bill also would require issuers of short-term, limited duration insurance to notify consumers that such insurance differs from coverage and benefits under qualified health plans. CBO estimates that any incremental administrative costs of those mandates would be small and fall below the annual threshold established in UMRA for private-sector mandates ($156 million in 2017, adjusted annually for inflation). Additionally, the bill would require state insurance commissioners to oversee the consumer notification process. CBO estimates that the costs of that requirement would fall well below the threshold for intergovernmental mandates ($78 million in 2017, adjusted annually for inflation).

PREVIOUS CBO ESTIMATE

On October 25, 2017, CBO transmitted a cost estimate for the Bipartisan Health Care Stabilization Act of 2017. The differences in the estimated costs reflect differences between the two pieces of legislation, primarily the appropriation of funding for reinsurance and invisible high-risk pools, and the effects of legislation that was enacted since the earlier estimate was prepared.

ESTIMATE PREPARED BY

Federal Costs: Kate Fritzsche, Kevin McNellis, and the staff of the Joint Committee on Taxation
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Making Health Insurance Enrollment As Automatic As Possible (Part 2)

Stan Dorn, James C. Capretta, Lanhee J. Chen

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Editor's note: Part 1 of this post discussed previous uses of auto-enrollment with health insurance and other benefits as well as recent efforts in Maryland to deploy auto-enrollment to improve the individual market's risk pool and reduce the number of uninsured. Part 2, below, explores how federal lawmakers could provide states with additional flexibility and build a supportive framework to facilitate future state innovation around health insurance auto-enrollment. Brief introductory material from part 1 is included below for context.

In December 2017, the Republican Congress, working with the Trump administration, repealed the tax penalties enforcing the Affordable Care Act's (ACA) individual mandate, effective in 2019. Although the degree of the mandate's efficacy is uncertain, its repeal is sure to lead to additional Americans

going without coverage, exacerbating the instability that now affects the individual insurance markets of many states.

In this context, it is incumbent on federal and state policymakers to enact replacement policies for the ACA's individual mandate. More fundamentally, the individual market's core dysfunction remains in place: Many young and healthy consumers remain outside the market, increasing average risk levels and premiums, and leaving millions of people needlessly uninsured. Those enrollment choices involve the perception and the reality of unaffordable coverage, but they also reflect burdens of enrollment and plan selection that have an outsize impact on program participation.

Similar dynamics extend beyond the individual market, leaving many people uninsured despite qualifying for Medicaid or employer-sponsored insurance. Most people who remain uninsured today qualify for insurance, often at very low cost to themselves.

One promising strategy to address these challenges involves the use of automatic, default enrollment into insurance. An automatic enrollment program can improve participation by creating options that require little or no premium payment and that require very little effort from the consumer—apart from providing consent, perhaps through failing to opt out.

We propose an approach aimed at making enrollment into insurance as automatic as possible. This will be a complex undertaking. Nonetheless, once it is up and running, we believe

this approach can dramatically improve enrollment into insurance, and thus help to stabilize the market and make it more attractive for all consumers.

A Federal Framework With Multiple Options For States And Employers

In addition to other steps to stabilize markets and increase coverage, the federal government could establish an overall framework for states to experiment with more frictionless enrollment into insurance. Flexibility is key, given the many challenges ahead and the need to garner lessons learned that can inform future policy. Such a federal framework could address the individual market, employer coverage, and Medicaid/CHIP.

The Individual Market: Increased State Flexibility

Several possible changes to federal law would increase state capacity to use default enrollment to provide individual market coverage to uninsured residents, including young and healthy adults whose participation would improve risk pools and lower unsubsidized premiums. First, states could be given the option to base eligibility for federal financial assistance on prior-year tax returns, eliminating the risks that auto-enrollment would otherwise create with later reconciliation. Other programs use similar eligibility methods to simplify enrollment, including federal grants and loans for post-secondary-education, tax rebates in the 2008 stimulus bill, and means-tested variations in

Medicare Part B and Part D premiums. In these programs, consumers can obtain additional assistance by demonstrating a recent drop in income, but increases to current-year income affect future assistance levels without requiring subsidy repayment.

Second, federal law could increase state flexibility to base eligibility determinations on reliable sources of objective data. For example, lawmakers could more clearly authorize states to determine eligibility for PTCs (premium tax credits) (and Medicaid) based entirely on third-party data sources, without obtaining affirmative attestations from consumers. Congress could authorize the IRS to share federal income tax data with states to help administer auto-enrollment programs, provided that affected tax filers give consent. With other sources of reliable and relevant data, federal legislation could permit their use to determine eligibility for subsidized coverage, so long as affected consumers receive clear notice and a chance to opt out of data sharing. The Medicaid statute already permits such an opt-out approach to obtaining information needed to verify eligibility, with guardrails to protect privacy and data security.

Third, Congress could give states more access to data about health coverage. This would help states target the uninsured for auto-enrollment and prevent public funds from being wasted to cover consumers who already have insurance. For example:

- Federal law could give states access to existing data sources that identify people with coverage. Such sources

include Medicare coordination-of-benefits records, information returns that carriers and sponsors provide under Internal Revenue Code Section 6055, coverage data provided by private contractors to HHS for purposes of verifying eligibility for special enrollment periods, and third-party-liability data sources for Medicaid. Currently, such data are available for specified purposes that do not include helping states focus enrollment efforts on people who are uninsured.

- The federal government could create an exemption from ERISA allowing states to compel self-insured plans to provide coverage information to the state.
- The federal government could incorporate information about recipients of employer-based coverage into the National Database of New Hires (NDNH) and make NDNH accessible both for determining eligibility for subsidies and helping state auto-enrollment programs.
- Federal agencies could give states access to information about who receives coverage through federal employment, Medicare, other states' Medicaid and CHIP programs, or the federally operated healthcare.gov website.

Fourth, the federally facilitated marketplace that serves most of the country could create options for data exchange and plan choice for states interested in collaborating around default-enrollment strategies.

Finally, states could receive the option to let consumers of all ages use PTCs to auto-enroll into catastrophic plans, letting

more people receive coverage that costs no more than PTC amounts. Currently, PTCs may not be used with such plans, and they are generally limited to people under age 30. Other plans could potentially be offered at even lower net cost to the consumer, bringing entirely PTC-funded coverage within reach of additional uninsured.

Enrollment in high-deductible plans improves the individual market's overall risk pool and shields enrollees from catastrophic costs, but such plans provide much more limited access to care than is typically furnished by group coverage, and many enrollees may not perceive their high-deductible plans as valuable. Reasonable people can disagree about the desirability of high-deductible plans—including bronze coverage—but several steps could mitigate concerns about their use for default enrollment.

As a starting point, states can improve such plans' short-term usefulness by encouraging or requiring high-deductible plans used for default enrollment to offer significant coverage of pre-deductible services, including generic medications and visits with primary care providers. In addition, federal law could permit carriers to let default enrollees quickly move up to silver coverage by combining PTCs with additional household premium payments. This might require revising current federal limits on changing plans outside open and special enrollment periods. Moreover, default enrollment into high-deductible plans, based on zero additional premium cost beyond PTC amounts (plus payments, if any, required by the state because of

coverage gaps the previous year), could be limited to consumers who: (1) were offered more generous plans and chose not to enroll; (2) are not offered more generous plans at zero additional premium cost; and (3) can opt out of the default high-deductible option, either before or within a defined period following auto-enrollment.

The Individual Market: A Supportive Federal Structure

Beyond increasing state flexibility, federal lawmakers could create a basic structure to support state auto-enrollment efforts. Short-term federal grants, perhaps with modest state matching requirements, could fund state policy planning and initial development of information technology infrastructure. The federal government could also fund independent studies that inform future policy choices about whether and, if so, how to pursue auto-enrollment.

To qualify for these federal resources, states could be asked to submit an outline describing key elements of the proposed auto-enrollment strategies, such as:

- *Venue For Auto-Enrollment*. Will the state use its income-tax system as the place to identify the uninsured and provide them with coverage? Will health care providers begin auto-enrollment for uninsured patients (perhaps leveraging systems hospitals already use to retroactively enroll uninsured patients into Medicaid)? Will auto-enrollment efforts begin when drivers' licenses are renewed or when workers are laid-off from jobs that provide employer-based

coverage? Will the state proactively identify the uninsured through analysis of coverage data and initiate auto-enrollment based on such identification?

- What data will the state access to determine eligibility for assistance? How will the state prevent default enrollment from reaching consumers who already have insurance? Will the state create new databases to supplement existing data sources? How will data privacy and security be protected? What notice will the state provide consumers? What opt-ins, opt-outs, and defaults will apply? How will consumers be able to review and correct their data, securely and easily?
- *Financial Assistance*. What financial assistance will pay for coverage? How will consumers be warned about or shielded from risks associated with claiming assistance, such as the risk of federal tax liability for advance PTC claims that turn out to be excessive? Will states impose a tax payment on consumers who fail to maintain coverage, and thus provide added incentive for insurance enrollment, or will they rely on automatic enrollment to boost coverage? If states impose a penalty for going without coverage, will they allow payments of those penalties to be applied toward enrollment in insurance?
- *Health Plan Selection.* What health plans will be used for auto-enrollment? If more than one plan is available, how will the default plan be chosen? How will the state promote consumers' receipt of coverage they value? Will consumers have options to make plan choices before auto-enrollment or to change or drop coverage after auto-enrollment?

As federal and state policymakers decide on their approach to auto-enrollment, several trade-offs are important to evaluate:

- *Enrollment Versus Privacy*. Requiring consumers to affirmatively waive privacy protections before a state accesses data establishing eligibility for assistance, for example, may protect privacy at the expense of coverage. Further analysis may be needed to assess the actual preferences of affected consumers and determine which default settings make consumers better off "as judged by themselves."
- *High-Deductible Coverage*. Default enrollment in the individual market reaches more people, all else equal, if such enrollment can put people into high-deductible plans. Some observers are concerned about the limited access to care such coverage provides, but few would argue that going completely uninsured is better.

Employer Coverage

While most working Americans and their families readily sign up for employer-sponsored insurance, some do not. According to a study published by the Kaiser Family Foundation, 3.7 million people were uninsured in 2016 despite offers of employer-sponsored coverage that disqualified them from subsidized health insurance in the ACA exchanges. In a separate study, based on survey data from employer plans, Kaiser found that 78 percent of workers whose employers offered coverage accepted those offers.

Federal law could make clear that employers, under certain conditions, have the flexibility to automatically enroll their employees into coverage. Employers electing this option would need to ask workers in advance if they have other coverage. Those who state that they are uninsured could be enrolled into the employer plan unless they opt out, with worker premium shares withheld from paychecks.

Employers could limit these default options to plans with minimal worker premium costs. Workers would need the right to decline coverage after their employers notify them of enrollment. This option would mirror some employers' current practice of automatically enrolling their employees into pension or retirement savings arrangements unless workers opt out.

Medicaid And CHIP

Federal policymakers could take several steps to let states automate and otherwise streamline enrollment into Medicaid and CHIP when reliable sources of data show that consumers qualify. States could receive the flexibility to enroll such consumers by default, without requiring an affirmative request for coverage. If a state picks this option, consumers would need to receive notice and a chance to opt out before coverage begins. As with Medicaid's current procedures for ex parte/administrative renewal, the notice could inform beneficiaries of their obligation to notify the state if household circumstances change in ways that may affect eligibility.

Congress could also give states the flexibility to use Express Lane Eligibility with adults as well as children. This would let states qualify families for health coverage when SNAP or other benefit programs have already found them to meet income and other eligibility requirements, notwithstanding small technical details about how different programs define households and measure income. When children and adults qualify based on ELE, states could be given the flexibility to enroll them by default, so long as they do not opt out. The expedient originally used by Louisiana—where eligible families showed affirmative consent by using a Medicaid card to seek care—would no longer be required if a state used opt-out rather than opt-in enrollment procedures for people who qualify through ELE.

What A State's Automatic Enrollment Program Might Look Like In Practice

With the above changes to federal law, here are examples of how a state might facilitate automatic enrollment.

Tax-Based Enrollment

The tax-based component of a state auto-enrollment plan might unfold as follows:

1. *Tax Season*. The state could require residents to disclose health insurance status during the prior calendar year as part of filing state income tax returns. By checking a single box, tax filers could authorize a state health agency to

obtain all necessary information to determine eligibility for free or low-cost insurance and to enroll uninsured household members into coverage through Medicaid, CHIP, or private marketplace coverage. The state has the option to impose taxes on those who were uninsured the prior year.

2. *Immediate Data Cross-Check And Eligibility Determination*. For tax filers who check the authorization box, the state would access coverage data and use information from the tax return as well as other third-party sources to identify uninsured tax filers and determine their eligibility for Medicaid, CHIP, and PTCs. Until the state has built a system for compiling and vetting coverage data, tax filers could be asked to indicate on their return whether they are uninsured at the time the return is filed.
3. *Rapid Enrollment*. Those found eligible for Medicaid and CHIP would be enrolled. Those who filed tax returns by April 15 and qualify for PTCs might have a brief special enrollment period in which they could choose from any available QHPs (qualified health plans). Those who fail to enroll during that period and who are offered QHPs costing no more than PTCs (plus tax payments for prior-year coverage gaps, in a state imposing such payments) would be auto-enrolled.

   To increase the number of residents with auto-enrollment options, the state might make catastrophic-level plans available for PTC use by auto-enrollees of all ages. To lessen consumer risks and reduce the need for affirmative consent, the state could base PTC eligibility on prior-year tax returns, without any need for later reconciliation on federal

income tax returns. Coverage would begin at the earliest practical date, given standard rules about coverage-effective dates.

4. *November-December Open Enrollment After Tax Time*. Individuals who were auto-enrolled into a QHP could change plans during open enrollment. If they did not make a selection, they would remain enrolled in the same QHP, following normal default renewal rules.

This cycle would repeat itself each year, with refinements over time making the process more seamless, less costly, and with fewer mistakes and errors.

What If The State Does Not Use Or Wants To Supplement Tax-Based Enrollment?

If the state has no income tax or hesitates to use tax filing for this purpose, it could develop automatic enrollment systems that find uninsured residents through other means. For example, a state could:

- Proactively reach out to residents who are reliably identified as uninsured based on a state-developed comprehensive, regularly updated coverage database;
- Leverage existing state functions that “touch” numerous residents, such as automobile registration or drivers’ license renewal, by asking about health insurance and requiring all uninsured consumers to say whether they want their contact information forwarded to the state health agency to see if they qualify for free or low-cost health insurance; and

- Creating systems through which health care providers can easily and quickly enroll their uninsured patients into coverage, perhaps building on successful state initiatives to let hospitals and clinics act as their patients' authorized representatives in signing up for health coverage. Newborn children could be a particular focus of hospital-based enrollment, given the surprisingly large percentage who lack coverage—5 percent of all children under age 1, a much higher proportion than for any other age group.

Even a state that uses its income tax system as a pathway to enrollment could supplement that effort with one or more of these other channels.

Employment-Based Enrollment

Auto-enrollment into employer-sponsored insurance could accompany any of the above methods for identifying uninsured state residents and signing them up for coverage. With hiring that can take place at any time, employers could offer automatic enrollment of new employees throughout the calendar year.

Looking Forward

We are convinced that auto-enrollment could greatly reduce the number of uninsured while lowering individual-market premiums substantially by increasing the participation among the young and healthy uninsured. Among other gains, such measures could more than offset the effects of ending the ACA's individual mandate enforcement and help remedy some of the core

dysfunctions plaguing the individual market. We hope that future analysis and state-level implementation will test these hypotheses and assess the magnitude of the effects we foresee.

The operational challenges of implementing auto-enrollment strategies would be significant. Numerous details, such as those involving immigration status and citizenship, would be critically important to design with great care. Nevertheless, state health officials have a track record of remarkable creativity, persistence, and effectiveness, given the right tools. We encourage federal policymakers to give such tools to their state colleagues so that the whole country can learn from state innovation in this promising and important arena.

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Making Health Insurance Enrollment As Automatic As Possible (Part 1)

Stan Dorn, James C. Capretta, Lanhee J. Chen

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Editor's note: Part 1 of this post, below, discusses previous uses of auto-enrollment with health insurance and other benefits as well as recent efforts in Maryland to deploy auto-enrollment to improve the individual market's risk pool and reduce the number of uninsured. Part 2, which will appear May 3, explores how federal lawmakers could provide states with additional flexibility and build a supportive framework to facilitate future state innovation around health insurance auto-enrollment.

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going without coverage, exacerbating the instability that now affects the individual insurance markets of many states.

In this context, it is incumbent on federal and state policymakers to enact replacement policies for the ACA's individual mandate. More fundamentally, the individual market's core dysfunction remains in place: Many young and healthy consumers remain outside the market, increasing average risk levels and premiums, and leaving millions of people needlessly uninsured. Those enrollment choices involve the perception and the reality of unaffordable coverage, but they also reflect burdens of enrollment and plan selection that have an outsize impact on program participation.

Similar dynamics extend beyond the individual market, leaving many people uninsured despite qualifying for Medicaid or employer-sponsored insurance. Most people who remain uninsured today qualify for insurance, often at very low cost to themselves.

One promising strategy to address these challenges involves the use of automatic, default enrollment into insurance. An automatic enrollment program can improve participation by creating options that require little or no premium payment and that require very little effort from the consumer—apart from providing consent, perhaps through failing to opt out.

We propose an approach aimed at making enrollment into insurance as automatic as possible. This will be a complex undertaking. Nonetheless, once it is up and running, we believe

this approach can dramatically improve enrollment into insurance, and thus help to stabilize the market and make it more attractive for all consumers.

Past Use Of Automatic Enrollment

401(k) Enrollment

Making participation rather than non-participation the default option has greatly increased take-up in contexts outside health coverage, illustrating the surprisingly significant impact of lifting small procedural barriers to enrollment. One classic example involves 401(k) retirement savings accounts. In companies where new employees must complete a form to establish such accounts, roughly one-third enroll within six months. By contrast, in firms where new employees are automatically enrolled unless they complete opt-out forms, 90 percent join.

Medicare Part B

Health programs have also used automatic enrollment to achieve high take-up levels. Perhaps the best known example involves Medicare Part B, which historically achieved 96 percent participation levels. People turning 65 are automatically enrolled by default, unless they object. Part B premium payments are withheld from Social Security checks.

Medicare Part D

Within six months of the Medicare Part D prescription drug benefit becoming available for enrollment in January 2006, the Centers for Medicare and Medicaid Services (CMS) achieved remarkable success, enrolling 74 percent of eligible seniors in the low-income subsidy (LIS) component of the program. Only 14 percent of eligible seniors completed applications for enrollment, however. The others were auto-enrolled based on data matches with state Medicaid programs and the federal Supplemental Security Income (SSI) program. Medicare beneficiaries continue to qualify automatically for LIS assistance based on their receipt of Medicaid or SSI during the previous year.

Louisiana Express Lane Eligibility

In 2010, Louisiana implemented Express Lane Eligibility (ELE), an option that lets states base Medicaid on the eligibility determinations of other need-based programs. Unlike other states that reached many fewer children because they required parents to complete forms requesting coverage, Louisiana used largely default-enrollment methods to provide children with Medicaid when their families participated in the Supplemental Nutrition Assistance Program (SNAP).

Only 1 percent of families whose children received SNAP but not Medicaid opted out of ELE. The remainder were sent Medicaid cards, which were automatically activated upon first use. Nearly 30,000 children received health coverage, substantially cutting the state's already low percentage of uninsured children. After

initial enrollment, 83 percent of ELE children used Medicaid to access care within a year—only slightly below the 88 percent of children who enrolled in Medicaid through other channels.

When information technology problems forced Louisiana to change its enrollment method to require parents to check an opt-in box on the SNAP application form, ELE enrollment fell by 62 percent.

Lessons Learned

Based on this prior experience, several features appear essential to the effective use of default or automatic enrollment:

- Eligibility criteria are structured to fit available data, so additional information or other action from the individual is not required before coverage begins.
- Either default enrollees are not required to make payments or the administrative entity doing the enrollment can make payments on the consumer's behalf (e.g., employers' paycheck withholding of workers' 401(k) contributions and the Social Security Administration's withholding of Medicare Part B premium payments from social security checks).
- Default choices are believed to match the preferences of most affected consumers, with consumer gains significantly exceeding costs.

Maryland Tests The Possibilities Of Default Enrollment In The Individual Market

Meeting these criteria in the context of individual-market coverage is not easy, but policymakers in Maryland have been pushing the boundaries of what is possible under current federal law. Legislation introduced in Maryland, the "Protect Maryland Health Care Act of 2018," would use the state's income tax system to replace federal enforcement of the ACA's individual mandate. Rather than simply impose a penalty, the legislation would encourage the uninsured to convert their penalties into "down payments" to buy health insurance, whenever possible.

Roughly 100,000 Maryland adults who were uninsured in 2016 could obtain Exchange coverage at zero additional premium beyond the applicable premium tax credit (PTC) plus the payment owed because of coverage gaps the previous year, according to a Families USA analysis of 2016 data from the American Community Survey and premium information from Maryland's Exchange. More than two-thirds of these 100,000 consumers could purchase gold plans with deductibles of $1,500 or less. Roughly two-thirds are adults under age 45, and 39 percent are under age 35, suggesting that their addition to the individual market could lower overall risk levels and unsubsidized premiums. However, several legal and policy obstacles prevented legislators from proposing full automatic enrollment:

- State mandate enforcement means that consumers who were uninsured the previous year identify themselves on state income tax returns. However, many who were uninsured the previous year have coverage by the time they file tax returns. The Maryland legislation therefore requires formerly uninsured tax filers to indicate whether they remain uninsured before tax-based enrollment begins.
- Tax return information provides most of the information needed to determine an uninsured taxpayer's eligibility for PTCs. But the state revenue agency cannot disclose return information to the Exchange without legal authorization. The Maryland legislation thus requires uninsured taxpayers to authorize disclosure of relevant return information before the Exchange moves forward.
- State tax returns do not provide all of the information needed to determine PTC eligibility. The Exchange can obtain some of the missing data elements based on matches from third-party data sources, authorization for which is provided by uninsured consumers on their tax returns. But other items may need to be furnished by the consumer, either on the tax return or through later provision of information to the Exchange.
- Advance PTCs are needed for taxpayers to enroll in coverage at zero additional premium cost. However, PTC claimants must file later federal tax returns that reconcile advance payments with annual circumstances shown on the return. Excess advance PTC claims can thus lead to federal tax debts. The Maryland proposal accordingly requires consumers, before enrollment, to be informed of and

acknowledge the need for tax reconciliation, the risk of year-end federal tax debts, and the obligation to notify the Exchange of changes in mid-year household circumstances.

The Legislature was unable to complete action on this complex, groundbreaking proposal during the brief 2018 legislative session, but it is a leading item on the agenda of a bipartisan legislative working group preparing legislation for action in early 2019. More broadly, Maryland's initial efforts illustrate what states can do under current federal law, as well as operational barriers that could be lowered through federal policy intervention, as we will discuss in part 2 of this post.

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First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse

Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February–March 2018

Tuesday, May 1, 2018

By Sara R. Collins (/about-us/staff-contact-information/program-staff/senior-program-research-staff/collins-sara-r), Munira Z. Gunja (/about-us/experts/gunja-munira-z), Michelle M. Doty (/about-us/staff-contact-information/program-staff/senior-program-research-staff/doty-michelle-m) and Herman K. Bhupal (/about-us/staff-contact-information/program-staff/program-support/bhupal-herman)

The marked gains in health insurance coverage made since the passage of the Affordable Care Act (ACA) in 2010 are beginning to reverse, according to new findings from the latest Commonwealth Fund ACA Tracking Survey. The coverage declines are likely the result of two major factors: 1) lack of federal legislative actions to improve specific weaknesses in the ACA and 2) actions by the current administration that have exacerbated those weaknesses. These include the administration's deep cuts in advertising and outreach during the marketplace open-enrollment periods, a shorter open enrollment period, and other actions that collectively may have left people with a general sense of confusion about the status of the law. Signs point to further erosion of insurance coverage in 2019: the repeal of the individual mandate penalty included in the 2017 tax law, recent actions to increase the availability of insurance policies that don't comply with ACA minimum benefit standards, and support for Medicaid work requirements.

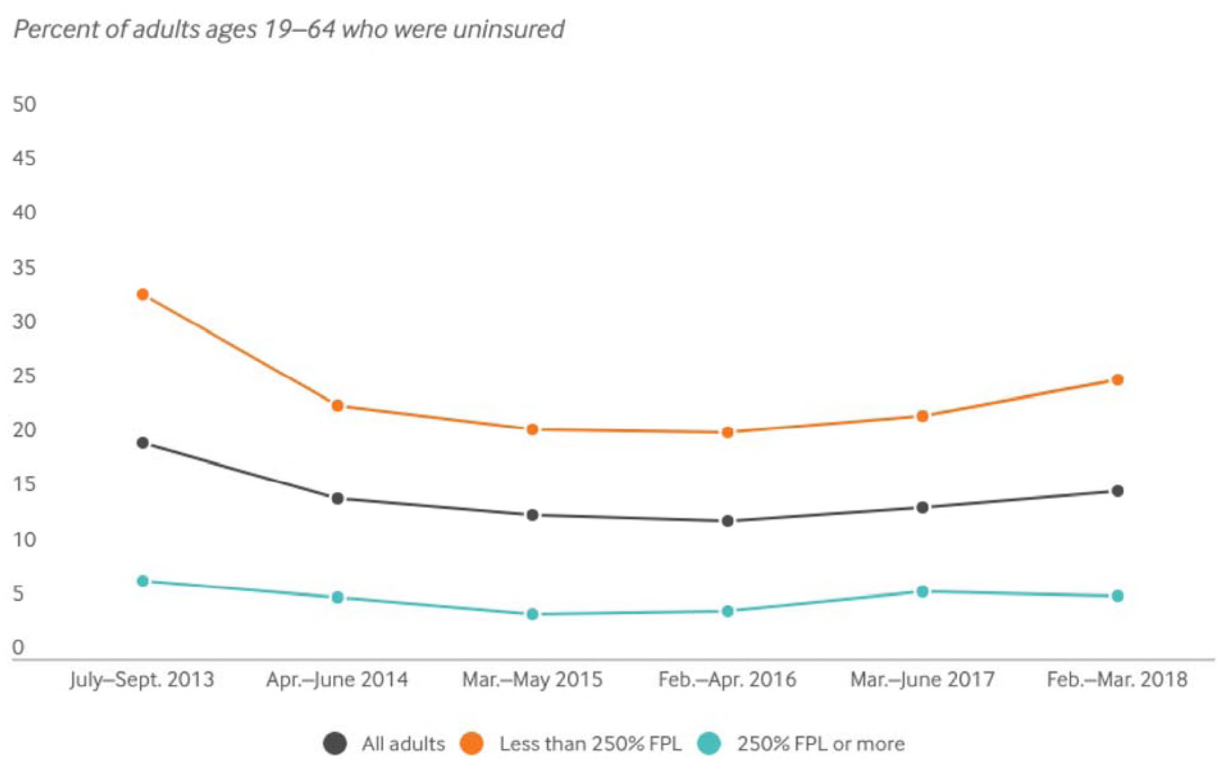
In this post, and another soon to follow, we will look at people's recent experiences with their insurance coverage and the affordability of their health insurance and health care.[1 (#/#1)] The ACA Tracking Survey is a nationally representative telephone survey conducted by SSRS that tracks coverage rates among 19-to-64-year-olds and has focused in particular on the experiences of adults who have gained coverage through the marketplaces and Medicaid. The latest wave of the survey was conducted between February and March 2018. Forthcoming results from large federal surveys like the National Health Interview Survey will shed more light on the trends our survey has identified.[2 (#/#2)]

Findings

Uninsured Rate Among Working-Age Adults Is Up Significantly Since 2016

The uninsured rate among working-age people — that is, those who are between 19 and 64 — is at 15.5 percent, up from 12.7 percent in 2016, meaning an estimated 4 million people lost coverage (Tables 1 (#/#Table 1) and 2 (#/#Table 2)). Rates were up significantly compared with 2016 among adults with lower incomes — those living in households earning less than 250 percent of poverty (about $30,000 for an individual and $61,000 for a family of four).

The uninsured rate among working-age adults increased to 15.5 percent



Note: FPL refers to federal poverty level; 250% FPL is about $31,150 for an individual and $61,500 for a family of four.
Data: Commonwealth Fund Affordable Care Act Tracking Surveys, July–Sept. 2013, Apr.–June 2014, Mar.–May 2015, Feb.–Apr. 2016, Mar.–June 2017, Feb.–Mar. 2018.

Source: Sara R. Collins et al., "First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018," *To the Point* (blog), Commonwealth Fund, May 1, 2018.

Uninsured rates were also up significantly among adults living in the 19 states that have not yet expanded their Medicaid programs.

. . . and among adults ages 35–49 and 50–64.

The uninsured rate among adults who identify as Republicans was also up significantly, rising from 7.9 percent in 2016 to 13.9 percent in the current survey period. The uninsured rate among those who identify as Democrats stood at 9.1 percent, statistically unchanged from 2016.

One of five adults living in the South were uninsured, up significantly from 16 percent in 2016. Adults were uninsured at a higher rate in southern states than they were in the Northeast, Midwest, and West.

Five Percent of Insured Adults Plan to Drop Insurance Because of the Individual Mandate Repeal

Congressional Republicans' 2017 tax bill repealed the penalty people currently owe on their income taxes if they do not have health insurance, effective in 2019. About 60 percent of all adults were aware that the tax bill had included a repeal of the penalty (data not shown). Among adults with insurance coverage, 9 percent of those who got their insurance through the individual market, 5 percent of those with employer coverage, and 5 percent of those with Medicaid said they intended to drop insurance because of the change (Table 3 (#/#Table 3)).

Policy Implications

If bipartisan agreement regarding the ACA were possible in Congress, there are several policy options available that have the potential to increase health insurance coverage. These include:

- providing financial support for advertising to improve awareness of coverage options in all states,
- improving health plan affordability in the individual market, and
- ensuring each market has a participating insurer.

Senators Susan Collins (R-Maine) and Bill Nelson's (D-Fla.) bill (https://www.congress.gov/115/bills/s1835/BILLS-115s1835is.pdf) to provide reinsurance for the marketplaces is one such example. Senator Elizabeth Warren (D-Mass.) recently introduced a bill (ttps://www.congress.gov/115/bills/s2582/BILLS-115s2582is.pdf) that would enhance marketplace premium and cost-sharing subsidies, and require private insurers that participate in Medicare and Medicaid to offer plans in the marketplace. Christine Eibner and Jodi Liu of RAND modeled (http://www.commonwealthfund.org/publications/fund-reports/2017/oct/expand-insurance-enrollment-individual-market) six incremental options to reduce individual market premiums and increase coverage, including extending premium tax credits to those above the income eligibility threshold and creating a federal reinsurance program. Each policy the researchers modeled increased coverage and affordability with either a minor cost to the deficit or, in the case of reinsurance, significant deficit savings.

Other policymakers have introduced legislation that would cover more people through Medicare. Senators Michael Bennett (D-Col.) and Tim Kaine (D-Va.) are proposing that a Medicare (https://www.congress.gov/115/bills/s1970/BILLS-115s1970is.pdf) plan open to people under age 65 be offered through the marketplaces. Senators Jeff Merkley (D-Ore.) and Chris Murphy (D-Conn.) go further by also allowing fully insured employers to offer a Medicare (https://www.murphy.senate.gov/download/medicare-bill) plan to their employees, enhancing marketplace subsidies, and lowering out-of-pocket costs for current Medicare beneficiaries. Senator Brian Schatz (D-Hawaii) introduced legislation last year that would establish a state public plan option through the Medicaid (https://www.congress.gov/115/bills/s2001/BILLS-115s2001is.pdf) program.

In the absence of bipartisan support for federal action, legislative activity has shifted to the states. Eight states have received, or are currently applying for, for federal approval to establish reinsurance (http://www.commonwealthfund.org/Interactives%20and%20Data/Infographics/2017/Oct/Status%20of%20Innovation%20Waivers%20Map) programs in their states. Hawaii, New Jersey, Vermont, and the District of Columbia may ultimately join Massachusetts in establishing a state individual mandate. Massachusetts and Vermont are providing additional subsidies for people in marketplace plans. At least one state, New Mexico, is exploring options to allow residents to buy into Medicaid (https://www.nmlegis.gov/Sessions/18%20Regular/final/HM009.pdf). Of the 19 states without Medicaid expansions, some, like Virginia, appear poised to expand this year; expansion may be on the ballot in as many as four states (https://www.vox.com/policy-and-politics/2018/4/16/17244108/medicaid-expansion-ballot-red-states) this fall.

The shift to states carries risks, as well as potential benefits, for consumers. Both Idaho and Iowa are pursuing changes in their individual markets (http://www.commonwealthfund.org/publications/blog/2018/apr/state-and-federal-actions-middle-income-americans) that might make insurance cheaper for some people, but leave them exposed to potentially high out-of-pocket costs if they become seriously ill or injured. These changes also will increase premiums for those who buy comprehensive plans. Similarly, experiments with Medicaid work requirements (http://www.commonwealthfund.org/publications/blog/2018/mar/medicaid-work-demonstrations) in at least 12 states are expected to depress enrollment. More broadly, leaving policy innovation to states will ultimately lead to a patchwork quilt of coverage and access to health care across the country, a dynamic that will fuel inequity in overall health, productivity, and well-being. At some point, Congress will likely face pressure to step in to level the playing field.

How We Conducted This Survey

The Commonwealth Fund Affordable Care Act Tracking Survey, February–March 2018, was conducted by SSRS from February 6 to March 30, 2018. The survey consisted of telephone interviews in English or Spanish and was conducted among a random, nationally representative sample of 2,403 adults, ages 19 to 64, living in the United States. Overall, 131 interviews were conducted on landline telephones and 2,272 interviews on cellular phones.

This survey is the seventh in a series of Commonwealth Fund surveys to track the implementation and impact of the Affordable Care Act. To see how the survey was conducted in prior waves, see here.

As in all waves of the survey, the February–March 2018 sample was designed to increase the likelihood of surveying respondents who had gained coverage under the ACA. Interviews in Wave 7 were obtained through two sources: 1) stratified RDD sample, using the same methodology as in Waves 1–6; and 2) households reached through the SSRS Omnibus where interviews were previously completed with respondents ages 19 to 64 who were uninsured, had individual coverage, had a marketplace plan, or had public insurance. SSRS oversampled adults with incomes under 250 percent of the federal poverty level to further increase the likelihood of surveying respondents eligible for the coverage options as well as allow separate analyses of responses of low-income households.

The data are weighted to correct for oversampling uninsured and direct-purchase respondents, the stratified sample design, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. Similar to wave 6's sample design, the weights also corrected for oversampling respondents with a pre-paid cell phone. The data are weighted to the U.S. 19-to-64 adult population by age by state, gender by state, race/ethnicity by state, education by state, household size, geographic division, and population density using the U.S. Census Bureau's 2016 American Community Survey. Data are weighted to household telephone use parameters using the CDC's 2016 National Health Interview Survey (NHIS).

The resulting weighted sample is representative of the approximately 190 million U.S. adults ages 19 to 64. Data for income, and subsequently for federal poverty level, were imputed for cases with missing data, utilizing a standard general linear model procedure. The survey has an overall margin of sampling error of +/– 2.8 percentage points at the 95 percent confidence level. The overall response rate, including the prescreened sample, was 7.5 percent.

Notes

[1] The survey firm SSRS interviewed a random, nationally representative sample of 2,403 19-to-64-year-old adults between February 6 and March 30, 2018, including 638 who have individual market, marketplace, or Medicaid coverage. The findings are compared to prior ACA Tracking Surveys. The survey has an overall margin of error is +/– 2.8 percentage points at the 95 percent confidence level. See How We Conducted This Survey (#/#methods) for more information on survey methods.

[2] For a comparison of the ACA Tracking Survey findings with other survey estimates, see the Appendix (#/#appendix).

May 2018 | Issue Brief

Individual Insurance Market Performance in 2017

Cynthia Cox, Ashley Semanskee and Larry Levitt

Concerns about the stability of the individual insurance market under the Affordable Care Act (ACA) have been raised in the past year following exits of several insurers from the exchange markets for 2017, and again last year during the debate over repeal of the health law.

In this brief, we look at recently-released annual financial data from 2017 to examine whether recent premium increases were sufficient to bring insurer performance back to pre-2014 levels, when new ACA insurance market rules took effect. These new data from 2017 offer further evidence that insurers in the individual market are regaining profitability, even as political and policy uncertainty, repeal of the individual mandate penalty as part of tax reform legislation, and proposed regulations to expand loosely-regulated short-term insurance plans cloud expectations for the future.

Annual financial data reflects insurer performance in 2017 through December of last year. The Administration ceased payments for cost-sharing subsidies effective October 12, 2017. The loss of these payments during the fourth quarter of 2017 diminished insurer profits, but nonetheless, insurers saw better financial results in 2017 than they did in earlier years of the ACA. Markets in parts of the country remain fragile, with little competition and an insufficient number of healthy enrollees to balance those who are sick. However, absent any policy changes, it is likely that insurers would generally have required only modest premium increases in 2018 and in 2019 as well. Insurers are now beginning to file proposed rates for 2019.

We use financial data reported by insurance companies to the National Association of Insurance Commissioners and compiled by Mark Farrah Associates to look at the average premiums, claims, medical loss ratios, gross margins, and enrollee utilization from 2011 through 2017 in the individual insurance market.[1] These figures include coverage purchased through the ACA's exchange marketplaces and ACA-compliant plans purchased directly from insurers outside the marketplaces (which are part of the same risk pool), as well as individual plans originally purchased before the ACA went into effect.

Medical Loss Ratios

As we found in our previous analysis, insurer financial performance as measured by loss ratios (the share of health premiums paid out as claims) worsened in the earliest years of the Affordable Care Act, but began to improve more recently. This is to be expected, as the market had just undergone significant

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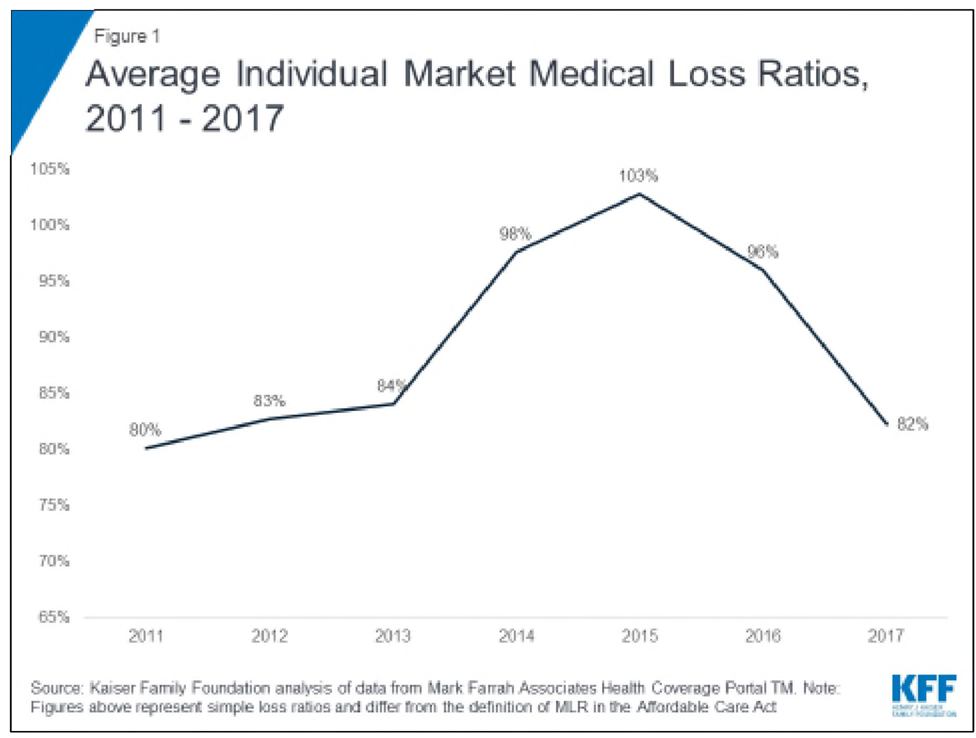
regulatory changes in 2014 and insurers had very little information to work with in setting their premiums, even going into the second year of the exchange markets.

Loss ratios began to decline in 2016, suggesting improved financial performance. In 2017, following relatively large premium increases, individual market insurers saw significant improvement in loss ratios, averaging 82%. Though 2017 annual loss ratios are impacted by the loss of cost-sharing subsidy payments during the last three months of the year, this is nevertheless a sign that individual market insurers on average were beginning to stabilize in 2017, better matching premium revenues to claims costs.



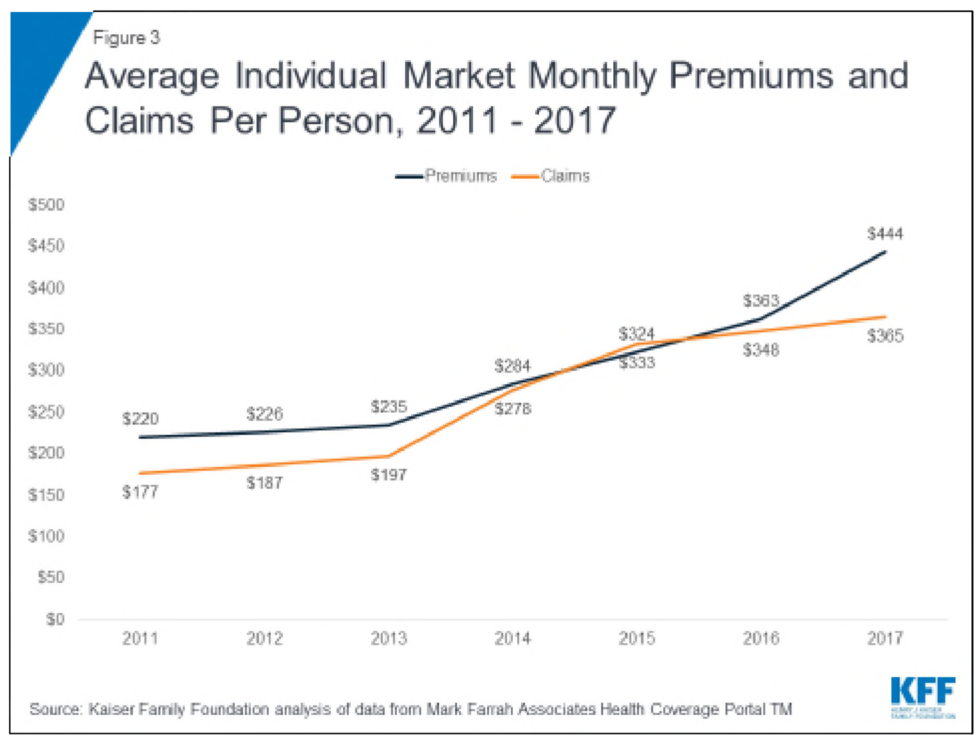
Margins

Another way to look at individual market financial performance is to examine average gross margins per member per month, or the average amount by which premium income exceeds claims costs per enrollee in a given month. Gross margins are an indicator of performance, but positive margins do not necessarily translate into profitability since they do not account for administrative expenses.

Looking at gross margins, we see a similar pattern as we did looking at loss ratios, where insurer financial performance improved dramatically through 2017 (increasing to $79 per enrollee, from a recent annual low of -$9 in 2015). These data suggest that insurers in this market are on track to reach pre-ACA individual market performance levels, and that insurers are generally now earning a profit in the individual market.

Underlying Trends

Driving recent improvements in individual market insurer financial performance are the premium increases in 2017 and simultaneous slow growth in claims for medical expenses. On average, premiums per enrollee grew 22% from 2016 to 2017, while per person claims grew only 5%.



One concern about rising premiums in the individual market was whether healthy enrollees would drop out of the market in large numbers rather than pay higher rates. While the vast majority of exchange enrollees are subsidized and sheltered from paying premium increases, those enrolling off-exchange would have to pay the full increase. As average claims costs grew very slowly through 2017, it does not appear that the enrollees in the market last year were noticeably sicker than in the early years of ACA implementation.

On average, the number of days individual market enrollees spent in a hospital in 2017 was similar to inpatient days in the previous two years.

Taken together, these data on claims and utilization suggest that the individual market risk pool is relatively stable, though sicker on average than the pre-ACA market, which is to be expected since people with pre-existing conditions have guaranteed access to coverage under the ACA.

Discussion

Annual results from 2017 suggest the individual market was stabilizing and insurers in this market were regaining profitability. Insurer financial results through 2017 – after the Administration's decision to stop making cost-sharing subsidy payments and before the repeal of the individual mandate penalty in the tax overhaul goes into effect – showed no sign of a market collapse. Annual premium and claims data from 2017 support the notion that 2017 premium increases were necessary as a one-time market correction to adjust for a sicker-than-expected risk pool. Although individual market enrollees appear on average to be sicker than the market pre-ACA -- which is to be expected once people with pre-existing conditions were guaranteed access to insurance -- data on hospitalizations in this market suggest that the risk pool was stable on average and was not getting progressively sicker. Some insurers have exited the market in recent years, but others have been successful and expanded their footprints, as would be expected in a competitive marketplace.

While the market on average was stabilizing, there remain some areas of the country that are more fragile. In addition, policy changes have the potential to destabilize the individual market generally. The decision by the Administration to cease cost-sharing subsidy payments led some insurers to leave the market or request larger premium increases than they would otherwise. A few parts of the country were thought to be at risk of having no insurer on exchange in 2018, though new entrants or expanding

insurers have since moved in to cover all areas previously at risk of being bare. Signups through the federal marketplace during the recently completed open enrollment period declined somewhat, but were higher than many expected, which could help to keep the market stable. However, repeal of the individual mandate as part of tax reform legislation will take effect in 2019, combined with the likely expansion of loosely-regulated short-term insurance plans that could siphon off healthy enrollees from the ACA-regulated individual market. These changes will increase uncertainty for insurers and likely push premiums higher.

Methods

We analyzed insurer-reported financial data from Health Coverage Portal TM, a market database maintained by Mark Farrah Associates, which includes information from the National Association of Insurance Commissioners. The dataset analyzed in this report does not include NAIC plans licensed as life insurance or California HMOs regulated by California's Department of Managed Health Care; in total, the plans in this dataset represent at least 80% of the individual market. All figures in this data note are for the individual health insurance market as a whole, which includes major medical insurance plans sold both on and off exchange. We excluded some plans that filed negative enrollment, premiums, or claims and corrected for plans that did not file "member months" in the annual statement but did file current year membership.

To calculate the weighted average loss ratio across the individual market, we divided the market-wide sum of total incurred claims by the sum of all health premiums earned. Medical loss ratios in this analysis are simple loss ratios and do not adjust for quality improvement expenses, taxes, or risk program payments. Gross margins were calculated by subtracting the sum of total incurred claims from the sum of health premiums earned and dividing by the total number of member months (average monthly enrollment) in the individual insurance market.

Endnotes

[1] The loss ratios shown in this data note differ from the definition of MLR in the ACA, which makes some adjustments for quality improvement and taxes, and do not account for reinsurance, risk corridors, or risk adjustment payments. Reinsurance payments, in particular, helped offset some losses insurers would have otherwise experienced. However, the ACA's reinsurance program was temporary, ending in 2016, so loss ratio calculations excluding reinsurance payments are a good indicator of financial stability going forward.

California Health Care Foundation

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Short-Term, Limited-Duration Insurance and Risks to California's Insurance Market

California has made dramatic progress in expanding insurance coverage through the implementation of the Affordable Care Act (ACA). But the expansion of short-term, limited-duration insurance could put California's consumers — and the stability of its individual health insurance market — at risk. This paper provides an overview of the short-term insurance market in California, analysis of how changes to federal policy are likely to affect it, and policy options the state could pursue to ensure that consumers are able to purchase affordable, comprehensive insurance.

Short-term, limited-duration insurance (short-term plans or short-term insurance) is a health insurance product designed to provide insurance that protects consumers during short gaps in full coverage. Under federal law, these products do not need to comply with the consumer protections of the Affordable Care Act (ACA). Short-term insurers can deny coverage based on a person's preexisting health conditions or other factors. Short-term insurance typically covers a limited set of services and has dollar limits on claims the plan will pay.

Combined with the elimination of the individual mandate penalty, recently proposed changes to federal regulation of short-term plans could expand enrollment in — and encourage new insurers to enter — the short-term insurance market. Insurers may promote products designed to be a cheaper alternative to comprehensive individual-market plans that comply with the ACA's consumer protections and benefit requirements (plans that are ACA-compliant). Since premiums are lower for short-term plans due their limited benefits and the ability to deny coverage to people with preexisting conditions, healthy people could be siphoned out of the individual market risk pool, including Covered California. As a result, consumers looking for comprehensive coverage may find themselves facing significantly higher premiums and fewer choices in the ACA-compliant market.

But the expansion of short-term, limited-duration insurance could put California's consumers — and the stability of its individual health insurance market — at risk.

Methodology

To understand the short-term insurance market in California, the researchers reviewed relevant state and federal statutes and regulations, conducted a market analysis to see what kinds of short-term insurance plans are available for sale in California, and completed 21 structured interviews with key informants. This research provided background both on the history and current state of the short-term market and on how evolving federal regulations are likely to affect the individual health insurance market, including Covered California. The interviews included four state officials, eight brokers and agents, two insurers that are currently or have recently sold products in the short-term market, three insurers selling individual market coverage through Covered California, and four experts on California insurance markets.

What Are Short-Term Plans?

Short term plans, referred to in federal and California law as "short-term limited-duration insurance," are promoted as an option to provide health insurance for consumers with brief gaps as they move from one coverage source to another. A common example of a person who might enroll in a short-term plan is somebody who changes jobs and has a waiting period before their new employee benefits start. Prior to the ACA, this person had limited options for purchasing insurance on their own, particularly if they had preexisting conditions.[1] The ACA provides an opportunity for most people losing one form of coverage to enroll in ACA-compliant insurance through a special enrollment period, often with a premium subsidy, regardless of any preexisting conditions. However, the ACA did not eliminate short-term plans — all of which are specifically exempted from federal consumer protections and requirements that apply to other health insurance products — from the market.

How Are Short-Term Plans Currently Regulated?

The federal government defines short-term plans in regulations issued by the Departments of Health and Human Services, Labor, and Treasury. Prior to 2016, federal regulations limited the duration of short-term plans to less than 12 months, and allowed consumers to extend the contract duration with the consent of the insurer.[2] Because of concerns that people were enrolling in short-term plans for an entire year in lieu of ACA-compliant comprehensive coverage — and to ensure that short-term plans remain a temporary solution to a short gap in coverage — the Obama administration changed the definition. It issued regulations in 2016 limiting the duration of short-term plans to less than three months and prohibiting extensions or renewals. However, recently proposed federal regulations would return to the pre-2016 definition, with duration limits of less than 12 months and extensions allowed with the consent of the insurer.[3]

While HMOs and some PPOs in California are primarily regulated by the Department of Managed Health Care, short-term plans are regulated by the Department of Insurance. The California Insurance Code defines short-term, limited-duration insurance as individual health insurance coverage that remains in effect for no more than 185 days and can only be renewed or continued for one additional 185-day period.[4] Short-term plans in California are currently limited to less than three months because of the 2016 federal regulations, but if the recently proposed federal regulations are finalized and there is no change in state law, California will revert to its statutory definition of short-term plans: a duration limit of 185 days with one 185-day renewal. However, a federal duration limit of 12 months means that the effective maximum renewal period would be limited to 179 days.[5] State law does not prohibit the purchase of a different short-term plan at the end of the renewal period, so it is possible for consumers to effectively remain enrolled in short-term plans indefinitely.

As is true across the US, short-term plans in California are not subject to guaranteed issue or renewal, which means insurers can deny coverage based on health status. As a result, if a person is enrolled in short-term insurance and they become sick or injured, they may be unable to purchase new short-term coverage at the end of the contract. California does not require short-term plans to meet an annual medical loss ratio (MLR), which requires ACA-compliant plans to spend 80% of collected premium dollars on medical claims and activities to improve quality. Short-term insurance plans are not required to comply with essential health benefit requirements (including maternity and prescription drug coverage), but California does require it to cover some other specific services or conditions that apply to individual market products regulated by the Department of Insurance. These are often referred to as state benefit mandates.[6] For example, short-term plans must cover diabetes education, management, and treatment; jawbone surgery; and behavioral health services for autism.[7] The combination of a 185-day duration limit, limitation on renewals, and the application of some state benefit mandates means that California regulates

Table 1. Examples of ACA Consumer Protections Not Required in Short-Term, Limited-Duration Insurance

	APPLICABLE TO…		APPLICABLE TO NON-GRANDFATHERED…	
	SHORT-TERM, LIMITED-DURATION INSURANCE	INDIVIDUAL MARKET / COVERED CALIFORNIA PLANS	SMALL GROUP PLANS	LARGE GROUP AND SELF-INSURED EMPLOYER PLANS
Essential health benefits. Plans must cover essential health benefits as defined in the ACA, such as care for maternity, mental health and substance use, prescription drugs, and hospital services.		✔	✔	
Preventive services. Plans must cover preventive services without cost sharing.		✔	✔	✔
Ban on dollar value limits. Plans cannot apply annual or lifetime dollar value maximums.		✔	✔	✔
Limits on out-of-pocket maximums. Places limits on maximum that enrollees pay out of pocket toward covered services in-network.		✔	✔	✔
Guaranteed issue. Plans must accept any individual who applies for coverage.		✔	✔	✔
Premium rating requirements. Prohibits plans from charging a higher premium based on health status or gender; allows rates to vary based solely on the number of enrollees covered, geographic area, and age (within limits).		✔	✔	
Medical loss ratio. Health insurers must spend at least 80% to 85% of premium revenue on health care and quality improvement.		✔	✔	✔

short-term plans more strictly than many states.[8] However, there are numerous state and federal consumer protections that do not apply to this market, as illustrated in Table 1.

What Does California's Short-Term Insurance Market Look Like?

Short-term plans currently marketed for sale in California exclude services that ACA-compliant plans must cover and have broad exclusions for preexisting conditions. Many do not cover critical benefits such as maternity and newborn care, mental health services, substance use services, and outpatient prescription drugs.[9] Short-term insurance available in California also limits the total amount plans will pay per day in the hospital and for particular services, such as surgeon fees. It also imposes a maximum the plan will spend toward claims covered by the policy (see Table 2 on page 4).[10] Such limits are not allowed in ACA-compliant plans, and they put consumers at risk for expensive medical bills. While plan durations are limited to less than three months, an insurer that recently left the short-term market in California said that people are remaining enrolled in short-term plans well beyond three months by enrolling in a new plan every 90 days.

Short-term plans, in part because they cover fewer services, cost less than individual market insurance. The average premium for an individual short-term

Table 2. Limits on the Amount the Plan Pays in the "Best Seller" Short-Term Plan Marketed in California

Policy coverage limits
$750,000 maximum
$10,000 for AIDS treatment
$150,000 for organ transplants
$250 for ambulance (per-trip)
Room and board, miscellaneous charges (per day)
$1,000 for inpatient hospital regular care
$1,250 for inpatient hospital intensive or critical care
Surgical and anesthesiology services
$2,500 per surgery
$5,000 per coverage period

Source: The "Best Seller" short-term plan available in Sacramento, offered through eHealth by the one licensed insurer currently selling short-term plans in California.

insurance plan in California sold through the online broker eHealth was $184 per month in 2017.[11] By comparison, the benchmark Silver plan for a 40-year-old consumer ineligible for premium subsidies through Covered California ranged from $258 to $426 in the same period.[12] Short-term plans are also less expensive because applicants are screened for health history before being accepted, allowing plans to limit the risk that they will need to pay for costly services.[13]

Insurer Participation Has Dropped in California's Short-Term Market

The short-term market in California is currently small. Based on self-reporting by insurers, the California Department of Insurance is aware of fewer than 10,000 policies in effect.[14] Market analysis and respondents identified only one insurer currently selling short-term plans in the state. This insurer sells short-term products directly as well as by co-branding with other health insurance companies, including one insurer participating in Covered California.

When this research began in January 2018, respondents reported an additional out-of-state insurer selling short-term insurance in California through a surplus line, which is an insurance product that a state's department of insurance approves for sale by an out-of-state insurer because state-licensed insurers are not willing to sell it (see Table 3 on page 5).[15] (For example, there may be no insurers in the state willing to insure a car worth $1 million, but an out-of-state insurer may be willing to sell such a policy to a consumer through a surplus line.) In California, in-state insurers only sell short-term products that deny coverage to people with certain preexisting health conditions. An out-of-state insurer, however, was willing to sell short-term plans regardless of health status through a surplus line. This surplus line insurer has since dropped its short-term product line in California.

Before the launch of Covered California in 2014, there were more insurers selling short-term plans in California. Interview respondents noted one health insurer currently selling through Covered California that previously sold short-term plans. Numerous insurers that sell other types of health-related insurance products that are not ACA-compliant, such as travel insurance or indemnity plans, also sold short-term health insurance products.

According to the Department of Insurance, at least two carriers dropped out of the short-term market in recent years after being informed that they were not in compliance with state mandate requirements. Respondents also noted a decreased demand for short-term products both as consumers were able to purchase coverage through Covered California and because short-term plans do not fulfill the federal individual mandate requirement that remains in effect through 2018.

Other Products Are Marketed as Short-Term Coverage Options in California

There are other products that are not technically short-term plans currently being marketed in California as short-term coverage. These plans do not have to comply with the same laws that apply to short-term plans (such as limits on duration and state benefit mandates). Some web brokers display fixed indemnity plans (see Table 3 on page 5), which pay fixed fees for covered health services, as an option for individuals searching for short-term insurance.[16] Fixed indemnity plans are designed to supplement a person's major medical coverage to help cover cost-sharing expenses. The plan pays the enrollee a set dollar amount for covered services, but does not cover the full cost of care. For example, one fixed

Table 3. Comparison of Different Types of Health Insurance Coverage Available in California

	MUST COVER ESSENTIAL HEALTH BENEFITS	MUST COVER PREVENTIVE SERVICES WITHOUT COST SHARING	DOLLAR VALUE MAXIMUMS PROHIBITED	LIMITS ON OUT-OF-POCKET MAXIMUMS	GUARANTEED ISSUE	SUBSIDIES AVAILABLE TO REDUCE PREMIUM COST
Fixed indemnity plans. Health plans designed to wrap around other coverage and cover enrollee cost sharing such as deductibles, copayments, and coinsurance. Fixed indemnity plans pay a set dollar amount for covered services that is often significantly lower than the cost of services. These policies do not have to meet any of the ACA's consumer protections.						
Health care sharing ministries. Members of a health care sharing ministry (HCSM) share a common set of religious beliefs and contribute funds to pay for the qualifying medical expenses of other members. HCSM coverage does not have to meet any of the ACA's consumer protections.						
Individual market health insurance. Comprehensive health insurance plans available to individuals purchasing their own coverage. Subsidies are available to reduce the premium costs of individual market plans purchased through Covered California for eligible enrollees earning between 100% and 400% of the federal poverty level.*	✔	✔	✔	✔	✔	✔
International insurance. International insurance, which is also known as travel insurance or expatriate insurance, is available to people for short durations while traveling in a foreign country, including nonresidents traveling to the United States, students, and people working temporarily. These policies do not have to meet any of the ACA's consumer protections.						
Short-term plans. Health plans designed to fill temporary gaps in coverage. Generally, short-term plans are only available to consumers who can pass medical underwriting, and they typically provide minimal benefits and financial protection for those who become sick or injured. These policies do not have to meet any of the ACA's consumer protections.						
Surplus lines. Products designed to fill gaps in the market where there are no insurance plans available from insurers licensed by the state. In the case of short-term plans in California, the surplus lines accepted enrollees regardless of health status. However, this is not required by law. These policies do not have to meet any of the ACA's consumer protections.						

*Most California residents with household income under 138% of the federal poverty level are eligible for Medi-Cal. Individuals eligible for Medi-Cal are not eligible for the premium subsidies through Covered California.

indemnity plan available in California provides $75 per physician office visit for up to six visits a year, $200 for only one advanced diagnostic service (such as an MRI) per year, and $1,000 per day for hospitalization (capped at $30,000 per year).

At least one health care sharing ministry (see Table 3, page 5) sells short-term coverage with a duration of up to 11 months.[17] Health care sharing ministries are not regulated as insurers under federal law. While they are not exempted from the California insurance code, they are not regulated by the state. Members enrolled in health sharing ministries pay a contribution or monthly share that goes toward paying for other members' medical expenses.[18]

Some brokers also mentioned selling international plans (see Table 3) to people looking for short-term coverage options, primarily to people who live overseas and are traveling to the United States for a short period. But one broker mentioned using an international carrier as a short-term coverage option for California residents.

Federal Policy Changes Could Lead to Increased Premiums If Enrollment in Short-Term Plans Grows

Covered California insurers and market experts agreed that the combination of recent and proposed federal policy changes, including the elimination of the individual mandate penalty and the proposed expansion of short-term plans, would create a "perfect storm" that could take healthy consumers out of Covered California and lead to increased premium rates and the possibility that fewer insurers offer ACA-compliant plans. The elimination of the mandate penalty takes away an incentive for consumers to enroll in ACA-compliant plans rather than less expensive options with fewer consumer protections, such as short-term plans. Allowing short-term insurance to be sold for half a year with a renewal makes it appear like a longer-term coverage option. According to one expert in California's insurance markets, the effect on Covered California could be "devastating."

Health Insurers May Enter Short-Term Market Under Weaker Federal Rules

All three of the individual market carriers interviewed for this research are watching the short-term market. They expressed concern that competitors will siphon away their healthy enrollees if they offer short-term plans. A few respondents predicted that one insurer participating in Covered California that used to offer short-term insurance will reenter the short-term market, as would "smaller players." One Covered California insurer is considering offering short-term plans if other carriers enter the market, to protect their market share.

An insurer selling short-term plans in California said it does not market its plans as long-term options or as alternatives to ACA-compliant coverage. However, statements from Department of Health and Human Services Secretary Alex Azar suggest that federal officials would like to allow short-term plans to be renewable and available for longer than one year.[19] This could encourage other insurers to enter the short-term market with the intent of offering a lower cost, longer-term alternative to the more comprehensive ACA-compliant plans sold through Covered California.

Increased Enrollment in Short-Term Plans by Healthier Consumers Could Lead to Increased Premiums in the Individual Market

There could be significant enrollment in expanded short-term plans. A recent study estimates that 620,000 people would enroll in short-term plans in California in 2019 following the elimination of the mandate penalty combined with the proposed federal rollback of short-term plan restrictions.[20] State regulators, insurers, and industry experts interviewed for this research agreed that the lower premiums offered by short-term insurance will encourage healthy people to shift away from the more expensive ACA-compliant market. An insurer could create a new short-term plan that looks like a cheaper ACA-compliant plan, keeping premiums low by denying coverage to anybody that has a preexisting health condition.

Those most likely to be attracted by the lower cost of short-term plans are consumers eligible for little or no premium subsidy. However, not all of these people will be able to shift to short-term plans. People with preexisting conditions can have their applications rejected, and people who need benefits not typically covered by these plans, such as maternity, will likely remain in the individual market.

The marketing activity of insurance brokers could also contribute to higher short-term plan enrollment.

Brokers and insurers noted that short-term insurers in California have paid broker commissions of 10% or 15%, compared to a 1% to 5% commission for selling ACA-compliant plans.[21] Short-term enrollment does not require an eligibility determination for financial assistance and some brokers receive commissions when individuals simply enroll via a link on the broker's website, making these plans an even more attractive line of business.

With the expectation that new insurers will enter the short-term market and enrollment will grow, Covered California insurers have to consider what the effect will be on their own risk pools while developing rates for 2019. One insurer representative said some insurers that are more cautious and "have to assume the worst" could increase premiums by 10% to adjust for short-term plans, or drop out of the individual market entirely.

Regulating the Short-Term Market: Examples from Other States

There are various policy options available to protect consumers, Covered California, and the individual health insurance market from the potential effects of a developing market for short-term plans that are offered as a long-term coverage option. As of April 2018, the California legislature is considering a bill that would ban the sale of short-term, limited-duration insurance.[22] Banning short-term plans would prevent any expansion of the market.

Most states have minimal regulation of short-term plans, but some have taken steps to restrict or regulate these products. Three states — Massachusetts, New Jersey, and New York — effectively banned short-term plans in the 1990s by requiring them to comply with the extensive consumer protections, including guaranteed issue and community rating, that apply to all new health insurance policies sold in the individual market.[23] The Massachusetts and New Jersey reforms also standardized benefit designs for individual market products that apply to short-term plans.[24] Consumers looking for short-term insurance options in these states can purchase ACA-compliant plans if they are buying during an open enrollment, or if a life event qualifies them for a special enrollment period.[25]

Six states limit short-term insurance from becoming a long-term alternative to ACA-compliant coverage by restricting the sale of multiple consecutive short-term plans, preventing consumers from remaining covered by one short-term insurer indefinitely.[26] For example, Michigan does not allow someone to be covered by short-term plans through one insurer for more than 185 days in a 365-day period, which means that someone cannot remain covered through one short-term insurer for an entire year.[27]

Whether or not these restrictions effectively reduce enrollment in short-term plans is unknown. To discourage a consumer from enrolling in consecutive short-term policies through multiple insurers, a state could apply limitations to enrollment with multiple short-term insurers. For example, Colorado limits the number of short-term plans an individual can enroll in during a12-month period and requires applications for short-term plans to include the question, "Have you or any other person to be insured been covered under two or more nonrenewable short-term policies during the past 12 months?" along with a statement that reads, "If 'yes,' then this policy cannot be issued."[28] The state could require insurers to ask potential enrollees if they have previously enrolled in short-term plans and provide notice on the application that failure to disclose prior enrollment in a short-term plan could result in termination of the plan contract.

Rhode Island prohibits short-term plans from excluding coverage of preexisting conditions and applies the same MLR requirements to them as apply to individual market coverage.[29] According to state legislators, there are currently no short-term plans for sale in Rhode Island in part because the combination of the prohibition on preexisting condition exclusion and the MLR requirements lower profit margins and discourage short-term insurers from entering the market.

Most of these policy options address the existence of other products, such as fixed indemnity products, that are currently sold or marketed as short-term coverage options. They do this by applying consumer protections to these products, including to fixed indemnity lines, travel insurance, and surplus lines. Policymakers can consider applying other limitations to insurance products marketed as short-term insurance, such as prohibiting the sale of a fixed indemnity plan unless an individual is enrolled in an ACA-compliant plan, and prohibiting the sale of short-term plans through surplus lines.

Conclusion

Based on interviews and existing reporting to state regulators, the existing market for short-term plans in California appears to be small. However, if the proposed federal regulatory change allowing longer short-term plans is finalized, a new, larger market could emerge. If this happens, insurers that decide to enter the new short-term market may design plans that meet the state's current requirements but keep risk and premiums low by denying coverage based on health status. Enrollment in these plans could grow significantly as people with little or no premium subsidy look for cheaper coverage options.

Growth in this new short-term market is likely to increase costs and reduce plan choices for consumers purchasing coverage through the individual health insurance market, including Covered California. Increased costs would be felt particularly by people eligible for little or no premium subsidy. Further, consumers who enroll in short-term plans may find themselves without coverage for the health services they need. Policymakers have options to limit the growth of the short-term market in California and mitigate the potential harm to consumers.

About the Authors

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Endnotes

1. The Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, limited group health plans from excluding coverage for preexisting conditions to 12 months. The 12-month period was lessened, or eliminated, if an individual had continuous health coverage through a type of insurance considered creditable coverage. Short-term plans are considered creditable coverage under HIPAA. See 45 CFR 144.103.
2. See Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg. 38032 (proposed June 10, 2016).
3. Short-Term, Limited Duration Insurance, 83 Fed. Reg. 7437 (proposed February 21, 2018).
4. The existing definition of "short-term limited duration health insurance" in the California Insurance Code is located at section 12671(e)(8) and defines the permissible duration as "not more than 185 days" with a single permissible renewal of "not more than 185 days." Cal. Ins. Code § 12671.
5. Per California Department of Insurance.
6. There are three benefit mandates in the California Code that explicitly do not apply to short-term limited duration insurance. Cal. Ins. Code § 10123.7 (Coverage for orthotic and prosthetic devices); Cal. Ins. Code § 10123.81 (Coverage for mammograms); and Cal. Ins. Code § 10123.865–66 (Coverage for maternity services).
7. Cal. Ins. Code §§ 10123.195, 10123.21, 10144.51.
8. Kevin Lucia et al., "State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market," The Commonwealth Fund, March 2018, www.commonwealthfund.org.
9. Based on author review of short-term plan brochures sold through eHealth in California. These findings also fit with plans that were sold when the authors started the research in January 2018 but that are no longer for sale on the market, based on author review of short-term

plan brochures marketed on a broker's website. While short-term plans exclude maternity care, many do cover services related to complications of pregnancy. Insurers define complications of pregnancy differently, but this could include services related to an ectopic pregnancy, treatment of gestational diabetes, or preeclampsia.

10. Based on author review of short-term plans sold through eHealth by the one admitted insurer selling plans in California.
11. *Short-Term Health Insurance Value, Benefits and Cost*, eHealth, March 2008, ehealthinsurance.com (PDF).
12. Amy Adams, "What Will Consumers Pay in Premiums for Covered California Silver Plans in 2017?" *The CHCF Blog*, October 20, 2016, www.chcf.org/blog.
13. Based on author review of short-term plans sold through eHealth.
14. Based on interview with CDI representative. See also Julie Appleby and Ana B. Ibarra, "Are Short-Term Plans Better Than None At All for Those Desperate for Health Coverage?," *Los Angeles Times*, December 8, 2017, www.latimes.com.
15. One example of a type of product offered as a surplus line is in automobile insurance. There are in-state insurers that offer automobile insurance, but there may not be in-state insurers willing to insure a car that costs $1 million. An individual with such a car might be able to find an out-of-state insurer willing to insure the car under a surplus line.
16. Based on author review of web brokers selling plans in California.
17. The health sharing ministry is included in this table distributed to Covered California's California Plan Management Advisory Group comparing short-term plans available in California and other states. "Plan Design Comparison: Covered California Silver Plan vs. Short-Term Limited Duration Insurance Plans (various states)," California Plan Management Advisory Group, March 7, 2018, coveredca.com (PDF).
18. For more information on health care sharing ministries, see note 8.
19. See, for example, Alex Azar, "HHS Secretary: Short-Term Health Insurance Plans Are an Affordable Option," CNN, February 23, 2018, www.cnn.com.
20. Linda Blumberg, Matthew Buettgens, and Robin Wang, *The Potential Impact of Short-Term Limited Duration Policies on Insurance Coverage, Premiums, and Federal Spending*, The Urban Institute, February 2018, www.urban.org (PDF).
21. "How Are California Health Insurance Brokers Paid?," Health for California Insurance Center, www.healthforcalifornia.com; see also Kevin Knauss, "Commissions Cut Again for Covered California Health Insurance Agents," Insure Me Kevin, November 1, 2017, insuremekevin.com.
22. "Short-Term Limited Duration Health Insurance," Cal. Sen. Bill 910, 2017–2018.
23. Insurance statutes in these three states do not mention short-term or limited-duration plans. By not specifically defining the plans within statute, they are not exempted from any consumer protections or regulations that apply to individual market health insurance. See Mass. Gen. Laws. Ann. Ch. 176M §§ 2 and 4, N.J.S.A. 17B:27A, and NY INS § 3231. See also Peter Newell, "As 2018 Open Enrollment Begins, Trump Administration Adds New Challenges for New York's Individual Market," United Hospital Fund, October 2017, uhfnyc.org and Leigh Wachenheim and Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets*, Milliman, March 2012, www.statecoverage.org (PDF).
24. Leigh Wachenheim and Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets*, Milliman, March 2012, www.statecoverage.org (PDF).
25. See note 8.
26. States are Colorado Colo. Rev. Stat. § 10-16-102(60), Michigan MCLS § 500.2213b - (9), Minnesota Minn. Stat. Ann. § 62A.65, Nevada Nev. Admin. Code § 689A.434, New Hampshire N.H. Rev. Stat. Ann. § 415:5, and Oregon Or. Rev. Stat. § 743B.005.
27. MCLS § 500.2213b - (9).
28. Colo. Rev. Stat. § 10-16-102(60).
29. Sabrina Corlette, JoAnn Volk, and Justin Giovannelli, "Short-Term, Limited Duration Insurance Proposed Rule: Summary and Options for States," State Health and Values Strategies, February 23, 2018, www.shvs.org.

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Understanding Short-Term Limited Duration Health Insurance

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Short-term, limited duration (STLD) health insurance has long been offered to individuals through the non-group market and through associations. The product was designed for people who experience a temporary gap in health coverage.[1] Unlike other products that are considered "limited benefit" or "excepted benefit" policies – such as cancer-only policies or hospital indemnity policies that pay a fixed dollar benefit per inpatient stay – short-term policies are generally considered to be "major medical" coverage; however, short-term policies are distinguished from other comprehensive major medical policies because they only provide coverage for a limited term, typically less than 365 days. Short-term policies are also characterized by other significant limitations, including the types of services covered, often with a dollar maximum.

Late last year, Congress repealed the Affordable Care Act's individual mandate penalty, the requirement that individuals have minimum essential health coverage or face a tax penalty. Starting in 2019, the tax penalty will be reduced to $0. It is possible this change could lead more consumers to consider purchasing short-term policies. In addition, late last year, President Trump issued an executive order directing the Secretary of Health and Human Services to take steps to expand the availability of short-term health insurance policies, and a proposed regulation to increase the maximum coverage term under such policies was published in February. This brief provides background information on short-term policies and how they differ from ACA-compliant health plans.

Background

As the name suggests, short-term health insurance policies are not renewable. Whereas federal law since 1996[2] has required all other individual health insurance to be guaranteed renewable at the policyholder's option, coverage under a short-term policy terminates at the end of the contract term. To continue coverage beyond that date requires applying for a new policy. As a result, an individual who buys a short-term policy and then becomes seriously ill will not be able to renew coverage when the policy ends.[3]

The Affordable Care Act (ACA) exempted short-term policies from market rules that apply to most major medical health insurance policies sold to individuals in the non-group market: rules that prohibit medical underwriting, pre-existing condition exclusions, and lifetime and annual limits, and that require minimum coverage standards. By contrast, short-term policies:

- are often medically underwritten – applicants with health conditions can be turned down or charged higher premiums, without limit, based on health status, gender, age, and other factors;
- exclude coverage for pre-existing conditions – policyholders who get sick may be investigated by the insurer to determine whether the newly-diagnosed condition could be considered pre-existing and so excluded from coverage;[4]
- do not have to cover essential health benefits – typical short-term policies do not cover maternity care, prescription drugs, mental health care, preventive care, and other essential benefits, and may limit coverage in other ways (Table 2);
- can impose lifetime and annual limits – for example, many policies cap covered benefits at $2 million or less (Table 1);
- are not subject to cost sharing limits – some short term policies, for example, may require cost sharing in excess of $20,000 per person per policy period, compared to the ACA-required annual cap on cost sharing of $7,350 in 2018 (Table 1); and
- are not subject to other ACA market requirements – such as rate review or minimum medical loss ratios; for example, while ACA-compliant non-group policies are required to pay out at least 80% of premium revenue for claims and related expenses, the average loss ratio for individual market short-term medical policies in 2016 was 67%; while for the top two insurers, who together sold 80% of all short-term policies in this market, the average loss ratio was 50%.[5]

How Short-Term Policies Compare to Minimum Essential Coverage

Due to these limitations in coverage, short-term policies, not surprisingly, cost less than ACA-compliant major medical health insurance policies. A review of short-term policies offered on two large online private insurance marketplaces, eHealth and Agile Health Insurance, shows it is not uncommon to find the cheapest short-term policy priced at 20% or less of the premium for the lowest cost ACA-compliant bronze plan in an area (Table 1).

There are 24 distinct short-term products on eHealth and/or Agile Health Insurance in 45 states and the District of Columbia, ranging from only one product in New Mexico to 22 in West Virginia. Each product has distinct benefits and exclusions, and is typically offered with varying levels of patient cost-sharing. Due primarily to more comprehensive state laws regulating short-term plans, in five states insurers do not offer any short-term plans on eHealth or Agile Health Insurance.[6]

Of the short-term products offered on eHealth and/or Agile Health Insurance across all states, 43% do not cover mental health services, 62% do not cover services for substance abuse treatment (both alcohol and other drugs), 71% do not cover outpatient prescription drugs, and no plans cover maternity care. In seven states, none of these four benefit categories are covered in the short-term policies offered. The availability of these select benefits is shown in Table 2 (including state variations as specified in plan brochures).

Even when short-term plans do cover mental health, substance abuse, and prescription drugs, limitations and exclusions almost always apply that would not be permitted under ACA-compliant plans. For example, six of the seven products that offer prescription drug coverage apply a dollar maximum cap on the benefit, such as $3,000. With respect to products offering some coverage for mental health and substance abuse treatment, all impose significant limits on the benefits. Examples of coverage limitations for these benefit categories include a $50 maximum for outpatient visits, a 31-day maximum for inpatient care, and/or a policy term maximum of $3,000. Some states have enacted stronger parity regulations for mental health and substance abuse services that extend to short-term policies.[7] All of the policies reviewed exclude coverage for pre-existing conditions, although one issuer provides a $500 allowance for benefits related to a pre-existing condition, and another issuer will reportedly launch a product in some states that provides a benefit for certain pre-existing conditions up to $25,000.[8,9]

Short-term policies are not considered minimum essential coverage (MEC) for purposes of satisfying the ACA individual mandate. Individuals who are covered only under short-term policies for a year and who do not otherwise qualify for exemptions from the mandate could face a tax penalty in 2018 – the greater of $695 or 2.5% of income above the tax filing threshold. However, even taking the tax penalty into account, short-term policies can be cheaper for individuals healthy enough to qualify to purchase them. Once ACA market rules took effect in 2014, some short-term policy marketing materials specifically highlighted this differential.[10] Once the individual mandate penalty drops to $0 in 2019, the cost differential between short-term policies and ACA-compliant policies will be even greater.

The number of short-term policies in effect today is not known. Most such policies appear to be sold through associations, though a small number are sold directly through the non-group market. News reports suggest short-term policy sales may have grown since ACA market reforms were implemented. One industry survey found that more purchasers cited lower price (51%) than the need for temporary coverage (39%) as the primary reason for buying short-term policies.[11]

Concerned that short-term policies were becoming an alternative to ACA-compliant major medical policies, and not just a bridge for short coverage gaps, the Obama Administration published new rules for such policies in 2016. The final regulation defined short-term policies as those with an expiration date specified in the contract, taking into account any extension that may be elected by the policyholder with or without the issuer's consent, which is less than 3 months after the original effective date of the contract. This new maximum policy term was consistent with the ACA individual mandate exemption for short periods (defined as less than 3 months) of uninsurance. The final regulation also required short-term policies to include prominent consumer notices that coverage does not constitute qualifying health coverage (MEC) for purposes of satisfying the individual mandate. These rules took effect for short-term policies sold on or after January 1, 2017.

Since the 2016 rule took effect, short-term policy terms appear to now be limited to less than 3 months; however, some issuers offer "four-packs" of short-term policies with sequential effective dates scheduled 3 months apart, enabling consumers to continue to buy up to a year of short-term coverage at a time.[12]

In February of this year, the Trump Administration published a proposed regulation amending the definition of short-term policies to include those offering a maximum coverage period of less than 12 months. The proposed rule also sought public comment on other regulation or guidance that could be issued to ease the sale of such policies.

Table 1: ACA Marketplace Plans vs. Short-Term Health Insurance Plans in Select Cities, 40-year-old male

	Premiums and Coverage Caps			
City	**Monthly Premium for Lowest Cost Bronze Marketplace Plan (unsubsidized)**	**Range of Monthly Premiums for Short-Term Plans**	**Range of Out-of-Pocket Cost-Sharing Maximums for Short-Term Plans**	**Range of Policy Coverage Caps for Short-Term Plans**
Phoenix, AZ	$405	$36 - $437	$500 - $30,000	$250,000 – $2 million
Los Angeles, CA	$264	$141 - $566	$2,500 - $10,000	$750,000 – $2 million
Denver, CO	$338	$35 - $262	$2,000 - $20,000	$250,000 – $1.5 million
Miami, FL	$297	$46 - $983	$250 – $22,500	$250,000 – $2 million
Atlanta, GA	$371	$47 - $503	$1,000 – $22,500	$250,000 – $2 million
Chicago, IL	$305	$55 - $573	$250 – $22,500	$250,000 – $2 million
St. Louis, MO	$281	$38 - $423	$1,000 – $20,000	$250,000 – $2 million
Columbus, OH	$289	$25 - $305	$250 - $20,000	$250,000 – $2 million
Houston, TX	$270	$55 - $644	$250 - $22,500	$250,000 – $2 million
Virginia Beach, VA	$479	$44 - $583	$250 - $20,000	$250,000 – $2 million

SOURCE: Kaiser Family Foundation Subsidy Calculator for ACA-compliant plan premiums; eHealth and Agile Health Insurance for short-term policy premiums and features.

NOTES: Monthly premiums for Marketplace plans do not reflect discounts for premium tax credits. Monthly premiums for short-term plans reflect prices posted online; these rates are not guaranteed and may be adjusted after medical underwriting. Short-term monthly premiums also do not all reflect association membership fees often required for purchase.

Out-of-pocket cost-sharing maximum for short-term plans applies to a 3-month term of coverage; by contrast, out-of-pocket cost-sharing maximum for an ACA-compliant plan in 2018 is $7,350 for the calendar year.

Table 2: Percentage of Short-Term Health Insurance Products Covering Select Benefits						
State	**Major City**	**Number of Short-Term Products Available**[1]	**Mental Health**	**Substance Abuse**[2]	**Prescription Drugs**[3]	**Maternity**
Alabama	Birmingham	17	71%	41%	24%	0%
Alaska	Anchorage	3	0%	0%	0%	0%
Arizona	Phoenix	21	57%	33%	33%	0%
Arkansas	Little Rock	21	57%	33%	33%	0%
California	Los Angeles	2	0%	0%	0%	0%
Colorado	Denver	7	57%	57%	0%	0%
Connecticut	Hartford	10	100%	100%	60%	0%
Delaware	Wilmington	21	81%	57%	33%	0%
DC	Washington	11	82%	36%	9%	0%
Florida	Miami	21	57%	33%	33%	0%
Georgia	Atlanta	19	53%	37%	37%	0%
Hawaii	Honolulu	3	0%	0%	0%	0%
Idaho	Boise	8	50%	25%	0%	0%
Illinois	Chicago	21	57%	33%	33%	0%
Indiana	Indianapolis	19	53%	26%	37%	0%
Iowa	Cedar Rapids	21	57%	33%	33%	0%
Kansas	Wichita	11	27%	27%	45%	0%
Kentucky	Louisville	19	53%	26%	37%	0%
Louisiana	New Orleans	18	50%	39%	33%	0%
Maine	Portland	5	20%	20%	0%	0%
Maryland	Baltimore	4	0%	0%	0%	0%
Massachusetts	Boston	0	NA	NA	NA	NA
Michigan	Detroit	16	44%	25%	44%	0%
Minnesota	Minneapolis	6	67%	67%	0%	0%

Mississippi	Jackson	21	57%	33%	33%	0%
Missouri	St. Louis	12	50%	50%	25%	0%
Montana	Billings	4	0%	0%	0%	0%
Nebraska	Omaha	20	55%	30%	35%	0%
Nevada	Las Vegas	18	50%	39%	33%	0%
New Hampshire	Manchester	2	100%	100%	0%	0%
New Jersey	Newark	0	NA	NA	NA	NA
New Mexico	Albuquerque	1	0%	0%	0%	0%
New York	New York City	0	NA	NA	NA	NA
North Carolina	Charlotte	16	44%	44%	38%	0%
North Dakota	Fargo	6	83%	50%	0%	0%
Ohio	Cleveland	20	55%	30%	30%	0%
Oklahoma	Oklahoma City	21	57%	33%	33%	0%
Oregon	Portland	13	62%	62%	23%	0%
Pennsylvania	Philadelphia	21	57%	33%	33%	0%
Rhode Island	Providence	0	NA	NA	NA	NA
South Carolina	Columbia	17	47%	35%	29%	0%
South Dakota	Sioux Falls	8	50%	50%	0%	0%
Tennessee	Nashville	17	71%	41%	29%	0%
Texas	Houston	18	72%	44%	28%	0%
Utah	Salt Lake City	3	0%	0%	0%	0%
Vermont	Burlington	0	NA	NA	NA	NA
Virginia	Richmond	15	73%	40%	20%	0%
Washington	Seattle	2	100%	100%	0%	0%
West Virginia	Huntington	22	59%	36%	32%	0%
Wisconsin	Milwaukee	18	72%	56%	39%	0%

Wyoming	Cheyenne	17	71%	41%	24%	0%
US Averages			**57%**	**38%**	**29%**	**0%**

SOURCE: Kaiser Family Foundation analysis of short-term health insurance plans on eHealth and Agile Health Insurance websites, April 2018.

NOTES: Information is based on the plan brochures and may not reflect all plan variations required by state law. Plans that offer coverage for these four benefit categories often apply limits and exclusions on these services which are not reflected in this table. Five states (MA, NJ, NY, RI, and VT) do not have short-term plan offerings on either of these websites.

[1] An insurer may offer a number of plans with variable cost-sharing structures within each product type. This analysis only looks at the number of distinct products offered.

[2] Products that cover services for alcohol and other drugs (excluding tobacco) are considered to cover substance abuse. Products that only offer coverage for treatment of alcohol disorders are not considered to cover substance abuse. Three of the short-term products available do not specify in the plan brochure whether treatment for substance abuse is covered; in these instances, we do not consider the benefit category to be covered.

[3] Products that cover both inpatient and outpatient prescription drugs are considered to offer prescription drug coverage. Products that only cover prescription drugs when administered in an inpatient setting are not considered to offer that benefit category.

Discussion

Short-term health insurance policies offer lower monthly premiums compared to ACA-compliant plans because short-term policies offer less insurance protection. Medically underwritten policies can only be purchased by people when they are healthy. Individuals who buy short-term policies and then develop health conditions will lose coverage when the contract ends. Short-term policies typically do not cover essential benefits, such as prescription drugs, and often apply dollar caps and higher deductibles on coverage that are no longer allowed under ACA-compliant individual market and group health plans. As a result, people who buy short-term policies today in order to reduce their monthly premiums take a risk that, if they do need medical care, they could be left with uncovered bills and/or find themselves "uninsurable" under such plans in the future (though they would be able to buy ACA-compliant policies at the next open enrollment period).

With significant attention focused recently on issues like rising drug prices, the opioid epidemic, and mental health awareness, it is notable that short-term plans generally exclude or severely limit coverage for mental health, substance use, and prescriptions drugs. As is the case with four of the 10 products offered on eHealth and/or Agile Health Insurance that cover at least some substance abuse and mental health services, an enrollee suffering from a dual diagnosis may only be covered for care received up to a maximum of $3,000. And in 15 states, no short-term plans offered on these platforms cover prescription drugs.

To the extent that healthy individuals opt for cheaper short-term policies instead of ACA-compliant plans, such adverse selection contributes to instability in the reformed non-group market and raises the cost of

coverage for people who have health conditions. Income-related premium subsidies in the non-group market offset the cost differential, and so help correct for adverse selection to a significant extent. Lower-income people would be protected by the premium subsidies, but middle-income people not eligible for subsidies who buy ACA-compliant plans would likely see premium increases. So far, the individual mandate penalty also has helped offset the cost differential between short-term plans and ACA-compliant plans, though this will disappear starting in 2019. The combined effect of repealing the individual mandate penalty and the administration's efforts to promote the sale of short-term plans could result in fewer people signing up for ACA-compliant plans and higher premiums in the ACA-compliant individual market, potentially adversely affecting the stability of the ACA-compliant individual market.[13]

Methods

We analyzed publicly-available information published on eHealth.com and AgileHealthInsurance.com in April 2018. While other online private health insurance exchanges selling short-term plans exist, we chose these two platforms for their prominence in the marketplace and breadth of plan offerings.

An insurer may offer several versions of the same product with variable cost-sharing structures; this analysis looks at the number of distinct products offered. Each short-term product has a unique plan name and set of benefits. We examined 24 distinct short-term products offered across 45 states and the District of Columbia; the same product was often offered in multiple states with state variations in plan benefits.

Rates and plan information in this brief are for a 40-year-old male (non-smoker).

While we made every effort to account for state-level plan variations, we only present information made available in insurers' published plan brochures, which may be incomplete or may not reflect all specific state requirements. In the case of three products available from one insurer on eHealth, the plan brochure does not specify whether treatment for substance abuse is covered; in these cases, we do not consider the benefit category to be covered.

[1] For example, a newly hired employee who must complete a probationary period before becoming eligible for group health benefits might seek coverage through a short term policy during the probationary period.

[2] The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

[3] See, for example, *Time Magazine,* "The Health Care Crisis Hits Home," March 5, 2009, available at http://www.pnhp.org/news/2009/march/the_healthcare_cris.php

[4] Short-term policies commonly exclude coverage for pre-existing conditions, often defined as conditions (1) for which medical advice, diagnosis, care or treatment was recommended or received preceding the date the covered person became insured under the policy, or (2) that was not diagnosed but manifested symptoms that would have caused an ordinarily prudent layperson to seek medical advice, diagnosis, care or treatment.

[5] National Association of Insurance Commissioners, Accident and Health Policy Experience Report for 2016, available at http://www.naic.org/prod_serv/AHP-LR-17.pdf

[6] The Commonwealth Fund. State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market. March 29, 2018. Available at http://www.commonwealthfund.org/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-aca

[7] ParityTrack. Parity Implementation National Survey. Accessed April 17, 2018. Available at https://www.paritytrack.org/parity-reports/state-reports/

[8] *Modern Healthcare,* "How Stakeholders in the Short-Term Medical Market are Gearing up to Attract More Customers", April 19, 2018. Available at http://www.modernhealthcare.com/article/20180419/TRANSFORMATION04/180419913/how-stakeholders-in-the-short-term-medical-market-are-gearing-up-to

[9] The IHC Group Interim Coverage Plus plan brochure: https://www.healthedeals.com/Media/Default/Anthem/Brochure_Interim_Coverage_Plus_0418.pdf

[10] See, for example, https://www.agilehealthinsurance.com/health-insurance-learning-center/term-insurance-costs-less-for-26-year-olds-with-penalty-and-subsidies

[11] *Wall Street Journal*, "Sales of Short-Term Policies Surge," April 10, 2016. Available at https://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539

[12] See, for example, brochure for one currently-marketed short-term policy explaining the length of coverage, "Current federal regulations limit short term medical plans to 90 days under one certificate of insurance. However, [we offer] you the convenient opportunity to apply for up to four back-to-back certificates at one time. You do not have to qualify again for the three additional certificates, and you can cancel at any time." https://www.pivothealth.com/_assets/pdf/Pivot_Health-Short_term_medical_brochure-20161027.pdf

[13] Association for Community Affiliated Plans. Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market. April 12, 2018. Available at https://www.communityplans.net/policy/effects-of-short-term-limited-duration-plans-on-the-aca-compliant-individual-market/

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MARKETPLACE PULSE: After the Silver Load

More May Face Steep Out-of-Pocket Costs

April 1, 2018

Author(s): Hempstead K

CMS recently announced some big shifts in marketplace enrollment by metal in 2018. Due to the quirks introduced by the elimination of cost-sharing reduction payments (CSRs), subsidy-eligible customers often found they could get better deals by choosing bronze or gold. The share of marketplace enrollees in bronze plans, in particular, increased from 23 percent to 29 percent. Among those new to the marketplace, the trend toward bronze was even greater—34 percent of new enrollees on healthcare.gov chose bronze plans. Yet this shift to bronze may have some unintended consequences for individuals and health care markets, since cost-sharing differs significantly by metal.

Marketplace plans as a rule have high deductibles; the medians for bronze, silver, and gold plans in 2018 are $6,400, $3,800, and $1,250, respectively. But size is not all that matters. Bronze plans not only have the biggest deductibles, but they are also the least likely to have cost-sharing for health services.

There are three main ways that marketplace plans provide cost-sharing before the deductible. The most common (more than 50% of all plans) uses co-insurance or even more often, a co-pay, usually $30. About 15 percent of all plans use one of two volume-dependent options that relate cost-sharing to the number of visits. For example, some plans provide a limited number of no-cost visits, and then switch to a co-pay or co-insurance until the deductible is met. A more austere option is to have a limited number of free or low co-pay visits, after which the deductible must be met. But about 30 percent of all market plans do not permit any cost-sharing at all until the deductible is met.

Download Bronze Enrollees by State chart (PDF) →

Download Cost-Sharing for Primary Care chart (PDF) →

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Cost-sharing for Primary Care in 2018 Marketplace Plans

Benefit Design	Bronze	Silver	Gold
Before deductible			
Cost-sharing before the deductible (co-pay or co-insurance)	23.8%	68.2%	77.1%
Limited number of no-cost visits, then cost-sharing before the deductible	2.1%	2.8%	1.9%
After deductible			
After limited number of no-cost or low-cost visits, deductible must be met	12.0%	5.8%	3.4%
No cost-sharing before deductible	62.1%	23.2%	17.6%

Source: Data from HIX Compare, a project of the Robert Wood Johnson Foundation

Using primary care as an example, we can see there are big differences by metal, particularly between bronze and silver. For example, 62 percent of bronze plans require that the deductible be met before any cost-sharing for primary care, while this is the case for less than 25 percent of silver and about 18 percent of gold plans. One clear takeaway is that the gap between bronze and silver is wide, and the choice of bronze can have big affordability implications for low-income consumers, since the average office-based primary care visit costs more than $100 (https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0959) .

There is also spatial variation in cost-sharing characteristics, reflecting insurer differences and the geography of market participation. Due to both supply and demand factors, the impact of this shift to bronze is likely to vary by market. Consequences for individuals and providers could include underutilization of care or an increase in bad debt. Another outcome could be higher use of retail clinics, where visit prices are lower, or greater use of cheaper cash market options, if the prospect of meeting the deductible seems unrealistic. Consumer dissatisfaction and lapsed enrollment is another possibility if plan characteristics are not well understood, although the very low premiums should be helpful in that regard.

Barring any surprise announcements from CMS, silver loading is likely to continue next year and will probably expand to more states. While silver loading has increased affordability for many subsidized consumers, and the low bronze premiums are attractive, the benefit design may prove challenging. Consumers, providers, plans, and regulators will be assessing their respective experiences, with the potential for further adjustments in plan design and/or metal choice going forward.

April 2018 | Issue Brief

Proposals for Insurance Options That Don't Comply with ACA Rules: Trade-offs In Cost and Regulation

Karen Pollitz and Gary Claxton

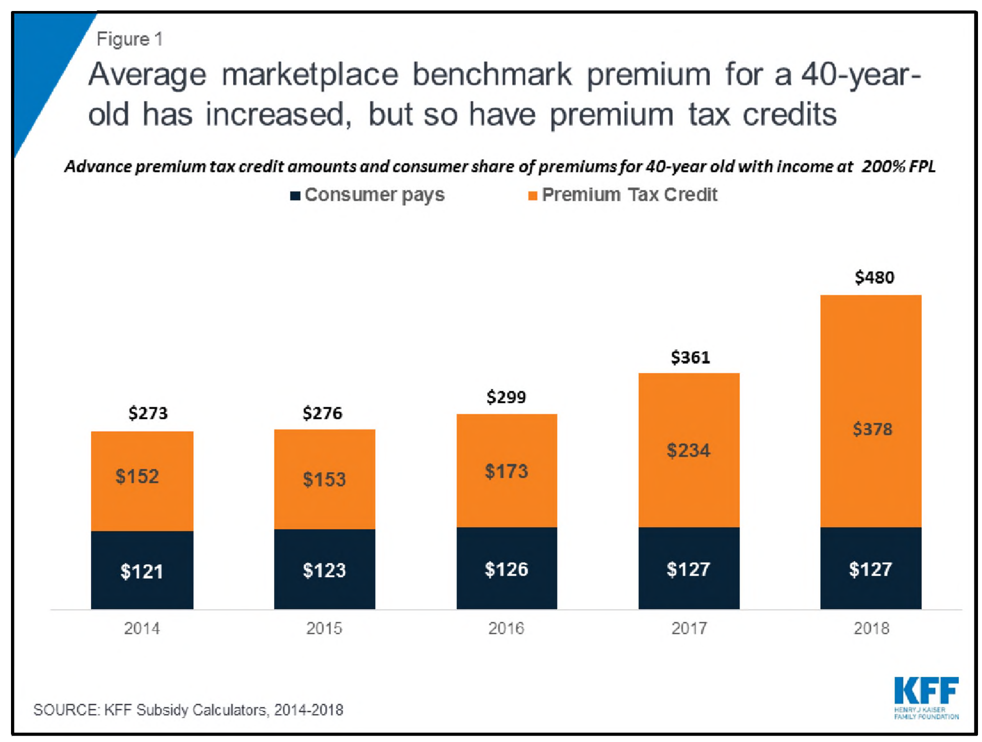
Now in the fifth year of implementation, the Affordable Care Act (ACA) standards for non-group health insurance require health plans to provide major medical coverage for essential health benefits (EHB) with limits on deductibles and other cost sharing. In addition, ACA standards prohibit discrimination by non-group plans: pre-existing conditions cannot be excluded from coverage and eligibility and premiums cannot vary based on an individual's health status. The ACA also created income-based subsidies to reduce premiums (premium tax credits, or APTC) and cost-sharing for eligible individuals who purchase non-group plans, called qualified health plans (QHPs), through the Marketplace. ACA-regulated non-group plans can also be offered outside of the Marketplace, but are not eligible for subsidies.

Individual market premiums were relatively stable during the first three years of ACA implementation, then rose substantially in each of 2017 and 2018. Last year, nearly 9 million subsidy-eligible consumers who purchased coverage through the Marketplace were shielded from these increases; but another nearly 7 million enrollees in ACA compliant plans, who do not receive subsidies, were not. Bipartisan Congressional efforts to stabilize individual market premiums – via reinsurance and other measures – were debated in the fall of 2017 and the spring of 2018, but not adopted. Meanwhile, opponents of the ACA at the federal and state level have proposed making alternative plan options available that would be cheaper, in terms of monthly premiums, for at least some people because plans would not be required to meet some or all standards for ACA-compliant plans. This brief explains state and federal proposals to create a market for more loosely-regulated health insurance plans outside of the ACA regulatory structure.

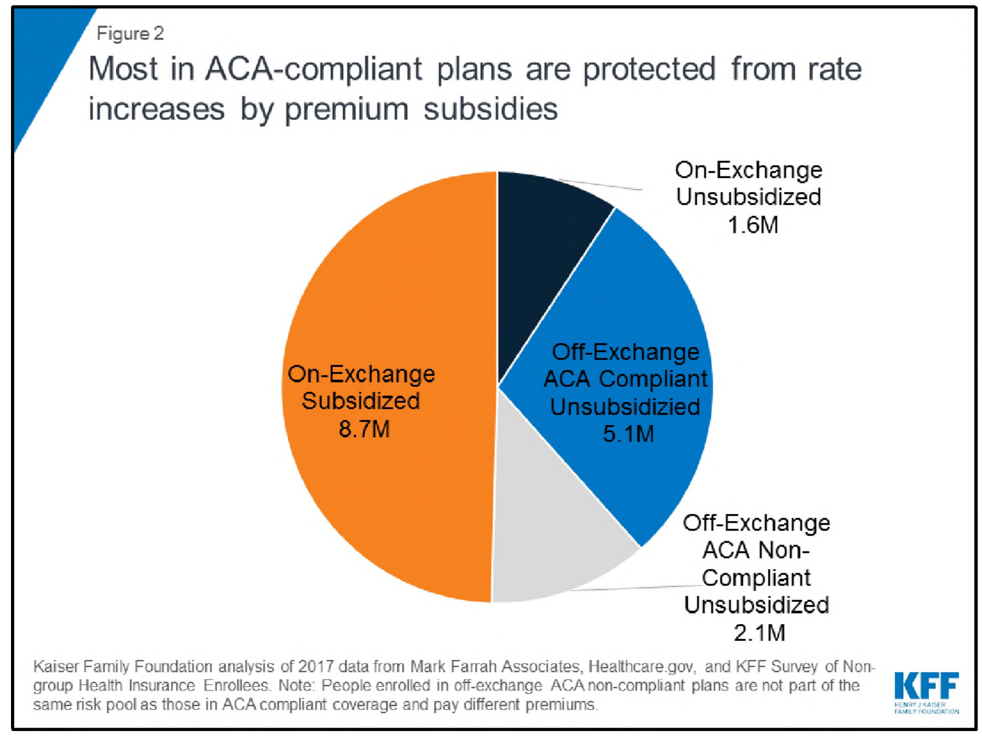
Background

When ACA Marketplaces first opened in 2014, on average, the cost of the benchmark silver QHP was lower than many had predicted. Many insurers underpriced QHPs at the outset, either because they couldn't accurately predict the cost of providing coverage to a new population under new ACA rules, or to aggressively compete for market share, or both. As a result, insurers offering ACA-compliant policies generally lost money in 2014-2016. In the fall of 2016, for the 2017 coverage year, most issuers implemented a substantial corrective premium increase for their benchmark QHP – on average, a 21% increase for a 40-year-old consumer. This increase, along with growing experience with new market rules, allowed many insurers to regain profitability in 2017, and, going forward, stabilization of QHP rates might otherwise have been expected.

Instead, though, a new wave of uncertainty arose last year as Congress debated repeal of the ACA and as the Trump Administration threatened administrative actions with the stated intent of undermining the program, including by ending reimbursement to insurers for required cost-sharing reductions (CSRs) that, by law, they must offer low-income enrollees in silver QHPs. The value of CSRs was estimated by CBO to be $9 billion for 2018. To compensate for the lost reimbursement, most insurers significantly increased 2018 premiums for silver level QHPs, through which cost sharing subsidies are delivered. Largely due to this so-called "silver load" pricing strategy, the average benchmark silver QHP premium for a 40-year-old rose another 33% for the 2018 coverage year. (Figure 1) Premiums for bronze and gold plans rose more slowly, but still substantially given uncertainty on a number of issues, including whether the ACA's individual mandate would be enforced.



For consumers who are eligible for APTC and who buy the benchmark silver plan (or a less expensive plan) through the Marketplace, subsidies absorb annual premium increases and the net cost of coverage has remained relatively unchanged from 2014 through today. Roughly 85% of Marketplace participants in 2017 were eligible for APTC. (Figure 2) However, for the 15% of Marketplace participants who were not eligible for subsidies, and for another roughly 5 million individuals who bought ACA compliant plans outside of the Marketplace, these consecutive annual rate increases threatened to make coverage unaffordable. That threat was even greater in some areas, where 2018 QHP rate increases were much higher than the national average.



Looking ahead, another round of significant premium increases is possible for the 2019 coverage year. A new source of uncertainty arose when Congress voted to end the ACA's individual mandate penalty, effective in 2019. The Congressional Budget Office (CBO) estimated repeal of the mandate would fuel adverse selection – as some younger, healthier consumers might be more likely to forego coverage – and average premiums in the non-group market would increase by about 10 percent in most years of the decade, on top of increases due to other factors such as health care cost growth.

ACA opponents have argued QHP premium increases reflect a failure of the federal law. As an alternative, some have proposed different kinds of health plan options to offer premium relief to consumers who need non-group coverage but who are not eligible for premium subsidies, primarily by relaxing rules governing required benefits, coverage of pre-existing conditions, and/or community rating. These include:

Short-Term, Limited Duration Health Insurance Policies

In 2018 the Trump Administration proposed a new draft regulation that would promote the sale of short-term, limited duration health insurance policies that offer less expensive coverage because they are not subject to ACA market rules.

Short-term limited-duration health insurance policies (STLD), sometimes referred to as limited-duration non-renewable policies, are designed to provide temporary health coverage for people who are uninsured or are losing their existing coverage but expect to become eligible for other, more permanent coverage in

the near future. Historically, people who have used these policies include graduating students losing coverage through their parents or their school, people with a short interval between jobs, or newly hired employee subject to a waiting period before they are eligible for coverage from their job. Because these policies are not intended to provide long-term protection (they generally cannot be renewed when their term ends), they are lightly regulated by states and are exempt from many of the standards generally applicable to individual health insurance policies. They also are specifically exempt under the ACA from federal standards for individual health insurance coverage, including the essential health benefits, guaranteed availability and prohibitions against pre-existing condition exclusions and health-status rating. These differences can make them considerably less expensive (for those healthy enough to qualify to buy them) than ACA compliant plans.

STLDs are similar to major medical policies in that they typically cover both hospitalization and at least some outpatient medical services, but unlike ACA-compliant policies, they often have significant benefit and eligibility limitations. STLD policies often either exclude are have significant limitations on benefits for mental health and substance abuse, do not have coverage for maternity services, and have limited or no coverage for prescription drugs. Policies also generally have dollar limits on all benefits or specific benefits and may have deductibles and other cost sharing that is much higher than permitted in ACA-compliant plans. Insurers of STLD policies typically use medically underwriting, which means that they can turn down applicants with health problems or charge them higher premiums. Policies also exclude coverage for any benefits related to a preexisting health condition: a backstop for insurers in case a person with a health problem otherwise qualifies for coverage and seeks benefits. Because STLD policies are not renewable, people who become ill after their coverage begins are generally not able to qualify for a new policy when their coverage term ends.

Due to their lower premiums, some people have been purchasing STLD policies instead of ACA compliant plans. This has happened even though STLD policies are not considered minimum essential coverage, which means that people who purchase them do not satisfy the ACA mandate to have health insurance and may be subject to a tax penalty. In 2016, CMS expressed concern about these policies being sold as a type of “primary health insurance” and issued regulations shortening the maximum coverage period under federal law for STLD policies from less than 12 months to less than three months and prescribing a disclosure that must be provided to new applicants. The intent of the regulation was to limit sale of these policies to situations involving a short gap in coverage and to discourage their use a substitute for primary health insurance coverage. The rule took effect for policies issued to individuals on or after January 1, 2017. In February 2018, the Trump Administration issued a new proposed regulation to reinstate the “less than 12 months” maximum coverage term for STLD policies. The preamble to the proposed regulation specified that this would provide more affordable consumer choice for health coverage. For more information about STLD policies, see this issue brief.

Extending the coverage period for STLD policies back to just under a year is likely to make them a more attractive choice for healthier individuals concerned about the cost of ACA-compliant plans. This is particularly true beginning in 2019 when the individual mandate penalty ends and purchasers will no longer need to pay a penalty in addition to the premiums for these policies.

Under the ACA framework, STLD plans may provide a lower-cost alternative source of health coverage for people in good health. With ACA policies as a backup, people who purchase STLD policies and develop a health problem would not be able to renew their short-term policy at the end of its term, but would be able to elect an ACA-compliant plan during the next open enrollment.

It is possible, as one estimate concluded, that more healthy individual market participants may switch to short-term policies as a result. Such "adverse selection" would raise the average cost of covering remaining individuals in ACA-compliant plans, leading to further premium increases in those policies. For people with pre-existing conditions who do not qualify for subsidies, the rising cost of ACA-compliant coverage could challenge affordability, especially for people with pre-existing conditions who have incomes that make them ineligible for premium subsidies.

Association Health Plans

Another draft regulation proposed by the Trump Administration would permit small employers and self-employed individuals to buy a new type of association health plan coverage that does not have to meet all requirements applicable to other ACA-compliant small group and non-group health plans. While many types of health insurance are marketed though associations, including STLDs, hospital indemnity plans and cancer or other dread disease policies, current policy discussions about AHPs tend to focus on arrangements formed by groups of employers (called multiple employer welfare arrangements, or MEWAs) which could also offer group health insurance coverage to self-employed people without any employees ("sole proprietors").

The U.S. Department of Labor recently proposed regulations under the Employee Retirement Income Security Act (ERISA) to expand the types of MEWAs that could offer health plans that would not be subject to certain ACA requirements. Under the draft regulation, AHPs – a type of MEWA - could offer health coverage to sole proprietors and to small businesses, but would be subject to large group health plan standards. Key ACA requirements for the non-group and small group market do not apply to large group health plans today, and so would not apply to AHP coverage sold to self-employed individuals or small employers. In particular, AHPs would not be required to cover essential health benefits; it would be possible under the proposed regulation for AHPs to offer policies that do not cover prescription drugs, for example.

Under the draft regulation, AHPs would be subject to a nondiscrimination standard that would prohibit basing eligibility or premiums on an enrollee's health status. However, other ACA rating standards in the non-group and small group market would not apply; in particular, AHPs would be allowed to vary premiums by more than 3:1 for age and without limit based on gender, geography, and other factors such type of industry or occupation.

As a result, AHPs could provide self-employed individuals an alternative to individual health insurance that provides fewer benefits with more rating flexibility.   As nearly one-third (31%) of individual market enrollees are self-employed, the impact of AHPs could be significant.

The draft regulation included other language related to state vs. federal regulatory authority over MEWAs, or AHPs. Currently, MEWAs are subject to a somewhat complex mix of regulatory provisions at the federal and state levels; the applicable standards vary depending on a number of things, including whether the MEWA is self-funded or provides benefits through insurance, whether the arrangement itself is considered to be sponsoring an employee benefit plan as defined in ERISA, the sizes of the employers participating in the arrangement, and how the states in which the arrangements operate approach MEWA regulation. The proposed rule generally leaves in place state authority over MEWAs/AHPs. However, the DOL requested comments on whether it should consider changes that would limit state regulation of self-funded AHPs to financial matters such as solvency and reserves, in effect, prohibiting states from regulating AHP rating and benefit design practices.

The degree of impact on individual health insurance markets will depend in part on the final rules, in particular whether the nondiscrimination provision is preserved and whether states retain current authority over AHPs.

Idaho Proposal for New State-Based Health Plans

In January 2018, pursuant to an executive order by Governor Otter, the Idaho Department of Insurance issued a bulletin outlining provisions of new individual health insurance products that insurance companies would be permitted to sell under state law. The new “State-Based Health Benefit Plans” would not have to comply with certain ACA requirements and, as a result, would likely be offered for premiums lower than those charged for ACA-compliant policies – at least for consumers who are younger and who don’t have pre-existing conditions.

State-Based Health Plans would be required to cover a package of health benefits and cost sharing that was less than that required for ACA-compliant plans. For example, certain essential health benefit categories, such as habilitation services and pediatric dental and vision, appear not to be required. In addition, ACA limits on cost sharing were not specified, and annual dollar limits on covered benefits could be applied. If consumers reach the annual dollar limit on coverage under a state-based plan, the insurer would be required to transfer their enrollment into an ACA-compliant plan.

In addition, state-based plans would not be allowed to deny applicants based on health status and could be sold year round, outside of Open Enrollment. However, State-Based plans could exclude coverage of pre-existing conditions for any individual who had experienced at least a 63-day break in coverage. These plans would also be permitted to vary premiums by a factor of 3:1 based on health status (prohibited by the ACA), and by 5:1 based on age (higher than the 3:1 ratio permitted by the ACA). In order to offer a State-Based Health Plan, insurers would also be required to offer at least one QHP through the Idaho Marketplace.

The bulletin required that state-based plans and exchange-certified plans must comprise a single risk pool, with a single index rate for all plans that does not account for differences in the health status of individuals who enroll, or are expected to enroll in a particular type of plan. However, the Academy of Actuaries noted that, because the two types of plans would not be competing under the same rules, "there would be, in effect, two risk pools – one for ACA coverage and one for state-based coverage. Premiums for ACA coverage would increase, threatening sustainability of the ACA market and its pre-existing condition protections."

The Idaho State-Based Health Plan proposal is similar in many respects to an amendment offered by Senator Ted Cruz during the ACA repeal debate in 2017. The amendment, which was not enacted, would have allowed insurers that sell ACA-compliant marketplace plans to also offer other policies that could be medically underwritten and that would not have to meet other ACA standards. Although CBO did not estimate how the amendment would impact premiums or coverage, representatives of the insurance industry predicted that, "As healthy people move to the less-regulated plans, those with significant medical needs will have no choice but to stay in the comprehensive plans, and premiums will skyrocket for people with preexisting conditions. This would especially impact middle-income families that that are not eligible for a tax credit."

The Idaho proposal appears to be not moving forward at this time. Recently, the director of the federal Center on Medicare and Medicaid Services (CMS) advised Idaho officials that these State-Based health plans would be in violation of federal law. Under the ACA, states do not have flexibility to authorize the sale of individual health insurance policies that do not meet federal minimum standards. In states that do not enforce federal minimum standards, the federal government is required to step in and enforce.

The CMS letter did generally express sympathy with Idaho's approach, citing "damage caused by the [ACA]," and encouraged the state to pursue modified strategies to expand availability of more affordable plans that do not meet all ACA requirements. The letter specifically urged Idaho to consider promoting short-term policies as a legal alternative to ACA-compliant health plans, and it invited the State to develop other alternative strategies using ACA state waiver authority.

Farm Bureau Health Plans Exempt from State Regulation

A new Iowa law enacted this month would permit the sale of health coverage by the state's Farm Bureau. The Farm Bureau is not a licensed health insurer. Under the new law, Farm Bureau health plans would be deemed to not be insurance and explicitly would not be subject to state insurance regulation. By extension, Farm Bureau plans also would not have to meet federal ACA standards for health insurance as these apply only to policies sold by state licensed health insurers.

The new Iowa law applies no other standards for Farm Bureau health plans – for example, it does not establish minimum benefit requirements, rating requirements, or rules prohibiting discrimination based on pre-existing health conditions. Appeal rights guaranteed to health insurance policyholders also would not apply to Farm Bureau enrollees, nor would state insurance solvency and other financial regulations. The

law does require the Farm Bureau to administer coverage through a state licensed third party administrator, or TPA (expected to be Wellmark, Iowa's Blue Cross Blue Shield insurer.) However, use of a TPA does not extend federal or state insurance law to the underlying Farm Bureau health plan.

The Iowa law closely resembles a Tennessee state law, enacted in 1993, which authorized the sale of health coverage by the Farm Bureau and deemed such coverage not to be health insurance subject to state regulation. In Tennessee, it has been reported that roughly 25,000 residents purchase non-group Farm Bureau health plans that are medically underwritten. (By comparison, more than 228,000 residents have ACA-compliant individual policies through the Marketplace this year.) Farm Bureau plan premiums can be as much as two-thirds lower than for ACA-compliant plans because the underwritten policies can and do deny coverage to people with pre-existing conditions. Adverse selection results, with sicker residents confined to the ACA-regulated market. An analysis of risk scores for state insurance markets finds that Tennessee's individual market has one of the highest risk scores in the nation.

Since 2014, Tennessee residents who buy underwritten Farm Bureau health coverage are not considered to have "minimum essential coverage" and so may owe a tax penalty under the ACA individual mandate. However, this disincentive to purchase Farm Bureau plans in Tennessee and Iowa will end in 2019 when repeal of the mandate penalty takes effect.

Discussion

Each of these proposals follows a similar theme. Creating parallel insurance markets with different, lesser consumer protections, allows insurers to offer lower premiums and less coverage to people while they are healthy, leaving the ACA-regulated market with a sicker pool and higher premiums. Once repeal of the ACA individual mandate penalty takes effect in 2019, the net cost differential between regulated and less-regulated coverage will be even greater.

Premium subsidies in the ACA-regulated market will help to curb adverse selection, protecting people with lower incomes from the impact of higher premiums, and providing some continued stability in the reformed market. However, middle-income people who are not eligible for subsidies, and who have pre-existing conditions, will not have any meaningful new coverage choices under these proposals. Instead, the cost of health insurance that covers essential benefits and their pre-existing conditions will increase, potentially further pricing them out of affordable coverage altogether.

(https://www.shvs.org/)

APR, 13, 2018

The 2019 Affordable Care Act Payment Rule: Summary and Implications for States

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On April 9, 2018, the U.S. Department of Health & Human Services (HHS) released its final Notice of Benefit and Payment Parameters for 2019 (https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07355.pdf), referred to here as the Payment Notice. This is an annual rule that includes a wide range of policy and operational changes for the Affordable Care Act (ACA) marketplaces, insurance market reforms, and premium stabilization programs. Among other things, the final rule aims to expand the role of state departments of insurance and marketplaces in ACA oversight and administration.

Concurrent with the 2019 Payment Notice, HHS also released sub-regulatory guidance, including the final annual letter to issuers (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf), key dates (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Key-Dates-Table-for-CY2018.pdf) for health plans participating in the individual and small-group markets in 2019, and an expansion

(https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2018-Hardship-Exemption-Guidance.pdf) of the circumstances under which individuals can qualify for exemptions to the ACA's individual mandate.

This expert perspective focuses on major provisions of the Payment Notice and accompanying guidance documents that require state decision-making or have other significant implications for states. More detailed summaries of the rule may be found here (https://www.healthaffairs.org/do/10.1377/hblog20180410.631773/full/), here (https://www.healthaffairs.org/do/10.1377/hblog20180411.618457/full/) and here (https://www.healthaffairs.org/do/10.1377/hblog20180412.184667/full/).

Provisions Affecting Health Insurance

Transitional Health plans

HHS has published guidance (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Extension-Transitional-Policy-Through-CY2019.pdf) to extend the administration's transitional policy, which allows insurers to re-enroll members in pre-ACA health plans (often referred to as "grandmothered" plans). If allowed by state regulators, insurers may re-enroll members in these plans through October 1, 2019, so long as all such policies end by December 31, 2019.

Essential Health Benefits

The final Payment Notice makes significant changes to the way in which states can select an essential health benefit (EHB) benchmark plan for plan year 2020 and annually thereafter. It also grants insurers greater flexibility to substitute benefits across the ten EHB benefit categories, if permitted by the state.

New Benchmark Selection Flexibility

The final rule permits states to change their EHB benchmark plan using one of the following three options:

- Selecting the EHB-benchmark plan that another state used for the 2017 plan year;
- Replacing one or more EHB categories of benefits in its EHB benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or
- Otherwise selecting a set of benefits that would become the state's EHB-benchmark plan.

The scope of benefits in the benchmark must be equal to that provided in a typical employer plan. HHS has defined “typical” to include either (1) one of the 10 plan options available for 2017 or (2) the largest health insurance plan by enrollment in any of the 5 largest large-group products by enrollment. If the state chooses a large-group plan as its EHB option, it must have significant enrollment in the state, meet the ACA’s minimum value standard, benefits cannot be excepted benefits (e.g., stand-alone dental or vision plans, fixed indemnity products, and certain flexible spending arrangements), and the plan must be from 2014 or later.

The generosity of the state’s new benchmark plan cannot exceed the generosity of the most generous of the plan options described above. Further, if the state selects a benchmark plan or category from another state that includes benefit mandates enacted after December 31, 2011, then the selecting state will have to defray any additional costs associated with those mandates.

States must make their new benchmark selection by July 2, 2018 in order to have it in place for the 2020 plan year. States may choose the process by which they choose a benchmark plan, so long as they provide reasonable notice on a public-facing website and opportunity for comment and comply with new data collection requirements. HHS has also released an example (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Example-Acceptable-Methodology-for-Comparing-Benefits.pdf) of the methodology state actuaries can use to compare the benefits of its benchmark selection.

Benefit Substitution

The final Payment Notice would allow insurers to substitute covered items and services both within and across the ten EHB benefit categories, beginning in 2020. However, insurers will only be allowed to do so if permitted by the state and after the state has notified HHS of its decision.

Rate Review

In conjunction with states, HHS is required to establish a process for the annual review of unreasonable health plan premium increases. In the 2019 Payment Notice, HHS is changing the definition of an “unreasonable” rate increase from 10 to 15 percent, effective January 1, 2019. HHS has also released new guidance (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-State-Specific-Threshold-Proposals-Guidance.pdf) for states that want a threshold higher than 15 percent (states seeking a definition lower than 15 percent are no longer required to request HHS approval).

Additionally, starting in 2019, states will be permitted to set a rate filing deadline later than the federal deadline for insurers who offer only off-marketplace plans. And HHS has reduced the timeframe for states to provide notice to HHS before posting final rate information, from 30 to 5 business days.

Medical Loss Ratio

The 2019 Payment Notice makes it easier for states to request a reduction in the medical loss ratio (MLR) standard for the individual market by reducing the amount of data states must submit to HHS. Further, the Final Notice clarifies that HHS may adjust the individual market MLR in any state if it determines that there is a "reasonable likelihood" that lowering the standard below 80 percent will help stabilize the market. HHS has released new guidance (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/MLR-Guidance-State-Adjustments-2018.pdf) for states outlining in more detail the process by which they can request an MLR adjustment.

Risk Adjustment

The final Payment Notice would give states the authority to reduce risk adjustment transfers in the small-group and individual markets.[1] Specifically, states can request an up to 50 percent reduction in risk adjustment transfers, but must submit evidence and analysis to HHS justifying the proposed reduction. States must further demonstrate that the reduced risk adjustment payments would result in less than a 1 percent increase in affected insurers' premiums. States must submit requests by August 1, two calendar years before the start of the applicable benefit year. For example, a state would have to submit a request by August 1, 2018 if it wants to reduce risk adjustment transfers for the 2020 plan year.

Provisions Affecting the Marketplaces

Certification of Qualified Health Plans

HHS is continuing its policy of increased deference to state oversight of plans participating on the health insurance marketplaces (known as QHPs). The Payment Notice provides state-based marketplaces that use the federal platform (SBM-FPs) with new flexibility to determine how to implement the ACA's network adequacy and essential community provider standards, so long as those states have an adequate review process. However, after receiving comments about limited state resources and staff, HHS decided not to finalize a proposal to defer to states for review of QHP accreditation, service areas, and compliance reviews.

Eligibility Standards

Under current rules, the marketplaces must generally discontinue an enrollee's advance premium tax credits payments (APTC) if they have failed to file a tax return reconciling APTC received for a prior year. However, the marketplace may discontinue APTC under this rule only if it first sends a direct notification to the enrollee informing them that their eligibility is at risk and why. Providing this notification has proved challenging for state-based marketplaces because their systems were not built to comply with Internal Revenue Service requirements for tax information privacy. The Payment Notice removes the direct notification requirement for 2019. As a result, state-based marketplaces must now discontinue APTC for a consumer who has failed to reconcile APTC regardless of whether they are able to provide a clear notification. In the past, many state-based marketplaces have instead sent a general notice that lets consumers know their APTC could be discontinued for several reasons, of which the failure to file and reconcile their last year's return would be just one.

Income Inconsistencies

Under current rules, marketplaces are required to generate a data matching issue in certain cases where the consumer projects having income significantly lower than is indicated by electronic data sources. The Payment Notice requires the marketplaces to also generate a data matching issue for consumers if (1) the consumer attests to income between 100 and 400 percent of the federal poverty line (FPL); (2) the marketplace has data indicating income is below 100 percent FPL; (3) the marketplace has not assessed that the consumer has income making them eligible for Medicaid or CHIP; and (4) the income projected by the consumer exceeds the income reflected in the data available from electronic data sources by not less than 10 percent (or a threshold dollar amount). If the consumer cannot provide documentation demonstrating income above 100 percent FPL, the marketplace would be required to discontinue APTC and cost-sharing reduction subsidies. Lawfully present immigrants who are ineligible for Medicaid are exempted from this policy, since the statute makes them eligible for APTC and cost-sharing reductions at incomes below 100 percent FPL.

HHS rejected requests from state-based marketplaces to be exempted from this policy due to the costs and time needed to implement it, arguing that requiring documentation for such data matching inconsistencies is critical for "program integrity," including in Medicaid expansion states.

Navigator Programs

The 2019 Payment Notice eliminates the requirement that marketplaces have at least two Navigator entities, and that one must be a community-based, consumer-focused non-profit organization. State-based marketplaces may continue to support two or more Navigator entities, but they are not required to do so. Additionally, HHS is removing the requirement that Navigator entities maintain a physical presence in the state's service area.

Special Enrollment Periods

HHS has finalized modifications to special enrollment periods (SEPs) rules to clarify that a new dependent can be added to the enrollee's existing plan or enrolled in a separate plan. The rule also aligns coverage effective dates for those who enroll through a SEP triggered by birth, adoption, placement for adoption, or placement in foster care. State-based marketplaces had asked for flexibility in implementing this proposal, and HHS will allow them to take additional time, "as needed," to comply with the change.

Small Business Health Options Program

State-based marketplaces operating small business health options program (SHOPs) will no longer be required to provide employee eligibility, premium aggregation, and online enrollment functionality for plan years beginning on or after January 1, 2018. Further, because the federally facilitated marketplace will no longer perform these functions, states operating a SBM-FP for SHOP (Kentucky and Nevada) will no longer be able to use the federal system for those functions.

Flexibility for State Marketplaces

HHS has sought input on how it can best support SBM-FP efforts to use commercial eligibility and enrollment platforms. In this final Payment Notice, HHS notes that while it remains unable to offer state-specific customization of healthcare.gov, it intends to explore options for streamlining current requirements and leveraging the private sector, including through enhanced direct enrollment through web-brokers or insurers.

Conclusion

The annual Payment Notice sets policy for the ACA's marketplaces, insurance reforms, and premium stabilization programs, and this 2019 rule is the first one issued by the Trump administration. The final rule reflects the administration's interest in expanding the role of states in providing oversight and administering the ACA. With

that expanded role comes a need for states to make important decisions about plan benefit design, affordability, and marketplace operations, in some cases within a very short timeframe.

[1] States with merged individual and small-group markets will also have the opportunity to request reductions in risk adjustment transfers.

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Unpacking The Final 2019 Payment Notice (Part 3)

Katie Keith

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The Centers for Medicare and Medicaid Services (CMS) finalized the Benefit and Payment Parameters rule for 2019 on April 9, 2018. The first post addressed the rule's changes in plan benefits, eligibility, and enrollment changes. The second post discussed the general market reforms, rate review, the medical loss ratio, and the SHOP exchanges. This final post discusses the rule's changes to the Affordable Care Act's (ACA's) risk adjustment program.

The ACA included three premium stabilization programs: risk corridors, reinsurance, and risk adjustment. The risk corridor and reinsurance programs lasted only for 2014, 2015, and 2016; they are now finished except for three dozen lawsuits that continue in the Court of Claims. These suits allege that the federal government failed to pay out all of the funds owed under the risk

corridor program, as well as funds that still remain to be collected and distributed under the reinsurance program. HHS will continue to make reinsurance payments in the 2018 fiscal year. These funds will be sequestered at a rate of 6.6 percent under fiscal year 2018 budget rules, as will risk adjustment funds collected during the 2018 fiscal year. If Congress takes no further action, the sequestered funds will become available in fiscal year 2019.

The third premium stabilization program, risk adjustment, remains very much alive and much of the final rule is devoted to the program's parameters for 2019. The risk adjustment program transfers funds from lower-risk, non-grandfathered plans in the individual and small group markets to higher-risk, non-grandfathered plans, both in and out of the exchange. The purpose of the program is to discourage cherry picking in that plans that end up with healthier populations must compensate plans that have more costly enrollees. Although states that operate their own exchanges can operate their own risk adjustment program, none currently do so, and CMS will operate the program in all states in 2019.

The risk adjustment model predicts plan liability for an average enrollee based on risk scores, which are based in turn on each enrollee's age, sex, and diagnoses. The CMS risk adjustment methodology uses separate models for adults, children, and infants to account for cost differences. In the adult and child models, each individual's age, sex, and diagnoses are added together to produce an individual risk score. Where applicable,

risk scores are multiplied by a cost-sharing reduction adjustment, recognizing that enrollees with lower cost-sharing use more services. The enrollment-weighted average risk score of all enrollees in a particular risk-adjustment covered plan within a geographic area is an input into the risk adjustment payment transfer formula, which determines the payment or charge an issuer will receive or have to pay under the program.

Recalibration

CMS made fairly significant changes to the risk adjustment model for plan years 2017 and 2018. These included incorporating preventive services; better reflecting growth in specialty drug expenditures; accounting for the higher cost of partial year enrollments; including prescription drug utilization factors; adding a special reinsurance program for very high-cost enrollees; and removing part of the premium to account for non-variable administrative costs. For 2019, CMS will simply recalibrate the 2018 plan year model, with small modifications in the drug classes used in the 2019 plan year adult models and incorporation of 2016 plan year enrollee-level EDGE data.

For the 2019 plan year, CMS will blend enrollee-level data from its own EDGE servers (for plan year 2016) with 2014 and 2015 Truven MarketScan® data to calibrate the coefficients in the risk adjustment model. CMS believes that these changes will make the risk adjustment model more accurate. This is because the EDGE server data reflects services use from its own program while Truven data is drawn from employer programs.

Commenters generally agreed and supported the incorporation of EDGE data because it will more closely reflect risk in the individual and small group markets. The coefficients will be equally blended among the data sources (instead of, say, weighing EDGE data more heavily than MarketScan data). The rule includes tables with the final coefficients.

Prescription Drugs

For 2018, CMS included for the first time twelve drug-diagnosis pairs into its model. In ten of these, the use of the drug could impute the existence of an otherwise undetected diagnosis or demonstrate the greater severity of an existing diagnosis. In two the prescription only predicted the severity of an existing diagnosis. For the 2019 plan year, CMS will remove the two severity-only drug-diagnosis pairs as they had extremely small coefficients and did not predict incremental plan risk. This change was supported by most commenters, and CMS will continue to evaluate the effects of incorporating prescription drugs into its models. CMS expects to publish a final 2018 plan year crosswalk in spring 2019 and will make quarterly updates to that crosswalk to incorporate new drugs; the 2019 crosswalk will be published on a similar quarterly schedule.

Payment Transfer Formula

CMS will continue to exclude the costs of enrollees whose costs exceed $1 million when calculating enrollee-level plan liability risk scores. Plans will be compensated directly for 60 percent of

costs above the $1 million threshold. Issuers will be charged a percentage of their total premiums separately in the individual (including catastrophic and non-catastrophic plans) and small group markets for this high-cost claim reinsurance program. These are the same parameters that apply to the 2018 plan year.

Once CMS has calculated the risk scores for each plan's enrollees, it will feed these into its payment transfer formula to determine, for each geographic area in a state, per-member-per-month amounts to be transferred among plans as payments or charges based on each plan's total member months for the plan year. Payment and charge terms are calculated separately for each state's market individual and small group risk pools and for a national individual and small group high risk pool for claims exceeding $1 million. Transfers are based on the statewide average premium and will be reduced by 14 percent to account for administrative costs that do not vary with claims. The payment transfer formula is not changed for 2019 and will not be discussed here.

The preamble includes an extended discussion on CMS' decision to base transfers on the statewide average premium (rather than using each plan's premium). This was presumably done in response to recent litigation where a federal district court found this part of the formula to be arbitrary and capricious. The use of a statewide average premium was adopted based on CMS' assumption that the risk adjustment program must be budget neutral, an assumption that CMS had not fully justified. By discussing the budget neutrality issue here,

CMS may be trying to address the court's concern that it had failed to provide a reasoned explanation for this assumption. Much of CMS' rationale tracks the reasoning outlined in a separate court decision that upheld the risk adjustment formula.

State-Specific Adjustments

Recognizing that insurance markets vary by state and committed to giving more flexibility to state regulators, CMS will allow states to request a percentage adjustment in the calculation of risk adjustment transfer amounts in the individual market, the small group market, and the merged market. This was a shift from the proposed rule where CMS had only proposed allowing this flexibility in the small group market. CMS estimates that no more than 25 states will make this request annually.

States can request adjustments of up to 50 percent of the premium used in the applicable plan year. States must be able to demonstrate that state-specific factors warrant an adjustment and that an adjustment would have a de minimis effect on premium increases to cover an issuer's reduced payments. CMS is not requiring states to submit actuarially certified reports, attestations, or simulations.

These adjustments can be applied beginning with the 2020 plan year. CMS had proposed to allow this in 2019 but cites the need to provide additional time for analysis and state requests. State requests will be published in each year's proposed annual

payment rule and will be subject to public comment. To accommodate this timeframe, states must submit their requests and supporting data to CMS by August 1 (i.e., August 1, 2018 for the 2020 plan year). CMS will also publish whether state reduction requests were approved or denied. CMS can approve a reduction amount that is lower than what a state requested, if warranted.

Some commenters raised concern that this policy will undermine the affordability of plans with higher-risk enrollees and encourage issuers to design plans in a way that tries to cherry pick healthier consumers. This risk selection behavior could encourage risk segmentation, reduce the effectiveness of the risk adjustment program, and lead to higher premiums. Some commenters emphasized that stability in the risk adjustment program would be especially important given proposed (now final) changes to state essential health benefits standards. In response, CMS noted that other ACA requirements—such as guaranteed issue and renewability and existing nondiscrimination standards—would sufficiently limit this type of issuer behavior and protect consumers.

Data Validation

Risk adjustment data collected from issuers must be validated, first by an independent validation auditor retained by the issuer and then by CMS. The issuer provides the auditor with demographic, enrollment, and medical record documentation for a sample of enrollees selected by CMS. The final rule makes a

number of changes to the audit process that will generally reduce the regulatory burden on issuers. CMS also released new guidance to exempt issuers in liquidation or entering liquidation from data validation requirements.

First, CMS adopts an "outlier" approach to error rates and risk score adjustments. CMS will evaluate error rates within each hierarchical condition category (HCC) or group of HCCs. This will be calculated during a risk adjustment validation audit and is based on whether an HCC was incorrectly assigned. An issuer's error rate will be calculated based on the percent of the EDGE risk score that is incorrect due to audit findings. If, for instance, two of four instances of the HCC on EDGE could not be validated, an issuer would have a 50 percent failure rate. An issuer's risk score will be adjusted only if it has an outlier failure rate (when compared to the total failure rate for a group of HCCs for all issuers that submitted initial validation audits). CMS intends to publish benchmark failure and error rate data based on 2016 plan year data validation results.

CMS addresses the issue of payment adjustments when issuers exit a market and is subsequently found to require a payment adjustment based on data validation. Payment adjustments based on data validation are normally made prospectively; that is by adjusting risk scores and payments for the year subsequent to the validation year. When an issuer leaves a market, however, CMS will make adjustments retroactively to the year being audited and reallocate the adjusted transfer amount to other issuers in the market in that year. CMS believes that this

is necessary to ensure that an issuer with inaccurate data does not benefit from its error to the harm of other issuers in the states, but recognizes that it will complicate the process. This requirement will go into effect beginning with risk adjustment data validation for the 2017 plan year.

Recognizing the burden on smaller issuers, the final rule effectively excludes issuers with 500 billable member months or fewer from risk adjustment data validation. These issuers do not have to hire a validation auditor or submit initial validation audit results and will be exempt from random sampling beginning in the 2018 plan year. Issuers with total annual premiums of $15 million or less will not be required to conduct an annual audit but will be subject to random audits approximately every three years.

CMS will not calculate a risk score or apply risk adjustment payment transfers, except for high-cost risk pool transfers, in a market and risk pool that has only one issuer. That issuer may be subject to risk adjustment in other markets in the state where there are other issuers, but not where it is the sole issuer. The issuer will not be required, therefore, to validate its data for that market.

Risk score validation is normally done by reviewing medical records from a random sampling of enrollees. This has caused problems where mental health and substance abuse records are involved, since they are subject to heightened protection under state and federal law. To address this, CMS will allow data

validation based on a provider's mental or behavioral health assessment rather than on the full patient record. This flexibility will not, however, apply to providers that are prohibited solely by federal law from providing a full mental or behavioral health record. Providers or issuers may have to obtain patient consent to disclose these records.

Initial auditors must report their inter-rater reliability scores to CMS, which should achieve a consistency measure of at least 95 percent. However, for initial years of validation, including 2016, a rate of 85 percent is sufficient.

CMS can impose civil money penalties for the violation of certain risk adjustment data validation requirements, including failure to engage an initial validation auditor, failure to submit to CMS validation results, misconduct or substantial noncompliance with validation standards or requirements, or intentionally or recklessly misrepresenting or falsifying validation information. In general, CMS intends to work collaboratively with issuers to address problems in the validation process and to only impose civil money penalties in the event of misconduct or substantial noncompliance. The preamble includes a number of examples of issuer misconduct that could warrant civil monetary penalties; these include knowingly hiring an auditor with conflicts of interest or failing to ensure privacy and data security. Substantial noncompliance would include an unreasonable delay in providing complete documentation to an auditor or failing to properly oversee an auditor.

Where CMS discovers demographic or enrollment errors in EDGE server data, it will adjust the applicable plan year transfer amount rather than the subsequent year risk score. Where errors in premium data are discovered, CMS will adjust transfer amounts if the error is to the detriment of other issuers in the market.

The final risk adjustment user fee for 2019 is $1.80 per billable member per year, or $0.15 per member-per month, the same as 2018. This is slightly higher than the $1.68 per billable member per year fee that was included in the proposed rule.

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April 11, 2018

Potential Impact of Short-Term Limited Duration Plans

Dear Mila:

In this letter, we provide estimates regarding the potential impact to the District of Columbia's (the District's) individual market, specifically for those members covered under Affordable Care Act (ACA) plans, which could occur as a result of the proposed rule related to short-term limited duration (STLD) plans. Please note that the estimates that follow are not based on robust actuarial micro-simulation modeling specific to the District. However, the unique characteristics of the District's ACA market have been taken into consideration, including but not limited to its distribution of membership by age, gender, and overall cost levels. In our opinion the estimates we have developed provide the District with a reasonable starting point for discussions related to the potential impact the proposed STLD rule could have on claim costs in the District's individual ACA market.

Results
In general, the impact that the proposed STLD rule is expected to have on claim costs in the District's individual ACA market could vary significantly depending on both issuer and consumer interest in STLD plans in the coming years. Given that, we have developed estimates for two separate scenarios related to STLD plans: a "Low" scenario which assumes individuals would be more risk averse when evaluating whether to purchase STLD plans and a "High" scenario which assumes individuals would be less risk averse in their STLD decision making process.

Overall, we are estimating that the proposed rule related to STLD plans could be expected to have the following impacts, depending on the assumptions employed:

Exhibit A - Estimated Impact of STLD Rule on Individual ACA Market

		Increase in Average Claim Costs[1,2]		Change in Enrollment[3]	
Scenario	**Description**	**Low**	**High**	**Low**	**High**
1	STLD plans fully implemented, individual mandate penalty remains	1.7%	3.1%	-500	-900
2	STLD plans fully implemented, individual mandate penalty is $0[4]	11.7%	21.4%	-3,800	-6,100

Notes

[1]On a per member per month basis, excluding the portion which can be rated for through the ACA age curve

[2] Estimates reflect the impact of additional changes in morbidity which would be expected to occur assuming initial changes in average claim costs resulting from enrollment in STLD plans and/or the repeal of the individual mandate penalty will be passed to remaining ACA enrollees in the form of rate increases, driving additional coverage losses; at a high level, it is being assumed that the additional coverage losses would lead to further increases in average claim costs (on a per member per month basis, excluding the portion which can be rated for through the ACA age curve) equal to approximately 20% of those which were calculated solely due to enrollment in STLD plans and/or the repeal of the individual mandate penalty

[3] The assumed enrollment volume prior to the changes described is approximately 17,000 covered lives

[4] Reflects the combined impact of the repeal of the individual mandate penalty and STLD plans being fully implemented

We note that these estimates assume full implementation of STLD plans as proposed in the draft rule released by the Internal Revenue Service, Employee Benefits Security Administration, and the Health and Human Services Department[1]. As a result, this study does not attempt to reflect that the impact of STLD plans on the ACA markets could be lower in the initial year(s) following effectuation of the proposed rule. Additionally, we note that we did not look at the impact on employer coverage or the Medicaid program and, therefore, these estimates do not include any increase in costs resulting from loss of coverage in the employer market or to the Medicaid program.

A description of the assumptions and methodology which was utilized to develop these estimates is provided in the following section of this letter.

Methodology

In conducting our analysis, we began with a dataset provided by the District of Columbia Health Benefit Exchange Authority (DCHBX) which includes the following key information for each member enrolled in the District's individual ACA market as of January 2018: Policy ID, Member ID, Date of Birth, and Gender. Utilizing this membership information, we created a cohort of simulated policies representative of the District's individual ACA market. That is, the simulated

[1] https://www.federalregister.gov/documents/2018/02/21/2018-03208/short-term-limited-duration-insurance

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policies have a similar distribution of membership by age and gender, have corresponding claim costs which vary as would be expected in the District, and have medical conditions which are representative of those that would be expected based on the underlying demographic mix.

To assess the impact of the proposed rule, we first estimated what each enrollee's projected cost would be if they were to enroll in an STLD plan, including their out-of-pocket costs for both covered and non-covered services, the annual premium rate for the STLD plan and, in the scenario where the individual mandate penalty is assumed to remain in place, the penalty owed as a result of not purchasing ACA-compliant coverage. Several assumptions were incorporated into the development of these cost estimates and we have outlined the key assumptions we have made related to STLD plans below:

- *Underwriting* - Coverage can be denied to individuals who do not meet a carrier's underwriting requirements
- *Pre-Existing Conditions* - Services associated with treating a pre-existing condition will not be covered
- *Pricing Assumptions*
    i. STLD carriers will utilize all rating factors which existed prior to the ACA (e.g. full age curve)
    ii. STLD carriers will target an overall loss ratio equal to 50%
    iii. STLD rates will be adjusted to account for the morbidity of the individuals projected to enroll in the plans
    iv. Allowed cost levels for services commonly covered by STLD plans and ACA plans will be the same (i.e., similar provider discounts will be available to insurers offering STLD plans as are available to insurers offering ACA plans)
- *Policy Limits* – A lifetime policy limit of $1,000,000 will be in force
- *Renewability* – STLD plans will be available for up to 364 days and will be "optionally renewable" (i.e. renewable at the option of the insurer)
- *Essential Health Benefits* – Coverage for the ten essential health benefits, excluding services associated with pre-existing conditions, will be as follows:
    i. Ambulatory Patient Services (i.e. outpatient services) – Covered
    ii. Prescription Drugs – NOT Covered
    iii. Emergency Services – Covered
    iv. Mental Health Services – NOT Covered
    v. Hospitalization (i.e. inpatient services) - Covered
    vi. Rehabilitative and Habilitative Services – NOT Covered
    vii. Preventive and Wellness Services – NOT Covered
    viii. Lab – Covered
    ix. Pediatric Care (i.e. pediatric dental and vision services– NOT Covered
    x. Maternity Care – NOT Covered
- *STLD Plan Design*[2] - For the purpose of this analysis, the STLD plan is assumed to have a $1,000 deductible (per person), 70% coinsurance rate (insurer responsibility), and a $5,000 out-of-pocket maximum (per person, in addition to the deductible)

[2] These assumptions related to plan design were chosen based on a review of short-term limited duration products which are currently available in the individual market

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- *Cost Levels of Not Covered Services* - For services not covered by STLD plans (e.g. maternity), it is assumed that the "allowed charges" for those services will be approximately 45% higher under the STLD plans than under ACA plans, due to a lack of provider discounts being available for those services.

Next, we estimated each enrollee's projected cost assuming they were to enroll in a silver level ACA plan. Similar to the approach used when assessing each enrollee's projected costs if they were to enroll in a STLD plan, we developed estimates for what each enrollee's expected out-of-pocket costs for covered services would be as well as what each enrollee's annual premium rate would be expected to be if enrolled in an ACA plan.

After developing projected costs at the enrollee level for both STLD and ACA coverage, in order to determine which ACA policyholders would potentially shift to an STLD plan, the assumptions outlined below were applied:

- If an individual had an occurrence of a Hierarchical Condition Category (HCC) over the past five years, that individual would be declined for STLD coverage
- If an individual is in the top quartile of ACA enrollees with respect to total claim costs in the prior year, that enrollee would choose not to enroll in STLD coverage due to the expectation that they would be more risk averse
- If an individual incurred a high volume of annual claim costs at some point over the past five years such that it would have been in the enrollee's best interest to remain in the ACA market in that year:
  - *More Risk Averse Scenario:* 100% of those individual will not purchase STLD coverage
  - *Less Risk Averse Scenario*: 100% of the individuals where this result occurred in the most recent year will not purchase STLD coverage, 80% of the individuals where this result occurred two years ago will not purchase STLD coverage, 60% of the individuals where this occurred three years ago will not purchase STLD coverage, 40% of the individuals where this result occurred four years ago will not purchase STLD coverage, and 20% of the individuals where this result occurred five years ago will not purchase STLD coverage
- For all other policyholders (i.e. after removing the enrollees identified in the three bullet points above), we compare their projected annual costs under both the STLD plan and the ACA plan. If the net cost to purchase the ACA plan is cheaper, it is assumed that the individual will remain in the ACA market. If the net cost to purchase the STLD plan is cheaper, it is assumed the individual will leave the ACA market to purchase an STLD plan
- Decisions to keep or change coverage are made at the policy/household level

After applying the criteria outlined above and ensuring that the projected STLD rates adequately reflect the morbidity of the membership expected to enroll in those plans, the average projected allowed claim costs of the enrollees expected to remain in the ACA market after the STLD plans are fully implemented was compared to the overall average allowed claim costs of the ACA market prior to the implementation of STLD plans. This comparison provides the expected change in average allowed claim costs in the individual ACA market (on a per member per month basis), and was then adjusted to exclude the portion of the change which can be rated for through the existing ACA age curve.

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Finally, the calculated difference in average allowed claim costs was increased by a factor of 20% (e.g. if the initial estimated change in average claim costs was 1.0%, the estimate was increased to 1.2%) to reflect the additional impact which would be expected to occur in the individual ACA market assuming the changes in average claim costs due to shifts in enrollment to STLD plans will be passed to remaining ACA enrollees in the form of a rate increase, driving additional coverage losses.

Combined Effect of STLD Plans, the Repeal of the Individual Mandate, and AHPs
In a prior letter dated February 6, 2018, we provided an estimate that the repeal of the individual mandate penalty is expected to result in an increase in average claim costs in the individual ACA market equal to approximately +7.2% (on a per member per month basis, excluding the portion which can be rated for through the ACA age curve). In an additional letter dated February 21, 2018, we provided an estimate that the combined effect of the proposed AHP rule being fully implemented and the repeal of the individual mandate penalty would be expected to have an impact on average claim costs in the individual ACA market equal to approximately +7.9% to +16.4%

To the extent STLD plans are fully implemented at the same time as the repeal of the individual mandate and the full implementation of AHPs, we would not expect the net impact to average claim costs in the individual ACA market to simply be the sum of the estimates referenced above and the STLD estimates provided earlier in the letter in Exhibit A. We would expect that a number of the policyholders who would exit the ACA market as a result of the full implementation of the STLD rule would also be those policyholders who would exit due to the repeal of the individual mandate penalty and/or the implementation of the AHP rule.

Overall, to the extent all three items are fully implemented at the same time, we would expect the combined impact on average claim costs in the individual ACA market to be equal to approximately +13.3% to +19.9% in the scenario where consumers are assumed to be more risk averse in determining whether to purchase STLD plans (i.e., the “Low” scenario) and +22.8% to +31.3% in the scenario where consumers are assumed to be less risk averse in determining whether to purchase STLD plans (i.e., the “High” scenario). The range provided within each of the “Low” and “High” scenarios is dependent upon the assumptions that are employed for AHPs. The low end of the ranges provided assumes the following related to AHPs: Only SHOP enrollees (excluding congressional employees) and sole proprietors in the Professional, Scientific, and Technical Services industries are eligible to purchase AHPs; Differences in pricing factors exist between the AHP and ACA plans; AHPs use pre-ACA rating factors; and there are no differences in covered benefits between the ACA and AHP plans. The high end of the ranges provided assumes the following related to AHPs: AHPs do not cover maternity benefits (for employer groups with fewer than 15 employees); sole proprietors in the individual market only consider AHPs if there are no females between ages 21-40 included on their policy; employers in the small group market consider AHPs only if they have less than 15 employees and 20% or less of their membership is made up of females between ages 21-40; differences in pricing factors exist between the AHP and ACA plans; AHPs use pre-ACA rating factors; and AHP rates reflect the exclusion of maternity benefits (for employer groups with fewer than 15 employees).

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Limitations and Considerations

Key limitations and considerations associated with our analysis include the following:

- Estimates rely on membership information provided by DCHBX. If the information used is inaccurate or has been misinterpreted, the underlying findings and conclusions may need to be revised
- Estimates are not based on robust microsimulation modeling and therefore may not fully recognize all interactions specific to the District's ACA markets that might exist.
- Values are based on estimates of future events; therefore, actual results will vary
- Actual results are expected to vary on a carrier specific basis
- Unless specified, estimates are based on the isolated impact of the proposed rule related to STLD plans and do not consider the impact of other changes to the proposed rule or in legislation or regulation at either the District or Federal level

Distribution and Use

This report was sponsored by DCHBX with the purpose of providing a reasonable starting point for discussions related to the range of the potential impact the proposed STLD rule could have on claim costs in the District's individual ACA market. Oliver Wyman's consent to any distribution of this report (whether herein or in the written agreement pursuant to which this report has been issued) to other parties does not constitute advice by Oliver Wyman to any such third parties and shall be solely for informational purposes and not for purposes of reliance by any such third parties. Oliver Wyman assumes no liability related to third party use of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein. This report should not replace the due diligence on behalf of any such third party.

Please let me know if you have any questions related to this letter.

Thank you.

Sincerely,

Ryan Schultz, FSA, MAAA

Copy: MaryBeth Senkewicz, DCHBX
Purvee Kempf, DCHBX
Debra Curtis, DCHBX
Tammy Tomczyk, Oliver Wyman

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Unpacking The Final 2019 Payment Notice (Part 2)

Katie Keith

APRIL 11, 2018 **DOI:** 10.1377/hblog20180411.618457

The Centers for Medicare and Medicaid Services (CMS) finalized the Benefit and Payment Parameters rule for 2019 on April 9, 2018. An earlier post addressed the rule's changes in plan benefits, eligibility, and enrollment. This post considers the rate review provisions, the medical loss ratio, the general market reforms, and the SHOP exchanges. A third post will cover the rule's provisions on risk adjustment.

Rate Review

Since 2011, issuers have been required to submit rate filing justifications for rate increases for non-grandfathered plans in the individual and small group market. This requirement was established to carry out CMS' responsibility to monitor premium increases for insurance offered inside and outside the

exchanges. The final rule adopts a number of changes relative to current rate increase disclosure and review requirements.

First, CMS exempts student health insurance from federal rate review requirements. This provision goes into effect for coverage that begins on or after July 1, 2018. Student health insurance is considered individual coverage but is not part of the individual market single risk pool and is sold more like large group coverage. CMS initially proposed this change for the 2019 plan year but changed the effective date to July 2018 to align with the timing of when most student health coverage begins. States can continue to regulate student health coverage. In states that do not have an effective rate review program or where CMS enforces the ACA, CMS will monitor whether student health coverage complies with the market rating reforms.

Second, the final rule raises the default threshold for review of “unreasonable” premium increases from the current 10 percent to 15 percent, recognizing that significant rate increases have been common in recent years. These changes will apply to single risk pool rate filings submitted by issuers for the 2019 plan year. All issuers must continue to submit to CMS the Uniform Rate Review Template (URRT), Part I, for all single risk pool rate submissions. Issuers offering a QHP or single risk pool submission with a rate increase (of any size) must submit URRT Part III and an actuarial memorandum. Only issuers with rate increases above the 15 percent threshold will have to submit URRT Part II, a narrative justification. CMS expects the number of Part II submissions to drop by about 125 based on data from

2018. CMS also released 2019 unified rate review instructions and rate review justification instructions for transitional policies.

States can impose higher or lower filing thresholds than the federal default but will have to obtain CMS permission for higher thresholds. State requests for a higher threshold must be submitted in the form and manner specified by CMS. CMS released additional guidance outlining this process: states must submit proposals to CMS by August 1, 2018.

Current rules require issuers to submit all rate review filings for non-grandfathered coverage in the individual and small group markets—both QHPs and non-QHPs—at the same time. Beginning with the 2019 plan year, states can set a different filing date for 1) rate filings for issuers that offer QHPs (even if they also offer non-QHPs) and 2) rate filings from issuers that only offer non-QHPs. The deadlines for issuers to submit rate filing information is June 1, 2018 for states without an effective rate review program and July 25, 2018 for states with an effective rate review program. CMS expects to post proposed rate changes on August 1, 2018.

Finally, states with an effective rate review program must post proposed rate increases all together and final rate increases all together, and give CMS five days' notice before posting. Previous rules had required states to provide thirty days' notice to CMS before posting rate information. CMS had proposed eliminating the uniform posting requirement but did not adopt that change after commenters noted its importance to

protecting issuers from shadow pricing and ensuring a level playing field. Commenters were similarly concerned that posting rate increases on a rolling basis could promote market manipulation and contribute to destabilization.

Medical Loss Ratio

The final rule includes significant changes to current medical loss ratio (MLR) standards. The ACA requires issuers to report the amount that they spend on claims, quality improvement activities, and other non-claims costs (excluding federal and state taxes and licensing or regulatory fees)—the numerator in the MLR—and the ratio of these expenses to premium revenue (after adjustment for the effects of the risk adjustment, reinsurance, and risk corridor programs)—the denominator in the MLR. If the percentage of premium revenue (after adjustment for the effects of the premium stabilization programs and excluding taxes and regulatory fees) expended on claims and quality improvement expenses (the MLR) is less than 80 percent in the individual and small group market or 85 percent in the large group market, the issuer must rebate to its enrollees the difference.

Issuers paid out more than a billion dollars in rebates for 2011, the first year of the program, but by 2016 they paid out only $397 million. In the interim, they reduced their overhead by a billion dollars, benefiting consumers. By 2016, the average individual market MLR was almost 92 percent and the average small group

MLR was almost 86 percent; only 1.5 percent of enrollees received rebates.

Despite this, the final rule weakens MLR standards substantially. CMS does so at a time when most issuers would be happy to simply reduce their MLR to 80 percent rather than trying to make a significant profit in the individual market. These new standards will likely permit issuers to spend more on administrative costs and profits, presumably driving up premiums.

First, the final rule allows issuers to automatically claim 0.8 percent of earned premium as quality improvement expenses. This gets incorporated into the numerator of the MLR. Issuers can take this automatic claim of 0.8 percent in lieu of tracking and reporting actual expenditures on quality improvement. This automatically increases the MLR for most issuers. Issuers that claim to spend more than this amount of quality improvement expenses can continue to claim their actual costs, even where higher than 08 percent. This will be allowed beginning with the 2017 MLR reporting year, but issuers and affiliates must be consistent across all states and markets and use the same reporting option for three consecutive reporting years. CMS estimates that this change alone will decrease rebate payments from issuers to consumers by about $23 million.

Second, states can petition for a reduction in the MLR in the individual market. During the first three years of the MLR program, states were permitted to request adjustments to the MLR during the phase-in of the ACA's market reforms; seventeen

states did so. Since then, MLR adjustments have remained possible but have not been requested by states.

The final rule will allow states to more easily request a MLR rebate adjustment in the individual market. States must show that a lower MLR standard could help stabilize its market. CMS can approve an adjustment if there is a reasonable likelihood that changing the 80 percent standard will help stabilize the individual market. Any MLR adjustments must be made for the entire individual market within a state. CMS is unable to grant issuer-specific MLR adjustments.

In seeking an adjustment, states will no longer need to describe the state's MLR standard and formula for assessing compliance, market withdrawal requirements, consumer options for alternate coverage, or student health coverage, or provide detailed individual market enrollment or premium data for each issuer at the product level and each issuer's market share. States will only have to submit data on total enrollees, total earned premium, total agent and broker commissions, risk-based capital, and total incurred claims. With the exception of risk-based capital data, states will only be required to present data on issuers actively participating in the individual market. This data will be reported by on-exchange, off-exchange, grandfathered, transitional, and non-grandfathered-single risk pool coverage.

States will no longer have to report net underwriting profit and total after-tax profit for issuers doing business in the state. They will rather have to report individual market net underwriting gain.

States will have to submit information on market entrance and exit from the exchange or specific geographic areas. States no longer have to justify how their proposed adjustment was determined or how it would affect rebates but do have to explain how an MLR adjustment would help stabilize the individual market. CMS released additional guidance on the process for states to request an adjustment to the MLR.

Third, the final rule clarifies the criteria to be used for evaluating MLR adjustments. These changes focus not just on forestalling issuer exits from state markets, but also on increasing issuer participation and consumer choice. The Secretary may consider, for instance, whether an MLR adjustment will improve access to agents and brokers and the likelihood that an MLR adjustment will increase competition. State requests for MLR adjustments will be treated as public documents, and the public will be provided with instructions for accessing the request and associated documentation online. There will also be opportunities for public comment on state MLR adjustment requests. CMS will determine the effective date for each adjustment in consultation with each state.

Consistent with estimates in the proposed rule, CMS assumes that 22 states will request MLR adjustments during the first year, resulting in reductions of MLR rebates to consumers of between $52 million and $64 million annually, assuming that states request reductions to 75 or 70 percent. This would be a reduction of 74 percent to 91 percent of individual market rebates from those states.

In the proposed rule, CMS had considered allowing issuers to exclude federal and state employment taxes (Social Security, railroad retirement, unemployment, etc.) from premium in calculating their MLR. These taxes had earlier been considered to be employment costs rather than the kind of taxes that the ACA intended to exclude from premium in rebate calculations. Instead of finalizing this requirement, CMS will collect data on this issue to better understand the impact on consumers and issuers. CMS intends to propose changes to the MLR Annual Reporting Form to include a separate line for taxes for each issuer.

CMS acknowledges that the MLR standard in isolation is generally not contributing to individual market instability. It is difficult to see how allowing issuers to reduce their MLRs to 70 or 75 percent will cure the ills of the individual market. This is true even as many issuers have seen improved individual market experience for 2017. Market stabilization would be better achieved by funding the cost-sharing reduction payments, settling the risk corridor cases, enforcing the individual mandate, and supporting outreach and enrollment efforts. Instead, the MLR changes risk eroding the value of coverage to consumers.

Special Enrollment Periods

Special Enrollment For Dependents

The final rule aligns special enrollment periods (SEPs) by clarifying that a new dependent can be added to a current

enrollee's QHP or enrolled in a separate QHP. The final rule also aligns the coverage effective dates for individuals who qualify for an SEP through birth, adoption, placement for adoption, or placement in foster care.

If a *current QHP enrollee* qualifies for certain SEPs, the enrollee and dependents can change to another QHP within the same level of coverage (or one metal level higher or lower if no such QHP is available). If a *dependent* of an exchange enrollee (i.e., a dependent who is not currently enrolled in a QHP) qualifies for a SEP, the enrollee can add the dependent to his or her QHP. If the QHP's business rules do not allow the dependent to enroll, both the enrollee and dependent can change to another QHP within the same level of coverage (or one metal level higher or lower if no such QHP is available). Or the enrollee can enroll the dependent in a separate QHP at any metal level. Third, if both the enrollee and the dependent qualify for certain SEPs, both can switch to a new QHP at the same metal level.

Most commenters supported the proposal to align these plan options. However, many state-based exchanges (SBEs) and states requested flexibility because they are in the midst of implementing other SEP restrictions. CMS will allow states to take additional time to comply with the changes. Other commenters noted that the plan option restrictions contradict the intent of SEPs and violate the ACA's guaranteed issue provision. CMS asserted that the SEP plan option restrictions are a reasonable interpretation of guaranteed issue and SEP statutes. Restrictions on SEP plan choice will not apply if an

enrollee qualifies for an SEP because of a material plan or benefit display error.

For individuals who qualify for an SEP through birth, adoption, placement for adoption, or placement in foster care, coverage is retroactive to the date of the qualifying event. The final rule adds the child support or other court order SEP to this list. This aligns the coverage effective dates for all SEPs based on gaining or becoming a dependent (with the exception of marriage).

Consumers will no longer be able to request that dependent coverage begin on the first of the month after the date of a qualifying event. This means that a consumer will only have one option for retroactive coverage, back to the date of the qualifying event. Exchanges can, however, allow consumers to select a prospective coverage date, such as the first of the month following the date of the event or other standard coverage effective dates.

Loss Of Coverage SEP

Women who lose access to pregnancy-related CHIP coverage for unborn children now qualify for a 60-day SEP. The final rule defines the loss of this coverage as the loss of MEC. This provides a pathway to coverage for new mothers who may not otherwise be eligible to enroll in a QHP after the birth of their baby. The 60-day SEP can apply before or after the loss of CHIP coverage. Commenters overwhelmingly supported this proposal and it could help provide coverage to women in 17 states that offer this type of coverage.

Prior Coverage Requirement

In the market stabilization rule, CMS added a prior coverage requirement to the SEPs for a permanent move and marriage. To satisfy the prior coverage requirement, consumers must show that they had health coverage for one or more days during the previous 60 days, or they moved from outside the U.S. or from a U.S. territory. There are no bare counties for the 2018 plan year. However, if there are in the future, a consumer who does not have an exchange option would be unable to show proof of prior coverage and thus unable to qualify for an SEP.

To address this, the rule exempts consumers from the prior coverage requirement if they lived in an area where there were no on-exchange QHPs offered for one or more days during the 60 days prior to the qualifying event or most recent open enrollment period. This change applies market wide, meaning issuers offering coverage outside the exchange also have to exempt individuals without QHP options from the prior coverage requirements. Thus, a consumer can enroll in off- or on-exchange coverage during the SEP without meeting a prior coverage requirement if they lived in a service area without exchange QHP options.

Commenters largely supported this proposal. If there are bare counties in the future, CMS may publish a list of service areas with bare counties to help issuers apply this exemption. CMS anticipates that the exemption will very rarely be granted.

Termination Effective Dates

Issuers must follow certain effective dates when an enrollee asks to end their coverage. Under current rules, an issuer must terminate coverage on a date specified by the enrollee (if the enrollee provides at least fourteen days' advance notice) fourteen days after the enrollee provides notice, earlier than fourteen days if both parties agree, or the day before the enrollee is determined eligible for Medicaid, CHIP, or the Basic Health Program (BHP).

The proposed rule would have ended all coverage on the day that the enrollee asked to be terminated or a future date selected by the enrollee. CMS also would have eliminated the separate termination rules regarding Medicaid, CHIP, and BHP eligibility. Some commenters cited a common consumer desire to end coverage at the end of the month. Others noted that same-day terminations are not feasible and urged CMS to use a more realistic timeframe such as next-day or five days with a default end-of-month date. Others pointed to an adverse impact on Medicaid, CHIP, and BHP enrollees who may not realize they need to terminate their coverage and could later be required to repay unpaid premiums.

CMS did not adopt these changes and instead made them optional for exchanges. Doing so recognizes that exchanges and state Medicaid and CHIP programs operate with varying degrees of coordination. The optional policy gives exchanges flexibility to implement this change at their discretion.

The SHOP Program

The final rule makes significant changes to the SHOP program. The ACA's SHOP exchanges grew out of federal bipartisan small group insurance reform legislation that antedated the ACA. The idea was that a marketplace would be created in which issuers would compete with each other for small group business; employers and employees could choose among a number of plans and issuers; premiums would be aggregated for employees into a single bill; and tax credits would be offered to encourage small employers to cover their employees.

The idea never really caught on. The Obama administration delayed the opening of the federal SHOP exchange website in 2014 and stated in the proposed 2018 payment rule that it was considering ending the SHOP exchange as an online enrollment tool. In May 2017, CMS announced that it would be taking this step. The 2019 payment rule essentially completes this process and states repeatedly that the SHOPs will operate in a "leaner fashion."

Although the changes in the final rule technically take effect 60 days after publication, CMS has already taken a number of steps to wind down the SHOP. Many entities have already been operating under the rule pursuant to guidance from October 2017. In that guidance, CMS allowed state and federal SHOP exchanges, issuers, agents and brokers, and employers to begin operating in accordance with the proposed 2019 payment rule

beginning with the first date on which employers can begin a group enrollment with a plan year that would take effect in 2018.

The 2018 payment rule eliminated a requirement that issuers with more than 20 percent of the small group market in a state had to participate in the SHOP exchange. Because of this change, CMS expects a substantial decrease in SHOP issuer participation along with fewer employer and employee enrollments. This has led CMS to conclude that it is no longer cost-effective for the federal government to maintain a SHOP website and payment platform, generate enrollment and payment transaction files, and perform enrollment reconciliation.

Under the final rule, therefore, SHOPs are no longer required to provide employee eligibility, premium aggregation, or online enrollment functionality. CMS concluded that the ACA does not require SHOPs to fulfill these functions. The federally facilitated SHOP will cease doing so, although state-based SHOPs have the flexibility to continue to operating as they choose in accordance with federal law. Current SHOP enrollees are not affected by the changes, which will take effect for plan years beginning on or after January 1, 2018; current regulations will remain in place for the beginning of the 2018 plan year to accommodate plans that started before the effective date of the rule. SHOPs will, under the new rules, continue to certify QHPs for sale through the SHOP, operate a website that displays and provides QHP information, provide a premium calculator that generates

estimated QHP prices, and offer a call center to answer questions about the SHOP.

Small employers will still get an eligibility determination from the SHOP exchange to qualify them for small employer tax credits. An employer can first purchase coverage and then subsequently obtain an eligibility determination, identifying its coverage as SHOP coverage. SHOPs will provide the IRS with information on employers deemed eligible only if the IRS requests it. If a small employer has received an eligibility determination and enrolled in a SHOP-certified QHP, choosing to have its enrollment identified as a SHOP enrollment, the issuer will have to comply with SHOP rules. Issuers are responsible for knowing which of their enrolled employers are SHOP enrollees. The SHOP is responsible for handling appeals as they relate to an employer's eligibility.

Small employers will, however, actually enroll in coverage through a SHOP-registered agent or broker or directly with an issuer. SHOP employers can offer their employees a choice of QHPs and stand-alone dental plans across metal levels, even across issuers. Employees can use the SHOP's plan comparison tool to compare the plans available. But the employer will have to obtain enrollment material from each issuer whose coverage it wants to offer to its employees; it will have to send employee enrollments to each issuer or send them through a SHOP-registered agent or broker. Employers will have to collect premiums from their employees and sent them to the appropriate issuer. The SHOP will not provide premium

aggregation services (although it could enter into an agreement with an employer to collect from a person enrolled in continuation coverage through the SHOP). SHOP issuers will no longer required to offer average premiums.

The SHOP exchange will not be required to determine the eligibility of employees for SHOP coverage, and the FF SHOP will not perform this function. SHOPs will not have to reconcile enrollments or notify employers if their employees dropped SHOP coverage. SHOP exchanges will no longer give employees notice when their employers withdraw from SHOP coverage. The SHOP exchange will not have to keep rosters of employees, and employers will need to notify the SHOP if their business status has changed.

SHOP rules will continue to apply to SHOP exchange issuers. Minimum participation rules will apply at the SHOP level, although SHOPs will not be involved in calculating participation rates. Participating issuers will not be able to deny coverage on the basis of the employer not enrolling a sufficient percentage of its employees with the specific issuer if the employer has met the applicable minimum participation rate across all of its employees. The SHOP will not, however, be required to collect information on participation rates. SHOP issuers must continue to offer an annual open enrollment period from November 15 to December 15 each year during which employers do not need to meet minimum participation requirements.

The SHOP will offer a premium calculator allowing employers and employees to compare the premiums of participating plans. The calculator will not, however, reflect the contributions of individual employers.

Current SHOP special enrollment periods will continue to apply and SHOPs will continue to provide rolling enrollment throughout the year. Employers will be required to inform employees hired outside the initial or annual open enrollment periods of enrollment opportunities. But otherwise enrollment timelines, deadlines, and coverage effective dates will be set by employers and issuers in accordance with state and federal law. These include requirements around renewals, annual employer election periods, and annual employee open enrollment periods.

Issuers will also be expected to comply with state and federal requirements for terminating coverage, including required timelines, effective dates, and notices. Employers will still be able to appeal SHOP eligibility determinations, but SHOPs will no longer handle employee appeals. Employers will be required to inform their issuer of an adverse SHOP eligibility determination within five days of the end of any applicable appeal process.

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How Will State and Federal Actions Affect Individual Health Insurance Coverage for Middle-Income Americans?

Tuesday, April 10, 2018

By Timothy S. Jost (/about-us/experts/jost-timothy-stoltzfus)

The Affordable Care Act (ACA) has accomplished much that its drafters intended. There is considerable evidence of increased access to health care (/publications/issue-briefs/2017/may/effect-aca-health-care-access) and reduced medical debt (https://www.healthaffairs.org/do/10.1377/hblog20170724.061160/full/). But there is growing concern about affordability of health insurance coverage for middle-income working-age consumers — those whose household income exceeds 400 percent of the federal poverty level (about $100,000 for a family of four) — who do not have

coverage through their work. This is virtually the only group of Americans who, when insured, do not receive some form of direct federal financial assistance or tax subsidies for health care coverage.

Trump Administration Actions Have Accelerated Individual Market Destabilization

It was hoped that the push of the ACA's individual mandate and the pull of the premium tax credits would create large and stable markets for individual insurance. However, since its beginning several factors have weakened the individual market — and Trump administration policies and repeal threats from Congress have accelerated its destabilization.[1 (#/#1)]

Actions such as the defunding of cost-sharing reduction payments and the 2019 repeal of the individual-mandate penalty make it difficult for insurers to offer stable and affordable rates. Steep premium increases (http://hbex.coveredca.com/data-research/library/CoveredCA_High_Premium_Increases_3-8-18.pdf) are likely in much of the country, and while premium tax credits will expand to cover these increases for lower-income consumers, individuals not eligible for tax credits will have to cover the full increase themselves.

The administration's response has been to propose lower-cost alternatives for young and healthy middle-income consumers, for example by expanding short-term coverage (https://www.healthaffairs.org/do/10.1377/hblog20180220.69087/full/) to last nearly a full year. Short-term coverage, intended to cover brief gaps in insurance, is not subject to any of the ACA's requirements because it is not meant to serve as major medical coverage. If consumers are offered full-year "short-term" coverage, 4.3 million (https://www.urban.org/research/publication/updated-potential-impact-short-term-limited-duration-policies-insurance-coverage-premiums-and-federal-spending) (likely healthier-than-average) consumers may flee the comprehensive insurance market, increasing premiums for those who remain.

Another administration proposal (https://www.healthaffairs.org/do/10.1377/hblog20180104.347494/full) would allow small employer groups and individuals who are — or claim to be — "working owners" to enroll in association health plans.[2 (#/#2)] These plans would not be subject to many of the ACA's individual and small-group market consumer protections. They also would attract lower-cost consumers, leaving those with higher risks behind to face higher premiums.

State Actions

Some states are seeking their own solutions. In January, Idaho proposed (/publications/blog/2018/feb/idaho-state-based-plan) authorizing "state-based" plans that would ignore some ACA requirements. Insurers offering state-based plans, for example, could charge higher rates to individuals with preexisting conditions and exclude some ACA-required benefits. The U.S. Department of Health and Human Services (HHS) informed Idaho (https://www.healthaffairs.org/do/10.1377/hblog20180309.633233/full/) that if it failed to enforce the ACA, HHS would have to do so. Idaho is reportedly still trying to find a way around the ACA, but it is unlikely that any insurer will offer ACA noncompliant coverage in the face of threatened HHS enforcement.

In contrast to Idaho's frontal assault, Iowa has opted to crawl through an ACA loophole. The ACA only regulates "issuers," that is health insurers licensed and regulated under state insurance law. Entities that offer coverage but are not insurers are not subject to the ACA's insurance reforms. Recently adopted Iowa legislation (https://www.desmoinesregister.com/story/news/politics/2018/03/27/obamacare-aca-mandates-iowa-legislature-governor-kim-reynolds/462087002/) would allow the Iowa Farm Bureau to offer health coverage free from all state insurance regulation — including solvency and consumer protections. The Farm Bureau plans would be administered by Wellmark Blue Cross plan, but Wellmark would not function as an

insurer and thus would not be subject to the ACA's insurance reforms (although it might be subject to the ACA's antidiscrimination provisions and perhaps some state regulation).[3 (#/#3)]

Each of these approaches will inevitably segment (http://healthyfuturega.org/ghf_resource/non-aca-compliant-plans-risk-market-segmentation/) the market. As they make cheaper insurance available to the young and healthy, they will make coverage more expensive for older and less healthy consumers. Consumers who are not eligible for premium tax credits must bear the full cost of these increased premiums, and many will not be able to afford real insurance coverage. The Urban Institute (https://www.urban.org/research/publication/updated-potential-impact-short-term-limited-duration-policies-insurance-coverage-premiums-and-federal-spending) projects that 2.6 million fewer people will have minimum essential coverage by 2019.

Strategies That Would Stabilize the Individual Market for All Consumers

There are, of course, steps states could take to stabilize the market for all. They could enact their own individual mandate, for example, as Maryland (http://www.baltimoresun.com/health/bs-hs-individual-mandate-20180216-story.html) and the District of Columbia (https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/Individual%20Mandate%20Recommendation%20Proposal%202-14-2018%20Clean.pdf) are considering. State reinsurance programs under ACA state innovation waivers, like those adopted by (http://www.shadac.org/news/state-1332-waiver-reinsurance-proposals-cms-sets-pass-through-funding-2018-minnesota-alaska-and) Alaska, Minnesota, and Oregon and being considered by Maryland (https://www.washingtonpost.com/local/maryland-governor-signs-bills-to-help-stabilize-health-care/2018/04/05/2e7e0738-38e2-11e8-af3c-2123715f78df_story.html?utm_term=.599bd220e515) and Wisconsin (https://walker.wi.gov/press-releases/governor-walker-%E2%80%9Cwe-want-provide-

health-care-stability-and-lower-premiums-wisconsin%E2%80%9D), could reduce premiums across the market. State efforts to regulate (/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-aca) short-term or association health plans could fend off the destruction of the ACA-compliant market. Massachusetts, New Jersey, and New York, for example apply extensive consumer protections, including guaranteed issue, to all new policies in the individual market and do not permit medical underwriting for short-term plans.

In the end, however, the federal government must confront a basic question of fairness. It subsidizes the purchase of insurance for the vast majority of Americans — the employed, the poor, the elderly, and low-income individuals in ACA marketplaces — but not for middle-income Americans who must purchase insurance on their own. There are a number of options the government could consider to reduce the cost of insurance for this remaining group. For example, reinsurance for the entire individual market significantly reduced premiums (https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf) for all during the first three years of the ACA and could be reinstated. Insurers whose highest claims are shared with the federal government would be able to cover consumers of all income levels for less, and the individual market would stabilize. RAND has found (/publications/fund-reports/2017/oct/expand-insurance-enrollment-individual-market) that extending the ACA's reinsurance program could result in both lower premiums and deficit savings. Reinsurance does not have to be politically controversial: all of the major Republican ACA repeal proposals of 2017 included it.

For eight years, fierce political conflict has prevented needed improvements in the ACA. If the United States is to avoid the specter of a growing number of uninsured — and unhappy — middle-class consumers, Congress will likely need to act soon to address the fact that many middle-income purchasers of individual insurance in the U.S. face unaffordable insurance prices without the financial assistance that so many of their countrymen receive.

Notes

[1] Early factors weakening the market include Congress' defunding of a premium stabilization program in 2015 and the Obama administration's decision to let consumers retain insurance that did not comply with ACA requirements beyond 2013.

[2] Anyone can attest to be a working owner and association health plans have no obligation to confirm their claims.

[3] Tennessee (https://www.healthaffairs.org/do/10.1377/hblog20170404.059494/full/) has operated a similar Farm Bureau program for some time although, while the individual mandate remained in place, consumers who chose coverage that was not compliant with the ACA had to pay the penalty if they did not otherwise qualify for an exemption.

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Unpacking The Final 2019 Payment Notice (Part 1)

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On April 9, 2018, the Centers for Medicare and Medicaid Services (CMS) finalized the Benefit and Payment Parameters rule for 2019. CMS also released the final 2019 letter to issuers in the federally facilitated exchanges and extended the previous policy for "grandmothered" or "transitional" policies for another year. Accompanying the rule and letter, CMS released a press release, fact sheet, and additional documents, including:

- Guidance on hardship exemptions from the individual mandate penalty for those experiencing limited coverage options or other circumstances;
- A sample methodology for comparing essential health benefits benchmark plans;
- A list of key dates in 2018 for the 2019 plan year;

- Unified rate review instructions for single risk pool plans and rate review justification reporting requirements for transitional plans;
- Guidance on state-specific rate review thresholds for 2019;
- Guidance on exemptions from risk adjustment validation requirements for issuers in liquidation; and
- Two guidance documents on the medical loss ratio, one on reporting and rebate requirements and the other for states on requesting an adjustment to the medical loss ratio.

Overview

The rule finalizes a proposed rule issued in October 2017 (discussed here and here) and November's draft issuer letter. The "payment notice," as the rule is typically called, is an annual CMS omnibus rule that includes all the major changes that CMS intends to implement for the next marketplace plan year, for the premium stabilization programs, and for the health insurance market reforms generally. Most of the provisions apply for 2019, but a few apply in 2018 and others, such as changes to essential health benefits benchmark plans, will begin with the 2020 plan year. The rule itself goes into effect 60 days after publication.

This is the first payment rule to be fully proposed and finalized by the Trump administration. The last payment notice—for 2018—was finalized in mid-December 2016, with an effective date of January 17, 2017. That rule had been finalized much more quickly than in previous years (with finalization typically in late February or early March). CMS had noted that an

accelerated timetable was needed to allow issuers to prepare their plans for 2018. However, the Obama administration likely also wanted to lay down the ground rules for the 2018 plan year before it left office in January 2017.

(Although the Trump administration has not issued a payment rule before, CMS has made a number of regulatory changes to marketplace and market reform standards and oversight. For instance, CMS quickly issued and finalized a market stabilization rule in April 2017 that included a number of changes that might otherwise have been included in a payment rule, such as reducing the 2018 open enrollment period from 90 days to 45 days.)

In the preamble, CMS notes that some commenters took issue with the shortened comment period for the proposed rule for 2019, which ended less than 30 days after official publication. CMS notes that this timeline was adopted to accommodate issuer filing deadlines for 2019 and that a longer comment period would have delayed publication of the final rule.

Despite the accelerated comment period, the 2019 payment rule is being finalized much later than in previous years. This reduces the window of time for insurers to develop or adjust their products in response to changes under the final rule. It also impacts the amount of time that state insurance regulators have to review and approve these new plans before they are certified by CMS in most states. This delay notwithstanding, CMS largely did not alter its final timeline for QHP certification for 2019 and

issuers must still submit their 2019 qualified health plans (QHPs) to CMS by June 20, 2018 for approval.

Throughout the rule, CMS notes its goals of enhancing the role of states, providing states with additional flexibility, reducing unnecessary regulatory burden, empowering consumers, and improving affordability. CMS cites the first executive order signed by President Trump in January 2017 that directed federal agencies to waive, defer, grant exemptions from, or delay ACA requirements that impose burdens on states, individuals, families, providers, and insurers, among others.

The 523-page rule is long and complex and addresses the following topics:

- Changes in plan benefits and qualified health plan provisions, such as allowing states to select a new essential health benefits benchmark plan, eliminating the standardized plan options from the federal marketplace, and deferring to states on essential community provider and network adequacy requirements;
- Eligibility and enrollment changes, such as income verification changes, changes to navigator requirements, and new standards for direct enrollment;
- The 2019 payment parameters, such as the federal exchange user fee and annual limits on cost-sharing;
- Changes to medical loss ratio rules and rate review standards;
- Changes to the risk adjustment program; and

- Changes to the SHOP program.

This post addresses changes in plan benefits, eligibility, and enrollment changes. A second post will consider the general market reforms, rate review, the medical loss ratio, and the SHOP exchanges. A third post will address the rule's risk adjustment provisions. A third post will consider the rule's changes to the ACA's risk adjustment program.

Qualified Health Plan Provisions

In what is arguably the rule's most significant change, CMS finalized a proposal to give states significantly more flexibility to define their essential health benefits (EHB) benchmark plan on an annual basis. CMS also deferred additional responsibility for regulatory review and oversight to state regulators and eliminated standardized plan options and meaningful difference standards for 2019.

Essential Health Benefits

Under Section 1302 of the ACA, health insurers in the individual and small group markets must cover 10 categories of EHB. The EHB must be covered to the extent that they would be covered under a typical employer plan. In the proposed rule, CMS had proposed to give states additional flexibility to define their EHB benchmark plan and to allow states to do so on an annual basis.

CMS finalized its proposal with a number of adjustments. First, CMS delayed the effective date of this policy change until the

2020 plan year. This means that each state's 2017 EHB-benchmark plan will remain in use for the 2019 plan year. Second, CMS will apply a "generosity test" to all potential EHB-benchmark plan options. Under the proposed rule, this test—which is designed to prohibit a new EHB-benchmark plan from being more generous than the most generous comparison plan in a state—applied only to the selection of an entirely new EHB-benchmark plan. In the final rule, CMS applied this generosity test to all three potential EHB-benchmark plan options (described below).

Third, CMS changed its definition of "typical employer plan" for purposes of this comparison among EHB-benchmark plan options. Finally, the final rule requires states to give notice of an opportunity for public comment on a state website and codifies a number of preexisting requirements for EHB coverage.

Beginning with 2020 plan year, the rule gives states additional flexibility to define their EHB benchmark plan and allows them to do so on an annual basis. States can maintain their current 2017 EHB-benchmark plan without taking any action. CMS notes that this was not an option in prior years because the federal default benchmark plan option was determined by enrollment and thus could vary between benchmark plan selection years.

Under the final rule, states have three options to select an EHB-benchmark plan: states can select another state's entire 2017 EHB-benchmark plan, replace one or more of its EHB categories using another state's 2017 EHB-benchmark plan, or select an

entirely new EHB-benchmark plan. States can, however, only select a benchmark plan that is 1) at least equal in scope to a typical employer plan (a minimum EHB standard); but 2) no more generous than the most generous comparison plan (a maximum EHB standard). Noting that states are the primary enforcers of EHB policy, CMS will defer to a selecting state's implementation of any benefits and limits (such as converting dollar limits on EHB to non-dollar limits). CMS will defer to the selecting state even when their interpretation differs from that of the originating state.

As in the proposed rule, CMS acknowledges that the effect of this policy change will vary based on how each state chooses to implement it. A state's EHB-benchmark decision could affect changes in benefits, premiums, out-of-pocket costs, and the amount of exchange subsidies for consumers (because premium tax credits are only available for the portion of premium attributed to EHB and cost-sharing reductions apply only to EHB). CMS specifically notes that the policy will impact consumers with specific health needs and acknowledges that consumers with less comprehensive plans might no longer have coverage for certain services.

Generosity Test

As noted above, states cannot select an EHB benchmark plan that is more generous than the most generous comparison plan. These comparison plans are the state's 2017 EHB-benchmark plan and any of the state's three (four in some states) largest

small group health plans by enrollment. The comparison plans were identified during the 2017 EHB-benchmark plan selection process and should be considered after being supplemented, if necessary. As noted above, this is a shift from the proposed rule where the generosity test would have only applied to the third benchmark plan option (rather than all three as it applies now under the final rule). CMS adopted this policy to prevent states from selecting a benchmark plan that would make coverage unaffordable and increase federal costs.

Typical Employer Plan

States must select an EHB benchmark plan that is equal in scope to a typical employer plan (or greater in scope only if supplementation is required). CMS also changed its definition of "typical employer plan" in the final rule. In the proposed rule, CMS defined a typical employer plan as an employer plan or a self-insured group health plan sold in one or more states with enrollment of at least 5,000 enrollees. Commenters took issue with this definition, noting that it would be difficult to obtain plan information about self-insured plans, that this definition could allow outlier plans to be selected, and that these plans should at least be required to provide minimum value.

In response to these concerns, the definition in the final rule includes two sets of typical employer plans for a state to choose from when establishing the minimum scope of EHB. First, a typical employer plan can be one of the state's 10 base-benchmark plan options from the 2017 plan year. This allows a

state to continue to use its previous benchmark options as a reference point for a typical employer plan. Second, a typical employer plan can be one of the five largest group health insurance products by enrollment in the state so long as 1) the product has at least 10 percent of the total enrollment among those products; 2) the plan provides minimum value as defined under the ACA; 3) the benefits are not excepted benefits; and 4) the benefits are from a plan year beginning after December 31, 2013.

These provisions offer additional consumer protections relative to the proposed rule. CMS adopted the 10 percent requirement to ensure that a state cannot select an outlier product and incorporated the federal definitions of “product” and “plan.” The rule also ensures that a typical employer plan is a major medical plan (rather than an excepted benefit). Further, the definition does not include self-insured plans; CMS recognized that these plans are more likely to include atypical benefit designs and pose challenges for states in collecting information to make informed benchmark plan decisions.

If one of these typical employer plans does not provide coverage of all 10 EHB categories, it must be supplemented to cover all 10 categories. However, this appears to be the only instance when a state’s benchmark plan can exceed the scope of benefits in a typical employer plan—i.e., only if supplementation is necessary to ensure that all EHB categories are being covered.

Concerns About A “Race To The Bottom”

Although some commenters supported the new proposed options, many urged CMS not to adopt the changes. These commenters noted that states already had flexibility to establish EHB, that the new policy would create “an endless set of options” (compared to the previously established 10 benchmark plan options per state), and that the policy would create a “race to the bottom” in terms of benefits. Other commenters raised concerns that the policy will increase costs for consumers in the large group market and in self-insured group health plans; these plans do not have to cover EHB but can select from among any state’s definition of EHB to implement annual and lifetime dollar limits and the annual limit on cost-sharing for enrollees.

CMS was not persuaded that the new policy creates a race to the bottom and notes that the final rule continues the deference given to states under the initial definition of EHB while providing additional benefit choices to foster innovation in plan design. CMS notes that all 10 EHB categories must be covered and that each state will be required to confirm that its benchmark plan selection meets all EHB requirements. CMS also asserts that it has appropriately restricted the scope of state flexibility within a limited range by requiring benefits to be equal or greater than the scope of benefits provided under a typical employer plan (a minimum EHB standard) but no more generous than a set of comparison plans (a maximum EHB standard). CMS does not expect a substantial change in scope for the annual and lifetime limit protections or the annual limit on cost-sharing for large group and self-insured group health plans.

Further, CMS did not make changes to other EHB regulations, including standards on prescription drug coverage (45 CFR 156.122), nondiscrimination (45 CFR 156.125), and the provision of EHB (45 CFR 156.115). CMS notes that these requirements will additionally ensure that there is no “race to the bottom” in benchmark plan selection. (Because the prescription drug standards are not changing, all plans required to comply with EHB will continue to have to cover at least one drug in the opioid reversal agent class. Because naloxone is the only active ingredient in that class, all plans required to comply with EHB must cover at least one form of naloxone.)

The rule also codifies many of the ACA’s statutory EHB requirements. For instance, EHB-benchmark plans must provide an appropriate balance of coverage of the ten EHB categories, provide benefits for diverse segments of the population, and not have benefits unduly weighted towards any of the categories. CMS also opted to incorporate an existing requirement that a state’s EHB-benchmark plan cannot include discriminatory benefit designs that contravene the standards in 45 CFR 156.125.

Benefit Mandates

For all three new benchmark plan options, CMS will continue its policy on additional state benefit mandates. Under this policy, a state does not have to defray the cost of a benefit mandated prior to or on December 31, 2011 but must defray the costs of benefits mandated after that date. Under the final rule, if a state

selects another state's benchmark plan (or category) that includes benefits mandated by an originating state that are EHB, those benefits will be incorporated into the selecting state's EHB-benchmark plan. In this case, the selecting state will *not* have to defray the costs related to the other state's mandated benefits (so long as the selecting state does not have its own mandate with the same benefits that was adopted after December 31, 2011).

That said, the final rule requires states to comply with the generosity test noted above so states are limited in their overall ability to select a new EHB-benchmark plan that incorporates large group-only mandates or benefit mandates adopted in 2012 or later. States are still required to defray the cost of any benefits included in that state's EHB-benchmark plan that are mandated after December 31, 2011.

EHB Benefit Substitution

Beginning in plan year 2020, the final rule allows EHB-compliant plans to substitute benefits both within and between EHB categories, although states must explicitly opt in to allowing cross-category substitution. Under the final rule, insurers can substitute benefits (other than prescription drug benefits) within the same EHB category and between EHB categories so long as the substituted benefit is actuarially equivalent to the benefit being replaced. Issuers would have to submit evidence of actuarial equivalence to state insurance regulators, and plans must still meet other EHB requirements (such as having an

appropriate balance among the EHB categories, covering preventive services without cost-sharing, and providing benefits for diverse segments of the population).

States would be responsible for enforcing these standards and would retain flexibility to prohibit benefit substitution or adopt a stricter standard. A state that wishes to allow benefit substitution *between* categories must notify CMS of this decision. Thus, a state must expressly opt in, and notify CMS of this decision, before allowing benefit substitution between categories. CMS delayed this requirement until plan year 2020 to give states more time to adopt legislative requirements allowing or prohibiting this type of substitution. CMS does not identify a formal process for communicating this decision but notes that a state's notification will remain in effect unless and until the state notifies CMS otherwise. CMS intends to post a list of states that will allow substitution between categories and estimates that only five states will want to allow benefit substitution between categories.

Cross-category benefit substitution was rejected by the Obama administration, which allowed plans to substitute benefits (other than prescription drug benefits) *within* categories but not *between* different statutorily required benefit categories. In the preamble, CMS notes that the majority of commenters expressed concerns about this proposal, citing the significant negative potential impact on the risk pool. Commenters were particularly concerned that this kind of benefit substitution will enable issuers to design products that discourage the

enrollment of higher-risk individuals, undermine state risk adjustment programs, interfere with market stability, violate nondiscrimination requirements, and make it more challenging for consumers to compare plans. CMS received no examples of a situation in which cross-category substitution would be useful and acknowledges that the rule will increase the burden on consumers who must spend more time and effort comparing benefits between plans.

Public Notice And Comment And Data Collection

CMS recognizes that states will need to invest resources to analyze the three new benchmark plan options and that annual benchmark changes will result in administrative burdens on states and issuers. CMS continues to estimate that ten states would choose to make a change to their EHB-benchmark plans in any given year. CMS declined to provide a specific date by which a state's EHB-benchmark plan must be finalized and intends to announce each year's plan selection deadline in the annual payment rule. If a state fails to make a selection in time or if its selection fails to meet statutory or regulatory requirements, the state will default to the benchmark plan from the previous year.

The final rule requires states to provide "reasonable" notice and public comment any time they select an EHB-benchmark plan. CMS declined to adopt specific standards—such as a 30-day comment period—except to require states to post a notice on the opportunity to provide public comment and associated

information on a relevant state website. As in previous years, CMS declined to specify which entity in a state, such as a governor or department of insurance, must select the benchmark plan and noted that the agency may consider additional technical assistance in the future.

The final rule also requires states to comply with four new data collection requirements beginning in plan year 2020. States must provide 1) a document that identifies the state's benchmark plan selection and confirms that the state's benchmark plan definition complies with federal requirements; 2) an actuarial certification and report that affirms that the selected plan is no more generous than the most generous comparison plan and equal in scope to a typical employer plan; 3) a summary of the selected plan that reflects benefits and limitations, a schedule of benefits, and potentially a drug formulary; and 4) any other documentation that might be required, such as an EHB summary chart for the CMS website. CMS also released an example of an acceptable methodology for comparing benefits of a state's EHB-benchmark plan selection; this example reflects a number of changes from the draft methodology.

These materials will be due to CMS on July 2, 2018 for the 2020 plan year, meaning states must submit this documentation to CMS this summer to take advantage of the final rule for 2020. CMS intends to publicly post all information it receives from a state, with the exception of the drug list which will be posted in the category and class count format.

Federal EHB Package

CMS had solicited comments on whether to establish a "federal default definition" for EHB. CMS notes that most commenters opposed a federal default definition, citing concerns that a definition would impose arbitrary benefit limits and diminish state flexibility. Others were supportive so long as a federal default definition served as a minimum floor of benefits, rather than a maximum that states or issuers could not exceed. Although CMS suggested that such a definition would be a longer-term project, it had proposed the possibility of a nearer-term national benchmark plan standard for prescription drugs. This, too, was opposed by most commenters who thought that states and issuers are best positioned to evaluate and respond to prescription drug needs.

CMS did not take further action on a federal default definition or national prescription drug benchmark plan standard but hinted that this could change in the future. In the preamble, CMS notes that states that make changes to their EHB-benchmark plan under the final rule would not be required to make additional changes to comply with a future federal default standard within three years of making a change. CMS offered this flexibility to avoid market instability and inefficiencies for states that want to take advantage of the flexibility under the final rule.

No Report On Updated EHBs

Some commenters noted that the rule's policy appears to be inconsistent with the requirement that the Secretary update EHB

based on coverage gaps or evidentiary changes in a report to Congress that has not yet been completed. CMS will not be completing the report required under Section 1302(b)(4)(G) for making changes to the EHB because the agency does not believe that a report will "provide conclusive results." CMS notes that the ACA plan benefit structures have not been stable enough for conclusive analysis because EHB and QHP requirements have varied from year-to-year (through, for instance, new guidance to implement federal mental health parity laws and preventive services requirements). CMS intends to issue this report "once the market has stabilized."

HDHPs And HSAs

The final rule did not adopt any specific changes, but CMS had sought comment on how to encourage value-based insurance design within the individual and small group markets and on ways to support issuers in using cost-sharing to incentivize more cost-effective enrollee behavior and better outcomes. Comments were mixed regarding the use of high-deductible health plans (HDHPs) that can be paired with a health savings account (HSA). The preamble notes that the proportion of available HSA-eligible HDHPs has been stable in the FFEs but that the percentage of enrollees in these plans has decreased slightly over the last 3 years due to technical barriers for issuers.

Qualified Health Plan Certification Standards

The final rule will transfer more regulatory review and oversight responsibility to state insurance regulators and defer to state standards. The final rule extends the QHP certification approach that it adopted in the market stabilization rule for network adequacy and essential community providers (ECPs) to the 2019 plan year and beyond.

CMS will defer to state review of network adequacy in states with the authority and capacity to enforce standards that are at least equal to the "reasonable access standard" in federal regulations. In states that do not have the authority or capacity to undertake network adequacy reviews, CMS will rely on an issuer's accreditation or the submission of an access plan. The access plan would need to demonstrate that an issuer has standards and procedures to maintain an adequate network consistent with the National Association of Insurance Commissioner's model law on network adequacy. With respect to ECPs, CMS will continue to allow issuers to use the ECP write-in process to identify ECPs that are not on the CMS list of available ECPs and to maintain the 20 percent ECP standard.

The final rule eliminates similar requirements for state-based exchanges that use HealthCare.gov (SBE-FPs) to enforce federally facilitated exchange (FFE) standards for network adequacy and ECPs. Instead, SBE-FPs can determine how to implement network adequacy and ECP standards for the 2019 plan year and beyond. CMS believes this deference will empower SBE-FPs to promote exchange competition and streamline the QHP certification process.

CMS did not, however, further expand state QHP oversight beginning in the 2019 plan year as had been proposed. CMS had proposed to defer to states in four additional review areas—accreditation requirements, compliance reviews, minimum geographic area, and quality improvement strategy reporting—and sought comment on whether states are already performing work in these areas. CMS did not finalize this proposal after receiving comments, including comments from some states, citing insufficient state resources and staff and the possibility of increased costs. CMS notes that the intention of the proposal was to eliminate duplicative federal and state reviews rather than to compel states to take on reviews they are not already performing.

CMS also summarized its approach to other QHP certification standards. CMS will continue to rely on state reviews of QHP certification standards for states with FFEs beginning in the 2018 plan year as outlined in guidance from April 2017. For FFE states that do not perform plan management functions, CMS will review QHP data but will rely on state review for licensure, good standing, and network adequacy. For FFE states that perform plan management functions, CMS will rely on state review for QHP certification standards, such as prescription drug formulary outliers and nondiscrimination in cost-sharing.

CMS similarly did not make changes to July 2017 guidance that outlines its approach to rely on states with an effective rate review program to identify rate outliers for purposes of QHP certification.

Meaningful Difference Standards

The final rule eliminates the requirement that QHPs offered through the FFEs or SBE-FPs be "meaningfully different" from other QHPs offered by the same insurer within a service area and metal level tier. Under previous rules, QHPs were considered meaningfully different if a reasonable consumer would be able to identify one or more material differences among five key characteristics between the plan and other plans to be offered by the same issuer. This standard was adopted to facilitate consumer comparison and choice.

The final rule eliminates this requirement, noting that there are fewer QHPs and issuers to choose from and asserting that eliminating this requirement will encourage plan design innovation and increase consumer choice. CMS does not believe that removing the meaningful difference requirement will substantially increase the number of materially similar plans offered by the same issuer. SBE-FPs will no longer need to establish and oversee meaningful difference standards.

Standardized Plan Options

The FFE began offering standardized plan options beginning in the 2017 plan year. These plans have standardized cost-sharing and benefit design elements, such as requiring drug tiers to have copays rather than coinsurance. The standardized options were based on the most popular QHPs in the 2015 individual market FFE and have been updated over time to incorporate new

enrollment data and SBE-FP data. Although insurers were not required to offer standardized plans, CMS encouraged them to do so and provided differential display of these plans on HealthCare.gov.

The final rule reverses course by abandoning the standardized plan options altogether. Citing concerns about stymied innovation and the need to mitigate the risk that consumers with special coverage needs will choose a standardized plan that does not meet their needs, CMS will no longer incentivize standardized plans for the 2019 plan year or provide differential display on HealthCare.gov. Agents, brokers, and issuers that perform direct enrollment are similarly not required to provide differential display of standardized plan options. CMS will no longer collect or release data on standardized plan options in public use files and asserts that doing so could cause competitive harm to issuers. However, CMS will release historical enrollment data for all QHPs including standardized options.

Exchange Provisions

Navigators

The final rule scales back requirements under the navigator program. First, the final rule eliminates the requirement that each exchange have at least two navigator entities and that one of these entities must be a community and consumer-focused nonprofit group. CMS asserts that requiring at least one

navigator to be a community and consumer-focused nonprofit group unnecessarily limits an exchange's ability to award grants to the strongest applicants. Thus, the rule allows an exchange to award a grant to a single navigator from any of the categories of navigator grantees, such as a trade association or chamber of commerce. CMS notes that exchanges are not limited to only one navigator but selecting a single navigator is now an option under the final rule.

The final rule also eliminates the requirement that navigators (and non-navigator entities like certified application counselors) maintain a physical presence in an exchange service area to provide in-person outreach and enrollment support. Individuals or entities cannot be disqualified from serving as a navigator or non-navigator assistance personnel solely because their principal place of business is outside the exchange service area. CMS acknowledges that entities with a physical presence and strong local community relationships "tend to deliver the most effective outreach and enrollment results" and the final rule may result in consumers having fewer navigator options and potentially no in-person enrollment assistance from a navigator or certified application counselor.

Direct Enrollment

The final rule adopts a few new requirements for entities participating in direct enrollment. These standards replace those laid out in the 2018 payment rule and are extended to QHP issuers, agents, and brokers doing direct enrollment. Under the

final rule, these entities will select their own third-party entities to conduct annual reviews and audits to demonstrate operational readiness. This is a shift from previous rules under which CMS was planning to create a process for evaluating and developing a list of approved third-party entities.

Under the final rule, agents, brokers, and issuers are required to engage an auditor of their choosing that complies with federal standards—such as privacy and security standards, data collection, and training—to conduct an annual operational readiness review. These entities must disclose any financial relationship between the third-party entity and the agent, broker, or issuer. The rule also deems third-party entities to be downstream or delegated entities of the agent, broker, or issuer, which makes them subject to CMS oversight. To the extent that an agent, broker, or insurer wants to engage multiple third-party entities for these audits, each entity must comply with all federal standards.

By letting issuers, agents, and brokers select their own auditor, CMS asserts it is reducing the burden on third-party entities, which will increase the number of qualified third-party entities and, in turn, enable higher participation in direct enrollment. However, most commenters were concerned that direct enrollment would occur without proper oversight and controls, leading to the risk of fraud or conflicts of interest. In response, CMS notes that it has adopted guidelines and process to oversee the activities of direct enrollment entities and will

continue to monitor the direct enrollment pathway for evidence of fraud or abuse.

Direct enrollment entities are also required to display all QHP data provided by the exchange to help promote informed choice and limit the potential for conflicts of interest. CMS recently published additional technical guidance outlining review standards, operational details, and other resources to assist third-party auditors with the enhanced direct enrollment pathway.

Exemptions

Even though the individual mandate penalty is eliminated beginning in the 2019 plan year, individuals may still need to seek a hardship exemption to, for instance, qualify for catastrophic coverage. For consumers who do not have access to employer-sponsored coverage, the exchanges generally assess whether affordable coverage is available using the annual premium for the lowest-cost bronze plan in each consumer's rating area.

Because there are a few counties without bronze plans available, the final rule allows exchanges to use the annual premium for the lowest-cost metal level plan (excluding catastrophic plans) at the county level. Thus, an individual can still qualify for a hardship exemption even if no bronze-level plan is available. This requirement will go into effect during the 2018 plan year,

allowing qualifying consumers to receive a hardship exemption under the rule for at least part of 2018.

Using methodology outlined in previous federal rules, the final rule adopts a required contribution percentage of 8.3 percent for 2019. If a consumer has to contribute more than 8.3 percent of their household income toward minimum essential coverage (MEC), they can qualify for catastrophic coverage and an exemption from the individual mandate so they will not have to pay the penalty for 2018. This is an increase of about 7.7 percent over the 2018 premium adjustment percentage. (The 2018 percentage of 8.05 percent had been down slightly compared to 2017 when it was 8.16 percent.) The rule's changes on hardship exemptions are in addition to more substantial guidance on exemptions released by CMS on the same day.

Minimum Essential Coverage

CMS had asked for comment on whether to categorically designate CHIP buy-in programs with coverage that is identical to the state's CHIP program as MEC. This proposal is not being adopted in the final rule because Congress statutorily designated CHIP look-alike plans as MEC when reauthorizing the CHIP program in January 2018.

Because the statute does not include all CHIP buy-in programs, states have the option to verify with CMS that their CHIP buy-in program meets the definition of a CHIP look-alike plan. States can submit documentation to CMS for review via the Health

Insurance Oversight System. If the state's CHIP buy-in program does not provide at least the same coverage as the Title XXI CHIP program, the state may work with HHS to modify the program or apply for MEC recognition under existing federal regulations. CMS will evaluate such programs based on whether the program complies with "substantially all" provisions of Title I of the ACA that apply to non-grandfathered individual coverage.

Although CMS sought comment on whether to create a less stringent "substantially resemble" standard of review for CHIP buy-in programs, the agency did not finalize this proposal. CMS notes only that it is important to provide clear standards of review for the MEC application process and to ensure that enrollees can obtain benefits similar to those offered in ACA-compliant plans. As such, CHIP buy-in programs that do not provide identical or greater benefits than the state's Title XXI CHIP program must meet the "substantially all" standard for MEC recognition.

Income Inconsistencies In APTC Verification

The final rule requires exchanges to generate new data matching inconsistencies for consumers who attest to a higher income than what is found in federal income data by more than a reasonable threshold. Currently, when a consumer attests that their income is *higher* than income data from sources such as the Internal Revenue Service (IRS) and Social Security Administration (SSA), exchanges must accept the consumer's

attestation without further verification. The primary concern has been with consumers attesting to income that is lower than their actual income, and thus claiming higher premium tax credits than they are entitled to. Exchanges generally cannot create data matching issues or inconsistencies that require the consumer to submit additional information because their attested income is higher than their federal income data.

Citing concerns about program integrity and the need to limit tax filers' liability to repay excess APTC, the final rule maintains this framework for some consumers but not others. In particular, the final rule changes this requirement for consumers who attest that their income is between 100 and 400 percent of the Federal Poverty Level (FPL) but whose federal income data is under 100 percent FPL.

Under the final rule, exchanges are required to create an income data matching issue if 1) a consumer attests to a projected annual income between 100 and 400 percent FPL; 2) the exchange has data that indicates that their income is below 100 percent FPL; 3) the exchange has not assessed or determined the consumer to be income-eligible for Medicaid or CHIP; and 4) the consumer's attested annual income exceeds the federal income data by a reasonable threshold (to be established by the exchange and approved by CMS). Under these circumstances, the exchange must request additional documentation to verify the consumer's attested income. Consumers who fail to provide documentation would have their APTC and CSR eligibility redetermined and likely discontinued.

The reasonable threshold established by the exchange can be a percentage or a fixed dollar amount but must be at least 10 percent. The final rule also applies the same reasonable threshold standard when a consumer's attested income is a certain amount *less than* income data from the IRS or SSA or when no electronic data sources are available. CMS intends to provide future guidance on appropriate thresholds for data matching issues and may do so in the context of future rulemaking on program integrity issues. This future rulemaking may address the failure to reconcile APTC, mid-year recalculations of APTC, and matching enrollment data with Medicare and Medicaid.

The final rule makes two changes from the proposed rule related to non-citizen applicants who are lawfully present and ineligible for Medicaid due go immigration status. The final rule exempts these applicants from the additional verification because they are able to qualify for APTC with a household income under 100 percent FPL and thus have no reason to inflate their household income.

CMS received comments from several SBEs expressing concerns over the cost and time to change their systems to accommodate this new process, and many requested flexibility to not conduct this verification. One SBE commented that there is no incentive for an applicant to inflate their income in states that expanded their Medicaid programs. CMS notes that each SBE will incur a cost of about $450,000 to make this change for a total of $5.4 million across all SBEs. CMS asserts that this is a

critical program integrity measure and that while primarily intended to safeguard APTCs in states that did not expand Medicaid, the verification could be helpful in Medicaid eligibility determinations.

Failure To File Taxes And Reconcile APTCs

To maintain eligibility for exchange subsidies, a consumer must file a tax return to reconcile their APTC. If a consumer fails to do so, the exchange will discontinue their APTC but must notify the consumer before doing so. In previous years, the FFE sent a general notification to each relevant household to inform consumers that APTC would be discontinued because of several reasons, which included failure to file and reconcile. The 2018 payment rule required the exchange to directly notify each tax filer that their APTC is at risk before discontinuing this benefit. This "direct notification" requirement was adopted in response to ongoing challenges with tax reconciliation (and possibly in light of other federal regulations and due process protections that prohibit exchanges from denying APTC unless the agency has provided direct notification to consumers).

The final rule eliminates the "direct notification" requirement. CMS does so while noting that nearly all commenters expressed concern that a non-specific notice is insufficient. CMS cited the difficulty of directly notifying tax filers about their noncompliance due to IRS privacy rules. In response to commenters arguing that tax filers have a property interest in the continued receipt of APTC, CMS states that enrollees have

adequate existing due process rights, that enrollees have the right to appeal the discontinuation of APTC, and that it believes that this requirement is necessary for program integrity.

Instead, the FFE sent “combined notices” to households; the goal of these combined notices is to include broad enough language that applies to all consumers, whether a tax filer had failed to reconcile their APTC or not. CMS also mailed warning notices known as “direct notices” in November 2017 to urge specific tax filers to file and reconcile to avoid losing APTC in 2018. CMS intends for the FFE to continue sending both a combined notice and a direct notice in advance of open enrollment where possible. CMS agrees with the need to gather data on the effectiveness of the notice process but opted not to delay this part of the rule in the interest of program integrity.

Eligibility Redeterminations

CMS did not propose regulatory changes to annual and ongoing eligibility redeterminations but did request comment on ways to encourage exchange enrollees to report life changes, such as income changes, during the benefit year that may impact their eligibility for coverage, APTC, or CSRs. Commenters noted the benefits of timely updates to household income or family size and recommended increasing exchange outreach efforts to remind consumers to report information about life changes and support navigators to engage with enrollees year-round.

CMS continues to consider shortening the time that the exchange is authorized to obtain updated tax return information. Currently, enrollees can authorize the exchange to obtain updated tax return information—which helps facilitate annual eligibility redeterminations and reenrollment—for 5 years. CMS sought comment on whether a shorter authorization period would help ensure that enrollees' applications were more accurate, updated on a more regular basis, and fully reflective of changes that may affect APTC and CSR eligibility. Many commenters opposed changing the length of time and noted that 5 years is the appropriate length of time for this type of authorization; others recommended extending the authorization past five years or retaining it indefinitely.

Verification Of Eligibility For Employer-Sponsored Insurance

Consumers who are eligible to enroll in employer-sponsored coverage are generally not eligible for APTC unless the plan's coverage is unaffordable (because it exceeds 9.5 percent of the employee's household income) or does not provide minimum value. Thus, when determining eligibility for APTC, exchanges must assess whether an applicant is enrolled in or eligible for qualifying employer-sponsored coverage. To do so, exchanges are supposed to obtain electronic employment data, such as federal employment data from CMS and SHOP data. If an exchange cannot access these types of data sources, CMS has allowed exchanges to collect sample data from employers

or—for 2016 and 2017—use a CMS-approved alternative process.

The final rule allows exchanges to continue to use a CMS-approved alternative process for verifying eligibility for employer-sponsored coverage through benefit year 2019. This is in part because the sampling process was quite expensive. Despite continuing the alternative process for another year, CMS encourages exchanges to compile databases and refine their approaches to sampling to meet verification requirements for employer-sponsored coverage.

User Fee For Federally Facilitated Exchange

The FFE will charge issuers a user fee of 3.5 percent of total monthly premiums for 2019. It will charge insurers in SBE-FPs a user fee of 3 percent of total monthly premiums for 2019, up from 2 percent in 2018. CMS notes that it expects a decrease in FFE user fee collections over time because of streamlined FFE operations, an increase in premiums, and lower enrollment.

Commenters noted that the FFE user fee rate should decrease over time, especially given the reduction in outreach and education activities by CMS. CMS responded only that “outreach and education efforts will be evaluated annually and funded at the appropriate level.” This is in contrast to the 2018 rule, which committed a percentage of user fees to these efforts. Because of the reduced functions of the SHOP exchange, user fees will

not be charged to issuers that offer QHPs through the SHOP after current SHOP services end.

Maximum Annual Limit On Cost-Sharing For 2019

The final rule includes a maximum annual out-of-pocket limit on cost-sharing for 2019 of $7,900 for self-only coverage and $15,800 for other than self-only coverage. This is a 7 percent increase over 2018, the highest increase since 2014. CMS also finalized a slight change to cost-sharing reduction plan variations. These amounts would be reduced by the cost-sharing reductions to $2,600 for self-only coverage and $5,200 for other than self-only coverage for individuals with incomes below 200 percent FPL, and to $6,300 and $12,600 for individuals and families with incomes between 200 and 250 percent FPL.

Actuarial Value Calculator

The actuarial value calculator is used by issuers and health plans for calculating the actuarial value of their plans and products. CMS did not make major changes in the calculator for 2019. States are permitted to submit state-specific datasets to HHS for approval as the standard population for purposes of calculating actuarial value for 2019.

State-Based Exchanges

CMS sought comment on how to make the SBE-FP option more attractive to the 34 states with an FFE, how to streamline current requirements, and how to leverage private sector and federal platform technologies to encourage SBE-FPs. Some commenters urged CMS to provide greater access to enrollment data and supported efforts to customize the federal platform to meet SBE-FP needs. Others encouraged the use of direct enrollment and enhanced direct enrollment technologies for use by SBE-FPs. Still others urged CMS to prioritize improvements to HealthCare.gov infrastructure before focusing on state-specific enhancements.

CMS remains unable to offer a “menu” of federal exchange services from which states can choose or a state-specific customization of the federal platform. This customization would enable CMS to explore branding options for the SBE-FPs, including state-specific landing pages on HealthCare.gov. CMS notes that HHS has provided the authority and flexibility for SBEs to use the direct enrollment pathway and encourages SBEs and SBE-FPs to explore this option.

The final rule eliminates the current option of allowing states to operate their own SHOP exchange using the federal platform. Nevada and Kentucky, which currently use the SBE-FP SHOP option, can choose to maintain their existing SBE-FPs for SHOP but would be limited to the remaining federal platform functions (which will largely no longer exist).

Quality Rating System

CMS observed that social risk factors play a major role in health outcomes and sought comment on the types of social risk factors that may be appropriate to include in QHP issuer quality reporting. Commenters largely supported the need to address socioeconomic factors that affect quality and identified social risk factors that include race and ethnicity, income, disability status, preferred language, sexual orientation, gender identity, and alcohol and tobacco use, among other factors. CMS did not make changes at this time but will take the comments under consideration.

Stand-Alone Dental Plans

Under previous rules, stand-alone dental plans (SADPs) were required to cover pediatric dental EHB at a low and high actuarial value level within an allowable de minimis variation. The final rule eliminates this requirement, allowing SADP issuers to offer pediatric dental EHB without selecting or calculating an actuarial value level of coverage.

CMS notes that the ACA does not specifically require SADP issuers to offer coverage at the high and low actuarial value levels and that these requirements have made it difficult to offer preventive care without cost-sharing. SADP issuers must continue to comply with the annual limit on cost-sharing and provide pediatric dental EHB but can otherwise offer SADPs at varying premiums and level of coverage. CMS opted to continue

to require actuarial certification of the actuarial value of SADP coverage of EHB.

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CMS Data Confirms Stable Marketplace Enrollment For 2018

Katie Keith

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On April 3, 2018, the Centers for Medicare and Medicaid Services (CMS) released a highly anticipated final report on the 2018 open enrollment period. The high-level finding is that about 11.8 million consumers in all 50 states and Washington, D.C. selected or were automatically reenrolled in marketplace plans during the 2018 open enrollment period.

The high-level figure of 11.8 million is somewhat old news. It is very consistent with data released by the National Academy for State Health Policy (NASHP) in February 2018, which similarly indicated that nearly 11.8 million consumers selected a marketplace plan for 2018. As noted in the NASHP analysis, this is only about 4 percent lower than the estimated 12.2 million consumers that selected a plan in 2017, meaning enrollment

remained largely stable despite a shortened open enrollment period and significant cuts to advertising and navigator funding.

The data is also highly consistent with previous enrollment periods in terms of the enrollment of young adults, the number of consumers who qualified for advance premium tax credits (APTCs), and even the gender breakdown of enrollees. Indeed, many of the percentage breakdowns are identical to 2017 enrollment data.

Breaking Down The Numbers

Of the 11.8 million total consumers, most—about 8.7 million consumers—enrolled through HealthCare.gov, with about 3 million consumers enrolled in state-based marketplaces. Enrollment through HealthCare.gov was down by about 5 percent relative to 2017, when 9.2 million consumers enrolled through the federal marketplace. Enrollment in state-based marketplaces remained steady from 2017 and is only slightly down from a peak of 3.1 million in 2016.

About 3.2 million enrollees were new consumers, and about 8.5 million were reenrolled in coverage. This means that 73 percent of enrollees were returning customers while 27 percent, more than one-quarter, were new consumers. Most of the returning customers actively reenrolled in coverage by assessing their options and shopping for a plan (rather than being automatically reenrolled). The number of all enrollees who actively reenrolled

in coverage—about 5.5 million enrollees or 47 percent—increased from 2017.

Consistent with previous years, consumers aged 18 to 34 accounted for 26 percent of all enrollees. (For 2017, 27 percent of HealthCare.gov consumers were aged 18 to 34, down slightly from 28 percent in 2016.) The vast majority of enrollees—about 9.8 million or 83 percent—received APTCs.

Of the 8.7 million individuals enrolled through HealthCare.gov, more than 7.7 million (88 percent) qualified for APTCs. APTCs covered 86 percent of consumers' gross monthly premium, leaving an average net premium of $89 per month. The average premium before APTC was $621 in 2018 versus $476 in 2017. Most enrollees—70 percent—had an income between 100 percent and 250 percent of the federal poverty level, making them eligible for both APTC and cost-sharing reductions.

A Movement From Sliver Plans To Gold And Bronze Plans

Perhaps unsurprisingly due to the effects of silver loading, there was a slight uptick in the selection of bronze and gold plans relative to silver plans in 2018. ("Silver loading" refers to the practice of insurers applying the full premium increase attributable to the loss of cost-sharing reduction payments to silver marketplace plans, rather than raising the premiums for all metal plans by a smaller amount.) The effects of silver loading meant that eligible consumers received more generous APTC

than previous years, resulting in the opportunity to purchase much lower premium bronze or gold plans.

Eligible consumers appear to have taken advantage of these more affordable premiums. Enrollment in bronze plans increased from 2.8 million (23 percent) in 2017 to nearly 3.4 million (29 percent) in 2018. Enrollment in gold plans nearly doubled—from almost 500,000 (4 percent) in 2017 to 833,000 (7 percent) in 2018. Enrollment in catastrophic and platinum plans remained largely the same, suggesting that most consumers moved from silver plans in 2017 to bronze or gold plans in 2018. Enrollment in silver plans declined from 8.7 million (71 percent) in 2017 to 7.3 million (63 percent) in 2018.

CMS also released public use files with state-, county-, and zip-code specific data on plan selection and demographic information, such as age, gender, race, and income, where available. As has been true in previous years, enrollment varies significantly by state.

Scaled-Back Federal Marketing And Outreach Efforts, But Important Contributions From Others

In a press release, CMS describes 2018 as the agency's "most cost-effective and successful open enrollment to date." HealthCare.gov used only 22.5 hours of regular maintenance time and consumer satisfaction through the federal call center

was high. CMS also states that the agency spent only $10 million on marketing and outreach—down from $100 million in previous years—which amounts to just over $1 per HealthCare.gov enrollee.

As has been noted previously, this appears to ignore the significant investment in outreach and education made by many foundations, nonprofits, community health centers, states, agents and brokers, insurers, and many others. In the absence of a robust federal outreach and education effort, these entities expended significant time, energy, and resources to help educate consumers about coverage options and the shortened open enrollment period in most states. Despite relative stability in enrollment in 2018, these investments likely cannot replace a fully funded federal marketplace outreach and advertising strategy.

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Association for Community Affiliated Plans

Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market

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Executive Summary

Wakely was retained by the Association for Community Affiliated Plans (ACAP) to conduct a qualitative and quantitative review of the effects of the recent short-term limited duration insurance (STLDI) proposed regulation on the ACA-compliant individual health insurance market.[1]

The Affordable Care Act (ACA) created an environment in which individuals could purchase coverage in the individual market (ACA-compliant individual market) without discrimination on the basis of health. Many of the additional provisions embedded in the ACA were designed to make the coverage more comprehensive or to enhance the stability of the ACA-compliant individual market. Recently, the Trump Administration has released a proposed regulation allowing individuals to enroll in STLDI plans for a longer time period than permitted by current regulation and also making it easier to renew coverage. Both of these proposed changes increase the availability and attractiveness of STLDI plans. The proposed regulation has the potential to increase market instability, market segmentation, and adverse selection in the ACA-compliant individual market because a substantial number of healthy members will likely migrate to STLDI plans.

This paper analyzed the proposed STLDI regulatory change and the potential effects it could have on the ACA-compliant individual market. We analyzed the impact using a variety of methodologies to develop a range of enrollment decreases and premiums increases within the ACA-compliant individual market. The scenarios were based on estimated impacts by the tri-agency departments[2], a comparison to ACA transitional enrollment[3], and 2016 ACA-compliant individual claims and membership data.

In the table below, Scenarios 1a, 1b, and 2 represent impacts in the first full year, 2019, of the proposed STLDI regulation. Scenarios 3a and 3b reflect total effects STLDI plans will have after an initial ramp up period (the "near term"), which we expect to occur after four to five years. In 2019, the proposed regulation to reduce limitations on STLDI plans is estimated to increase ACA-compliant individual market premiums by approximately 0.7% to 1.7% and decrease enrollment by approximately 2.7% to 6.4%, or between 396,000 to 826,000 people (Scenarios 1a, 1b, and 2). To compare, the Departments of Treasury, Labor, and Health and Human Services (known as the tri-agency departments), displayed in Scenarios 0a and 0b below, estimated the impact of the

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[1] If this paper is distributed to outside parties, the paper should be distributed in its entirety. Anyone receiving this paper should retain their own experts in interpreting its contents. The opinions expressed in this paper are those of the authors and do not necessarily reflect those of Wakely. This paper is intended to discuss the impact of STLDI plans on the ACA-compliant individual market; other uses may be inappropriate.

[2] The proposed regulation was submitted by the Departments of Treasury, Labor, and Health and Human Services.

[3] Transitional plans, also known as grandmothered plans, are non-ACA compliant plans that existed in 2013 and allowed to continue into 2014. See https://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

STLDI regulatory changes on the ACA-compliant individual market would decrease enrollment between 100,000 and 200,000 people, for on-Exchange only. Note that Wakely's estimates apply to the total on and off-Exchange market. After issuers have time to fully implement and market STLDI plans (i.e., near term) the impact is larger, with an estimated premium increase of 2.2% to 6.6% and enrollment decrease ranging from 8.2% to 15.0% (Scenarios 3a and 3b).

Note, that these estimates are based on a market in which there is no individual mandate penalty. The repeal of the mandate tax has further compounded the impact of the proposed STLDI regulation change as individuals are no longer required to pay this penalty when enrolled in a STLDI plan and because higher premiums in the ACA-compliant individual market will drive more individuals to drop coverage. Details regarding the enrollment and premium impacts due to the removal of this tax can be found in Table 2. Federal policy makers should consider the effects of this proposed regulation on consumers and market stability before finalizing, and state policy makers should consider options to address these potential issues if the proposed regulation is implemented.

Table 1 - Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market

Scenario	Scenario 0a	Scenario 0b	Scenario 1a	Scenario 1b	Scenario 2	Scenario 3a	Scenario 3b
Method	Proposed Rule Low	Proposed Rule High	Proposed Rule Adjusted Low	Proposed Rule Adjusted High	Transitional Enrollment	Individual ACA Claims Cost Data Low	Individual ACA Claims Cost Data High
Year of Impact	**2019**	**2019**	**2019**	**2019**	**2019**	**Near Term**	**Near Term**
Estimate Performed By?	Tri-Agency [4]	Tri-Agency [4]	Tri-Agency, Wakely Adjusted	Tri-Agency, Wakely Adjusted	Wakely	Wakely	Wakely
Off-Exchange Population Included?[1]	No	No	Yes	Yes	Yes	Yes	Yes
Increase in Premiums[2]	0.3%	0.6%	0.7%	1.4%	1.7%	2.2%	6.6%
Decrease in Enrollment	-1.0%	-2.1%	-2.7%	-5.4%	-6.4%	-8.2%	-15.0%
ACA-Compliant Individual Enrollment, Prior to Impact of STLDI Plans[3]	9,730,000	9,730,000	14,730,000	14,730,000	13,000,000	13,000,000	13,000,000
Reduction of Members	100,000	200,000	396,000	791,000	826,000	1,070,000	1,948,000
ACA-Compliant Individual Enrollment, After Impact of STLDI Plans[3]	9,630,000	9,530,000	14,334,000	13,939,000	12,174,000	11,930,000	11,052,000

[1] The population includes only on-Exchange ACA-compliant individual membership within the proposed rule (scenarios 0a and 0b) analyses. Both on and off-Exchange membership are included within the additional scenarios. Because the proposed rule analyses do not account for effects of the off-Exchange market, there will be downstream impacts to market premiums.
. All scenarios reflect the repeal of the individual mandate.
[2] Scenarios 1a - 3a assume that members who leave the ACA-compliant individual market for STLDI coverage cost 25% less on average compared to enrollees that remain in the ACA-compliant individual market. Scenario 3b assumes this differential is 38%.

[3] The baseline ACA-compliant individual market membership, prior to impacts due to the repeal of the individual mandate and STLDI plan regulation change, in scenarios 0 and 1 are based on higher on and off-Exchange estimates. These estimates align with CBO assumptions. Scenarios 2 and 3 rely on smaller on and off-Exchange baseline estimates. Refer to the quantitative section "Scenario 2 – Transitional Enrollment as Guide (2019 Impact)" for further explanation.
[4] See note above regarding the Departments of Treasury, Labor, and Health and Human Services (known as the tri-agency departments) proposed rule. Further detail is described within the quantitative section of the report.

Introduction

On October 12th, 2017, President Trump signed an executive order instructing the Federal government to promulgate regulations that would, among other things, make it easier for individuals to receive coverage through STLDI plans. STLDI plans do not have to follow the ACA market reform rules that were instituted in 2014 to protect consumers. These rules prevent insurance companies from denying coverage or charging more to individuals with pre-existing conditions and contain many requirements regarding benefit designs to maintain adequate coverage. Since STLDI plans do not have to cover costly members with pre-existing conditions and also offer less generous benefits, the premiums are far lower than plans that follow the market reform rules (ACA-compliant plans).

A proposed regulation was released by the Trump administration on February 28th, 2018, which proposes to extend the maximum coverage period for STLDI plans from approximately 3 months to 364 days. Additionally, policyholders will be able to renew and reapply for STLDI coverage much more easily than before, and can potentially extend coverage beyond the proposed 364 day maximum limit. In turn, STLDI plans will become more attractive for certain individuals and enrollment in such plans is expected to increase.

If the proposed regulation change is implemented, a portion of lower cost members are expected to migrate from the ACA-compliant individual market to STLDI plans. Consequently, the ACA-compliant individual market risk pool would contain a greater proportion of sick people (this effect is also known as adverse selection). This impact to the ACA-compliant individual market is further worsened due to the repeal of the individual mandate, which will be in effect beginning in 2019, creating more adverse selection through additional individuals choosing to migrate to a STLDI plan or remain uninsured. As adverse selection increases, premiums will also increase to cover the rising average claims costs. The higher premiums in turn make it less likely that healthy individuals will enroll and stay enrolled, which creates a loop of higher premiums, causing greater adverse selection, which, in turn, again leads to higher premiums. When this cycle continues unfettered it is called a 'death spiral,' which results in market collapse.

It is important to note that the concept of a death spiral is less applicable to subsidized enrollees given the current structure of premium subsidies (tax credits). Individuals eligible for premium tax credits are insulated from market premium increases as the amount of premium owed is a function of their income, not overall premium. Consequently, as premiums increase, subsidized individuals will not have their out-of-pocket costs increase. Therefore, this subsidy structure shelters some individuals from these large rate increases, making them more likely to remain in the ACA-

compliant individual Exchange market. Unsubsidized enrollees, however, directly bear the full brunt of premium increases. The dynamics of premium increases and worsening morbidity does directly affect them and their ability to afford health insurance. Significant adverse selection within the unsubsidized population may still impact issuer participation or lead to a death spiral.

Additionally, instability driven by the high churn of membership, rising claims costs, and uncertainty of market risk will deter some issuers from offering coverage, which has been witnessed in the ACA-compliant individual market in recent years. In the initial years of the ACA, 2014 and 2015, market forces (such as attempts to gain market share, uncertainty regarding the number of young and healthy individual entering the market, competitor positioning, etc.) drove premium rates very low, to an unsustainable level, in many states. As the markets corrected over the next few years (due to financial losses, instability in the market, and unexpected loss of risk corridor funding) numerous issuers exited the ACA-compliant individual market, leaving many consumers with one or few options. The issuers that remained charged higher premiums. Higher premiums increase the likelihood of unsubsidized enrollees choosing lower cost STLDI plans.

This is not to say that all enrollment in STLDI plans will come from the current ACA-compliant pool. It can also be expected that some individuals who are or will become uninsured (further exacerbated by the repeal of the individual mandate effective 2019) will also choose to purchase STLDI plans. The IRS reports that for the 2015 benefit year (2016 tax filing season) 6.5 million people paid the individual mandate penalty. Additionally, 12.7 million people claimed one or more health care coverage exemptions to avoid having to pay the mandate penalty.[4]

Due to data limitations, this analysis will focus on the impacts that the STLDI regulation change will have on the ACA-compliant individual market and the behavioral effects of those currently in the individual market. As discussed, the projected effects of STLDI plans are after accounting for the repeal of the individual mandate. The proposed STLDI plan regulation will also have effects, both direct and indirect, on other coverage cohorts, such as the uninsured.

Short-Term Limited Duration Insurance Plans: Differences from ACA-Compliant Plans

STLDI plans are designed to fill temporary coverage gaps. Historically, their benefits and cost-sharing differed from ACA-compliant plans in a number of key aspects. The Commonwealth Fund recently noted that STDLI plans do not have a ban on rating for or excluding coverage for pre-existing conditions, do not provide any of the ten essential health benefits[5] (e.g., prescription drug

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[4] https://www.irs.gov/pub/newsroom/commissionerletteracafilingseason.pdf
[5] https://www.healthcare.gov/glossary/essential-health-benefits/

coverage), and do not have cost-sharing requirements.[6] Below is a listing of some specific differences between the two coverage options:

- Many STLDI plans have deductibles of $7,000 to $20,000 for three months of coverage, compared to ACA-compliant plans which are for a year of coverage and legally cannot exceed an amount preset by the Secretary (for example, deductibles for ACA-compliant individual plans were essentially capped at the maximum out of pocket amount of $7,150 in 2017).[7]

- The American Academy of Actuaries notes that many STLDI plans have coverage limits of $1 million while ACA-compliant plans do not have annual limits.[8]

- At the time of renewal or purchase, STLDI plans can exclude coverage for any condition developed in the prior coverage period. Individuals not only can be excluded due to illness when they initially purchase the coverage, but if re-occurring or chronic conditions occur while individuals have STLDI, then they would be unlikely to be covered again at the time of renewal. This is different from even pre-ACA individual market coverage, in which additional underwriting was not conducted at renewal.

- Additionally, ACA rating rules, such as age and gender restrictions, do not apply so these plans can charge higher premiums for individuals who have health conditions or can charge more based on a person's sex.

- STLDI plans do not have to follow Medical Loss Ratio[9] (MLR) restrictions so fewer premium dollars go to paying medical coverage and instead go to administration and profit. Historically, these ratios have been much lower in STLDI plans (for example the largest insurer of STLDI products in 2016 had a MLR below 50%, far below the 80% required MLR in the ACA-compliant individual market).[10]

- Individuals in STLDI plans would be at risk for rescission. Rescissions are retroactive cancellations of coverage, often occurring after individuals file claims due to medical necessity. While enrollees in ACA coverage cannot have their policy retroactively cancelled, enrollees in STLDI plans can. According to Georgetown University, reports

[6] http://www.commonwealthfund.org/publications/blog/2017/aug/short-term-health-plans
[7] Ibid.
[8] http://www.actuary.org/files/publications/Executive_Order_Academy_Comments_110717.pdf
[9] The ACA requires that all issuers spend at least 80% of premium revenues on medical costs.
[10] http://www.commonwealthfund.org/publications/blog/2017/aug/short-term-health-plans

suggest issuers offering STLDI plans have been aggressive at using rescissions to shift their liability onto consumers.[11]

The difference in benefits and premiums between the plans that comply with ACA regulations and STLDI plans would effectively create separate risk pools[12] and risk segmentation. As the American Academy of Actuaries notes, "Noncompliant plans would likely be structured to be attractive to low-cost enrollees through fewer required benefits, higher cost-sharing, and premiums that vary by health status".[13] Given the regulatory flexibility, STLDI plans would attract healthier enrollees, removing them from the ACA-compliant risk pool, increasing risk selection, and further increasing premiums, continuing the downward spiral. Over time the difference between the two risk pools would increase and escalate the instability and uncertainty in the ACA-compliant individual market.

Context: Changes Since 2014

Evolution of Regulations on STLDI plans

Following the full implementation of the ACA requirements in 2014, marketing of STLDI plans changed. In particular, they were marketed as alternatives to ACA coverage, with STLDI plans being renewed indefinitely (generally every three months). This allowed individuals to stay in STLDI plans if both the plan and consumer wished to extend coverage. The result was that enrollment in STLDI plans increased from 1.0 million to 1.5 million member months between 2013 and 2015.[14]

In the fall of 2016, the Obama Administration introduced rules to limit the duration individuals could stay enrolled in STLDI plans to no more than three months (including renewals). The rules also required that application materials include clear language stating that the coverage did not meet standards—known as minimum essential coverage—exempting individuals from the mandate penalty. The Administration noted that these plans could have limitations for consumers, for the above stated reasons, and they could produce adverse selection in the ACA risk pool. The Administration did not ban the sales of these products because "the individual shared responsibility provision…provides sufficient incentive to discourage consumer from purchasing multiple successive short-term, limited duration insurance policies".[15]

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[11] http://chirblog.org/state-options-to-respond-to-executive-order-on-short-term-plans/
[12] In the ACA-compliant market premiums are set in reference to a state's entire risk mix for all enrollees in ACA-compliant plans. A worsening ACA-compliant risk pool would affect all ACA-compliant premiums (excluding the effects of APTCs)
[13] ibid
[14] https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-26162.pdf
[15] ibid

Individual Mandate in the ACA

The individual mandate ("shared responsibility provision") was designed to reduce risk selection. The requirement has a tax penalty for individuals that can afford insurance but choose not to purchase coverage. The result of the policy was that incentives exist for healthy individuals to enroll in ACA-compliant coverage, as individuals that enrolled only in STLDI plans for more than three months would still be required to pay the mandate penalty. Individuals that were uninsured for less than three months were exempt from the mandate penalty, and STLDI plans were meant to serve as a backstop for individuals who might need just a short-term policy to fill such a short gap. While some criticized the mandate penalty as being too small, it did still have effects on the ACA-compliant individual market. For coverage relating to the 2015 benefit year, approximately 6.6 million people paid about $3 billion in individual responsibility payments or about $457 per tax household.[16]

However, these incentives will change starting in 2019. In December of 2017, President Trump signed into law a bill that, among other things, would effectively repeal the individual mandate.[17] Repealing the mandate resulted in both direct and indirect effects that will serve to make the STLDI plans popular. First is that by repealing the mandate, the total cost to consumers of being covered by STLDI plans will be lower since individuals only have to pay the premiums and not both the premiums and the mandate penalty. In other words, repealing the mandate should increase enrollment in STLDI plans. Secondly, by repealing the mandate, ACA premiums will be higher due to an increase in adverse selection,[18] therefore increasing the premium differential between ACA-compliant plans and STLDI plans. The larger the premium difference between the two types of plans, the greater the popularity of STLDI plans, creating a continued cycle of adverse selection.

Implications of New Regulations

On February 28, 2018, the Trump administration released a proposed regulation which would relax current limitations on STLDI plans.[19] The regulation, among other things, proposes two key changes. The first amends regulations so that the maximum coverage period for STLDI plans is now 364 days. This is an increase of approximately 9 months relative to current regulations. The second key change makes it easier for policyholders to renew or reapply for coverage beyond the

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[16] https://www.irs.gov/pub/irs-soi/17sprbul.pdf
[17] https://www.vox.com/policy-and-politics/2017/11/14/16651698/obamacare-individual-mandate-republican-tax-bill. The penalty for the individual mandate was set at $0. For brevity will refer to this change as mandate repeal.
[18] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf
[19] https://www.federalregister.gov/documents/2018/02/21/2018-03208/short-term-limited-duration-insurance

364-day limit.[20] Both of these actions are designed to increase the availability and attractiveness of STLDI plans.

The most direct impact the regulation has is the likelihood of removing healthy and young individuals from the ACA-compliant individual market. The regulation itself notes that short-term limited duration insurance is likely to attract young or healthy individuals. The proposed regulation notes that removing healthy individuals from the ACA risk pool results in higher premiums for those without premium subsidies and higher Federal costs due to the increased subsidy levels as a result of the worsening risk pool and higher premiums.

Consumers who switch to STLDI plans may also be harmed. As the regulation notes "… consumers who switch to such policies (STLDI plans) from ACA-compliant plans would experience loss of access to some services and providers and an increase in out-of-pocket expenditures related to such excluded services…"[21] Additionally, consumers may be harmed as STLDI plans would still not be considered minimum essential coverage and so they would not be protected if their STLDI coverage were to lapse. For example, if an individual was diagnosed with a serious medical condition mid-year and therefore unable to afford the new higher premium at the time of renewal,[22] or experienced a coverage rescission, the person would be unable to get access to ACA coverage via a special enrollment period (SEP). While this does have the benefit of protecting the ACA risk pool, it could lead to individuals having spells of no coverage and higher levels of uncompensated care. And the ACA-compliant risk pool would still ultimately bear the expenses of delayed coverage once the consumer is finally able to enroll during open enrollment.

States do retain significant authority in regulating STLDI plans, which will affect the impact from state to state. According to the Urban Institute, eight states currently have regulations that would limit STLDI expansion.[23] These limitations mostly take the form of how long an individual can consecutively have coverage in a STLDI (e.g., a STLDI can only provide coverage for a maximum of three months and not be renewed). The proposed regulation would not preempt state law on STLDI plans, but it also does not require states to regulate STLDI plans.

In the proposed regulation, HHS provided an impact analysis of the effects of STLDI plans on the ACA-compliant individual market. They estimated that between 100,000 and 200,000 members would exit the Exchanges to take up coverage in STLDI plans in 2019, further increasing the morbidity of the ACA-compliant risk pool, premiums, and Federal expenditures via higher

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[20] https://www.healthaffairs.org/do/10.1377/hblog20180220.69087/full/
[21] https://www.federalregister.gov/documents/2018/02/21/2018-03208/short-term-limited-duration-insurance
[22] While not included in the analysis, there have been several Congressional proposals making renewal of STLDIs easier for consumers. If approved, this would directionally increase enrollment in these plans and premium increases in the ACA market.
[23] https://www.urban.org/sites/default/files/publication/96781/stld_draft_0226_finalized_0.pdf

premium subsidies (advanced premium tax credits – APTC). In the next section, we will examine potential effects of the proposed regulation on the ACA-compliant individual market.

Analysis of Proposed Regulations

Case Study: Tennessee

The unique case of Tennessee's individual market may provide a preview of the effects on the ACA-compliant individual market of offering non-ACA products. Due to a 1993 law, the state allows the Tennessee Farm Bureau to sell coverage to individuals. This coverage is not exclusively provided to farmers but is generally available to all Tennesseans and is similar to the type of plans that existed in the pre-ACA world. As a matter of state law, the coverage is not considered insurance. As a result, when the ACA's key provisions, such as guaranteed issue and not denying coverage based on pre-existing conditions, came into the effect, they did not apply to the Tennessee Farm Bureau plans. This allowed the Tennessee Farm Bureau to continue to sell new coverage options that compete against ACA-compliant plans.

The Tennessee Farm Bureau has been very successful at attracting and keeping healthy enrollees. According to one report, in 2017 they covered as many as 73,000 enrollees (this includes 50,000 "grandfathered plans" and 23,000 enrollees that have signed up since the ACA market reform rules went into effect).[24] To put these numbers into context, in 2017, approximately 200,000 members, on average, were enrolled on-Exchange for the first half of 2017.[25] While we do not yet have the average total ACA-compliant individual market enrollment for 2017, 73,000 Farm Bureau enrollees likely would represent approximately a quarter of the total "individual market" (Farm Bureau coverage plus ACA-compliant market) in 2016.[26]

A Society of Actuaries paper analyzed the risk mix in ACA plans in 2015[27] and found that, excluding Arkansas,[28] Tennessee's ACA-compliant individual market had the worst risk score (or relative measure of how costly individuals are in the ACA-compliant market) of any state in the country. Tennessee had an adjusted risk score of 2.80 while the national average was 2.31.[29] To further the instability within the ACA-compliant individual market, Tennessee also has

[24] http://chirblog.org/whats-going-tennessee-one-possible-reason-affordable-care-act-challenges/
[25] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf
[26] Using the 2016 June 30th Report, Wakely estimated the size of the Tennessee's ACA individual market using billable member months. If one were to combine both the individual market and Farm bureau into a singular risk pool, the Farm Bureau's 73,000 enrollees would represent 26.7% of the total market
[27] https://www.soa.org/research-reports/2016/relative-risk-aca-market/
[28] Arkansas was excluded since its ACA risk pool includes Medicaid expansion beneficiaries.
[29] The SOA adjusted risk scores for differences in age and actuarial value to better differences between states due to health differences.

experienced large rate increases. All three of the major issuers increased rates in 2017 in excess of 40%.[30] Overall the second lowest cost silver plan increased 278% between 2014 and 2018.[31] This is the largest increase of any Healthcare.gov state. At the end of 2016 one issuer (United) exited the market and several issuers reduced their footprint. The situation was so dire the Insurance Commissioner characterized the Exchange market as "very near collapse."[32]

As can be seen in the Tennessee case study, allowing products that underwrite to directly compete with ACA products will increase risk selection in the ACA-compliant individual market. Healthier individuals migrated to the less expensive (underwritten) products which caused morbidity to increase in the ACA products, resulting in premium increases, issuer exits, and overall uncertainty in the market.

While illustrative of the overall dynamics of how non-ACA products may affect the ACA risk pool, the Tennessee experience may not be directly comparable in the short-term because of the Tennessee Farm Bureau's long history in the state, large pre-ACA enrollment, and significant advertising presence. The aforementioned dynamics of the Tennessee experience are largely qualitative in nature; in the next section, we will provide quantitative analyses on the potential effects STLDI might have on the ACA-compliant individual market.

Quantitative Analyses

The reintroduction of underwriting and rescissions at a larger scale are not immediate; for many issuers, it may take some time to implement (the proposed regulation estimates only 160,000 people are currently enrolled in STLDI plans). Furthermore, it may take time to market the products to individuals. To control for the fact that the effects of STLDI plans should grow over time, we have analyzed the effects of STLDI plans both in the short term (scenarios 1 and 2 below) and the near term (scenario 3 below).

Neither sets of analyses account for potential reduction in issuer participation and competition. As enrollment shrinks and morbidity increases, fewer issuers may be willing to provide coverage, which again may result in higher premiums. In the extreme case of a bare county (no ACA-compliant issuer coverage) the results would be catastrophic for enrollees in those areas. Consequently, these analyses can be considered to underestimate the impact as enrollment losses and premium increases could be higher if the resulting issuer behavior was accounted for.

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[30] https://www.healthinsurance.org/tennessee/
[31] https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf
[32] https://www.tennessean.com/story/money/industries/health-care/2016/08/23/insurers-get-approval-for-2017-obamacare-rates/89196762/?from=global&sessionKey=&autologin=

Scenarios 0 and 1 – Extension of Proposed Regulation Regulatory Impact Analysis (2019 Impact)

As part of the proposed regulation, the Departments of Treasury, Labor, and Health and Human Services (known as the tri-agency departments or simply tri-agency) estimated the impact of the STLDI regulatory changes on the ACA-compliant individual market. In particular, they estimated that between 100,000 and 200,000 people would leave the Exchanges and enroll in STLDI plans. This shift of young and/or healthy individuals to STLDI products was estimated to increase premiums in the ACA-compliant individual market 0.3% to 0.6%, on average nationwide. Note, these impacts are specific to year 2019. The tri-agency estimates are shown in Scenarios 0a and 0b in the table below.

However, there are a number of reasons to believe the tri-agencies' estimate may be understated. First, the tri-agencies' estimate that the relative morbidity of those that leave ACA coverage for STLDI plans compared to those that stay in ACA coverage is 75% (meaning those that are expected to leave cost 25% less on average compared to average enrollees that remain in the ACA-compliant individual market). Other estimates of the morbidity of individuals that leave the ACA-compliant individual market on a relative basis are lower.[33] For example, using CBO's analysis of the mandate repeal, Wakely estimated that CBO assumed a morbidity differential of individuals leaving due to the mandate repeal as approximately 62% (meaning those that are expected to leave cost 38% less on average compared to average enrollees that remain in the ACA-compliant individual market). In other words, individuals leaving the ACA-compliant risk pool could be healthier/less costly than what the tri-agency's rule assumed. The larger the difference in health status between those that leave the ACA-compliant risk pool versus those that stay results in larger premium increases in the ACA-compliant market. Second, and more important, the tri-agency's analysis does not include the ACA-compliant individual off-Exchange market. As part of the single risk pool, off-Exchange ACA enrollees should be included in the total impacts. Since off-Exchange ACA enrollees are all unsubsidized, they are directly affected by premium increases and, therefore, more likely to exit the ACA-compliant individual market for STLDI plans compared to the subsidized population.

For Wakely's modeling of scenario 1, we assumed a 75% morbidity differential to align with the Federal impact analysis.[34] Also, we adjusted the tri-agency's results to include the ACA-compliant individual off-Exchange market. To estimate what proportion of the off-Exchange membership would exit for STLDI coverage, we used the tri-agency's estimated percent of unsubsidized on-

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[33]Https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

[34] While the morbidity difference is likely around 75%, it could be lower, a point that is explored later in the analysis. The larger the morbidity difference, the larger the premium impact.

Exchange enrollees that would migrate to STLDI plans. To estimate the size of the ACA-compliant individual off-Exchange market, we relied on the same CBO analysis that the tri-agencies relied on to estimate the effects of the mandate repeal.[35] Please note that the tri-agencies' analysis does not specifically state the methods and assumptions used to arrive at their estimated number of people who would transition to short-term duration plans. Nor was it indicated what difference in assumptions were used to develop the low and high scenario results.

By using the tri-agency's initial findings and adjusting for off-Exchange membership, we estimate that, after accounting for the removal of the individual mandate, the entire ACA-compliant individual market would further decrease by between 400,000 enrollees (scenario 1a) and 790,000 enrollees (scenario 1b). The high and low scenarios were also modeled in the tri-agency's report. This represents 2.7% to 5.4% of the total estimated ACA-compliant individual market in 2019 (based on membership after no individual mandate). Updating the membership component of the tri-agency analysis to include off-Exchange membership results in an estimated premium increase of 0.7 to 1.4% in 2019, significantly higher than the tri-agency's estimates.

Scenario 2 – Transitional Enrollment as Guide (2019 Impact)

To provide further sensitivity testing, Wakely used a second methodology to estimate the effects of STLDI plans on the ACA-compliant individual market in 2019. In this analysis, we varied our assumptions regarding the estimated size of the ACA-compliant individual market from the baseline in the tri-agency's analysis assumed in scenario 1. In 2017, the off-Exchange market decreased in size severely.[36] Consequently, we assumed the size of the off-Exchange market may be smaller than the CBO estimate relied on in scenario 1. The result was an overall baseline individual ACA-compliant enrollment of 15.0 million (both on and off-Exchange) compared to 18.1 million as assumed in scenario 1.

As discussed, scenario 1 aligned with CBO assumptions of both baseline enrollment (on and off-Exchange) and effects of the mandate. A smaller off-Exchange in the baseline could imply that the mandate repeal enrollment effects are correspondingly lower. To avoid biasing the analysis (i.e., smaller off-Exchange and larger mandate repeal effect), we used all of the key CBO projected inputs. If we aligned both the on and off-Exchange market size in scenario 1 with what

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[35] Theoretically, off-Exchange enrollees would also be at risk for leaving the ACA risk pool due to the mandate repeal. However, since the tri-agency analysis included the full effect of the mandate repeal (3 million) on-Exchange it would be inappropriate to double count these losses off-Exchange as well.

[36] http://www.markfarrah.com/healthcare-business-strategy/A-Brief-Look-at-the-Turbulent-Individual-Health-Insurance-Market.aspx

was used for scenario 2, the expected premiums effects of STLDIs are 0.9% and 1.8%, respectively, higher than they otherwise would have been in scenario 1.

Given the smaller enrollment baseline, we used the Office of the Actuaries' estimated enrollment loss due to the mandate repeal (or 2 million), which is less than the CBO estimated enrollment loss.[37] Finally, we relied on the experience of transitional enrollment to estimate the demand for STLDI plans. In 2014, the Obama Administration allowed individuals that had 2013 (i.e., pre-ACA) coverage to continue enrollment in their current plans—often referred to as "grandmothered" plans and known as "transitional" plans for the purposes of this analysis. The Brookings Institute estimated that approximately 1.6 million people who had initially purchased non-ACA coverage before the mandate went into effect in 2014 maintained their non-ACA transitional coverage rather than choosing to be uninsured or purchase ACA-compliant coverage.[38]

While not a perfect proxy, STLDI plans do represent a non-ACA coverage alternative, similar to how transitional plans functioned as a non-ACA coverage option for many Americans in 2014. Furthermore, not every state allowed transitional plans to exist. States that intervened to protect the ACA-compliant individual market and disallow transitional plans may similarly map to states that will intervene to protect the ACA market from STLDI plans, which would decrease the STLDI market compared to the transitional plan market in 2014. One difference between transitional plans and STLDI plans that may impact take-up is that in STLDI plans, individuals would have to undergo underwriting at renewal; individuals in transitional plans did not undergo underwriting. Also, transitional plans are more generous than STLDI plans and so may attract a somewhat different population mix. Individuals that were enrolled in transitional policies in 2014 may have since dropped coverage and may not be enrolled in the ACA-compliant individual market— thus shifting from different coverage or uninsured status.

To account for the more stringent enrollment requirements for STLDI plans and differences compared to transitional plans, as detailed above, we reduced the number of people in transitional plans by 50% to create a proxy for the potential STLDI market. The results of this scenario estimate that 830,000 people out of 13 million total enrollees, representing 6.4% of enrollment, may exit the ACA-compliant individual market. We again assumed a 75% morbidity differential of enrollees migrating to STLDI plans from the ACA-compliant individual market. This would result in a premium increase of 1.7%. Although this scenario is intended to estimate the impact in 2019, there is some sensitivity in the potential STLDI market. In increasing the assumption that the potential STLDI market is approximately 50% of the transitional market, the STLDI market may begin to converge to a nearer term estimate. This assumes, similar to scenario 3, that it will take

[37]https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf
[38] https://www.brookings.edu/wp-content/uploads/2017/10/individualmarketprofitability.pdf

issuers longer to develop STLDI products compared to the pre-ACA products that had been in place for quite some time.

Scenario 3 – Individual ACA Claims Cost Analysis (Near Term Impact)

The final methodological approach we used was to examine health status and metal level in the ACA-compliant individual market as a proxy for an enrollee's propensity to shift from an ACA plan to a STLDI plan. This estimate should be considered a near term estimate, in four to five years, as the full impact of the proposed regulation is not immediate; it will take a few years for the full effect of STLDI plans to be felt on the ACA-compliant individual market. It will take time for issuers to develop STLDI products and (re)build the necessary operations to underwrite. In 2019, as illustrated in scenarios 1 and 2, not enough time has lapsed for issuers to have the operational capabilities to fully implement STLDI plans. Therefore, scenario 3 estimates are larger than the initial two.[39]

Wakely used a proprietary dataset of nationwide 2016 ACA-compliant individual market enrollees that consists of approximately 6.4 million members. We grouped individuals into one of three categories listed below to determine those who would be most likely at risk of switching from ACA-compliant coverage to STLDI coverage, referred to as the "at risk" group.

Category 1. Individuals enrolled in lower metal level plans. Lower metal levels were defined as catastrophic, bronze, and silver regular (no cost-sharing reduction variant) plans.

Category 2. Individuals who were unsubsidized.

Category 3. Individuals who had lower cost sharing (copay, deductible, coinsurance) spending levels. Lower spending levels were defined as less than the average cost of a STLDI plan premium as identified by the tri-agency's rule ($124 average monthly premiums in the fourth quarter of 2016). Since females would likely to be charged higher than males (due to the underwriting process in STLDI plans), different premium levels were assumed by gender.[40]

Based on the criteria defined above, we identified that approximately 36% of enrollees within the individual dataset fell into both Categories 1 and 3. Then, based on the 36% of enrollees, we estimated different propensities for shifting coverage from the ACA-compliant individual market to the STLDI market by also taking Category 2, the unsubsidized population, into account as

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[39] Please note that in reality the ACA-compliant individual market will experience large churn between STLDI plans as those that become unhealthy will shift to the ACA-compliant individual market and those who consider themselves healthy shift out.

[40] The ACA requires plans to conform to a particular level of actuarial value (i.e., metal levels). Wakely only used enrollees that were in catastrophic, bronze, or non-CSR silver plans. Individuals that selected these plans could be considered to have revealed preferences for lower premiums and less cost-sharing protection. Lower spending levels were identified as having less claims cost than an average STLDI plan as noted in the tri-agency regulation ($124).

subsidized members are much less likely to drop ACA-compliant individual market coverage. We adjusted the data as follows:

- Two scenarios, high and low, were modeled to produce a range of estimates.
- All individuals enrolled off-Exchange and members in catastrophic plans on-Exchange (unsubsidized, within Category 2) would be most likely to drop or shift coverage. In the low scenario, we assumed a majority of these members would dis-enroll from the ACA-compliant individual market. In the high scenario, we assumed 100%.
- Individuals enrolled on-Exchange in bronze and regular silver metal level plans are less likely to drop, since a larger portion of these members are likely to be eligible for subsidies. For these plans, in the low scenario, we assumed 80% of the unsubsidized members would dis-enroll from the ACA-compliant individual market and none of the subsidized enrollees would drop coverage. In the high scenario, we assumed 100% of the unsubsidized and a small portion of the subsidized members, based on the tri-agency's analysis in scenario 1b, would exit the ACA-compliant individual market.
- By accounting for all three categories listed above, the at risk group ranges from 20% to 26% of total market enrollees, based on the high and low scenarios. These percentages represent the proportion of members, based on the 2019 estimated ACA-compliant individual market membership prior to mandate repeal, that will leave due to combined impacts of the removal of the individual mandate and the proposed changes to the STLDI regulation.
- Applying the enrollment decrease percentages to the ACA-compliant market enrollment, pre-repeal mandate, would equate to approximately 3.0 to 3.9 million enrollees in high and low scenarios.

Because the identified at risk group would be largely the same population that would be at risk for becoming uninsured due to the effective individual mandate repeal, we reduced the potential pool of enrollees by the expected enrollment loss due to the mandate repeal, as estimated by CMS' Office of the Actuary, or 2.0 million enrollees.[41] This produced the proportion of enrollees that are estimated to shift into STLDI coverage. The initial at risk group includes members that may drop coverage due to the repeal of the individual mandate or may have disenrolled in 2017 or 2018. The data has not been adjusted from 2016; therefore, our estimates reflect higher bounds. This results in an estimated 1.0 to 1.9 million individuals who would ultimately be at risk for shifting from ACA-compliant individual plans to STLDI plans in the near term.

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[41] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf

It should be noted that in a world where mandate repeal has stronger effects, the marginal effect of STLDI plans may be less. This is because enrollees who are healthier are more likely to be uninsured. The extent to which mandate repeal has less of an effect, there is a larger pool of ACA individuals that may shift to STLDI plans.

In the high and low scenarios, the same post-mandate repeal enrollment baseline as assumed in scenario 2 was used (i.e., an ACA-compliant individual market of 13 million enrollees). The low scenario assumes that the relative morbidities of those that leave for STLDI plans compared to those that stay in ACA coverage is 75%, whereas the high scenario decreases the morbidity differential to 62%. It is possible that in the event of large enrollment decreases, the morbidity differential between those that stay and those that leave could be large. To account for the potential of more extreme morbidity differences we used a larger difference in health status in the high scenario. The final impact results in an enrollment decrease of 8.2% to 15.0% in the ACA-compliant individual market and a 2.2% to 6.6% increase in premiums. Again, these assumptions show a near term impact of four to five years. The table below includes enrollment for the ACA-compliant individual market (both on and off-Exchange) in total and for subsidized enrollees, premium impacts, and enrollment impacts. Enrollment levels are estimated prior to the repeal of the individual mandate. Then, enrollment and premium impacts are re-estimated based on the repeal of the individual mandate, and again after the proposed STLDI regulation change. Both the loss of the individual mandate and proliferation of STLDI plans would impact the unsubsidized market much more drastically than the subsidized market. The combined impact of both the repeal of the mandate and the easing restrictions on STLDI plans would result in premium increases of 20.5% to 26.3% higher than they otherwise would have been.

Table 2 - Effects of STLDI Proposed Regulation on ACA-Compliant Individual Market Risk Pool (Different Scenarios)

Scenario	Scenario 0a	Scenario 0b	Scenario 1a	Scenario 1b	Scenario 2	Scenario 3a	Scenario 3b
Method	Proposed Rule Low	Proposed Rule High	Proposed Rule Adjusted Low	Proposed Rule Adjusted High	Transitional Enrollment	Individual ACA Claims Cost Data Low	Individual ACA Claims Cost Data High
Year	**2019**	**2019**	**2019**	**2019**	**2019**	**Near Term**	**Near Term**
Estimate Performed By?	Tri-Agency[5]	Tri-Agency[5]	Tri-Agency, Wakely Adjusted	Tri-Agency, Wakely Adjusted	Wakely	Wakely	Wakely
Off-Exchange Population Included?[1]	No	No	Yes	Yes	Yes	Yes	Yes
Baseline, with enforcement of Individual Mandate							
Individual Total Enrollment[2]	13,130,000	13,130,000	18,130,000	18,130,000	15,000,000	15,000,000	15,000,000
Individual Subsidized Enrollment	8,459,000	8,459,000	8,459,000	8,459,000	8,459,000	8,459,000	8,459,000
Baseline, with removal of Individual Mandate							
Increase in Premiums	10.0%	10.0%	10.0%	10.0%	5.8%	5.8%	5.8%
Reduction of Members[3]	3,400,000	3,400,000	3,400,000	3,400,000	2,000,000	2,000,000	2,000,000

Scenario	Scenario 0a	Scenario 0b	Scenario 1a	Scenario 1b	Scenario 2	Scenario 3a	Scenario 3b
Method	Proposed Rule Low	Proposed Rule High	Proposed Rule Adjusted Low	Proposed Rule Adjusted High	Transitional Enrollment	Individual ACA Claims Cost Data Low	Individual ACA Claims Cost Data High
Individual Total Enrollment	9,730,000	9,730,000	14,730,000	14,730,000	13,000,000	13,000,000	13,000,000
Individual Subsidized Enrollment	8,122,000	8,122,000	8,122,000	8,122,000	8,122,000	8,122,000	8,122,000
Scenario, Impact of STLDI Plans							
Increase in Premiums[4]	0.3%	0.6%	0.7%	1.4%	1.7%	2.2%	6.6%
Reduction of Members	100,000	200,000	396,000	791,000	826,000	1,070,000	1,948,000
Decrease in Enrollment	-1.0%	-2.1%	-2.7%	-5.4%	-6.4%	-8.2%	-15.0%
Individual Total Enrollment	9,630,000	9,530,000	14,334,000	13,939,000	12,174,000	11,930,000	11,052,000
Individual Subsidized Enrollment	8,112,000	8,102,000	8,112,000	8,102,000	8,122,000	8,122,000	8,122,000
Total Impacts due to Removal of Individual Mandate and STLDI Plans							
Increase in Premiums	10.3%	10.6%	10.8%	11.6%	7.6%	8.2%	12.8%
Reduction of Members	3,500,000	3,600,000	3,796,000	4,191,000	2,826,000	3,070,000	3,948,000
Decrease in Enrollment	-26.7%	-27.4%	-20.9%	-23.1%	-18.8%	-20.5%	-26.3%

[1] The population includes only on-Exchange ACA-compliant individual membership within the proposed rule (scenarios 0a and 0b) analyses. Both on and off-Exchange membership are included within the additional scenarios. Because the proposed rule analyses do not account for effects of the off-Exchange market, there will be downstream impacts to market premiums.
[2] The baseline ACA-compliant individual market membership, prior to impacts due to the repeal of the individual mandate and STLDI plan regulation change, in scenarios 0 and 1 are based on higher on and off-Exchange estimates. These estimates align with CBO assumptions. Scenarios 2 and 3 rely on smaller on and off-Exchange baseline estimates. Refer to the quantitative section "Scenario 2 – Transitional Enrollment as Guide (2019 Impact)" for further explanation.
[3] The reduction in members due to the repeal of the individual mandate in scenarios 0 and 1 are based on CBO assumptions, as assumed within the proposed rule analyses. Scenarios 2 and 3 rely on a smaller reduction in members due to the repeal of the individual mandate, as assumed by the Office of the Actuaries'. Refer to the quantitative section "Scenario 2 – Transitional Enrollment as Guide (2019 Impact)" for further explanation.
[4] Scenarios 1a - 3a assume that members who leave the ACA-compliant individual market for STLDI coverage cost 25% less on average compared to enrollees that remain in the ACA-compliant individual market. Scenario 3b assumes this differential is 38%.
[5] See note above regarding the Departments of Treasury, Labor, and Health and Human Services (known as the tri-agency departments) proposed rule. Further detail is described within the quantitative section of the report.

Conclusion

In 2016, the Obama Administration enacted a regulation that limited enrollment in STLDI plans. Individuals were not allowed to enroll in STLDI plans for more than three consecutive months. This was done to prevent STLDI enrollment from harming the ACA-compliant risk pool and to limit consumer's exposure to underwriting, rescissions, annual limits, and other harmful policies that were in effect prior to the ACA in 2014. In February of 2018, the Trump Administration proposed to reverse the Obama era regulation to make it easier for individuals to stay enrolled in STLDI plans. While it would provide healthy individuals access to cheaper, less generous coverage, it would also increase premiums for individuals in the ACA risk pool. The effective repeal of the mandate starting in 2019 introduces additional uncertainty into the ACA risk pool and is expected to increase the morbidity of the risk pool.

The combination of removing restrictions on STLDI plans and repealing a mandate penalty for individuals that sign up for these plans should increase the attractiveness of STLDI plans to current ACA enrollees. Using a variety of scenarios, Wakely estimates that STLDI plans will have an adverse effect on the ACA individual market and that the effect will grow with time. The impact in 2019 is estimated to increase premiums 0.7% to 1.4% and decrease enrollment by 2.7% to 5.4% in the ACA-compliant individual market. In the near term, once the STLDI market has had a chance to expand, we estimate that premiums for ACA-compliant individual enrollees could be 2.2% to 6.6% higher and enrollment 8.2% to 15.0% lower. The STLDI regulation change combined with the repeal of the individual mandate will further exacerbate the impacts and increase premiums from 10.8% to 12.8% and decrease enrollment from 20.9% to 26.3% (based on 2019 and near term estimates).

RESEARCH ARTICLE AFFORDABLE CARE ACT

HEALTH AFFAIRS > VOL. 37, NO. 4: CULTURE OF HEALTH, THE ACA & MORE

Effects Of The ACA's Health Insurance Marketplaces On The Previously Uninsured: A Quasi-Experimental Analysis

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ABSTRACT

Descriptive studies have suggested that the Affordable Care Act's (ACA's) health insurance Marketplaces improved access to care. However, no evidence from quasi-experimental studies is available to support these findings. We used longitudinal survey data to compare previously uninsured adults with incomes that made them eligible for subsidized Marketplace coverage (138

–400 percent of the federal poverty level) to those who had employer-sponsored insurance before the ACA with incomes in the same range. Among the previously uninsured group, the ACA led to a significant decline in the uninsurance rate, decreased barriers to medical care, increased the use of outpatient services and prescription drugs, and increased diagnoses of hypertension, compared to a control group with stable employer-sponsored insurance. Changes were largest among previously uninsured people with incomes of 138–250 percent of poverty, who were eligible for the ACA's cost-sharing reductions. Our quasi-experimental approach provides rigorous new evidence that the ACA's Marketplaces led to improvements in several important health care outcomes, particularly among low-income adults.

TOPICS

HEALTH INSURANCE EXCHANGES | AFFORDABLE CARE ACT | ACCESS TO CARE | MEDICAL EXPENDITURE PANEL SURVEY | UNINSURED | COSTS AND SPENDING | MEDICAID

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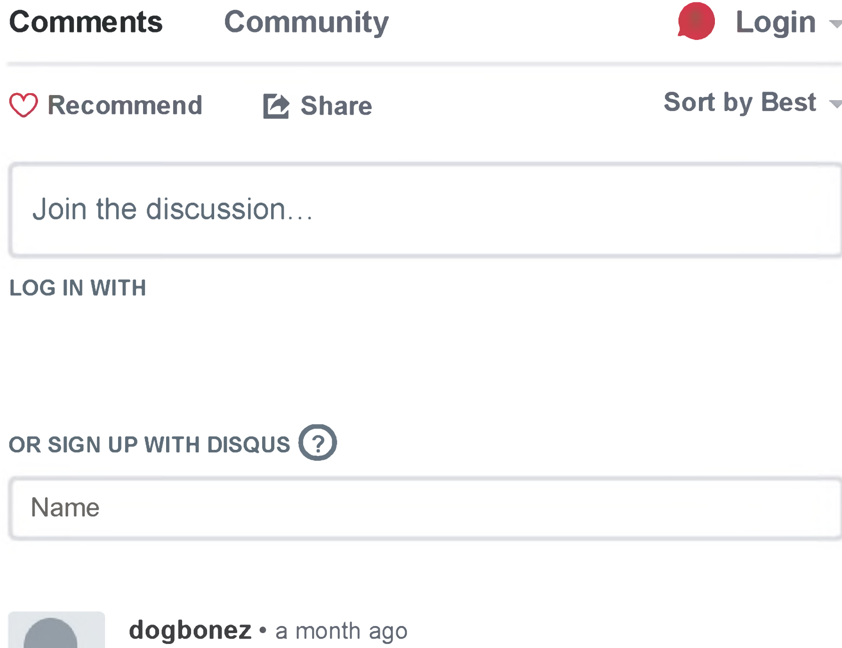

U.S. Health Reform—Monitoring and Impact

Changes in Marketplace Premiums, 2017 to 2018

March 2018

By John Holahan, Linda J. Blumberg, and Erik Wengle

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**.

There have been widespread reports of very large marketplace nongroup premium increases in most states in 2018.[1,2] Below, we provide national estimates for changes in the lowest silver and gold plan premiums between 2017 and 2018. The national average increase was 32.0 percent for the lowest-priced silver plans and 19.1 percent for gold plans, but the increases varied by states. Several reasons are behind these large increases. The premium increases reflect significant policy changes and policy debates specifically affecting insurer decisions for the 2018 plan year as well as more typical annual considerations such as trend and healthcare costs. We delineate the factors that contributed to large 2018 marketplace premium increases, provide state-by-state estimates of average premium increases in silver (70 percent actuarial value) and gold (80 percent actuarial value) plans in the marketplaces and provide more detailed analysis of changes in select markets within 20 states.

Other findings include the following:

- Increases in the lowest silver plan premiums tended to be larger than the increases in the lowest gold premiums, but there were several exceptions.
- There was tremendous variation across states in rates of increase. Some of the smallest increases (including some decreases) were in states with high 2017 premiums.
- The average lowest silver premiums remained below the average lowest gold premiums in each state we studied, but the difference between the two ranged from 3.0 percent (District of Columbia suburbs in Maryland) to 77.4 percent (Augusta, Georgia), in the selected large markets analyzed.
- More insurers exited markets than entered new markets in 2018 in our study areas.
- States with Medicaid managed care organizations and/or many competing insurers offering marketplace coverage tended to have the lowest premiums.

BACKGROUND: FACTORS CONTRIBUTING TO PREMIUM INCREASES

Elimination of Federal Reimbursements of Cost-Sharing Reductions. The U.S. Department of Health and Human Services has stopped reimbursing insurers for the cost-sharing reductions (CSRs) that marketplace insurers are legally required to provide eligible enrollees with incomes below 250 percent of the federal poverty level (FPL). The Congressional Budget Office (CBO) estimates that this change will increase the federal deficit by $194 billion over 10 years.[3]

Without the federal reimbursement for CSRs, CBO estimates that insurers would increase silver premiums by an estimated 20 percent in 2018; this increase would be over and above increases due to medical cost inflation or other reasons. The CBO assumption, consistent with other analyses,[4–6] is that the insurers' costs for the CSRs would be incorporated entirely into the silver marketplace premiums because there was no economic reason to adjust premiums for gold, bronze, or nonmarketplace plans. As originally legislated, eligible individuals could receive CSRs only if they purchased silver marketplace premiums using a tax credit. An insurer that spread CSR costs into plans not eligible for CSRs would charge premiums higher than the value associated with that plan,

leaving them at a competitive pricing disadvantage relative to insurers who did not.

In the end, however, the federal government allowed states to decide how insurers could address this issue. States could require insurers to select from several approaches, from exclusive loading of costs into silver marketplace premiums to spreading the costs across plans in all metal tiers on and off the marketplace. Corlette, Lucia, and Kona found that 26 states had insurers allocate the CSR costs to silver marketplace premiums alone, 8 states had the costs allocated to silver plans on and off the marketplaces, three states had insurers spread the costs across all metal tiers in the marketplace, three had insurers spread the costs across all metal tiers on and off the marketplace, and in three states' approaches varied across insurers.[7] Information on the remaining states was not available.

Policy Changes Anticipated to Reduce Enrollment in Private Nongroup Coverage. Beyond adjustments to account for elimination of federal reimbursement for CSRs, premiums increased for other reasons. Throughout 2017, the Trump administration indicated it might not enforce the individual mandate penalties, and the Tax Cuts and Jobs Act of 2017 explicitly set the penalties to zero beginning in 2019.[8] The virtual elimination of advertising funds, the large reduction in enrollment assistance funds, the shortened open enrollment period in the federally facilitated marketplaces and some state-based marketplaces, and reduced hours of access to the *healthcare.gov* enrollment platform, all further increased the uncertainty in the market. Insurers feared that these changes would reduce enrollment, leave a less healthy risk pool, increase average claims costs per enrollee, and provide insurers strong incentives to increase premiums at all coverage levels. Such incentives affect premiums both on and off the marketplaces because the entire nongroup insurance market is risk adjusted as a uniform pool.

Annual Adjustments Based on the Prior Year's Experience. Finally, the 2018 premium increases that we observe reflect how insurers felt about the adequacy of their 2017 premiums. First, if the risk pool was better or worse than had been anticipated in 2017, insurers likely adjusted their risk expectations (and their premiums) for 2018. Second, if there is significant market competition, insurers will not increase premiums more than necessary because large premium increases would risk losing market share. Larger-than-necessary premiums also mean insurers would be forced to provide rebates because of medical loss ratio regulations. However, if an insurer is facing little or reduced competition (perhaps due to other insurers exiting the market in 2018 or low prior insurer participation), premium increases tend to be higher.[9] Third, premiums are adjusted based on medical inflation or expectations of changes in the intensity of health care service use.

DATA AND METHODS

We analyze nongroup marketplace premium and insurer participation data for the 2017 and 2018 plan years. These data were taken from the *healthcare.gov* public use files, state marketplace websites, and state department of insurance websites when necessary. We use the state department of insurance websites to access insurer rate filings to obtain data that were unavailable from state marketplace websites.

Our premium analyses focus on the lowest silver and lowest gold premiums for a 40-year-old nonsmoker. Because of the fixed age rating curves in each state, using premiums for a 40-year-old does not affect our findings. The lowest silver premium is the lowest-priced option available in the most popular actuarial value (metal) tier. We also analyzed percentage changes in the benchmark (second lowest cost silver) premiums in each rating region and found them similar to the percentage changes in the lowest silver premiums; these are shown in Appendix Table A-1. We also present data for the lowest gold premiums because 2018 silver premiums were more frequently affected by the cessation of federal CSR payments.

We present these data in three different ways. First, we compute state-specific weighted averages of the lowest silver premium available in each of the state's premium rating regions; we do the same for the lowest gold premium available in each of the state's regions. These averages are weighted by the population in each region and are presented in (Table 1). Second, we present rating region–level premium data for 32 large metropolitan areas in 20 states (Table 2). We present the lowest silver and gold premiums in each of these rating regions in 2017 and 2018. We then calculate the percentage change in the lowest premium within each region. Third, we show the lowest silver and gold premiums offered by *each insurer* participating in each rating region in 2017 and 2018 to show the competitive dynamics in these large population areas (Tables 3 through 22). The average percentage change across insurers, also shown in these tables, are calculated over the insurers participating in both years.

RESULTS

Table 1 provides statewide averages for the lowest silver and gold plan premiums and the relative change in the premiums between 2017 and 2018 in addition to population weighted national averages.[10] These findings are consistent with those of the Kaiser Family Foundation.[1] These population-weighted average premiums for the lowest silver and lowest gold premiums (2017 and 2018) are for a 40-year-old nonsmoker. The national average increase in the lowest silver and lowest gold premiums between 2017 and 2018 are 32.0 percent and 19.1 percent, respectively, but the variation across states is substantial. State changes in average lowest-priced silver premiums ranged from a 22.5 percent reduction (Alaska) to a 117.5 percent increase (Iowa). Lowest gold plan premium changes ranged from a 27.9 percent reduction (Alaska) to a 62.1 percent increase (Kentucky). Fifteen states had increases in average lowest silver premiums of more than 40 percent. But four states had increases of 10 percent or less, and four others had reductions in average lowest silver premiums.

Silver premium increases were generally higher than gold premium increases, but this was not consistent across all states. For example, growth in gold premiums exceeded that in silver premiums in Connecticut and Maryland, even though insurers in both states were instructed to load all expected CSR costs into their silver marketplace premiums.[7] Growth in average lowest silver and gold premiums were comparable in Colorado, Mississippi, and Oklahoma, but those states instructed insurers to spread their CSR costs across all actuarial value tiers.

Table 1: Increases in Lowest Marketplace Silver and Gold Premiums by State, 2017–2018

Monthly Premiums are for a 40-year-old nonsmoker

State	State Average Lowest Silver Premium			State Average Lowest Gold Premium		
	2017	2018	Percentage Change 2017–2018	2017	2018	Percentage Change 2017–2018
U.S. Average	$342	$444	32.0%	$439	$518	19.1%
Alabama	$435	$515	18.5%	$571	$582	2.0%
Alaska	$901	$698	-22.5%	$1,080	$778	-27.9%
Arizona	$497	$487	-2.0%	$660	$627	-4.9%
Arkansas	$281	$341	21.2%	$365	$410	12.3%
California	$317	$394	24.1%	$360	$411	14.3%
Colorado	$317	$413	30.2%	$380	$501	31.9%
Connecticut	$433	$539	24.7%	$450	$603	34.0%
D.C.	$275	$317	15.0%	$353	$385	9.3%
Delaware	$414	$573	38.3%	$537	$706	31.5%
Florida	$323	$458	41.8%	$429	$489	13.9%
Georgia	$312	$482	54.7%	$439	$617	40.7%
Hawaii	$325	$437	34.4%	$379	$449	18.3%
Idaho[1]	$344	$475	37.9%	$446	$485	8.6%
Illinois	$350	$474	35.3%	$470	$536	14.0%
Indiana	$261	$332	26.9%	$345	$456	32.2%
Iowa[2]	$320	$695	117.5%	$558	$787	40.9%
Kansas	$362	$481	32.8%	$402	$446	11.0%
Kentucky	$253	$420	66.2%	$334	$541	62.1%
Louisiana	$403	$455	12.9%	$519	$562	8.3%
Maine	$371	$551	48.6%	$526	$636	20.9%
Maryland	$324	$436	34.7%	$309	$456	47.6%
Massachusetts	$241	$306	26.8%	$329	$375	14.1%
Michigan	$260	$349	34.0%	$343	$381	11.1%

Table 1 continued

State	State Average Lowest Silver Premium			State Average Lowest Gold Premium		
	2017	2018	Percentage Change 2017–2018	2017	2018	Percentage Change 2017–2018
Minnesota	$429	$365	-15.1%	$496	$458	-7.6%
Mississippi	$327	$478	46.5%	$435	$648	48.9%
Missouri[3]	$365	$487	33.5%	$490	$715	45.7%
Montana	$418	$494	18.2%	$560	$582	3.8%
Nebraska[4]	$464	$689	48.6%	$518	$753	45.5%
Nevada	$306	$445	45.6%	$412	$516	25.0%
New Hampshire	$266	$457	71.9%	$345	$524	51.5%
New Jersey	$338	$399	18.1%	$606	$646	6.7%
New Mexico	$239	$414	73.4%	$279	$347	24.5%
New York	$439	$484	10.3%	$517	$571	10.5%
North Carolina	$517	$601	16.3%	$670	$656	-2.1%
North Dakota	$325	$293	-9.8%	$416	$392	-5.7%
Ohio[5]	$251	$347	38.2%	$328	$420	27.8%
Oklahoma	$495	$520	5.1%	$623	$662	6.4%
Oregon	$311	$410	31.9%	$370	$444	20.1%
Pennsylvania	$347	$453	30.6%	$435	$462	6.2%
Rhode Island	$243	$287	18.3%	$307	$300	-2.3%
South Carolina	$389	$524	34.4%	$493	$550	11.5%
South Dakota	$430	$467	8.6%	$576	$559	-2.9%
Tennessee[6]	$433	$597	37.9%	$673	$910	35.2%
Texas	$279	$394	41.3%	$349	$435	24.6%
Utah	$308	$528	71.3%	$466	$615	32.1%
Vermont	$470	$474	0.8%	$531	$569	7.1%
Virginia	$309	$506	64.0%	$426	$631	48.1%
Washington	$238	$326	37.0%	$318	$399	25.3%
West Virginia	$440	$514	16.9%	$552	$686	24.3%
Wisconsin	$350	$502	43.5%	$444	$517	16.4%
Wyoming	$494	$860	74.0%	$606	$710	17.3%

Source: Healthcare.gov public use files and relevant state marketplace websites and rate filings

1: Idaho combined rating area 7 into rating area 5 for the 2018 plan year.

2: Rating regions 1–3 did not have a gold plan offered in 2017 and have been removed from the gold average.

3: Rating region 4 did not have a gold plan offered in 2017 and has been removed from the gold average.

4: Rating regions 2–4 did not have a gold plan offered in 2017 and have been removed from the gold average.

5: Rating region 6 did not have a gold plan offered in 2018 and has been removed from the gold average.

6: Rating region 2 did not have a gold plan offered in 2017 and has been removed from the gold average.

Table 2 shows the lowest silver and lowest gold premiums in 32 rating regions in 20 states in 2017 and 2018, the percentage change between years, and the percentage difference between silver and gold premiums in 2018. States are ordered from lowest 2017 silver premiums to highest 2017 silver premiums. Consistent with Table 1, 2018 increases in lowest silver premiums tend to be high in these markets, many around 40 percent, though there is considerable variation. Lowest gold premium increases are usually smaller, but this is not always the case. Differences between 2017 and 2018 gold premiums in many markets are between 20 and 40 percent. Silver premiums in all but 6 of the 20 states (West Virginia, Oklahoma, Arizona, Georgia, Indiana, and Missouri) would have been expected to increase more than gold plan premiums because insurers were instructed to load their expected costs for providing CSRs into their silver plans only.[11]

Table 2: Increases in Silver and Gold Marketplace Premiums in Selected Large Markets, 2017–2018

Monthly Premiums are for a 40-year-old nonsmoker

State	City	Lowest Silver Premium Offered			Lowest Gold Premium Offered			Percentage Difference between Silver and Gold Premiums 2018
		2017	2018	Percentage Change 2017–2018	2017	2018	Percentage Change 2017–2018	
Washington	Seattle (Region 1)	$235	$328	39.6%	$317	$414	30.7%	26.2%
Rhode Island	Entire state (Region 1)	$247	$287	16.2%	$307	$300	-2.6%	4.3%
Ohio	Columbus (Region 9)	$284	$385	35.4%	$367	$464	26.6%	20.6%
	Cleveland (Region 11)	$224	$307	36.8%	$312	$376	20.3%	22.3%
Michigan	Detroit (Region 1)	$233	$298	27.7%	$306	$341	9.0%	14.5%
Indiana	Indianapolis (Region 10)	$284	$364	28.2%	$364	$501	37.6%	37.5%
Texas	Dallas–Fort Worth (Region 8)	$277	$411	48.4%	$334	$438	31.2%	6.6%
	Houston (Region 10)	$283	$390	37.9%	$341	$426	25.0%	9.2%
Virginia	Richmond (Region 7)	$289	$439	51.6%	$403	$483	19.8%	10.2%
	Northern Virginia (Region 10)	$296	$447	51.4%	$396	$483	21.9%	8.0%
Georgia	Atlanta (Region 3)	$264	$417	57.8%	$362	$465	28.3%	11.5%
	Augusta (Region 5)	$322	$464	44.3%	$495	$824	66.5%	77.4%
California	West Los Angeles (Region 16)	$256	$339	32.4%	$287	$353	22.8%	3.9%
	San Diego (Region 19)	$297	$392	32.1%	$332	$416	25.1%	6.2%
	Sacramento (Region 3)	$402	$446	11.0%	$445	$460	3.5%	3.2%
Florida	Miami (Region 43)	$296	$435	46.7%	$372	$456	22.4%	4.9%
	Tampa (Region 28)	$305	$428	40.3%	$395	$460	16.4%	7.5%
Maryland	Baltimore (Region 1)	$309	$436	41.1%	$401	$450	12.1%	3.1%
	DC Suburbs (Region 3)	$309	$436	41.1%	$401	$450	12.1%	3.0%
Missouri	Kansas City (Region 3)	$342	$484	41.7%	$448	$709	58.4%	46.5%
	St. Louis (Region 6)	$305	$421	38.0%	$400	$636	59.2%	51.2%
Maine	Portland (Region 1)	$334	$489	46.2%	$472	$570	20.7%	16.6%
Tennessee	Nashville Region 4)	$400	$550	37.7%	$542	$824	67.0%	49.8%
	Memphis (Region 6)	$398	$601	51.2%	$539	$989	83.6%	64.5%
Alabama	Birmingham (Region 3)	$457	$542	18.5%	$600	$612	2.0%	13.0%
New York[1]	New York City (Region 4)	$454	$504	11.2%	$533	$595	11.6%	17.9%
	Long Island (Region 8)	$446	$480	20.6%	$525	$567	8.1%	18.3%
West Virginia	Charleston (Region 2)	$505	$555	9.8%	$638	$747	17.0%	34.5%
Oklahoma	Oklahoma City (Region 3)	$485	$507	4.5%	$610	$690	13.1%	36.0%
Arizona	Phoenix (Region 4)	$475	$471	-0.9%	$661	$621	-6.0%	31.9%
	Tucson (Region 6)	$349	$332	-4.9%	$455	$438	-3.8%	31.9%
North Carolina	Charlotte (Region 4)	$565	$659	16.7%	$716	$703	-1.8%	6.7%

Source: Healthcare.gov public use files and relevant state marketplace websites and rate filings

1: New York has pure community rating and as such this premium is not necessarily representative of a 40-year-old.

In each market, the lowest gold premium remains higher than the lowest silver premium in 2018 despite the differences in growth across the tiers, but in many markets, the relative difference between the silver and gold premiums has decreased considerably. In a few markets, premium increases are low or even negative, likely reflecting adjustments from large premium increases in the previous year and the desire to avoid paying rebates in 2018.

The increase in the lowest silver and gold premiums available in each area varies considerably. Many markets with low premiums in 2017 have large increases in 2018. This includes the Seattle, Washington market, with a 39.6 percent increase in its lowest silver premium and 30.7 percent increase in its lowest gold premium. In Richmond, Virginia, the lowest silver premium increased by 51.6 percent, and the lowest gold premium increased by 19.8 percent. In Northern Virginia, the lowest silver premium increased by 51.4 percent, and the lowest gold premium increased by 21.9 percent. In Miami, Florida, the lowest silver premium increased by 46.7 percent, and the lowest gold premium increased by 22.4 percent. In Tampa, Florida, the lowest silver premium increased by 40.3 percent, and the lowest gold premium increased by 16.4 percent.

At the other extreme, premium increases were small in several markets, though generally smaller for gold than for silver, given the necessary adjustments for CSRs. These small increases were typically in states with 2017 premiums higher than the national average. For example, in Charlotte, North Carolina, the lowest silver premium increased by 16.7 percent, and the lowest gold premium declined by 1.8 percent. In Birmingham, Alabama, the lowest silver premium increased by 18.5 percent, and the lowest gold premium increased by 2.0 percent. In Phoenix, Arizona, the lowest silver premium declined by 0.9 percent, and the lowest gold premium declined by 6.0 percent. In Tucson, the lowest silver plan premium decreased by 4.9 percent, and the lowest gold premium declined by 3.8 percent.

The last column of Table 2 shows that the lowest silver and gold premiums in many of these markets were similar by 2018, even though the actuarial value of the gold plans are 14 percent (80/70=1.14) higher than that of the silver plans. Generally, before 2018, gold premiums exceeded silver premiums by more than 14 percent, owing to insurers pricing in higher utilization for gold plans because of their lower cost-sharing requirements and other factors. To a substantial degree, the reduction in premium differences between gold and silver plans in 2018 is because most insurers adjusted their silver premiums up to account for the federal government eliminating reimbursement for CSRs. In 15 of the 32 markets studied, the difference between silver and gold premiums is now less than 14 percent. In Baltimore; the D.C. suburbs of Maryland; Sacramento and West Los Angeles, California; and Rhode Island, the premium differences are 4 percent or less. But large relative premium differences between silver and gold plans persist where the CSR adjustments were made more broadly (e.g., Indianapolis and Oklahoma City), and even in Nashville (49.8 percent difference) and Memphis (64.5 percent difference), Tennessee, where CSR adjustments were all made to silver plan premiums.

A Closer Look at Changes in 32 Large Markets in 20 States

Table 2 shows the increases in premiums for the lowest-priced silver and gold plans in large markets in 20 states. Below, we look at the increases in the lowest-priced plans offered by each insurer in these markets. We also note the insurers who enter and exit each market and which insurers remain and offer the lowest premium option. In the 32 rating regions we study, 21 regions saw exits, and 7 regions had an additional insurer enter the market for 2018. Anthem and Humana left 8 and 7 regions, respectively. In 17 of the 32 regions, the lowest-priced silver plan was offered by an insurer that previously operated only in the Medicaid market but entered the private market because of the Affordable Care Act (ACA). We present the states in the same order as they appear in Table 2, from the lowest 2017 silver premiums to the highest.

Table 3: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Washington

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 1: Seattle, Bellevue						
Coordinated Care	$235	$328	39.6%	$317	$419	32.3%
Molina HealthCare	$257	$385	49.7%	$320	$476	48.9%
Group Health (Kaiser)	$280	$404	44.2%	$344	$414	20.2%
BridgeSpan	$315	NA	NA	$409	NA	NA
Lifewise	$324	NA	NA	$417	NA	NA
Regence	$326	NA	NA	$433	NA	NA
Premera	$404	$517	27.9%	$501	$617	23.4%
Average Percentage Change Across Insurers			40.3%			31.2%
Percentage Change in Region's Lowest-Premium Option			39.6%			30.7%

Source: Washington Healthplan Finder

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Washington (Table 3). In the Seattle region, three Blue Cross Blue Shield insurers left the marketplace after 2017: Lifewise, BridgeSpan, and Regence. The lowest silver premium increased by 39.6 percent between 2017 and 2018, and the lowest gold premium increased by 30.7 percent. Coordinated Care, a product of the national Medicaid chain Centene Corporation, offers the region's lowest silver premium. Molina, another national Medicaid chain, is the second lowest cost insurer. Coordinated Care and Group Health (now owned by Kaiser) have the lowest 2018 gold premiums. Each insurer's lowest gold premium exceeds its lowest silver premium, although Group Health's lowest gold premium is only $10 per month higher than its lowest silver premium.

Table 4: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Rhode Island

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 1: Entire State						
Neighborhood Health Plan	$247	$287	16.2%	$307	$300	-2.6%
Blue Cross Blue Shield of Rhode Island	$270	$385	42.7%	$360	$327	-9.1%
Average Change Across All Insurers			29.5%			-5.9%
Percentage Change in Lowest-Premium Option			16.2%			-2.6%

Source: Healthsource RI

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Rhode Island (Table 4). Rhode Island has a single statewide rating region, and the lowest silver premium increased by 16.2 percent between 2017 and 2018, while the lowest gold premium decreased by -2.6 percent. The insurer with the lowest 2017 premium, Neighborhood Health Plan, increased its premium the least, by 16.2 percent, and reduced its gold premium by 2.6 percent. In contrast, Blue Cross Blue Shield increased its silver premium by 42.7 percent, presumably because of adjustments due to elimination of CSR reimbursements but also perhaps out of fear of the implications of reduced enforcement of the individual mandate and other sources of uncertainty about the 2018 insurance risk pool. Blue Cross Blue Shield lowered its lowest gold premium by more than 9 percent relative to 2017, and it is now below its lowest silver premium.

Table 5: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Ohio

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 9: Columbus						
CareSource	$284	$385	35.4%	$367	$464	26.6%
Molina Marketplace	$301	$461	53.5%	$383	$501	30.8%
MedMutual	$326	$423	29.9%	$402	$515	28.0%
Anthem Blue Cross and Blue Shield	$342	NA	NA	$467	NA	NA
Ambetter from Buckeye Health Plan	NA	$417	NA	NA	$531	NA
Average Percentage Change Across Insurers			39.6%			28.5%
Percentage Change in Region's Lowest-Premium Option			35.4%			26.6%
Rating Region 11: Cleveland						
Ambetter from Buckeye Health Plan	$224	$307	36.8%	$312	$391	25.3%
Molina Marketplace	$252	$346	37.2%	$321	$376	16.9%
CareSource	$253	$319	26.2%	$326	$385	18.0%
Anthem Blue Cross and Blue Shield	$363	NA	NA	$496	NA	NA
MedMutual	$376	$364	-3.1%	$470	$440	-6.3%
Oscar	NA	$434	NA	NA	$509	NA
Average Percentage Change Across Insurers			24.3%			13.5%
Percentage Change in Region's Lowest-Premium Option			36.8%			20.3%

Source: Healthcare.gov Public Use File

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Ohio (Table 5). Ohio has had low premiums because of marketplace competition from Medicaid managed care organizations. Anthem left the Columbus and Cleveland marketplaces after 2017, while Oscar entered the Cleveland marketplace for 2018. Caresource, the lowest silver premium option in Columbus in 2017, increased its premium by 35.4 percent in 2018 but remained the lowest-priced option. Caresource increased its lowest gold premium by 26.6 percent. Molina, another Medicaid managed care organization, was the second-lowest-cost insurer in 2017, but its 53.5 percent silver premium increase makes it the highest-priced insurer in 2018. Molina had a smaller but still large increase in their lowest gold premium (30.8 percent).

In Cleveland, the lowest silver premium increased by 36.8 percent, and the lowest gold premium increased by 20.3 percent. MedMutual, Cleveland's highest-priced insurer in 2017, lowered the premiums for its lowest-priced silver and gold options, yet its 2018 premiums remain high relative to most of its competitors there.

Table 6: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Michigan

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 1: Detroit						
Meridian Health Plan	$233	$360	54.4%	$313	$345	10.0%
Molina	$237	$358	51.4%	$306	$361	18.2%
Total Health Care USA, Inc.	$244	$298	22.0%	$311	$341	9.7%
Blue Care Network of Michigan	$261	$332	27.2%	$416	$486	16.9%
Health Alliance Plan (HAP)	$299	NA	NA	$364	NA	NA
McLaren Health Plan, Inc.	$308	$411	33.2%	$398	$448	12.4%
Priority Health	$312	$375	20.0%	NA	$525	NA
Humana Medical Plan of Michigan Inc.	$315	NA	NA	NA	NA	NA
Blue Cross Blue Shield of Michigan (MSP)	$371	$519	40.1%	$581	$702	20.8%
Average Percentage Change Across Insurers			35.5%			14.7%
Percentage Change in Region's Lowest-Premium Option			27.7%			11.6%

Source: Healthcare.gov Public Use File

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Although required by law under the Affordable Care Act, neither Humana nor Priority Health appeared to offer gold-level plans in 2017, and Humana does not seem to be offering one in 2018 either.

Michigan (Table 6). Michigan required insurers to allocate CSR expenses in full to silver marketplace plans. The Detroit market had nine insurers in 2017, and premiums were low. Humana and Health Alliance Plan left the marketplace before 2018. The lowest silver premium increased by 27.7 percent, and the lowest gold premium increased by 11.6 percent. Molina and Meridian Health Plan offered the lowest silver premiums in 2017, but they both increased those premiums by more than 50 percent for 2018, making Total Healthcare USA and the BlueCare Network's silver offerings the lowest priced in Detroit for 2018. Meridian's lowest gold premium is $15 per month below its lowest silver premium in 2018, and Molina's lowest gold premium is only $3 higher than its lowest silver premium.

Table 7: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Indiana

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 10: Indianapolis						
Ambetter	$284	$364	28.2%	$391	$514	31.2%
Caresource	$286	$366	28.1%	$364	$501	37.6%
MDwise	$317	NA	NA	$424	NA	NA
Anthem	$414	NA	NA	$647	NA	NA
Average Percentage Change Across Insurers			28.2%			34.4%
Percentage Change in Region's Lowest-Premium Option			28.2%			37.6%

Source: Healthcare.gov Public Use File

Note: Insurers instructed to load the cost of cost-sharing reductions into all marketplace metal tiers.

Indiana (Table 7). In Indiana, insurers were required to spread premium increases for CSRs across all metal tiers in the marketplace. The increases in silver premiums are more comparable with increases in gold premiums. Anthem and MDwise, left the Indianapolis marketplace after 2017. The remaining insurers are the national Medicaid chains Ambetter and CareSource. Their lowest silver and gold premiums are similar to each other, as were their 2017 premiums. Ambetter increased its lowest silver premium by 28.2 percent and its lowest gold premium by 31.2 percent. CareSource increased its lowest silver premium by 28.1 percent and its lowest gold premium by 37.6 percent.

Table 8: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Texas

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 8: Dallas/Fort Worth						
Molina Healthcare of Texas	$277	$411	48.4%	$334	$438	31.2%
Ambetter	$322	$415	29.0%	$450	$481	6.9%
Blue Cross Blue Shield of Texas	$449	$570	27.0%	$563	$559	-0.7%
Average Percentage Change Across Insurers			34.8%			12.5%
Percentage Change in Region's Lowest-Premium Option			48.4%			31.2%
Rating Region 10: Houston						
Molina Healthcare of Texas	$283	$399	41.3%	$341	$426	25.0%
Community Health Choice, Inc.	$311	$460	48.0%	$364	$503	38.1%
Blue Cross Blue Shield of Texas	$431	$545	26.5%	$540	$534	-1.1%
Ambetter	NA	$390	NA	NA	$452	NA
Average Percentage Change Across Insurers			38.6%			20.7%
Percentage Change in Region's Lowest-Premium Option			37.9%			25.0%

Source: Healthcare.gov Public Use File

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Texas (Table 8). Texas also required insurers to allocate the cost of CSRs to marketplace silver plans. The lowest silver premiums in Dallas–Fort Worth increased by 48.4 percent and the lowest gold premium increased by 31.2 percent. The increase in the lowest silver premium in Houston was 37.9 percent, and the increase for the lowest gold premium was 25.0 percent. Molina and Ambetter, both national Medicaid chains, have the lowest premium silver plans in both markets in 2018, as well as the lowest gold premiums. Ambetter entered the Houston marketplace in 2018. For Ambetter, Molina, and Community Health Choice, their respective lowest gold premium in 2018 is higher than the lowest silver premium. Blue Cross Blue Shield's lowest gold premium is now $11 per month lower than its lowest silver premium for a 40-year-old nonsmoker.

Table 9: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Virginia

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 7: Richmond						
Aetna	$289	NA	NA	NA	NA	NA
Cigna	$296	$439	48.0%	$403	$719	78.2%
Anthem HealthKeepers	$303	$497	64.2%	$435	$740	70.1%
Kaiser Permanente	$329	$447	36.0%	$457	$483	5.7%
United Healthcare	$333	NA	NA	$482	NA	NA
Anthem (MSP)	$341	NA	NA	NA	NA	NA
Piedmont Community Health Care	$357	$572	60.0%	$437	$696	59.3%
Optima Health	NA	$900	NA	NA	$1,343	NA
Average Percentage Change Across Insurers			52.0%			53.3%
Percentage Change in Region's Lowest-Premium Option			51.6%			19.8%
Rating Region 10: Washington D.C. suburbs						
Innovation Health Insurance Company	$296	NA	NA	$396	NA	NA
Cigna	$313	$458	46.1%	$426	$750	75.8%
United Healthcare[1]	$319	NA	NA	NA	NA	NA
Kaiser Permanente	$329	$447	36.0%	$457	$483	5.7%
Anthem HealthKeepers	$336	$511	52.3%	$482	$770	59.7%
Anthem (MSP)	$378	NA	NA	NA	NA	NA
CareFirst BlueChoice, Inc.	$432	$720	66.7%	$498	$653	31.1%
Group Hospitalization and Medical Services (Carefirst)	$466	$928	98.9%	$556	$807	45.1%
Average Percentage Change Across Insurers			60.0%			43.5%
Percentage Change in Region's Lowest-Premium Option			51.4%			21.9%

Source: Healthcare.gov Public Use File

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

1: Although required by law under the Affordable Care Act, United did not offer a gold plan during the 2017 plan year.

Virginia (Table 9). In Richmond, Aetna, Anthem (Multistate Plan, a Preferred Provider Organization), and United Healthcare left the marketplace after 2017, and Optima Health entered for 2018. In Northern Virginia, Anthem (Multistate Plan), Innovation, and United Healthcare left the marketplace. The lowest silver premium increased by 51.6 percent in Richmond and by 51.4 percent in the Washington, D.C. suburbs. The lowest gold premium increased by 19.8 percent in Richmond and 21.9 percent in the Washington, D.C. suburbs. Almost all insurers (Kaiser is the exception) have large premium increases in both metal tiers, despite the state requirement that CSR costs be loaded onto silver marketplace premiums alone. Anthem HealthKeepers and Cigna increased their lowest gold premiums more than 70 percent in Richmond and 60 and 76 percent, respectively, in the Washington, D.C. suburbs. These are larger increases than those made for their lowest silver premiums in both rating areas.

Although not the lowest-priced insurer in 2017, Kaiser offers the lowest silver and gold premiums in the DC suburbs. In Richmond, Kaiser has by far the lowest gold premium and is just slightly above Cigna's lowest priced silver option. Kaiser's lowest silver premium increased 36.0 percent in each market, and its gold premium increased only 5.7 percent in 2018. These were the smallest increases of any insurer in these marketplaces. Kaiser's lowest gold premium is only $36 per month higher than its lowest silver premium in both markets for a 40-year-old nonsmoker.

Table 10: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Georgia

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 3: Atlanta						
Ambetter	$264	$417	57.8%	$362	$465	28.3%
Blue Cross Blue Shield of Georgia (Anthem)	$324	$581	79.2%	$499	$1,030	106.5%
Kaiser	$372	$421	13.3%	$444	$552	24.3%
Humana	$538	NA	NA	NA	NA	NA
Average Percentage Change Across Insurers			50.1%			53.1%
Percentage Change in Region's Lowest-Premium Option			57.8%			28.3%
Rating Region 5: Augusta						
Blue Cross Blue Shield of Georgia (Anthem)	$322	$464	44.3%	$495	$824	66.5%
Average Percentage Change Across Insurers			44.3%			66.5%
Percentage Change in Region's Lowest-Premium Option			44.3%			66.5%

Source: Healthcare.gov Public Use File

Note: Insurers instructed to load the cost of cost-sharing reductions into all silver plans, both on marketplace and off.

1: Although required by law under the Affordable Care Act, Humana did not offer a gold plan during the 2017 plan year.

Georgia (Table 10). In Georgia, insurers were allowed to decide whether to adjust for CSRs but were required to make any adjustments to all silver plans both on and off the marketplace. In Atlanta, the lowest silver premium increased by 57.8 percent, and the lowest gold premium increased by 28.3 percent. Ambetter remained the lowest-priced insurer at the gold and silver tiers. Kaiser had a 13.3 percent increase for its lowest silver premium and a 24.3 percent increase for its lowest gold premium. Blue Cross Blue Shield of Georgia had significant increases in both its lowest silver premium (79.2 percent) and lowest gold premium (106.5 percent). Humana left the Atlanta marketplace in 2018.

Only Blue Cross Blue Shield of Georgia participates in the Augusta marketplace. Its lowest silver premium increased by 44.3 percent, and its lowest gold premium increased by 66.5 percent in 2018. Why premium increases would be larger for Kaiser gold plans in Atlanta and Blue Cross Blue Shield in Augusta is unclear. Insurers are required to treat all enrollees in all tiers of coverage as one risk pool, but they are permitted to adjust for higher utilization in gold plans because of lower cost-sharing requirements. Such changes might reflect concerns insurers have over the relative health care risks of enrollees in higher actuarial value coverage.

Table 11: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

California

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 16: West Los Angeles						
Molina Healthcare	$256	$390	52.4%	$287	$406	41.4%
L.A. Care	$270	$339	25.4%	$319	$353	10.7%
Health Net	$289	$344	19.0%	$364	$386	5.8%
Anthem	$302	NA	NA	$370	NA	NA
Oscar	$332	$417	25.5%	$385	$460	19.4%
Kaiser Permanente	$335	$409	22.1%	$371	$394	6.1%
Blue Shield	$358	$418	16.7%	$434	$494	13.7%
Average Percentage Change Across Insurers			26.9%			16.2%
Percentage Change in Region's Lowest-Premium Option			32.4%			22.8%
Rating Region 19: San Diego						
Molina Healthcare	$297	$418	41.1%	$332	$435	30.9%
Health Net	$307	$392	27.6%	$387	$439	13.5%
Kaiser Permanente	$354	$432	22.1%	$392	$416	6.1%
Sharp	$356	$479	34.8%	$419	$461	10.1%
Blue Shield	$406	$394	-2.9%	$504	$466	-7.5%
Anthem	$444	NA	NA	$543	NA	NA
Average Percentage Change Across Insurers			24.5%			10.6%
Percentage Change in Region's Lowest-Premium Option			32.1%			25.1%
Rating Region 3: Sacramento						
Kaiser Permanente	$402	$478	19.1%	$445	$460	3.5%
Western Health Advantage	$426	$557	30.7%	$512	$568	11.0%
Anthem	$471	NA	NA	$595	NA	NA
Blue Shield	$479	$446	-6.9%	$595	$527	-11.4%
Health Net	$501	$584	16.5%	$625	$673	7.7%
Average Percentage Change Across Insurers			14.8%			2.7%
Percentage Change in Region's Lowest-Premium Option			11.0%			3.5%

Source: Cover California

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

California (Table 11). West Los Angeles, San Diego, and Sacramento are competitive marketplace insurer markets, with six, five, and four participating insurers, respectively, in 2018. California required plans to add the costs associated with CSRs onto premiums for its silver marketplace plans. In the West Los Angeles market, the lowest silver premium increased by 32.4 percent, while the lowest gold premium increased by 22.8 percent. In San Diego, the lowest silver premium increased by 32.1 percent, and the lowest gold premium increased by 25.1 percent. In Sacramento, the lowest silver premium increased by 11.0 percent, and the lowest gold premium increased by 3.5 percent.

The lowest 2018 silver premiums are offered by Health Net and LA Care in West Los Angeles, Blue Shield and Health Net in San Diego, and Blue Shield and Kaiser Permanente in Sacramento. Blue Shield reduced the premium of its lowest-priced silver and gold offerings in San Diego and Sacramento, making it more competitive. Molina offered the lowest-priced silver plan in West Los Angeles and San Diego in 2017, but its high premium increases (52.4 percent and 41.1 percent, respectively) for 2018 changed their relative standing in these markets. Anthem, a mid-to-high-priced insurer in each of these markets in 2017, stopped selling marketplace coverage in all three regions in 2018.

Despite the larger increases in silver premiums relative to gold for 2018, gold premiums remained higher than silver premiums for all insurers except for Kaiser Permanente in each of the rating areas and Sharp in San Diego.

Table 12: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Florida

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 43: Miami						
Ambetter	$296	$435	46.7%	$407	$467	14.9%
Health Options	$318	$442	39.0%	$412	$456	10.6%
Molina	$320	$567	77.5%	$372	$537	44.2%
Florida Blue (Blue Cross Blue Shield of Florida)	$422	$583	37.9%	$623	$640	2.7%
Humana	$477	NA	NA	$559	NA	NA
Average Percentage Change Across Insurers			50.3%			18.1%
Percentage Change in Region's Lowest-Premium Option			46.7%			22.4%
Rating Region 28: Tampa						
Ambetter	$305	$428	40.3%	$418	$460	9.9%
Health Options	$325	$481	48.1%	$421	$495	17.8%
Molina	$339	$567	67.3%	$395	$537	35.9%
Florida Blue (Blue Cross Blue Shield of Florida)	$341	$496	45.5%	$502	$544	8.3%
Humana[1]	$428	NA	NA	NA	NA	NA
Average Percentage Change Across Insurers			50.3%			18.0%
Percentage Change in Region's Lowest-Premium Option			40.3%			16.4%

Source: Healthcare.gov Public Use File

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

1: Although required by law under the Affordable Care Act, Humana did not offer a gold plan during the 2017 plan year.

Florida (Table 12). Florida required insurers to load the cost of cost sharing reductions onto silver marketplace plans. As a result, the premium of the lowest priced silver plan increased by 46.7 percent in Miami, and the premium of the lowest priced gold plan increased by 22.4 percent. In Tampa, the lowest silver premium increased by 40.3 percent, and the lowest gold premium increased by 16.4 percent. There was considerable variation across insurers in the premium increases at both metal levels. Molina's lowest silver premium increased by 77.5 percent in Miami and by 67.3 percent in Tampa, increases that exceeded its competitors' increases of 38 to 48 percent. Molina also had the highest increases in its lowest gold premiums, with 44.2 percent in Miami and 35.9 percent in Tampa. Ambetter and Health Options offer the lowest silver and gold premiums in Miami and Tampa in 2018. Humana left both marketplaces in 2018.

Table 13: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Maryland

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 1: Baltimore						
Kaiser	$309	$436	41.1%	$401	$450	12.1%
Carefirst	$355	$559	57.5%	$416	$516	24.0%
Cigna	$415	NA	NA	$548	NA	NA
Average Percentage Change Across Insurers			49.3%			18.1%
Percentage Change in Region's Lowest-Premium Option			41.1%			12.1%
Rating Region 3: D.C. Suburbs						
Kaiser	$309	$436	41.1%	$401	$450	12.1%
Carefirst	$355	$559	57.5%	$416	$516	24.0%
Cigna	$409	NA	NA	$540	NA	NA
Average Percentage Change Across Insurers			49.3%			18.1%
Percentage Change in Region's Lowest-Premium Option			41.1%			12.1%

Source: Maryland Health Connection

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Maryland (Table 13). In Baltimore and the D.C. suburbs, only CareFirst and Kaiser Permanente offer marketplace coverage in 2018. Cigna left both markets. Kaiser offers the lowest silver and gold premiums in both regions. Kaiser's lowest silver premium increased 41.1 percent in both markets, and its lowest gold premiums increased 12.1 percent. Carefirst increased its lowest silver premium in each region by 57.5 percent and its lowest gold premium in each by 24.0 percent. Carefirst participates in the marketplace throughout the state, but Kaiser does not. Kaiser also has provider capacity constraints, which limits its ability to add market share and thus limits effective competition in the state.

Table 14: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Missouri

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 3: Kansas City						
Cigna	$342	$484	41.7%	$448	$744	66.0%
Blue Cross Blue Shield of Kansas City[1]	$420	NA	NA	NA	NA	NA
Humana[1]	$430	NA	NA	NA	NA	NA
Ambetter	NA	$518	NA	NA	$709	NA
Average Percentage Change Across Insurers			41.7%			66.0%
Percentage Change in Region's Lowest-Premium Option			41.7%			58.4%
Rating Region 6: St. Louis						
Cigna	$305	$421	38.0%	$400	$647	61.7%
Healthy Alliance Life	$352	NA	NA	$509	NA	NA
Ambetter	NA	$465	NA	NA	$636	NA
Average Percentage Change Across Insurers			38.0%			61.7%
Percentage Change in Region's Lowest-Premium Option			38.0%			59.2%

Source: Healthcare.gov Public Use File

Note: It is unknown what the state DOI required insurers to do regarding the cost-sharing reductions.

1. Although required by law under the Affordable Care Act, neither Humana nor Blue Cross Blue Shield of Kansas City appeared to offer gold-level plans in 2017.

Missouri (Table 14). In Missouri, Humana and Blue Cross Blue Shield left the Kansas City marketplace after the 2017 plan year, and Healthy Alliance Life left the St. Louis marketplace. Ambetter entered both markets in 2018, pricing competitively with the only other insurer, Cigna. Cigna was the lowest-premium insurer in 2017 in both markets and remains so for silver coverage. Ambetter's gold premiums are lower than Cigna's in 2018. In Kansas City, the lowest available silver premium increased by 41.7 percent, and the lowest available gold premium increased by 58.4 percent. In St. Louis, the lowest silver premium increased by 38.0 percent, and the lowest gold premium increased by 59.2 percent. Information on Missouri's instructions regarding the costs associated with CSRs was not available.

Table 15: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Maine

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 1: Portland						
Anthem	$334	NA	NA	$498	NA	NA
Harvard Pilgrim	$345	$489	41.7%	$472	$608	28.8%
Maine Community Health Options	$354	$536	51.3%	$480	$570	18.9%
Average Percentage Change Across Insurers			46.5%			23.8%
Percentage Change in Region's Lowest-Premium Option			46.2%			20.7%

Source: Healthcare.gov Public Use File

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Maine (Table 15). In Portland, Anthem, the insurer with the lowest silver premium, left the marketplace after 2017. Maine Community Health Options and Harvard Pilgrim are the only 2018 marketplace participants. The lowest silver premium increased by 46.2 percent, and the lowest gold premium increased by 20.7 percent in 2018. Maine Community Health Options increased its lowest silver premium by 51.3 percent, and Harvard Pilgrim increased its lowest silver premium by 41.7 percent. The lowest gold premiums for the two insurers increased by 18.9 percent and 28.8 percent, respectively, the growth rates reflecting the instructions to incorporate CSR costs into silver marketplace premiums only. Harvard Pilgrim has the lowest silver premium, but Maine Community Health Options has the lowest gold premium in 2018.

Table 16: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Tennessee

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 4: Nashville, Clarksville						
Cigna Health and Life Insurance Company	$400	$550	37.7%	$542	$905	67.0%
Humana Insurance Company	$500	NA	NA	$635	NA	NA
Oscar	NA	$585	NA	NA	$824	NA
Average Percentage Change Across Insurers			37.7%			67.0%
Percentage Change in Region's Lowest-Premium Option			37.7%			52.0%
Rating Region 6: Memphis						
Cigna Health and Life Insurance Company	$398	$601	51.2%	$539	$989	83.6%
Humana Insurance Company[1]	$426	NA	NA	NA	NA	NA
Average Percentage Change Across Insurers			51.2%			83.6%
Percentage Change in Region's Lowest-Premium Option			51.2%			83.6%

Source: Healthcare.gov Public Use File

Note: Insurers instructed to load the cost of cost-sharing reductions into all silver plans, both on marketplace and off.

1: Although required by law under the Affordable Care Act, Humana did not offer a gold-level plan during the 2017 plan year.

Tennessee (Table 16). Two insurers offer marketplace coverage in the Nashville-Clarksville market, and one insurer offers coverage in the Memphis market. In Nashville-Clarksville, Oscar entered the market in 2018. Humana left both markets, and Cigna was the only insurer participating in both 2017 and 2018. Cigna's lowest silver premium in Nashville-Clarksville increased by 37.7 percent in 2018, from $400 to $550 for a 40-year-old. Cigna increased its lowest gold premium by 67.0 percent, taking its lowest gold premium from $542 to $905 for a 40-year-old. Why Cigna's increase for gold premiums was higher than for silver premiums is unclear, particularly because the state required that the cost of CSRs be loaded onto all silver plans (both on and off the marketplace). As was the case with insurers in Augusta, Georgia, concerns about risk selection into gold plans may be affecting relative premium pricing across tiers, although the law intends to prohibit this.

Table 17: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Alabama

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 3: Birmingham						
Blue Cross Blue Shield of Alabama	$457	$542	18.5%	$600	$612	2.0%
Bright Health Plan	NA	$546	NA	NA	$672	NA
Average Percentage Change Across Insurers			18.5%			2.0%
Percentage Change in Region's Lowest-Premium Option			18.5%			2.0%

Source: Healthcare.gov Public Use File

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Alabama (Table 17). Bright Health Plan entered the Birmingham marketplace for 2018, joining Blue Cross Blue Shield of Alabama as the only insurers offering marketplace coverage in Birmingham. Blue Cross Blue Shield increased its lowest silver premium by 18.5 percent and its lowest gold premium by 2.0 percent in 2018. The different increases between the tiers reflects the state requirement that the cost of CSRs be incorporated into silver marketplace premiums alone. Blue Cross Blue Shield's lowest gold premium is still higher than its lowest silver premium ($612 versus $542 per month for a 40-year-old).

Table 18: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

New York

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Area 4: New York City						
Healthfirst	$454	$531	17.1%	$533	$612	14.8%
New York Fidelis	$456	$510	11.7%	$537	$603	12.3%
Metro Plus	$468	$504	7.7%	$550	$595	8.0%
Oscar	$483	$538	11.3%	$635	$640	0.8%
Affinity - All Standard Benefits	$483	NA	NA	$576	NA	NA
Northshore LIJ[1]	$487	NA	NA	NA	NA	NA
Emblem	$518	$652	25.7%	$628	$794	26.4%
Empire Blue Cross Blue Shield	$575	$883	53.5%	$700	$1,058	51.2%
United Healthcare of N.Y.	$714	$825	15.5%	$844	$1,009	19.6%
Average Percentage Change Across Insurers			20.4%			19.0%
Percentage Change in Region's Lowest-Premium Option			11.2%			11.6%
Rating Area 8: Long Island						
Fidelis	$446	$480	7.5%	$525	$567	8.1%
Health First	$454	$564	24.4%	$533	$650	21.9%
Oscar	$483	$538	11.3%	$635	$640	0.8%
North Shore LIJ	$487	NA	NA	NA	NA	NA
Affinity	$494	NA	NA	$589	NA	NA
Empire HMO	$510	$783	53.4%	$621	$939	51.1%
Emblem HIP	$590	$741	25.7%	$715	$904	26.4%
United Healthcare of N.Y.	$714	$825	15.5%	$844	$1,009	19.6%
Average Percentage Change Across Insurers			23.0%			21.3%
Percentage Change in Region's Lowest-Premium Option			7.5%			8.1%

Source: New York State of Health

Cost-sharing reduction effect minimal given Basic Health Plan.

1: Although required by law under the Affordable Care Act, Northshore LIJ did not offer a gold-level plan during the 2017 plan year.

New York (Table 18). New York is an unusual state because it developed a Basic Health Plan, known as the Essential Plan, that provides coverage for low premiums and with low cost-sharing requirements for enrollees otherwise eligible for marketplace tax credits who have incomes below 200 percent of the FPL.[12] Thus, adjustments to incorporate costs associated with CSRs were smaller than was the case in non–Basic Health Plan states, because only marketplace enrollees with incomes between 200 and 250 percent of the FPL receive the reductions, and their reductions are smaller than what the law provides for those with incomes below 200 percent of the FPL. New York has several competing insurers, although Northshore LIJ and Affinity left the New York City and Long Island marketplaces in 2018. Seven insurers compete in New York City and six insurers compete in Long Island in 2018.

In New York City, the lowest silver premium increased by 11.2 percent, and the lowest gold premium increased by 11.6 percent in 2018. On Long Island, the lowest silver premium increased by 7.5 percent, and the lowest gold premium increased by 8.1 percent. In 2018, the Medicaid managed care organizations Metro Plus and Fidelis offered New York

City's lowest-priced plans. On Long Island, Fidelis offers the lowest premium options, followed by Oscar.

The 2018 premium increases do not reflect a significant increase because of the elimination of federal CSRs reimbursement, so the increases must reflect concerns over anticipated changes in the risk pools and other policy uncertainty. There were large differences in premium increases across insurers. Empire Blue Shield, for example, increased both its lowest silver and gold premiums by over 50 percent in New York City and Long Island. At the other extreme, Metro Plus, Fidelis, and Oscar had small premium increases for their lowest-priced silver and lowest-priced gold plans, about 8 percent for Metro Plus and about 12 percent for Fidelis in New York City and about 8 percent in Long Island for Fidelis. Oscar increased its lowest silver premium by about 11 percent, and its lowest gold premium increased by less than 1 percent in 2018.

Table 19: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

West Virginia

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 2: Charleston						
CareSource	$505	$555	9.8%	$638	$747	17.0%
Highmark Blue Cross Blue Shield West Virginia	$541	$653	20.7%	$664	$834	25.6%
Average Percentage Change Across Insurers			15.3%			21.3%
Percentage Change in Region's Lowest-Premium Option			9.8%			17.0%

Source: Healthcare.gov Public Use File

Note: Insurers instructed to load the cost of cost-sharing reductions into all metal tiers, both on marketplace and off.

West Virginia (Table 19). Highmark Blue Cross Blue Shield West Virginia and CareSource offer plans on the Charleston marketplace. Highmark has been the state's dominant insurer. West Virginia required marketplace insurers to spread their costs associated with CSRs across all metal tiers for plans offered both on and off the marketplace. The lowest silver premium increased by 9.8 percent, and the lowest gold premium increased by 17.0 percent. CareSource remained the lowest-priced insurer, increasing its premiums by smaller margins than Highmark. The widening difference in premiums between CareSource and Highmark should, however, make CareSource more competitive in the Charleston marketplace in 2018.

Table 20: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Oklahoma

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 3: Oklahoma City						
Blue Cross Blue Shield of Oklahoma	$485	$507	4.5%	$610	$690	13.1%
Average Percentage Change Across Insurers			4.5%			13.1%
Percentage Change in Region's Lowest-Premium Option			4.5%			13.1%

Source: Healthcare.gov Public Use File

Note: Insurers instructed to load the cost of cost-sharing reductions into all metal tiers, both on marketplace and off.

Oklahoma (Table 20). Oklahoma required that the 2018 cost of CSRs be spread across all metal tiers and across plans both on and off the marketplace. Only Blue Cross Blue Shield of Oklahoma continues to operate on the Oklahoma City marketplace. The lowest silver premium increased by 4.5 percent, and the lowest gold premium increased by 13.1 percent in 2018. The lowest gold premium remains higher than the lowest silver premium ($690 versus $507 per month for a 40-year-old).

Table 21: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

Arizona

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 4: Phoenix						
Health Net of Arizona, Inc.	$475	$471	-0.9%	$661	$621	-6.0%
Average Percentage Change Across Insurers			-0.9%			-6.0%
Percentage Change in Region's Lowest-Premium Option			-0.9%			-6.0%
Rating Region 6: Tucson						
Health Net of Arizona, Inc.	$349	$332	-4.9%	$455	$438	-3.8%
Blue Cross Blue Shield of Arizona, Inc.	$502	$487	-3.1%	$614	$595	-3.0%
Average Percentage Change Across Insurers			-4.0%			-3.4%
Percentage Change in Region's Lowest-Premium Option			-4.9%			-3.8%

Source: Healthcare.gov Public Use File

Note: One insurer assumed cost-sharing reduction payments would not continue and made cost-sharing reduction adjustments across all metal tiers for both on- and off-marketplace plans.

Arizona (Table 21). Two insurers participate in Arizona's marketplace. One insurer assumed CSR payments would not continue and adjusted premiums across all metal tiers both on and off the marketplace. HealthNet is the only insurer participating in the Phoenix market, and Blue Cross Blue Shield of Arizona and HealthNet both offer marketplace plans in the Tucson market. In both markets, the insurers lowered their lowest-priced gold and silver options in 2018. In Phoenix, HealthNet's lowest silver premium decreased by 0.9 percent, and its lowest gold premium decreased by 6.0 percent. Its lowest Tucson silver premium decreased by 4.9 percent, and its lowest gold premium decreased by 3.8 percent. Blue Cross Blue Shield's lowest premiums in Tucson decreased by about 3 percent in both tiers. These decreases reflect the high 2017 premiums that were more than adequate to meet expected claims in 2018 and the insurers' desire to avoid paying rebates. Both insurers' lowest gold premiums were higher than their lowest silver premiums.

Table 22: Lowest Silver and Gold Monthly Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2017–2018

North Carolina

Insurer	Lowest Silver Premium			Lowest Gold Premium		
	2017	2018	Percent Change 2017–2018	2017	2018	Percent Change 2017–2018
Rating Region 4: Charlotte						
Blue Cross and Blue Shield of North Carolina	$565	$659	16.7%	$716	$703	-1.8%
Average Percentage Change Across Insurers			16.7%			-1.8%
Percentage Change in Region's Lowest-Premium Option			16.7%			-1.8%

Source: Healthcare.gov Public Use File

Note: Insurers instructed to load the cost of cost-sharing reductions into all silver plans, both on marketplace and off.

North Carolina (Table 22). As was the case in 2017, only Blue Cross Blue Shield of North Carolina offers marketplace insurance in the Charlotte market. In 2018, the lowest silver premium increased by 16.7 percent, and the lowest gold premium declined by 1.8 percent. The differential reflects CSR-related premium adjustments being made to silver plan premiums only. Despite the difference in premium growth across the tiers, the premium of the lowest-priced gold plan remains higher than the premium of the lowest-priced silver plan ($703 versus $659 per month for a 40-year-old).

DISCUSSION

It is difficult to find consistent patterns in marketplace premium changes between 2017 and 2018. Variation in premium growth characterized these markets in previous years,[9,13,14] but there were strong correlations between market characteristics and prior pricing and growth rates. The uncertainty about future enrollment, risk pools, and numbers of competitors has been exacerbated because of ongoing debates over the Affordable Care Act, enforcement of the law's components, cessation of federal reimbursement for CSRs, and administrative policy changes expected to reduce enrollment in the nation's private nongroup insurance markets both on and off the marketplaces. In setting their 2018 premiums, insurers appear to have incorporated varying degrees of uncertainty and different judgments (e.g., how big or small the effect of CSRs would have on premium increases) as to the implications of policy changes with which they have no experience. Some might also be incorporating differential risk expectations in gold versus silver plans, although the law prohibits such differences.

In states that instructed insurers to load costs associated with CSRs into their silver plans alone, silver premiums generally increased faster than gold plans, but this was not always the case. The impact of CSR adjustments appear to have varied among insurers across and within states. In few instances, the lowest gold premiums fell below the lowest silver premiums, but this outcome was not consistent even among insurers in a given state. Consistent with prior experience, however, areas with high previous-year premiums tended to have smaller premium increases than areas with low previous-year premiums.

More insurers left marketplaces than entered them this year in our study areas, reflecting uncertainty over previous and future policy changes. Without a renewed focus on promoting stability and for insurers and consumers, this dynamic will persist in the coming year.

NOTES

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10. The percentage changes between 2017 and 2018 for lowest-cost and second-lowest-cost silver plans are similar. Data for the second-lowest-cost silver plans (the premium tax credit benchmark plan) are shown in the appendix.
11. West Virginia, Oklahoma, and Indiana were instructed to spread CSR costs across all actuarial value tiers, insurers in Arizona and Georgia took varied approaches to addressing the CSR issue, and information was not available for Missouri. See note 7.
12. The only other state with a Basic Health Plan is Minnesota. In addition, the District of Columbia maintains an insurance program that was in place before the ACA that also covers those with incomes below 200 percent of the FPL outside the marketplace structure.
13. Holahan J, Wengle E, Blumberg LJ, Solleveld P. *What Explains the 21 Percent Increase in 2017 Marketplace Premiums, and Why Do Increases Vary Across the Country?* Washington: Urban Institute; 2017. https://www.urban.org/research/publication/what-explains-21-percent-increase-2017-marketplace-premiums-and-why-do-increases-vary-across-country.
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Table A-1: Increases in Second Lowest Priced Marketplace Silver Premiums by State, 2017-2018

Monthly Premiums are for a 40-year-old nonsmoker

State	2017 Average Benchmark Premium	2018 Average Benchmark Premium	Percentage Change in Average Benchmark Premiums 2017 to 2018
U.S. Average	$356	$470	34.3%
Alabama	$468	$555	18.7%
Alaska	$927	$727	-21.6%
Arizona	$540	$517	-4.3%
Arkansas	$303	$365	20.6%
California	$335	$424	26.6%
Colorado	$341	$432	26.7%
Connecticut	$436	$541	24.1%
D.C.	$298	$324	8.7%
Delaware	$423	$591	39.5%
Florida	$337	$477	41.9%
Georgia	$325	$496	52.6%
Hawaii	$347	$456	31.6%
Idaho[1]	$353	$483	36.8%
Illinois	$360	$497	38.0%
Indiana	$273	$343	25.5%
Iowa	$333	$695	108.7%
Kansas	$363	$486	33.9%
Kentucky	$267	$443	65.6%
Louisiana	$421	$497	18.2%
Maine	$378	$577	52.4%
Maryland	$296	$456	54.0%
Massachusetts	$252	$316	25.4%
Michigan	$266	$372	39.8%
Minnesota	$442	$382	-13.7%
Mississippi	$332	$519	56.3%
Missouri	$369	$521	41.2%
Montana	$450	$522	16.0%
Nebraska	$476	$757	59.0%
Nevada	$314	$466	48.3%
New Hampshire	$267	$475	77.8%
New Jersey	$339	$411	21.3%
New Mexico	$254	$431	69.5%
New York	$454	$498	9.7%
North Carolina	$540	$619	14.6%
North Dakota	$334	$310	-7.3%
Ohio	$262	$364	38.8%
Oklahoma	$503	$658	30.7%
Oregon	$321	$423	31.6%
Pennsylvania	$367	$524	42.5%
Rhode Island	$261	$311	19.0%
South Carolina	$390	$524	34.3%
South Dakota	$457	$497	8.7%
Tennessee	$471	$743	57.8%
Texas	$287	$404	41.0%
Utah	$311	$550	77.1%
Vermont	$492	$505	2.8%
Virginia	$319	$525	64.8%
Washington	$247	$335	35.6%
West Virginia	$461	$532	15.4%
Wisconsin	$360	$524	45.5%
Wyoming	$502	$861	71.7%

Source: Healthcare.gov public use files and relevant state marketplace websites and rate filings

1: Idaho combined rating area 7 into rating area 5 for the 2018 plan year.

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How Did State-Run Health Insurance Marketplaces Fare in 2017?

March 21, 2018

Authors

Justin Giovannelli, Emily Curran

Citation

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Abstract

- **Issue:** Sixteen states and the District of Columbia manage their own health insurance marketplaces under the Affordable Care Act. These states, which were broadly supportive of health reform, chose to run their marketplaces to exert greater control over their insurance markets and tailor the portals to suit local needs. Though federal policy changes and political uncertainty around the ACA in 2017 have posed challenges across the country, states that operate their own marketplaces had greater flexibility than others to respond.

- **Goal:** To understand how states on the forefront of health reform perceived and responded to federal policy changes and political uncertainty in 2017.

- **Methods:** Structured interviews with the leadership staff of 15 of the 17 state-run marketplaces.

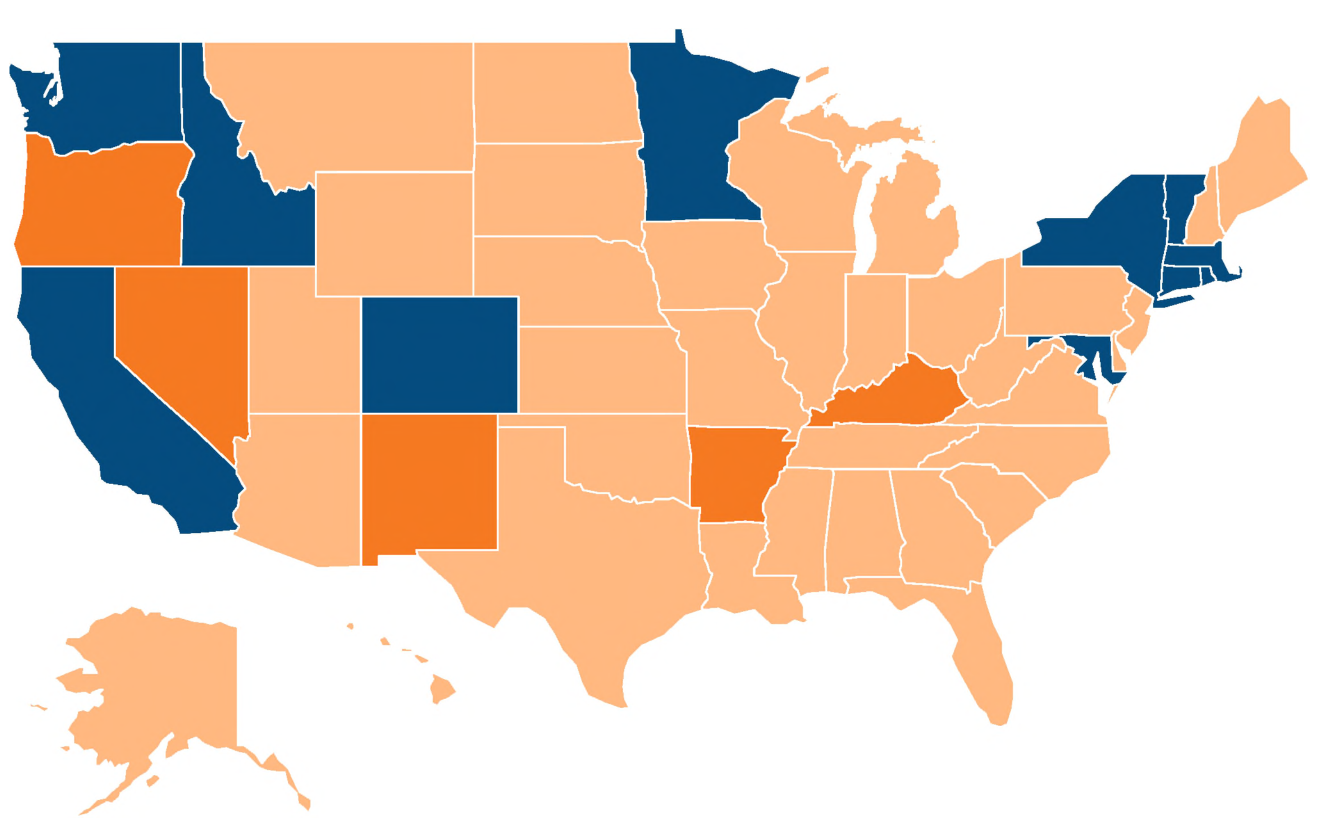
- **Findings and Conclusions:** Respondents unanimously suggested that federal administrative actions and repeal efforts have created confusion and uncertainty that have negatively affected their markets. The state-run marketplaces used their broader authority to reduce consumer confusion and promote stable insurer participation. However, their capacity to deal with federal uncertainty has limits and respondents stated that long-term stability requires a reliable federal partner.

Background

The Affordable Care Act created health insurance marketplaces, also known as exchanges, in each state to help people who don't have access to insurance through an employer or public program. The marketplaces act as a gateway to coverage for residents, providing a platform through which they can compare and purchase plans. Sixteen states and the District of Columbia are responsible for managing their own marketplaces; 34 states rely on the federal government to operate their exchange (Exhibit 1).[1 (#/#1)]

Exhibit 1

Affordable Care Act Health Insurance Marketplaces by Type, 2017



State-run marketplace (11 states and D.C.)

State-run marketplace using the federal eligibility and enrollment platform (5 states)   Federally run marketplace (34 states)

Data: Authors' analysis.

Source: J. Giovannelli and E. Curran, *How Did State-Run Health Insurance Marketplaces Fare in 2017?* The Commonwealth Fund, March 2018.

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States that decided to manage their marketplaces wanted to retain control over their insurance markets and have the authority to tailor the portal to meet local needs.[2 (#/#2)] Compared with states using the federally run marketplace, nearly all these states have expanded their Medicaid programs and have been much more likely to adopt the ACA's consumer protections into state law — potentially making it easier to enforce these reforms.[3 (#/#3)]

Since President Trump's election, the ACA and marketplaces have faced an uncertain future. The president has been openly hostile to the ACA and sought its repeal.[4 (#/#4)] At the same time, the administration has made regulatory and other implementation changes and reduced the funding that supports the marketplaces. These decisions have all affected how the law operates in practice and have had serious repercussions across the country.[5 (#/#5)] However, the impact has not been uniform. It has varied, in part, based on the choices state policymakers have made in implementing the ACA — including whether to run their own exchange.

We sought to understand how states that have been more actively engaged in reform have perceived federal policy changes and political uncertainty in 2017, and to explore whether these states were better able to promote stability within their markets. To do so, we interviewed the leadership staff of 15 of the 17 state-run marketplaces in September and October 2017.[6 (#/#6)] This brief explores key themes that emerged from those interviews. It identifies the major challenges facing the marketplaces as they went into the fifth open enrollment period, how states responded to those challenges, and the limits on states' capacities to act.

Key Findings

Federal Actions Made It Harder for States to Manage Their Own Marketplaces

Marketplace respondents were unanimous in suggesting that actions taken by the Trump administration and ongoing efforts to repeal the ACA have created confusion and uncertainty that have negatively affected their markets. While these marketplaces had experienced ups and downs during their first three years of operation, many respondents were relatively optimistic in the fall of 2016 about future enrollment growth and stability in terms of plan participation and premiums — a view supported by independent analyses.[7 (#/#7)] But federal developments in 2017 made the challenges of the previous year "pale in comparison," and respondents described a far more uncertain future.

Officials highlighted four federal-level developments during 2017 that jeopardized stability. First, respondents said that the administration's repeated threats to end federal payments supporting the ACA's cost-sharing reduction (CSR) plans caused protracted confusion and disruption and placed states in a "real jam." These threats were eventually carried out, after months of uncertainty, in October 2017. But as deadlines for marketplace participation and rate setting for the upcoming year (2018) came and went with no clarity on whether the administration would continue to reimburse insurers for the cost of the CSR subsidies, marketplaces struggled to get insurers to commit to participate and to develop responses to the significantly higher premiums the insurers sought to offset the lost payments.[8 (#/#8)]

Second, most respondents noted that actions taken by the administration to undermine the ACA's individual mandate had the effect of undermining their marketplaces, as well. The requirement to maintain coverage, ultimately repealed on a prospective basis in December, was the law of the land throughout 2017 (and remains so in 2018). However, officials noted that an executive order, signed by the president on Inauguration Day, cast doubt on the enforcement of the mandate and caused insurers to be more cautious when setting rates.[9 (#/#9)] Many priced higher than they would

have otherwise, fearing that a weakened mandate would lead to a sicker and more expensive risk pool.[10 (#/#10)] The president's actions and words were also perceived to have caused widespread confusion among consumers about whether the requirement to maintain coverage was still the law.

In a related vein, officials repeatedly expressed frustration at "federal noise": ongoing but thus far inconclusive discussions about repealing and replacing the ACA, and related rhetoric by administration officials and congressional allies asserting that the health law was "dead" or "collapsing." Respondents said it was a challenge to ensure residents had accurate information. They reported many instances of consumer confusion about the marketplaces, the mandate, coverage options, and the status of the health law, in general.

Fourth, a majority of respondents predicted that the administration's decision to reduce advertising spending for the federal marketplace by 90 percent would have negative side effects for the state-run exchanges. Officials in both big and small states explained that because the federal marketing campaign was national in scope and used television advertising — a medium too expensive for several state marketplaces — it was effective in reaching their residents and had complemented state messaging efforts in prior years. Several respondents also lamented the perceived political ramifications of the funding cut, suggesting that the administration's action would cause enrollment through the federal exchange to diminish, putting the entire program at greater risk of repeal.[11 (#/#11)]

State Marketplaces Used Their Authority to Promote Stability Despite Federal Uncertainty

Extending Open Enrollment

While the administration used its first major ACA-related rulemaking to reduce the open enrollment period for the federal marketplace from 90 to 45 days, nine of the 12 state marketplaces with authority to choose their enrollment dates extended their sign-up periods beyond the federal deadline (Exhibit 2). (The five state-run marketplaces that use HealthCare.gov for enrollment are not permitted to deviate from the federal government's default enrollment dates.) Most reported that this decision was designed to counteract confusion caused by "federal noise" and that an extension was critical to fulfilling outreach strategies and giving consumers sufficient time to enroll.

When selecting a deadline, many states sought — with some difficulty — to balance the interests of consumers who needed more time to decide on a plan with insurers' requests for a longer coverage period with a full 12 months of premium payments. In the three states that chose not to extend, officials reported that prior year trends showed most consumers enrolled by the federal December 15 deadline.

On the other hand, one respondent from a state marketplace that uses HealthCare.gov expressed frustration in not having the same flexibility to choose a deadline. The respondent noted that even a few additional days would have helped to manage operational tasks and increase sign-ups.

Promoting Consumer Choice

Respondents suggested the uncertain federal policy environment led their marketplaces to work diligently to maintain insurer participation and thus, more choices for consumers. In California, officials modified insurers' contracts to allow carriers that incur 2018 losses because of federal policy or enrollment changes to recoup lost funds in subsequent years.[12 (#/#12)] In New York, the governor issued an executive order preventing any insurer that withdrew from the individual marketplace from offering plans in another state program.[13 (#/#13)] One state refrained from making major changes to plan requirements to avoid creating additional burdens in an already difficult year, and several respondents noted that state officials and governors personally reached out to insurers to encourage them to remain in the marketplace and maintain competition.

Combating Consumer Confusion

In the face of widespread consumer confusion, several state marketplaces increased marketing budgets to compensate. In California, for instance, officials credit past investments in marketing and outreach for producing increased enrollment, a better risk mix, lower premiums, and greater certainty for health plans. They budgeted $111 million for these responsibilities in 2018 — up from $99 million in 2017 and more than twice what the administration spent on the federal marketplaces combined. In Oregon, the state increased spending during the final weeks of 2017 enrollment — after the administration cut federal marketing — and found the added funding drove higher enrollment.

Many other state marketplaces reallocated limited funds or modified their marketing strategies to more effectively target the uninsured and reduce misinformation. Most state-run marketplaces began advertising earlier — several months before the start of 2018 open enrollment — to assure consumers they were "open for business." They also revised their messaging to emphasize the value of insurance and financial assistance, rather than focusing on the individual mandate. Others reported shifting from more expensive outreach efforts, like television marketing and brick-and-mortar enrollment locations, to promotional activities designed to cultivate free and local media, and grassroots initiatives. For example, in Connecticut, the marketplace reduced spending on television marketing and increased its community outreach, including attending local football games. In Colorado, the marketplace invested in "geo-code outreach" to identify the uninsured by zip code, and in Minnesota, marketplace staff devoted more time to traveling throughout the state, promoting enrollment in person.

Proactive Problem-Solving on CSRs

Respondents viewed the administration's equivocating over CSR funding as seriously destabilizing; their marketplaces moved ahead under their own authority to mitigate the damage. Months before the administration would end the uncertainty by stopping the payments, the California marketplace became the first to announce a workaround. Officials directed insurers to assume CSR reimbursements would not be made and to allocate the premium increase needed to offset the funding cut-off onto their silver-tier marketplace plans.[14 (#/#14)] This innovative approach — ultimately adopted by 30 states — enabled subsidized consumers to access a larger premium tax credit and exercise greater buying power on the marketplaces. It also insulated unsubsidized shoppers from the effects of the CSR-related surcharge.[15 (#/#15)]

For Long-Term Market Stability, States Need a Reliable Federal Partner

Though respondents expressed confidence in the ability of their marketplaces to use existing authority to do right by their residents, most made plain that long-term stability depended on a constructive partnership with and support from the federal government. Respondents repeatedly invoked a kind of "Hippocratic Oath" for health insurance, imploring the administration to first do no harm to their markets. The "biggest thing" that could happen, said one, would be for the administration to stop sowing uncertainty. To that end, most urged, during the fall of 2017, that the government commit to funding CSRs and enforce existing federal law.

Beyond these rather remarkable requests to stop undercutting their efforts, respondents saw value in several steps the federal government might take to support their markets and the consumers who rely on them. Most expressed that reinsurance programs were effective in reducing premiums and could "help everyone" — the subsidized and unsubsidized alike. Several states were pursuing such programs using a blend of state and federal funding, under the ACA's Section 1332 innovation waiver program.[16 (#/#16)] But respondents noted that state budget constraints limited the potential of this mechanism. They suggested that a permanent federally funded reinsurance program would do far more to promote stability across the nation.[17 (#/#17)]

Respondents also generally favored modest changes to the 1332 waiver program. While they were strongly supportive of the "guardrail" provisions that protect state residents from waivers that might worsen the comprehensiveness, affordability, or availability of coverage, respondents suggested that efforts to streamline the application process and provide greater flexibility in the interpretation of the program's deficit neutrality requirements would be welcome.

Discussion

The states that chose to manage their own marketplaces viewed the portals as an important tool for broadening access to affordable coverage for their residents and embraced the opportunity to make them work.[18 (#/#18)] Though their experiences in the first three years of operation varied and sometimes were rocky, these marketplaces appeared fundamentally stable heading into 2017.

Since then, the Trump administration and its congressional allies have engaged in a sustained effort to undermine the ACA. These actions have had a destabilizing effect on marketplaces across the country, including — as respondents made clear — the marketplaces run by the states.

However, because these 17 states retained local control over their marketplaces, they have been able to respond to threats to their stability and act more nimbly in the face of changing circumstances. All respondents detailed actions their states were taking to counter consumer confusion and market uncertainty and increase the chances of a successful fifth open enrollment season. These efforts appear to have paid dividends. On average, the state marketplaces were able to retain insurers at a higher rate than were the federal exchanges.[19 (#/#19)] Their premium rate increases, though substantial, were on average less than in federal marketplace states.[20 (#/#20)] And total plan selections through the state exchanges during the most recent open enrollment period rose slightly, year-over-year, even as sign-ups through the federal marketplace modestly declined.[21 (#/#21)]

States may chart their own course in other ways. Though recent proposed changes to federal rules would eliminate consumer-friendly innovations for plans sold on the federal marketplaces, including optional standardized plans to facilitate consumer decision-making, the state marketplaces have authority to maintain these improvements.[22 (#/#22)] Administration proposals that would expand the availability of benefit plans that do not meet the ACA's consumer protections do not stop states — regardless of marketplace type — from regulating such plans if policymakers choose. And though the federal individual mandate goes away in 2019, states may replace it and adopt policies that encourage residents to maintain coverage.

States' capacity to deal with federal uncertainty is not unlimited. Though the administration has made it a goal to empower states, the experiences of the states that have embraced responsibility for their marketplaces show the limits of this federal commitment. For the marketplaces to work for the people who need them, constructive federal engagement and support will be essential.

Notes

[1] Unless otherwise noted, we count the District of Columbia as a state in this analysis.

[2] S. Dash, C. Monahan and K. Lucia, "Health Policy Brief: Health Insurance Exchanges and State Decisions (https://www.healthaffairs.org/do/10.1377/hpb20130718.132696/full/)." *Health Affairs,* July 18, 2013; see also J. Giovannelli and K. Lucia, *The Experiences of State-Run Marketplaces That Use HealthCare.gov (/publications/issue-briefs/2015/sep/state-run-marketplaces-use-healthcaregov)* (The Commonwealth Fund, Sept. 2015).

[3] K. Keith and K. Lucia, *Implementing the Affordable Care Act: The State of the States (/publications/fund-reports/2014/jan/implementing-the-affordable-care-act)* (The Commonwealth Fund, Jan. 2014); and Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision (https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)* (Henry J. Kaiser Family Foundation, Nov. 2017).

[4] See, e.g., I. Bobic, "Trump Says There's 'No Such Thing As Obamacare Anymore' One Month Before Enrollment Starts (https://www.huffingtonpost.com/entry/trump-obamacare-dead_us_59e4de47e4b0a52aca19aefb)." *Huffington Post,* Oct. 16, 2017; R. Pear, "Governors Rally Around Health Law Fixes as White House Pushes Repeal (https://www.nytimes.com/2017/09/07/us/politics/governors-obamacare-fixes-trump-repeal.html)." *New York Times,* Sept. 7, 2017; and A. Carlsen and H. Park, "The Same Agency That Runs Obamacare Is Using Taxpayer Money to Undermine It (https://www.nytimes.com/interactive/2017/09/04/us/hhs-anti-obamacare-campaign.html)." *New York Times,* Sept. 4, 2017. In December 2017, Republican congressional majorities passed, and the president signed, legislation that effectively repealed the ACA's individual mandate: the requirement that individuals maintain minimum essential health coverage or else pay a tax penalty. This change takes effect beginning in 2019.

[5] See, e.g., J. Rovner, "Timeline: Roadblocks to Affordable Care Act Enrollment (https://khn.org/news/timeline-roadblocks-to-affordable-care-act-enrollment/)." *Kaiser Health News,* Nov. 1, 2017; S. Kliff, "This Is What Obamacare Sabotage Looks Like (https://www.vox.com/policy-and-politics/2017/9/5/16240282/obamacare-sabotage-trump)." *Vox,* Sept. 5, 2017; and J. Giovannelli and K. Lucia, "Amid Market Uncertainty, Trump Administration Retreats from Health Plan Oversight (/publications/blog/2017/jun/retreat-from-health-plan-oversight)." *To the Point,* The Commonwealth Fund, June 20, 2017.

[6] We sought to interview officials representing all 17 state-run marketplaces and ultimately conducted structured interviews with executive staff from 15 of the exchanges, primarily the marketplace's CEO or executive director. The interviews took place in September and October 2017, prior to the start of open enrollment on November 1 and before Congress passed legislation repealing the ACA's individual mandate, in late December.

[7] M. Fielder, *Taking Stock of Insurer Financial Performance in the Individual Health Insurance Market Through 2017 (https://www.brookings.edu/research/taking-stock-of-insurer-financial-performance-in-the-individual-health-insurance-market-through-2017/)* (Brookings Institution, Oct. 2017); C. Cox and L. Levitt, *Individual Insurance Market Performance in Early 2017 (http://files.kff.org/attachment/Issue-*

Brief-Individual-Insurance-Market-Performance-in-Early-2017) (Henry J. Kaiser Family Foundation, July 2017); and D. Banerjee, *The ACA Individual Market: 2016 Will Be Better Than 2015, But Achieving Target Profitability Will Take Longer (https://morningconsult.com/wp-content/uploads/2016/12/12-22-16-The-ACA-Individual-Market-2016-Will-Be-Better-Than-2015-But-Achieving-Target-Profitability-Will-Take-Longer.pdf)* (S&P Global Ratings, Dec. 22, 2016). See also K. Giesa, *Analysis: Market Uncertainty Driving ACA Rate Increases (http://health.oliverwyman.com/transform-care/2017/06/analysis_market_unc.html)* (Oliver Wyman Health, June 2017); and C. Garthwaite and J. Graves, "Success and Failure in the Insurance Exchanges (http://www.nejm.org/doi/full/10.1056/NEJMp1614545)," *New England Journal of Medicine,* March 9, 2017 376(10):907–10.

[8] S. Corlette and K. Lucia, "Down to the Wire: Indecision on ACA Cost-Sharing Reduction Payments Creates Confusion for States (/publications/blog/2017/sep/cost-sharing-reduction-payment-indecision)," *To the Point,* The Commonwealth Fund, Sept. 8, 2017.

[9] N. Bagley, "Trump's Executive Order on Obamacare (https://theincidentaleconomist.com/wordpress/trumps-executive-order-on-obamacare/)," *Incidental Economist,* Jan. 21, 2017.

[10] R. Kamal, C. Cox, C. Shoaibi et al., *An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges* (https://www.kff.org/health-reform/issue-brief/an-early-look-at-2018-premium-changes-and-insurer-participation-on-aca-exchanges/) (Henry J. Kaiser Family Foundation, Aug. 2017); and S. Corlette, K. Lucia, J. Giovannelli et al., *Uncertain Future for Affordable Care Act Leads Insurers to Rethink Participation, Prices (https://www.urban.org/sites/default/files/publication/87816/2001126-uncertain-future-for-affordable-care-act-leads-insurers-to-rethink-participation-prices_1.pdf)* (Urban Institute, Jan. 2017).

[11] See also D. Scott, "Obamacare Enrollment Is Shrinking After Trump's Sabotage (https://www.vox.com/policy-and-politics/2017/10/11/16447504/obamacare-open-enrollment-trump-sabotage)," *Vox,* Dec. 15, 2017.

[12] Covered California, *Policy and Action Items (http://board.coveredca.com/meetings/2017/08-17/PPT%20-%20Board%20Policy%20and%20Action%20Final%20-%20August%202017.pdf)* (Covered California, Aug. 17, 2017).

[13] Office of Governor Andrew Cuomo, *Executive Order No. 167: Ban on Insurers that Withdraw from New York State of Health (https://www.governor.ny.gov/news/no-167-ban-insurers-withdraw-ny-state-health-new-yorks-official-health-plan-marketplace)* (New York State Office of the Governor, June 30, 2017).

[14] Covered California, *Supplemental Guidance on Rate Filing Instructions Related to the Cost-Sharing Reduction Program (http://board.coveredca.com/meetings/2017/06-15/Background/Covered-CA-CSR%20Supplemental%20Rate%20Filing%20Instructions%206-6-17.pdf)* (Covered California, June 6, 2017).

[15] S. Corlette, K. Lucia, and M. Kona, "States Step Up to Protect Consumers in Wake of Cuts to ACA Cost-Sharing Reduction Payments (/publications/blog/2017/oct/states-protect-consumers-in-wake-of-aca-cost-sharing-payment-cuts)," *To the Point,* The Commonwealth Fund, Oct. 27, 2017.

[16] The ACA's Section 1332 waiver program allows states to waive enumerated provisions of the health law to facilitate state-specific strategies to improve coverage. Section 1332 allows states to access federal funding for a waiver program in certain circumstances. By 2018, three states — Alaska, Minnesota, and Oregon — were using Section 1332 waivers to tap federal funding to support a state-based reinsurance program. See J. Giovannelli and K. Lucia, *The ACA's Innovation Waiver Program: A State-by-State Look (/interactives-and-data/infographics/2017/oct/status-of-innovation-waivers-map)* (The Commonwealth Fund, March 2018).

[17] Many respondents suggested a permanent federal reinsurance program could be modeled on the temporary one established under the ACA, which was successful in moderating premiums during its operation from 2014–2016.

[18] This view was universal, common both to the states that use their own eligibility and enrollment websites, as well as to those that rely on HealthCare.gov.

[19] A. Semanskee, C. Cox, G. Claxton et al., *Insurer Participation on ACA Marketplaces, 2014–2018 (https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/)* (Henry J. Kaiser Family Foundation, Nov. 2017). See also E. Curran, J. Giovannelli, and K. Lucia, "Insurer Participation in ACA Marketplaces: Federal Uncertainty Triggers Diverging Business Strategies (/publications/blog/2018/jan/insurer-participation-in-aca-marketplaces)," *To the Point,* The Commonwealth Fund, Jan. 5, 2018.

[20] M. Hall and M. McCue, "Health Insurance Markets Perform Better in States That Run Their Own Marketplaces (/publications/blog/2018/mar/health-insurance-markets-states)," *To the Point,* The Commonwealth Fund, March 7, 2018; C. Gaba, *And with That, I'm Done. Final 2018 Rate Hike Average: ~29.5%, 3/5ths Caused Directly by Trump Sabotage (http://acasignups.net/17/11/01/and-im-done-final-2018-rate-hike-average-295-35ths-caused-directly-trump-sabotage)* (ACASignups.net, Oct. 27, 2017); and C. F. Pearson and C. Sloan, *Silver Exchange Premiums Rise 34% on Average in 2018 (http://avalere.com/expertise/managed-care/insights/silver-exchange-premiums-rise-34-on-average-in-2018)* (Avalere, Oct. 25, 2017).

[21] Kaiser Family Foundation, *National ACA Marketplace Signups Dipped a Modest 3.7 Percent This Year (https://www.kff.org/health-reform/press-release/national-aca-marketplace-signups-dipped-a-modest-3-7-percent-this-year/)* (Henry J. Kaiser Family Foundation, Feb. 2018).

[22] In a proposed rule intended to take effect in 2019, the Trump administration would eliminate two features of the federal marketplace intended to improve consumer decision-making: standardized plan options and the "meaningful difference" standard. Patient Protection and Affordable Care Act, "HHS Notice of Benefit and Payment Parameters for 2019, Proposed Rule," *82 Fed. Reg.* 51052, 51081, 51111 (Nov. 2, 2017). A standard plan is a plan with a standardized cost-sharing structure (deductibles, copayments, and coinsurance) that is intended to make it easier for consumers to make apples-to-apples comparisons between plans. The federal marketplace specified optional standard plan designs in 2017 and 2018 and provided differential display of these plans on HealthCare.gov. The "meaningful difference" standard is intended to reduce consumer confusion and make the task of health plan selection more manageable by prohibiting the same insurer from selling multiple marketplace health plans that are so similar to one another in terms of cost-sharing structure, provider networks, covered, benefits, and plan type, that a reasonable consumer could not distinguish between them.

Seven state-run marketplaces use standard plans and many have established a "meaningful difference" standard. These marketplaces may continue to apply these features notwithstanding the proposal by the federal government to eliminate them for the federal exchange.

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A Proposal to Lower ACA Premiums by More than 40% and Cover 3.2 Million More

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ACTIONABLE INSIGHT

"We estimate 3.2M more people will be covered in the non-group market, and reinsurance program funds will result in 40% lower premiums. #ACA"

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In our December 9, 2017 article, we analyzed the effects of a proposal the US Senate was considering to fund cost-sharing reduction (CSR) payments and appropriate $5 billion in 2019 and 2020 for states to establish reinsurance programs to stabilize their individual insurance markets. We discussed how pass-through savings could provide reinsurance coverage equal to roughly $15 billion in protection for high-cost claimants, and how this protection, combined with CSR funding, would bring more people into the individual market and lower premiums by over 20 percent.

More recent congressional attention is focusing on a proposal that includes an extension of CSRs and a reinsurance program in 2019, 2020, and 2021, funded with a $10 billion appropriation in each year, with a federal fallback option available to states in 2019. The federal fallback option would likely be based on – and use the federal infrastructure built to administer – the Transitional Reinsurance Program in place from 2014 through 2016.

Our healthcare microsimulation model, used to understand this package's likely effects on the market, assumed states would use federal pass-through savings under Section 1332 of the Affordable Care Act (ACA) to supplement and leverage the $10 billion the considered legislation would authorize and appropriate each year. Pass-through savings result from the fact that the premium subsidies available under the ACA cover the difference between the second lowest cost silver plan available in a rating area and a fixed percentage of a household's income, varying only by federal poverty level (FPL). Lower premiums result directly in lower premium subsidies, and under a Section

1332 waiver, these savings from lower premiums may be used to provide additional reinsurance.

In our modeling, we are presuming that states will take advantage of these pass-through savings in 2019. In reality, states that have not already begun working on a waiver will be challenged to get a 1332 waiver filed and approved under the current regulatory regime in time to impact 2019 premiums. The current regulatory regime includes a requirement that a state enact enabling legislation, develop an application, hold public hearings during a 30-day public comment period, and submit the application to the US Health and Human Services (HHS). HHS then undertakes a two-step review process that can span up to 225 days – up to 45 days for a completeness determination followed by up to 180 days for review. But even those states unable to get a waiver in place for 2019 would still benefit from that year's federal fallback program.

Therefore, we estimate, under the assumptions described above, that an additional 3.2 million people will be covered in the non-group market, and the proposal would result in premiums that are at least 40 percent lower than they would have been without the proposal in place, across all metal levels. In those states that are not able to obtain a 1332 waiver and take advantage of pass-through savings for 2019, we estimate that premium would decline by more than 20 percent across all metal levels. Those estimates include an average 10 percent reduction due to the funding of CSRs, with the remaining reduction coming from the reinsurance program.

As a note, our modeling reflects elimination of the mandate penalty, but does not consider the proposed regulation's likely effects on association health plans or on short-term, limited duration coverage.

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