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

COVERED CALIFORNIA

WORKING DRAFT

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Please send comments on this draft report to policy@covered.ca.gov by 1/24/19

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TABLE OF CONTENTS

EXECUTIVE SUMMARY 1

INTRODUCTION 5

OVERVIEW OF THE INDIVIDUAL MARKET PROVISIONS OF THE AFFORDABLE CARE ACT 5

Benefits and Coverage Levels 5

Premium Tax Credits 6

Cost Sharing Reductions........ 8

Individual Shared Responsibility Provision 8

Risk and Market Stabilization Programs 8

THE IMPACT OF THE AFFORDABLE CARE ACT ON CALIFORNIA'S INDIVIDUAL MARKET 9

Actions to Support Unsubsidized Enrollees 10

AFFORDABILITY CHALLENGES IN THE INDIVIDUAL MARKET 11

Affordability Challenges for Low- and Middle-Income Californians Eligible for Federal Subsidies........ 11

Affordability Challenges for Middle-Income Californians Ineligible for Federal Subsidies 12

Recent Federal Changes Undermine the Affordable Care Act and Introduce Uncertainty........ 13

AB 1810 AFFORDABILITY REPORT 15

AB 1810 and Covered California's Legislative Charge........ 15

OPTIONS TO IMPROVE AFFORDABILITY IN THE INDIVIDUAL MARKET 17

Selection of Policy Options 17

Summary of Analytic Approach – the Microsimulation Model 17

APPROACH 1: MARKET-WIDE AFFORDABILITY ENHANCEMENTS........ 18

Discussion of Projected Aggregate Impacts of Policy Options under Approach 1 19

Impact on Take Up and the Remaining Uninsured 25

APPROACH 2: TARGETED AFFORDABILITY ENHANCEMENT 27

Potential Impacts Beyond 2021 33

IMPLEMENTATION CONSIDERATIONS 34

Implementation Timing 34

Premium Subsidies 34

Cost-Sharing Subsidies 35

DRAFT

Individual Mandate 36
Reinsurance 36
APPENDIX I 38
STATUTORY LANGUAGE OF AB 1810 (2018) 38
APPENDIX II 39
STAKEHOLDER WORKGROUP MEMBERS 39
APPENDIX III 40
2019 FEDERAL POVERTY LEVEL TABLE 40
APPENDIX IV 41
2019 PATIENT-CENTERED BENEFIT DESIGNS 41
APPENDIX V 42
TECHNICAL INFORMATION 42
APPENDIX VI 45
ADDITIONAL INFORMATION FOR APPROACH 1 45
APPENDIX VII 47
SELECTED RESOURCES 47
ENDNOTES 48

DRAFT

EXECUTIVE SUMMARY

The 2018-19 budget trailer bill (Assembly Bill 1810, Chapter 34, Statutes of 2018) requires Covered California, in consultation with stakeholders and the Legislature, to develop a health care affordability report to the Legislature, Governor, and the new Council on Health Care Delivery Systems, by February 1, 2019. The legislation tasks Covered California with developing options for providing financial assistance to help low- and middle-income Californians access health care coverage, including options to assist low-income individuals paying a significant percentage of their income on health coverage. This Report has been developed jointly by Covered California staff and economists Wesley Yin, PhD, University of California at Los Angeles, and Nicholas Tilipman, PhD, University of Illinois at Chicago. Covered California was advised throughout the development of this Report by a stakeholder workgroup. Appendix I provides the legislative text and Appendix II provides a list of workgroup membership.

This Report is organized into three main sections. The first section describes the tools of the Affordable Care Act that apply to the individual health insurance market, provides an overview of enrollment in California's individual market, and discusses some key remaining affordability challenges. The second section provides options to improve affordability for individual market enrollees and those who are eligible but remain uninsured. The third section provides an overview of key policy and operational decisions that would be required to implement the affordability options modeled in this Report.

The Affordable Care Act included several policies to stabilize the individual market and provide financial support to low- and middle-income consumers who previously had no help paying for coverage. These include advanceable tax credits to lower monthly premiums; cost-sharing subsidies to reduce deductibles and other out-of-pocket expenses; an individual mandate to maintain health insurance coverage and a penalty for noncompliance; and a temporary reinsurance program that lowered premiums charged to consumers by reimbursing health insurance issuers for a portion of high cost claims. Taken together, these policies have provided direct financial assistance to 1.2 million consumers enrolled through Covered California – the state's health benefit exchange – and have moderated premium increases for an additional one million Californians who purchase individual market coverage but earn too much to qualify for premium tax credits or cost-sharing subsides.

While California has made significant progress in the last five years using the tools of the Affordable Care Act, affordability challenges remain. Survey research highlights affordability as the top challenge for individuals who are insured as well as those who remain uninsured. A significant share of consumers who receive premium tax credits and cost-sharing support still report difficulty paying their monthly premiums and out-of-pocket expenses, and despite significant subsidies, enrollment among the consumers who are currently eligible for federal subsidies is only slightly above seventy percent – significantly lower than the take up rate for employer-sponsored coverage and Medi-Cal, which are the two most common coverage sources for individuals under 65 years of age. Consumers who earn too much or do not qualify for subsidies receive no financial protection from premium or out-of-pocket costs. Premiums in the individual market vary by age and region leading to very different cost experiences depending on a consumer's particular situation. For consumers nearing retirement age living in high-cost regions, premium costs can exceed 30 percent of income for the most common benefit package. Consumers who opt for lower cost plan options may have an annual medical deducible of more than $6,000.

This Report presents two approaches to enhancing affordability in California's individual market to address these challenges. Approach 1, "Market-wide Affordability Enhancements," presents three policy options that build upon each other with the goal of enhancing affordability for all individual market enrollees. Policy Option 1 eliminates the tax credit cliff and significantly expands cost-sharing subsidies; Policy Option 2 which adds an individual mandate penalty to Policy Option 1; and Policy Option 3 which adds a reinsurance program to Policy Option 2. Approach 2, "Targeted Affordability Enhancements," presents several options for enhancing affordability within specific income groups. The modeling forecasts how each of the policies would affect five outcomes within the individual market: enrollment, coverage rates, plan choice, new funding for proposed subsidies, and impacts on federal premium tax credits.

Full implementation of Approach 1 – including expansion of premium and cost-sharing support and implementation of a state-based individual mandate and reinsurance program – would achieve significant coverage gains, cap and reduce premium contributions, make care more affordable, and lower premiums market-wide. Enrollment would increase by about 764,000 Californians and the "take up" of individual market coverage would increase from 51 percent to 70 percent (see Policy 3 in Summary of Approach 1). The increase in cost-sharing generosity would increase enrollment in higher value (Silver tier or higher) plans by 10 percentage points. New state spending on premium and cost-sharing support would cost approximately $2.5 billion in policy option three. This new state cost could be offset by penalty revenue and federal funding that could be provided through a Section 1332 waiver.

Summary of Approach 1 – Market-wide Affordability Enhancements

Outcomes	ACA Baseline 2021	Policy Option 1	Policy Option 2	Policy Option 3
Enrollment Increase		**290,000**	**648,000**	**764,000**
<250		*66,000*	*120,000*	*139,000*
250-400		*153,000*	*342,000*	*358,000*
400+		*71,000*	*187,000*	*267,000*
Individual Market Take Up Rate	51%	58%	67%	70%
Percent of Enrollees in Silver Coverage or Higher	69%	79%	77%	79%
New State Spending		**$2,209,000,00**	**$2,562,000,000**	**$4,201,000,000**
Premium Support		*$1,561,000,000*	*$1,886,000,000*	*$1,874,000,000*
Cost Sharing Support		*$649,000,000*	*$676,000,000*	*$604,000,000*
Reinsurance		*None*	*None*	*$1,724,000,000*
Potential State Spending Offsets				
Penalty Revenue		None	**$441,000,000**	**$393,000,000**
Potential 1332 Funding				**$1,132,000,000**
Change in Federal Tax Credit Expenditures		$670,000,000	$975,000,000	($331,000,000)

Approach 2 estimates the impact of targeted affordability enhancements for three populations of interest: 1) consumers under 400 percent FPL; 2) consumers over 400 percent FPL; and 3) consumers under 600 percent FPL. These options use the same affordability tools as Approach 1 but, with respect to premium and cost-sharing support, are more limited in eligibility and magnitude of reduction in consumer cost. The targeted options generally result in lower enrollment gains compared to Approach 1 with most in the range of 50,000 to 125,000 new enrollees. They are also less costly from a state budget perspective. Most would cost less than $500 million in 2021, and options with reinsurance and a state individual mandate could be offset by 1332 waiver funding or penalty revenue, respectively. The range of enrollment and state budget impacts are reported below in Summary of Approach 2.

Summary of Approach 2 – Targeted Affordability Enhancements

Policy Objective	Policy Options	New Enrollment	New State Cost
Targeted improved affordability for consumers earning less than 400 percent FPL	**T1. Premium support** that lowers premium contributions for consumers earning less than 400 percent FPL	70,000	$425,000,000
	T2. Cost-sharing support that reduces out-of-pocket costs for consumers between 200-400% FPL who do not qualify for more generous federal cost-sharing subsidies	27,000	$215,000,000
Targeted improved affordability for consumers earning more than 400 percent FPL	**T3. Premium support** that lowers premium contributions for consumers earning between 400 and 600 percent FPL	47,000	$285,000,000
	T4. Premium support that lowers premium contributions for consumers earning more than 400 percent FPL	50,000	$324,000,000
	T5. Reinsurance that lowers premiums by 10 percent per year	118,000	$1,456,000,000 *($878,000,000 potential offset from 1332 reinsurance waiver)*
Targeted improved affordability for consumers earning less than 600 percent FPL	**T6. Premium support** that lowers premium contributions for consumers earning between 0 and 600 percent FPL	125,000	$765,000,000
	T7. Premium support that lowers premium contributions for consumers earning between 0 and 600 percent FPL **and an individual mandate**	478,000	$891,000,000 *($482,000,000 potential offset from penalty revenue)*

IMPLEMENTATION CONSIDERATIONS

These options build on the affordability and market stability policies of the Affordable Care Act and are modeled assuming implementation in 2021. Building on existing mechanisms will reduce the time it will take to implement new state affordability enhancements. The Report concludes with a discussion of key decisions that will need to be made to implement each policy option, including:

- Determining whether premium subsidies will be advanced to defray monthly premium costs – as they are under the Affordable Care Act– or refundable through the income tax system;
- Determining the process for ensuring that consumers are receiving the correct subsidy amount throughout the year;
- Determining how new cost-sharing subsidies will be overlaid onto the federal cost-sharing subsidy program without negatively impacting the current federal financing approach;

- Determining how to conform a state individual mandate and penalty with the federal individual mandate; and
- Developing a 1332 waiver strategy if a reinsurance program is desired.

Each option will require decisions about which state agencies will be responsible for the various administrative components of each option. Finally, as noted above, the Report assumes a 2021 implementation date. To meet that date, Covered California would need to begin development work on systems changes and benefit design changes as early as fall of 2019. Other state agencies, health insurance issuers, and enrollment entities, among others, will have additional implementation considerations.

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INTRODUCTION

OVERVIEW OF THE INDIVIDUAL MARKET PROVISIONS OF THE AFFORDABLE CARE ACT

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

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

Benefits and Coverage Levels

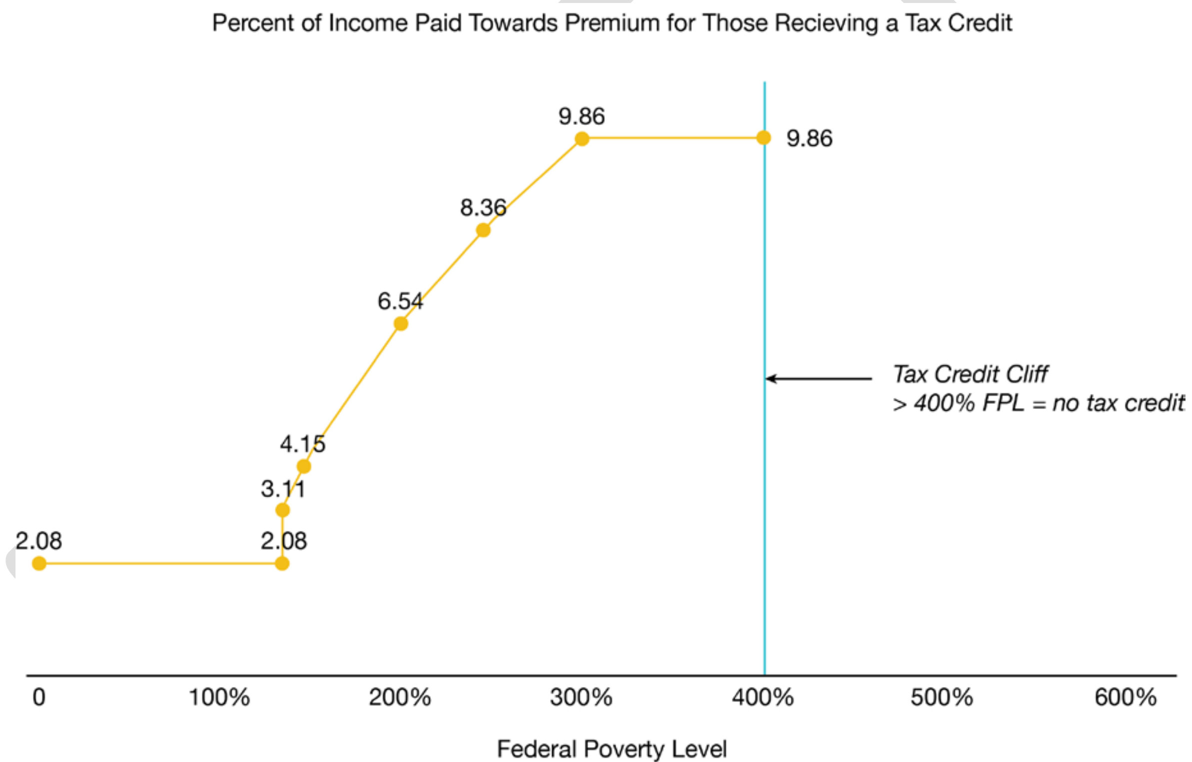
The Affordable Care Act requires that products sold in the individual market cover ten essential health benefit categories. The Affordable Care Act defines four "metal tiers" of coverage for these benefits that vary by actuarial value (AV), which is the portion of the total cost of a plan that is collected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

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

Premium Tax Credits

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

Figure 1. Affordable Care Act Required Contributions for 2019



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

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

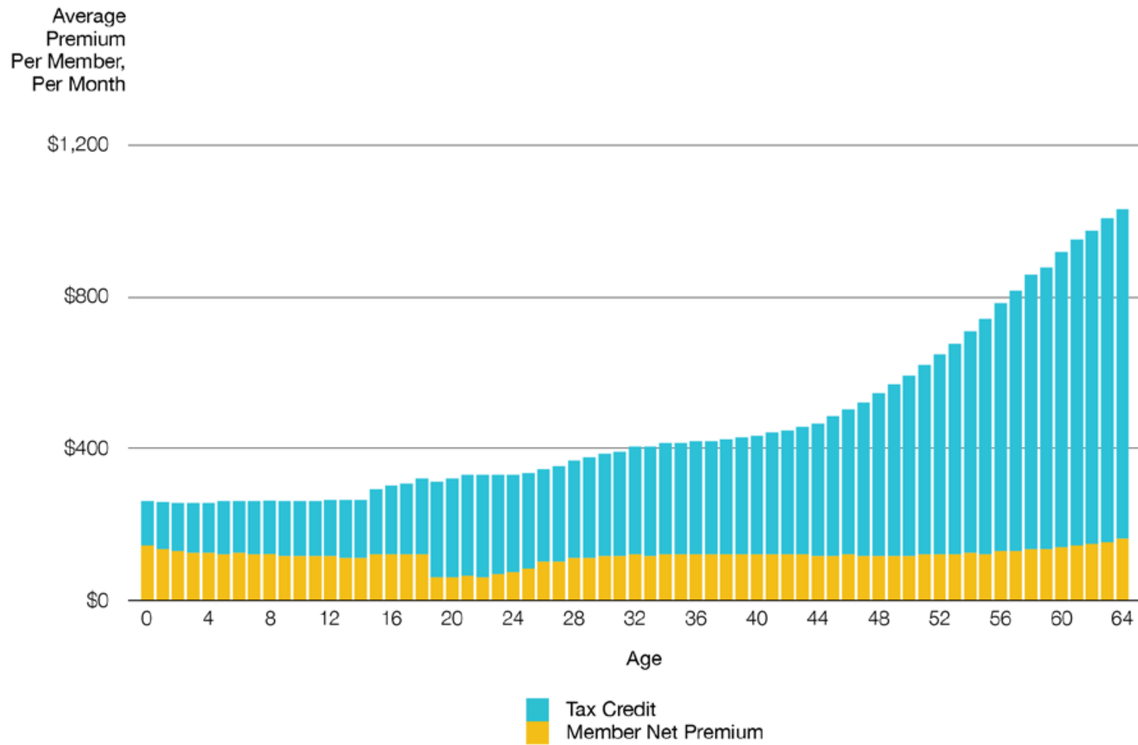
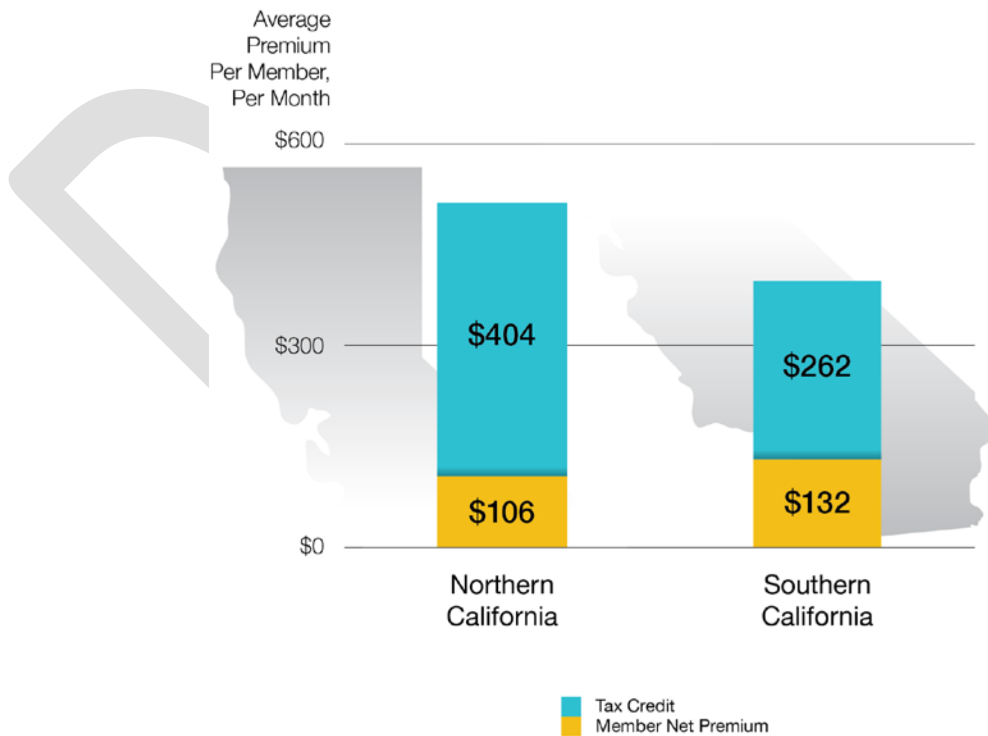


Figure 3. Average Premiums for Subsidy-Eligible Silver Plan Enrollees in Northern and Southern California in 2018, Showing Portion Paid by Enrollee and Portion Covered by Premium Tax Credits



Cost Sharing Reductions

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

Table 1. Cost Sharing Reduction Plan Variations

Plan & Eligibility	**Standard Silver**	**Silver 94** Up to 150% FPL	**Silver 87** 151-200% FPL	**Silver 73** 201-250% FPL
Actuarial Value	70% AV	94% AV	87% AV	73% AV
Individual Deductible Medical / Pharmacy	$2,500 / $200	$75 / $0	$650 / $50	$2,200 / $175
Office Visit	$40	$5	$15	$35

Individual Shared Responsibility Provision

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

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

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

Risk and Market Stabilization Programs

The Affordable Care Act included a temporary federal reinsurance program that lowered premiums in the individual market by about 10 percent each year between 2014 and 2016. Reinsurance funding helped offset the higher costs of the known worse health risk in the individual market by providing funding to issuers for certain defined high cost claims. Reinsurance offers a direct mechanism to assist consumers who are ineligible for federal premium subsidies. By covering a portion of medical costs for enrollees who experience extremely high medical claims, a reinsurance program lowers plan costs,

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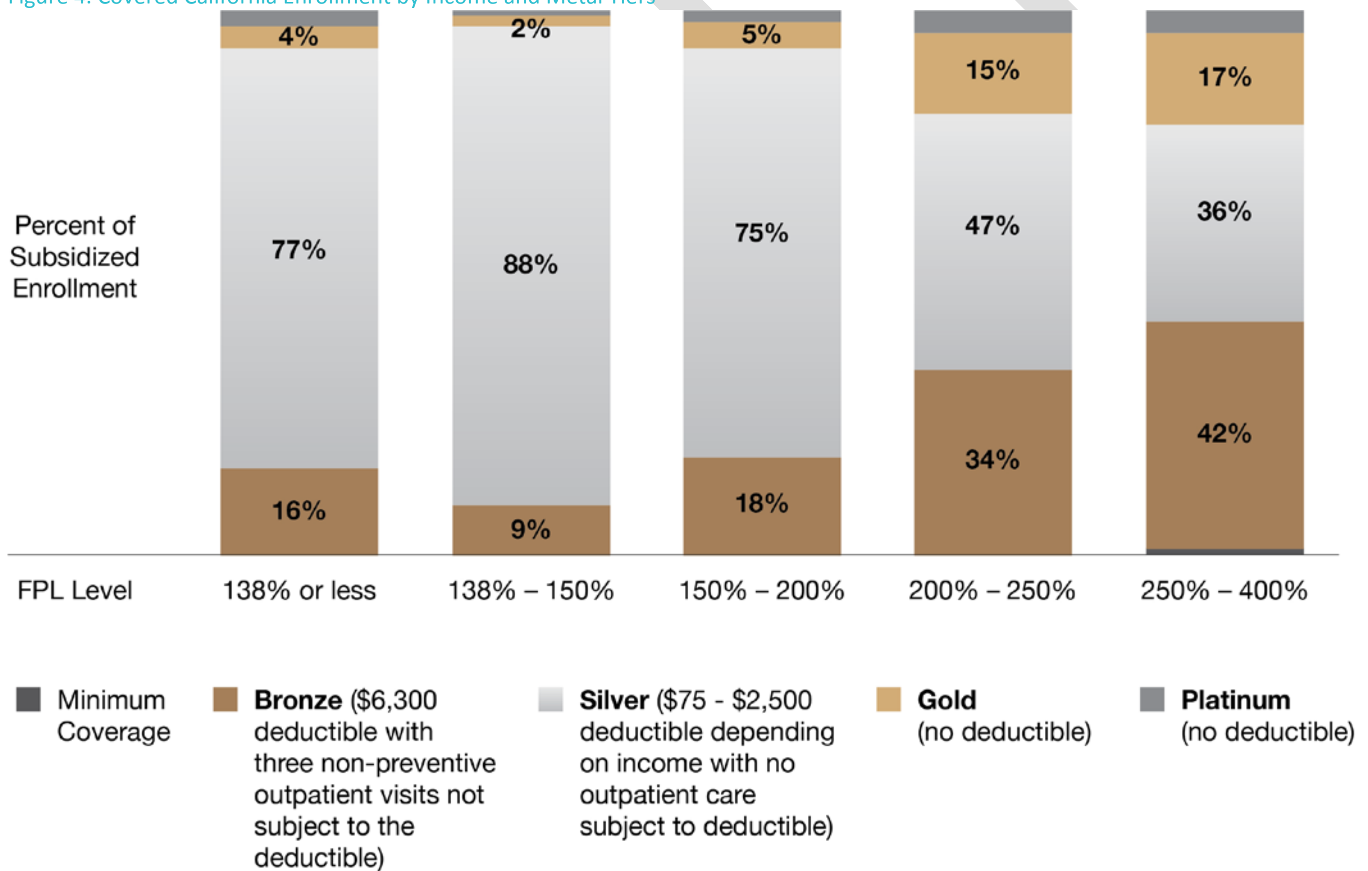
resulting in lower premiums for all plans sold in the individual market. Since the expiration of the program, seven states have implemented reinsurance programs to stabilize premium increases in their individual markets using the federal Section 1332 "state innovation" waiver process. The Affordable Care Act also includes a permanent risk adjustment program that transfers dollars at the end of the plan year from health insurance issuers within a state market with lower relative risk to issuers with higher risk.

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

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

Figure 4. Covered California Enrollment by Income and Metal Tiers



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

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

Table 2. Covered California Enrollment by Age and Subsidy Status

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

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

Covered California's subsidized members pay on average $115 per month in premiums, or about 20 percent of the average gross premium cost of $558 per month as shown in Table 3. In addition, members enrolled in cost sharing reduction plans receive reduced deductibles, copayments and coinsurance estimated to be worth roughly $131 on average. Unsubsidized consumers who do not qualify for tax credits pay on average about $446 per month in premiums. The difference in average gross premiums between the subsidized and unsubsidized membership reflects the fact that enrollment in Bronze coverage is twice as high among unsubsidized enrollees.[2]

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

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

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

Actions to Support Unsubsidized Enrollees

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

Decisions by California policymakers and the Covered California Board have contributed significantly to the stability of the individual market. Notable actions include the expansion of Medicaid; the establishment of a state-based exchange rather than a federally-facilitated exchange; and the decision to require health insurance companies to bring their non-grandfathered individual market products into

compliance with Affordable Care Act-standards. In 2017, Covered California took further action to protect unsubsidized consumers from premium increases on Silver plans that resulted from the elimination of the direct payment of cost-sharing subsidies by the federal government.[3]

California's actions to promote the stability and affordability in the individual market have provided a measure of financial protection to unsubsidized consumers. Covered California's five-year average premium rate increase is just under eight percent.[4] Broadly, the California individual market has a healthy "risk mix," which has consistently ranked in the lowest ten percent of states.[5] Recent research suggests that premiums in California would have been 20 percent higher if California's risk mix mirrored the national average. [6]

AFFORDABILITY CHALLENGES IN THE INDIVIDUAL MARKET

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

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

Although the Affordable Care Act caps premium contributions for individuals with income below 400 percent FPL, "take up" of coverage among those who are eligible for premium tax credits is just slightly above 70 percent,[7] and affordability is cited as the top reason for lacking insurance coverage among the uninsured eligible for Covered California.[8] Among those who do enroll in coverage, recent research shows that, roughly 40 percent of enrollees reported having at least some difficulty paying their monthly insurance premiums.[9] Notably, regardless of having income that allows access to premium tax credits, 39 percent of enrollees with incomes below 250 percent FPL and 41 percent with incomes between 250 and 400 percent FPL reported having "some" or "a lot" of difficulty paying their monthly premiums.[10] Consumers concerned about affordability also may face a difficult choice when deciding on metal tier, as those who choose Bronze plans to lower their monthly premiums not only pay more at point of care, but also may forego a portion of the premium tax credit for which they are eligible, and those in Bronze with income below 250 percent FPL give up access to cost sharing reductions.

Many consumers also face challenges meeting deductibles and paying for out-of-pocket costs whether or not they qualify for cost sharing reductions. Recent survey results showed that one-third of all enrollees under 400 percent FPL had difficulty paying for out-of-pocket costs.[11] Due to federal actuarial value requirements, Bronze plans have an individual medical deductible of over $6,000. Covered California has led efforts to address this problem, as part of its Patient-Centered Benefit Design, by making the first three visits for primary care, specialty care, and urgent care not subject to a deductible,[12] thus helping consumers access needed care. However, the burden of a Bronze deductible is still significant. In addition, eligibility for cost sharing reductions ends at 250 percent FPL, while for

individuals between 200 to 250 percent FPL out-of-pocket costs for a Silver 73 plan are only marginally less expensive than a Silver plan with no cost-sharing assistance. For example, a primary care visit for a Silver 73 plan costs $35, while a basic Silver-tiered plan is $40 (see Appendix IV). Enrollment in Bronze plans increases as the generosity of cost sharing reductions deceases, which can be seen in Figure 4.

Taken together, challenges in paying premiums and out-of-pockets costs can lead to lower utilization. Recent survey results showed that nearly 25 percent of enrollees in the individual market delayed or avoided medical care due to cost.[13] Even with federal premium assistance, the combination of premiums and out-of-pocket spending can exceed 10 percent of income for some Californians with median health use and can reach up to 30 percent of income for those with very high medical use.[14]

Affordability Challenges for Middle-Income Californians Ineligible for Federal Subsidies

Many middle-class Californians are not protected by the Affordable Care Act's cap on premium contributions because their income is above the level needed to qualify for premium tax credits. Premium tax credits are available to individuals and families with income up to 400 percent FPL, which is just over $48,000 for an individual and just over $100,000 for a family of four (see Appendix III for FPL levels for 2019). Once household income exceeds this percentage, sometimes referred to as the "tax credit cliff," consumers are abruptly cut off from any federal assistance. Premiums for consumers who are ineligible for tax credits are on average nearly *four times* the premiums of similar consumers receiving financial assistance (see Table 3 above) and they are growing more rapidly. Figure 5 illustrates the differential rate increases experienced by unsubsidized enrollees above 400 percent FPL and subsidized enrollees, as demonstrated by a five-year average annual rate increase of 7.9 percent v. 3.8 percent, respectively. These higher premiums are driving affordability challenges for many consumers: based on a survey conducted in 2017, 38 percent of respondents with income above 400 percent FPL reported having "some" or "a lot" of difficulty paying their monthly premiums.[15]

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

The premium tax credit cliff disproportionately impacts individuals 50 and older, and individuals with income between 400 percent and 600 percent FPL.[16] Analysis by researchers at the University of California shows that factoring in the local cost of living, the premium assistance provided for households up to four times the federal poverty level under the Affordable Care Act is equivalent to five times the federal poverty level in California as a whole and six times the federal poverty level in high-cost areas such as San Francisco.[17] Even when choosing the cheapest Bronze plan available with a $6,300 individual medical deductible, older consumers living in high-cost areas can face premiums equal to more than 20 percent of their income.

Recent Federal Changes Undermine the Affordable Care Act and Introduce Uncertainty

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

consumers and provided market stability, it has also created a price differential between on and off exchange Silver plans that implementing state legislation sought to avoid. The pricing differences between these products is a factor to consider when contemplating potential cost sharing reduction options.

In late 2017, the Tax Cuts and Jobs Act set the tax penalty associated with the individual shared responsibility requirement to zero beginning in 2019. The Congressional Budget Office has estimated that nationally, the zero-dollar penalty will cause average premiums in the individual market to be about 10 percent higher than they would have been with the mandate in most years of the decade.[18] Likewise, researchers publishing in Health Affairs estimated that California specifically could see a four to seven percent premium increase due to the zero-dollar penalty.[19] Although the consequences of this federal action within each state will vary based on a variety of factors, including the health of the state's risk pool, carrier competition, and the strength of marketing and outreach efforts, reduced enrollment in the individual market will have direct consequences, primarily in the form of higher premiums and a sicker, costlier population.

Enrollment in Covered California is expected to suffer as a direct outcome of the zero-dollar penalty, although the full impact remains unclear. Researchers using the California Simulation of Insurance Markets (CalSIM) microsimulation model and a range of assumptions about the extent to which the penalty influences enrollment decisions, projected that 150,000 to 450,000 more Californians will be uninsured in 2020 as a result of the penalty removal. In 2023, that number is expected to grow to between 490,000 and 790,000 more uninsured, compared to the projected number for 2023 had the penalty been maintained. The most substantial enrollment changes will occur in the individual market, where enrollment is projected to decline by 10.1 percent in 2020 and 14.4 percent in 2023.[20]

In fact, University of California researchers estimate that, by 2020, approximately 530,000 subsidy-eligible individuals will be uninsured with 70 percent – or 370,000 – having income between 201 and 400 percent FPL. An additional 500,000 individuals with income above 400 percent FPL but eligible to purchase coverage in the individual market will also be without coverage.[21] In conjunction with the zero-dollar penalty, rising costs, lack of knowledge of subsidies, and affordability concerns act as deterrents to enrollment.[22]

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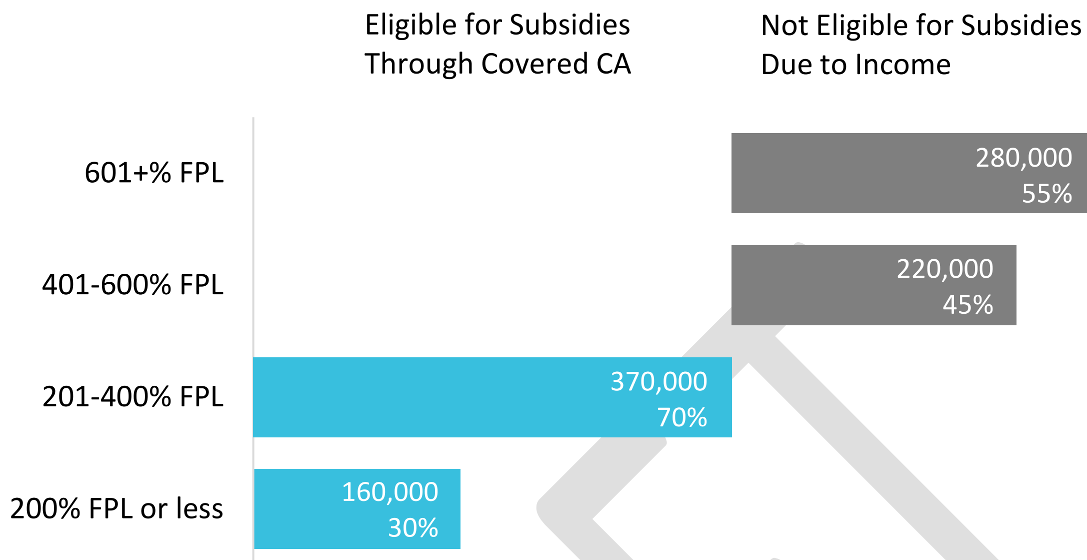
Figure 6. California Non-Elderly Uninsured by Eligibility Category and Income, 2020 Midpoint Estimate



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

AB 1810 AFFORDABILITY REPORT

AB 1810 and Covered California's Legislative Charge

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

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

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

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OPTIONS TO IMPROVE AFFORDABILITY IN THE INDIVIDUAL MARKET

The affordability challenges discussed in the prior section of this Report reflect the premium and cost-sharing burden experienced by different consumer populations. This section of the Report provides policy options to address these cost burdens by expanding affordable coverage and stabilizing the individual insurance market.

Selection of Policy Options

The policy options considered in this section build on the following elements of the Affordable Care Act:

- ***Premiums subsidies:*** these options reduce the Affordable Care Act's income-based premium contribution cap for individuals currently eligible for federal premium tax credits up to 400 percent FPL and/or extend the contribution cap to higher income levels.
- ***Cost-sharing subsidies:*** these options enhance the value of cost-sharing subsidies for currently-eligible individuals up to 250 percent FPL and extend eligibility for cost-sharing subsidies to individuals up to 400 percent FPL.
- ***Individual mandate and penalty:*** this option models the impact of a state-level individual mandate and penalty using the federal framework.
- ***Reinsurance:*** this option models the impact of a reinsurance program funded at the level required to reduce individual market premiums by 10 percent per year.

The Report presents two approaches to enhancing affordability. Approach 1, "Market-wide Affordability Enhancements", presents three options that build upon each other with the goal of enhancing affordability for all individual market enrollees by 1) eliminating the tax credit cliff and significantly expanding cost-sharing subsidies, 2) lowering premiums through reintroduction of the individual mandate penalty, and 3) implementing a reinsurance program. Approach 2, "Targeted Affordability Enhancements", present several options for enhancing affordability within specific income groups. The modeling presented here forecasts how each of the policies would affect five outcomes within the individual market: total enrollment, coverage rates, metal tier choice, new funding for proposed subsidies, and impacts on federal premium tax credits. Outcomes are reported for the entire individual market, and separately by consumer income groups. The analysis below assumes implementation of the policy options in 2021. (See Implementation Considerations for a discussion of timing considerations.)

Summary of Analytic Approach – the Microsimulation Model

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

For all analyses, the baseline model was calibrated to year 2021, which is assumed to be the earliest potential implementation date. (See Implementation Considerations below for more information.)

Baseline 2021 premiums and income reflect widely-used medical cost inflation and price inflation, respectively. Eligible enrollment, by income, is calibrated to UCLA-UC Berkeley CalSIM version 2.2 forecasts.[23] Also assumed is the continued zero-dollar federal penalty into 2021. Its impact on enrollment is calibrated using estimates from the literature and Covered California budget estimates. In scenarios that reinstate the penalty, incomplete recovery of lost enrollment, due to inertial behavior, is assumed. The recent federal compliance rates were also assumed when estimating penalty revenue. (See Appendix V for more details on calibration assumptions.)

APPROACH 1: MARKET-WIDE AFFORDABILITY ENHANCEMENTS

The policy options modeled in Approach 1 are summarized in Table 4. The aggregate impacts of these policies are then discussed and summarized in Table 6 followed by a presentation of consumer scenarios in Tables 7a and 7b.

Table 4. Summary of Approach 1 Policy Options

Policy Option	Description	Policy Objectives
Policy 1: Enhance and extend premium and cost-sharing support	Lower and extend required contribution cap: • 0-138% FPL: 0% cap • 138-400% FPL: cap rises linearly from 0 to 8% • 400-600% FPL: cap rises linearly from 8 to 12% • 600%+ FPL: cap rises linearly from 12 to 15% Expand eligibility for and generosity of cost-sharing support: • 150-200% FPL: 87 to 94 • 200-250% FPL: 73 to 87 • 250-400% FPL: 70 to 80	• Significantly increase enrollment in the individual market • Cap premium contributions for all individual market enrollees by eliminating the tax credit cliff • Make care more affordable for all enrollees under 400 percent FPL
Policy 2: Enhance and extend premium and cost-sharing support plus individual mandate	Policy 1 plus reintroduction of a state-level individual mandate and penalty modeled on the Affordable Care Act framework in place in 2018	• All Policy 1 objectives • Restore a significant share of projected enrollment loss in the individual market due to zero-dollar federal penalty • Lower gross premiums through improved risk mix
Policy 3: Enhance and extend premium and cost-sharing support plus individual mandate plus reinsurance	Policy 2 plus funding for a reinsurance program modeled on the temporary federal reinsurance program funded at the level required to lower premiums by 10 percent per year	• All Policy 2 objectives • Reduce individual market premiums by 10 percent per year to address affordability for individuals who do not receive premium subsidies.

Discussion of Projected Aggregate Impacts of Policy Options under Approach 1

Policy Option 1 – Enhance and Extend Premium and Cost-Sharing Support

Policy Option 1 effectively caps premium contributions at no more than 15 percent of income for all eligible Californians and lowers significantly the premium contribution cap for a benchmark plan for consumers at or below 400 percent FPL who qualify for federal premium tax credits as shown in Table 5. This policy option also markedly reduces the cost-sharing burden for low- and middle-income individuals by providing enhanced cost-sharing support for individuals at or below 400 percent FPL.

Table 5. Monthly Benchmark Premium Contributions for a Single Individual under the Affordable Care Act and Approach 1 based on the 2019 Federal Poverty Level

	ACA Required Contribution	Approach 1 Required Contribution
0-138% FPL	$0-29	$0
138-150% FPL	$43-63	$0-6
150-200% FPL	$63-132	$6-38
200-250% FPL	$132-211	$38-86
250-400% FPL	$211-$399	$86-$324
400-600% FPL	No Cap	$324-$728
600%+ FPL	No Cap	$728-$1,821

Policy Option 1 results in an increase in enrollment by approximately 290,000 people as shown in Table 6. Most of the enrollment increase is among individuals earning below 400 percent FPL who are more responsive to price reductions than higher income earners. Policy Option 1 would also directly benefit the 1.2 million existing Covered California enrollees who would see their premiums drop due to the enhanced premium subsidies. The enhanced cost-sharing support for consumers below 400 percent FPL, while not as salient to consumers as premium reductions, will also encourage new enrollment.

This Policy Option also leads to increased financial protection among the insured when accessing care. Even when insured, cost-sharing obligations have been shown to discourage medical care utilization, including high value medical care.[24] By design, the enhanced cost sharing reduction benefit increases Silver plan actuarial value from between seven and fourteen percentage points for eligible consumers earning between 150 and 400 percent FPL. The market share of Silver plans (or higher) increases from 69 percent to 79 percent in response to newly insured consumers disproportionately enrolling in Silver plans, and existing lower metal tier consumers switching to now-more generous Silver plans in response to subsidized coverage enhancement offered in Silver.

Lowering required contribution caps would also generate an indirect benefit for subsidy-*ineligible* consumers. By inducing new enrollment—enrollment which is likely to be healthier—additional premium subsidies are likely to improve the risk mix in Covered California, causing premiums to fall for the entire individual market.[25] Among subsidy-eligible consumers, lower premiums would trigger equal reductions in federal premium tax credits per enrollee. In contrast, subsidy-*ineligible* consumers would experience the full benefit of any premium reduction.

In total, Policy Option 1 transfers roughly $2.9 billion per year to California's individual market insured and providers. This consists of $1.56 billion in new funding for additional premium support and $650 million to finance the more generous cost sharing reduction benefit. The increased enrollment among

federal subsidy-eligible consumers also triggers increases in federal premium tax credit outlays of $670 million.

Policy Option 2 – Enhance and Extend Premium and Cost-Sharing Support with an Individual Mandate

Policy Option 2 builds on Option 1 with a reinstatement of the individual mandate and penalty modeled on the federal framework in place in 2018. Compared to Policy Option 1, adding the penalty raises enrollment in the individual market by 663,000—or 375,000 more than Policy Option 1. The increased enrollment over Policy Option 1 comes from two related effects: the institution of the penalty, itself; and lower premiums associated with the improved risk mix as a result of this new enrollment. This is estimated to lower gross premiums by an additional three percent over Policy Option 1, generating further enrollment increases.[26] The increase in the share enrolled in Silver (or higher metal tier) of 8 percentage points is slightly lower than the 10 percent increase in Policy Option 1. This is due to relatively healthy enrollees induced into coverage by the mandate penalty choosing Bronze plans.

Compared to Policy Option 1, Policy Option 2 results in $459 million (or 22 percent) more in new premium support and cost-sharing subsidy spending per year. However, when penalty revenue is accounted for, Policy Option 2 would require $88 million *less* spending.[27] Moreover, this scenario induces $305 million *more* in annual federal transfers to the State, further highlighting the projected impact of reinstating the tax penalty when combined with policies that make plans affordable. Note that the estimated increase of 648,000 reflects enrollment gains generated in the individual market only and does not account for potential gains in other sources of coverage.

Policy Option 3 – Enhance and Extend Premium and Cost-Sharing Support with an Individual Mandate and Reinsurance Program

This policy option adds to Policy Option 2 by implementing a reinsurance program funded at the level needed to reduce premiums by 10 percent per year. The goal of this scenario is to add a mechanism to address affordability challenges for consumers who – beyond premium declines associated with improved risk mix—would not benefit directly from federal premium support, or the premium support proposed in Policy Options 1 and 2. Under this scenario, enrollment in the individual market would increase by over 763,000. As expected, almost all of the enrollment gains over Policy Option 2 come from individuals who do not qualify, or are ineligible, for federal or new state premium subsidies. The increase in enrollment over Policy Option 2 also leads to lower revenue from the tax penalty.

For the subsidized market, the benefit of gross premium reductions is realized as lower subsidy spending. Indeed, the federal premium tax credits expenditures *fall* approximately $330 million per year in aggregate despite the increased enrollment base. Note that the $330 million in total premium tax credit savings reflects the net effect of two factors: reduced premium tax credits per enrollee and increased number of premium tax credit recipients due to the proposed premium and cost-sharing subsidies. If instead the budget impact of reinsurance were isolated (that is, using the *new* enrollment levels as a baseline in premium tax credit savings calculations), estimates show that the reinsurance program would reduce federal premium tax credit expenditures by $1.13 billion per year. If federal "pass

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through" funding was obtained by a Section 1332 waiver, the transfer would offset 66 percent of the spending on the proposed reinsurance program. (See Implementation Considerations for details.)

Table 6. Summary of Projected Aggregate Impacts of Approach 1 in 2021

Summary of Approach 1 – Market-wide Affordability Enhancements				
Outcomes	**ACA Baseline 2021**	**Policy Option 1**	**Policy Option 2**	**Policy Option 3**
Enrollment Increase		**290,000**	**648,000**	**764,000**
<250		*66,000*	*120,000*	*139,000*
250-400		*153,000*	*342,000*	*358,000*
400+		*71,000*	*187,000*	*267,000*
Individual Market Take Up Rate	51%	58%	67%	70%
Percent of Enrollees in Silver Coverage or Higher	69%	79%	77%	79%
New State Spending		**$2,209,000,00**	**$2,562,000,000**	**$4,201,000,000**
Premium Support		*$1,561,000,000*	*$1,886,000,000*	*$1,874,000,000*
Cost Sharing Support		*$649,000,000*	*$676,000,000*	*$604,000,000*
Reinsurance		*None*	*None*	*$1,724,000,000*
Potential State Spending Offsets				
Penalty Revenue		None	$441,000,000	$393,000,000
Potential 1332 Funding				$1,132,000,000
Change in Federal Tax Credit Expenditures		$670,000,000	$975,000,000	($331,000,000)

Approach 1 - Consumer Scenarios

Tables 7a and 7b provides hypothetical scenarios to illustrate the monthly and annual impacts, respectively, of Policy Options 1 through 3 on different types of consumers. Note: these are not necessarily "average" scenarios, but instead are shown to help illustrate how the policy options would help a consumer in a specific situation.

Alfonso represents young lower-income consumers. To purchase the second lowest cost Silver plan, Alfonso currently would have to pay $136 per month, after receiving $214 in federal premium tax credits. Under Policy Option 1, Alfonso's monthly premiums would drop by $97, lowering his contribution to $39 per month. Policy Option 2 highlights the tax penalty Alfonso would face if he did not obtain minimum coverage. Policy Option 2 also highlights how further reduction in premiums due to improved risk mix (estimated to be about five percent) lowers federal subsidies, while leaving State subsidies unchanged. A similar effect happens in response to State reinsurance. Moving to Policy Option 3, premiums fall by another 10 percent, generating an equal reduction in Alfonso's premium tax credit. Alfonso also benefits from increased cost-sharing benefits provided under Policy Options 1-3. The actuarial value of a Silver plan under these scenarios increases from 73 to 87, which would typically lower Silver plan deductibles by $1,500 (from $2,200 to $650), and primary care office copayments by $20 (from $35 to $15).

Bianca illustrates the benefits to consumers earning between 250-400 percent FPL, who, in addition to new premium subsidies, newly receive cost-sharing reduction benefits. Bianca earns slightly more than Alfonso, so would currently contribute no more than 9.86 percent of her annual income towards premiums. Under Policy Options 1-3, Bianca would receive additional premium subsidy of $134 per month over her federal subsidy, lowering her monthly premium for the second lowest cost Silver plan from $329 to $194 per month—or 5.83 percent of her income. In addition to the additional premium support, Bianca is eligible to receive a cost-sharing reduction, which is expanded to consumers earning between 250-400 percent FPL. Under Policy Options 1-3, the actuarial value of a Silver plan increases from 70 to 80, which would eliminate any deductible requirement (assuming the current benefit design for AV 80) and lower primary care office visit copayments by $10 (from $40 to $30).

Cara illustrates the benefit of extending premium support above 400 percent FPL. Cara earns $50,000 per year, just above the earnings threshold where federal premium tax credits phase out. The premium contribution cap in Policy Options 1-3 dramatically lowers her monthly premiums. Cara's case also highlights how reductions in gross premiums associated with either improved risk mix or reinsurance triggers savings for the State on a per-member basis. This is because the federal government provides no subsidy above 400 percent FPL so that any reduction in premiums above the individual's contribution cap would result in a reduction in Cara's new premium subsidy.

Don shows the benefit of reinsurance to California's consumers. Don is self-employed, earning $80,000 per year. Under Policy Option 2, he would pay roughly 10.5 percent of his income for the benchmark Silver plan, which is below the new premium cap of about 12 percent for someone with his earnings (659 percent FPL). As with any consumer who either does not qualify, or is ineligible to receive premium support, Don would not benefit directly from the lower contribution cap subsidy, but would benefit indirectly from premium declines associated with improved risk mix and would benefit from a state reinsurance program.

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

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Table 7a. Approach 1: Consumer Impact Scenarios on a Monthly Basis

	Alfonso		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	25	Monthly Premium (SLS)	$350	$343	$333	$299
Region	Low Cost Region	Net Premium	$136	$39	$39	$39
Income	$25,000	Net Premium Income Share	6.54%	1.89%	1.89%	1.89%
FPL	206					
		Federal Premium Subsidy	$214	$207	$196	$163
		New Premium Subsidy	$0	$97	$97	$97
		Silver Plan Medical Deductible	$2,200	$650	$650	$650
		Annual Penalty	None	None	$695	$695

	Bianca		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	45	Monthly Premium (SLS)	$720	$706	$684	$616
Region	Medium Cost Region	Net Premium	$329	$194	$194	$194
Income	$40,000	Net Premium Income Share	9.86%	5.83%	5.83%	5.83%
FPL	329					
		Federal Premium Subsidy	$391	$377	$355	$287
		New Premium Subsidy	$0	$134	$134	$134
		Silver Plan Medical Deductible	$2,500	None	None	None
		Annual Penalty	None	None	$700	$700

	Cara		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	45	Monthly Premium (SLS)	$720	$706	$684	$616
Region	Medium Cost Region	Net Premium	$720	$385	$385	$385
Income	$50,000	Net Premium Income Share	17.28%	9.25%	9.25%	9.25%
FPL	412					
		Federal Premium Subsidy	$0	$0	$0	$0
		New Premium Subsidy	$0	$320	$299	$230
		Silver Plan Medical Deductible	$2,500	$2,500	$2,500	$2,500
		Annual Penalty	None	None	$950	$950

	Don		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	45	Monthly Premium (SLS)	$720	$706	$684	$616
Region	Medium Cost Region	Net Premium	$720	$706	$684	$616
Income	$80,000	Net Premium Income Share	10.80%	10.58%	10.26%	9.23%
FPL	659					
		Federal Premium Subsidy	$0	$0	$0	$0
		New Premium Subsidy	$0	$0	$0	$0
		Silver Plan Medical Deductible	$2,500	$2,500	$2,500	$2,500
		Annual Penalty	None	None	$1,700	$1,700

	Erin and Francis		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	62	Monthly Premium (SLS)	$2,250	$2,205	$2,138	$1,924
Region	High Cost Region	Net Premium	$2,250	$578	$578	$578
Income	$75,000	Net Premium Income Share	36.00%	9.25%	9.25%	9.25%
FPL	456					
		Federal Premium Subsidy	$0	$0	$0	$0
		New Premium Subsidy	$0	$1,627	$1,559	$1,346
		Silver Plan Medical Deductible (family)	$5,000	$5,000	$5,000	$5,000
		Annual Penalty	None	None	$3,150	$3,150

Table 7b. Approach 1: Consumer Impact Scenarios on an Annual Basis

	Alfonso		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	25	Annual Premium (SLS)	$4,200	$4,116	$3,990	$3,591
Region	Low Cost Region	Net Premium	$1,635	$473	$473	$473
Income	$25,000	Net Premium Income Share	6.54%	1.89%	1.89%	1.89%
FPL	206					
		Federal Premium Subsidy	$2,565	$2,481	$2,355	$1,956
		New Premium Subsidy	$0	1,163	1,163	1,163
		Silver Plan Medical Deductible	$2,200	$650	$650	$650
		Annual Penalty	None	None	$695	$695

	Bianca		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	45	Annual Premium (SLS)	$8,640	$8,467	$8,208	$7,387
Region	Medium Cost Region	Net Premium	$3,944	$2,332	$2,332	$2,332
Income	$40,000	Net Premium Income Share	9.86%	5.83%	5.83%	5.83%
FPL	329					
		Federal Premium Subsidy	$4,696	$4,523	$4,264	$3,443
		New Premium Subsidy	$0	1,612	1,612	1,612
		Silver Plan Medical Deductible	$2,500	None	None	None
		Annual Penalty	None	None	$700	$700

	Cara		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	45	Annual Premium (SLS)	$8,640	$8,467	$8,208	$7,387
Region	Medium Cost Region	Net Premium	$8,640	$4,250	$4,250	$4,250
Income	$50,000	Net Premium Income Share	17.28%	8.50%	8.50%	8.50%
FPL	412					
		Federal Premium Subsidy	$0	$0	$0	$0
		New Premium Subsidy	$0	$4,217	$3,958	$3,137
		Silver Plan Medical Deductible	$2,500	$2,500	$2,500	$2,500
		Annual Penalty	None	None	$950	$950

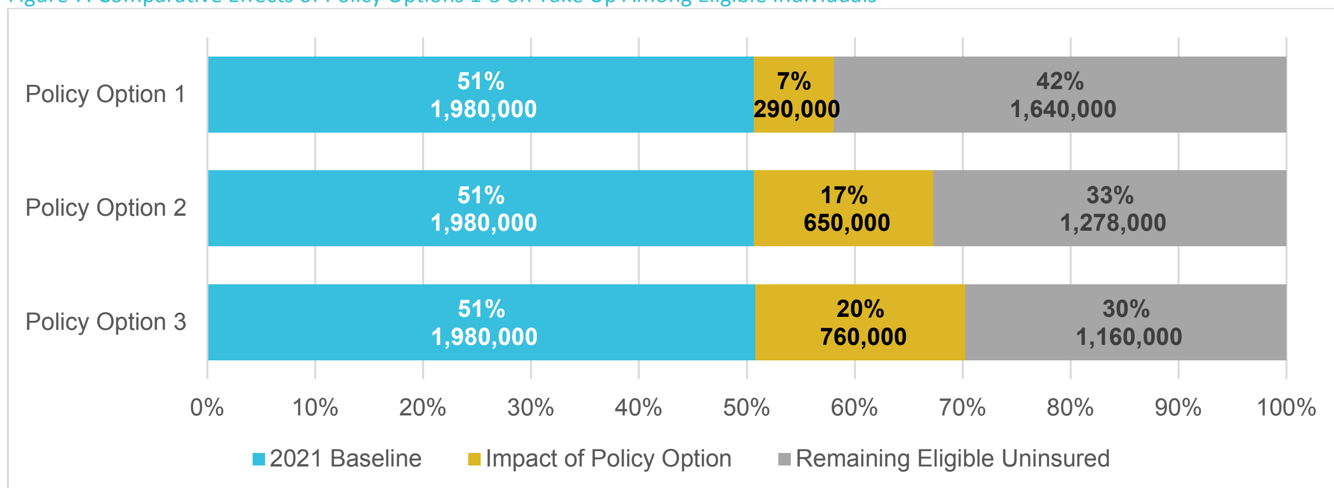
	Don		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	45	Annual Premium (SLS)	$8,640	$8,467	$8,208	$7,387
Region	Medium Cost Region	Net Premium	$8,640	$8,467	$8,208	$7,387
Income	$80,000	Net Premium Income Share	10.80%	10.58%	10.26%	9.23%
FPL	659					
		Federal Premium Subsidy	$0	$0	$0	$0
		New Premium Subsidy	$0	$0	$0	$0
		Silver Plan Medical Deductible	$2,500	$2,500	$2,500	$2,500
		Annual Penalty	None	None	$1,700	$1,700

	Erin and Francis		Baseline	Policy Option 1	Policy Option 2	Policy Option 3
Age	62	Annual Premium (SLS)	$27,000	$26,460	$25,650	$23,085
Region	High Cost Region	Net Premium	$27,000	$6,938	$6,938	$6,938
Income	$75,000	Net Premium Income Share	36.00%	9.25%	9.25%	9.25%
FPL	456					
		Federal Premium Subsidy	$0	$0	$0	$0
		New Premium Subsidy	$0	$19,523	$18,713	$16,148
		Silver Plan Medical Deductible (family)	$5,000	$5,000	$5,000	$5,000
		Annual Penalty	None	None	$3,150	$3,150

Impact on Take Up and the Remaining Uninsured

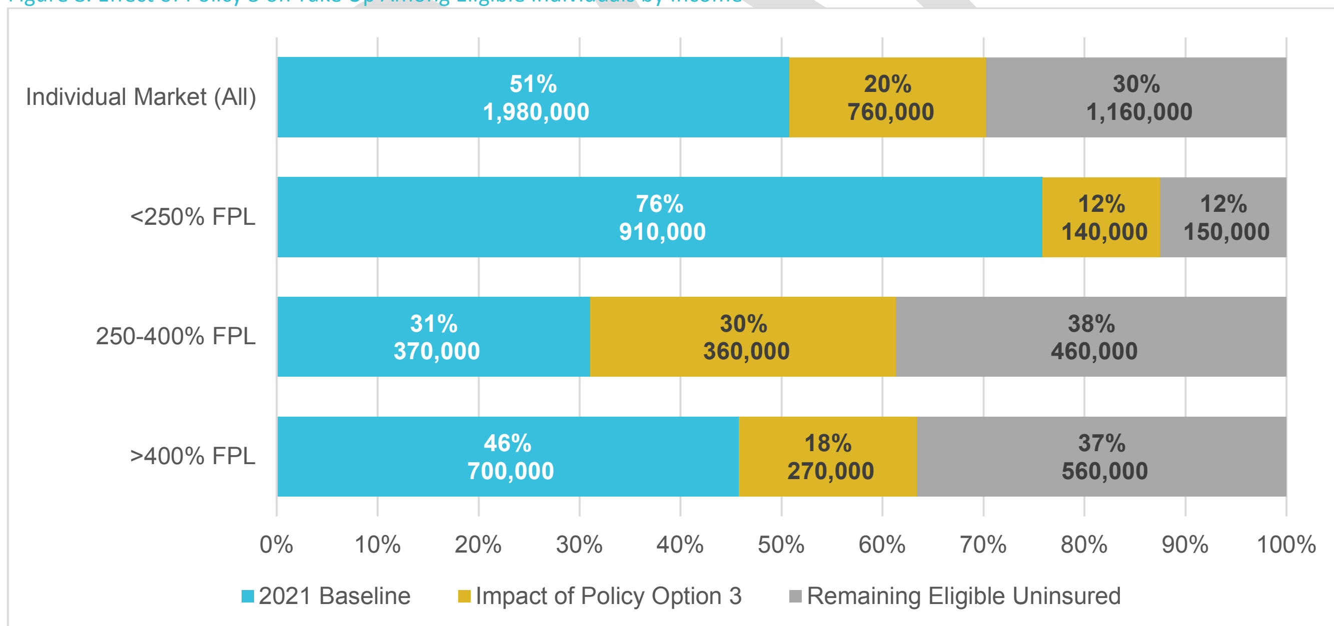
Of the three options, Policy Option 3 generates the largest increases in enrollment as shown in Figure 7, bringing coverage rates in the individual market below 250 percent FPL from 78 to 88 percent as shown in Figure 8. The overall individual market coverage rates increase from 51 percent to 70 percent as shown in Figure 9.

Figure 7. Comparative Effects of Policy Options 1-3 on Take Up Among Eligible Individuals



Source: Authors calculations based on UCLA-UC Berkeley CalSIM version 2.2

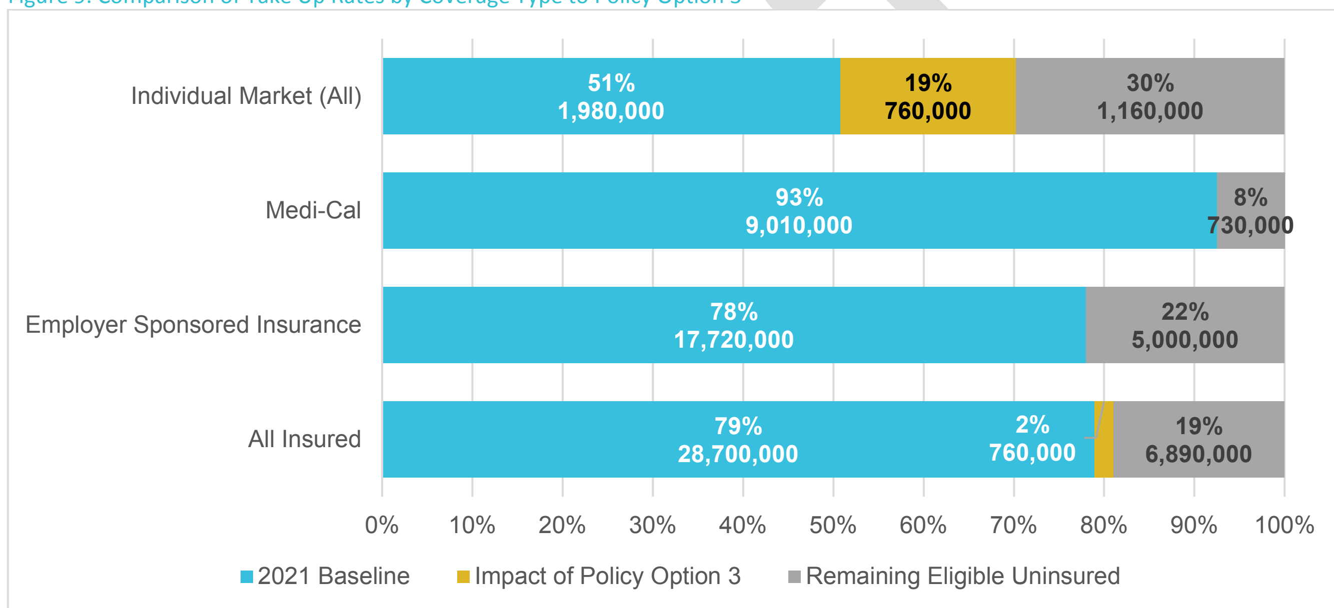
Figure 8. Effect of Policy 3 on Take Up Among Eligible Individuals by Income



Source: Authors calculations based on UCLA-UC Berkeley CalSIM version 2.2

Note about Policy Limitations
While the coverage gains projected in Approach 1 are significant, achieving near-universal take up in the individual market may be a challenge even among subsidy-eligible consumers. Despite its generosity, any state premium support still requires individual premium contributions, which may deter take up. As shown in Figure 9, individual market take up would still lag enrollment in employer-sponsored insurance even under Policy 3. Consumers may also lack awareness of subsidy benefits, or may be discouraged from enrolling due to inattention, hassle costs, or other behavioral frictions.[28] This suggests that increased premium support would still lead to increased enrollment. But as funding increases beyond the levels proposed here, an increasing share of new funding would go toward reducing consumer spending among the already-insured, with decreasing effect on coverage.

Figure 9. Comparison of Take Up Rates by Coverage Type to Policy Option 3



Sources: Author's calculations based on: 1) California Employer Health Benefits Survey: 2018, CHCF/NORC; 2) UCLA-UC Berkeley CalSIM version 2.2. Note that this figure does not account for any potential impacts of Policy 3 on non-individual market coverage.

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APPROACH 2: TARGETED AFFORDABILITY ENHANCEMENT

Approach 2 estimates the impact of targeted affordability enhancements for three populations of interest: 1) consumers under 400 percent FPL; 2) consumers over 400 percent FPL; and 3) consumers under 600 percent FPL. Table 8 presents a summary of the seven options modeled in Approach 2, and the aggregate impacts of these policies are then discussed and summarized in Table 9.

Table 8. Summary of Approach 2 Policy Options

Policy Objective	Policy Option	Description	New State Cost
Targeted improved affordability for consumers earning less than 400 percent FPL	T1	**Premium support** that lowers premium contribution caps • 0-138% FPL, 0% • 138-250% FPL, new caps rise linearly from 0-8% • 250-400% FPL, the new caps rise from 8-9%	$425,000,000
	T2	**Cost sharing reduction** so that those 200-400% FPL get AV 80 plans (Gold AV)	$215,000,000
Targeted improved affordability for consumers earning more than 400 percent FPL	T3	**Premium support between 400 and 600% FPL** that extends the cliff • Contribution cap is 9.86% at 400% FPL • Rises linearly to 15% at 600% FPL	$285,000,000
	T4	**Premium support above 400% FPL** that eliminates the cliff • Contribution cap is 9.86% at 400% FPL • Rises linearly to 15% at 1200% FPL, 15% thereafter	$324,000,000
	T5	**Reinsurance** that lowers premiums by 10 percent per year	$1,456,000,000 *($878,000,000 potential offset from 1332 reinsurance waiver)*
Targeted improved affordability for consumers earning less than 600 percent FPL	T6	**Premium support** that lowers premium contribution caps and extends the cliff to 600% FPL • Policy Option T1 for people below 400% FPL • 400-600% FPL, caps rise from 9% to 15% at 600% FPL	$765,000,000
	T7	**Premium support + penalty reinstatement** • Policy Option T6 • Reinstate the mandate tax penalty	$891,000,000 *($482,000,000 potential offset from penalty revenue)*

Discussion of Projected Aggregate Impacts of Policy Options under Approach 2

Policy Option T1 – Targeted Premium Subsidies Below 400 Percent FPL

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

The policy option causes total individual market enrollment to rise by roughly 70,000. Most of this enrollment, as expected, is in the below-400 percent FPL segment, where this scenario targets

premiums subsidies. The premium declines due to modest improvements in the risk mix leads to an increase among the unsubsidized segments of the market.

The increased subsidies for lower income consumers also causes a small shift in the share of enrollment in Silver or higher metal tiers. The additional premium subsidies reduce consumer net premiums across all tiers by roughly the same amount. In response, some consumers switch to Bronze plans, while some upgrade plan generosity, to Silver or higher, depending on their price sensitivity and demand for plan generosity. The net effect is an increase in coverage in more generous plans. This policy option would require roughly $425 million per year in State spending and induces about $125 million in additional federal premium subsidies.

Policy Option T2 – Enhanced and Expanded Cost Sharing Reduction between 200-400 Percent FPL

This policy option aims to lower cost-sharing burden for consumers earning under between 200-400 percent FPL. Currently, consumers earning between 200-250 percent FPL can enroll in an enhanced Silver plan with actuarial value of 73, higher than the typical Silver AV of 70. Under Policy Option T2, the State would increase the actuarial value to 80 AV (equivalent to a Gold tier plan). In addition, the State would expand cost-sharing reduction benefits to consumers earning between 250-400 percent FPL, also making their Silver plans 80 AV.

This Policy Option causes enrollment to increase by nearly 27,000 people, primarily among consumers earning between 200-400 percent FPL. Beyond increases in enrollment, this Policy Option also results in an increase in the share of the market enrolling in Silver tier plans or higher, from 69 percent to 73 percent. This increase comprises new enrollees who disproportionately enroll in – and current enrollees who switch to—now more generous Silver plans. This policy option would require $215 million per year in new State spending and is also expected to increase federal premium subsidies by $63 million per year.

Policy Option T3 – Targeted Premium Subsidies between 400-600 Percent FPL

This policy option aims to increase affordability of plans for individuals who currently receive no federal tax credits earning above 400 percent FPL. Under this policy option, the State would finance premium support to cap premium contribution for consumers earning between 400-600 percent FPL. The cap at 400 percent FPL would be set at 9.86 percent and rise linearly to a maximum of 15 percent at 600 percent FPL. For the majority of single-person households, this policy would eliminate the subsidy cliff. That is, for most consumers living in low- to moderate-health care cost areas, or those below age 60, the subsidy would naturally phase out at income levels below 600 percent FPL. Consumers purchasing multi-person policies, or nearing Medicare eligibility age, and residing in higher health care cost areas, will still experience a (now-smaller) cliff, at 600 percent FPL.

Policy Option T3 causes enrollment to increase by 47,000. Compared to Policy Option T1, targeting higher income consumers in Policy Option T3 has a similar per-new State subsidy dollar impact on enrollment than when targeting lower income consumers. This would seem to go against conventional wisdom, where lower income individuals, who are more price-elastic, should be more responsive to increases in subsidies. Lower income individuals are indeed more price responsive. But given the large baseline enrollment and higher coverage rates among lower income individuals, a comparatively larger

DRAFT

share of the funding required by Policy Option T1 goes to lowering consumer premium contributions of *existing* enrollees.

The small reduction in the total federal advanced premium tax credit expenditure is a byproduct of the decline in gross premiums due to the small improvement in risk mix associated with the increased enrollment.

Policy Option T4 – Targeted Premium Subsidies Above 400 Percent FPL

This Policy Option is similar to Policy Option T3, except that new premium support is extended to all consumers, not just to those between 400-600 percent FPL. Under this policy option, the State would finance premium support to cap premium contribution for consumers earning above 400 percent FPL. The cap at 400 percent FPL would be set at 9.86 percent and rise linearly to a maximum of 15 percent at 1,200 percent FPL and remain 15 percent above that.[29] This would eliminate the subsidy cliff, and institute a premium cap for all eligible consumers.

This Policy Option causes enrollment to increase by 51,000. The increase in enrollment over Policy Option T3 is primarily comprised of older consumers purchasing multi-person policies, and older consumers residing in high health care cost areas, who benefit from the elimination of the subsidy cliff at 600 FPL. Here, too, the small reduction in federal advanced premium tax credits is a byproduct of the decline in gross premiums due to the small improvement in risk mix associated with the increased enrollment.

Policy Option T5 – Reinsurance

This policy option offers an alternative to Policy Options T3 and T4 to increase affordability for all consumers who are either ineligible or not qualified for federal subsidies. Under this Policy Option, the State would finance a reinsurance program that lowers premiums in the entire non-group markets by 10 percent. Net of Section 1332 waiver offsets, the resulting State spending would not exceed $600 million per year.

Reinsurance lowers premiums by 10 percent, resulting in improved affordability among consumers who are ineligible for federal tax credits. The increase in enrollment of 118,000 occurs almost entirely among people earning above 400 percent FPL, and by design, some consumers below 400 percent FPL, purchasing in the off-exchange market. Among subsidy-eligible consumers, lower gross premiums trigger a commensurate decrease in federal tax credits, leaving net-of-subsidy premiums unchanged. Total federal savings is about $878 million per year. If transferred to the State as part of a Section 1332 waiver, this amount represents 60 percent of State spending on reinsurance, reflecting the resulting fraction of the individual market that is subsidized by federal premium tax credits in this scenario.

Policy Option T6 – Targeted Premium Subsidies Below 600 Percent FPL

This policy option aims to increase affordability of plans for individuals earning between zero and 600 percent FPL. This scenario lowers premium contribution caps, effectively a combination of Policy Options T1 and T3 (but with a slight adjustment around 400 percent FPL to eliminate the small discontinuity). Compared to the contribution caps of the main policy options analyzed above in Approach 1, targeted Policy Option T6 finances smaller reductions in consumer premium contribution, so that the impact on

State spending is roughly $765 million per year. This scenario does not include enhanced or extended cost-sharing benefits.

This Policy Option causes total non-group market enrollment to rise by nearly 126,000. Elimination of the subsidy cliff at 400 percent FPL results in much larger reductions in dollar amount of consumer premium contributions right above 400 percent FPL than below. Hence, half of the enrollment impact in this scenario occurs among consumers between 400-600 percent FPL.

As in Policy Option T1, the increased subsidies cause a small increase in the share of enrollment in Silver or higher metal tiers. The new premium subsidies reduce consumer premiums across all tiers by roughly the same amount, causing some consumers downgrade metal tier, and others to shift to more generous Silver or higher plans. The net effect is an increase in coverage in more generous plans.

Policy Option T7 – Targeted Premium Subsidies Below 600 Percent FPL With Penalty

This policy option aims to achieve significant coverage expansions, but at lower cost to the State than the Policy Options 1-3 in Approach 1, discussed above. To this end, Policy Option T7 institutes the same contribution caps as in Policy Option 6 but reinstates the tax penalty in order to generate greater enrollment and penalty income. This scenario was designed to increase significantly individual market coverage rates, but without state spending exceeding $1.25 billion per year, net of tax penalty income.

This scenario increases enrollment by nearly 478,000, or roughly 350,000 more than the enrollment gains generated by Policy Option T6. The impact in comparison to scenario T6 illustrates two related effects of the mandate tax penalty: the institution of the tax penalty, itself; and the improved risk mix associated with this new enrollment (estimated to lower gross premiums by an additional 3 percent over Policy Option T6), which generates further enrollment increases.

Net of penalty revenues, Policy Option T7 results in net State spending of approximately $410 million per year, or $356 million *less* than Policy Option T6.[30] Moreover, Policy Option 7 results in an increase of $590 million in federal subsidies over Policy Option T6, net of tax penalty revenue. Taken together with the projected impacts of enrollment and State spending, these outcomes highlight the effectiveness of the penalty at generating enrollment at lower spending, when combined with policies that make plans affordable.

DRAFT

Table 9. Summary of Projected Aggregate Impacts of Approach 2 in 2021

Summary of Approach 2 – Targeted improved affordability for consumers earning less than 400 percent FPL			
Outcomes	**ACA Baseline 2021**	**Policy Option T1**	**Policy Option T2**
Enrollment Increase		**70,000**	**27,000**
<250		*29,000*	*4,000*
250-400		*29,000*	*18,000*
400+		*11,000*	*4,000*
Individual Market Take Up Rate	51%	52%	51%
Percent of Enrollees in Silver Coverage or Higher	69%	72%	73%
New State Spending		**$425,000,000**	**$215,000,000**
Premium Support		*$425,000,000*	*None*
Cost Sharing Support		*None*	*$215,000,000*
Reinsurance		*None*	*None*
Potential State Spending Offsets			
Penalty Revenue		None	*None*
Potential 1332 Funding			
Change in Federal Tax Credit Expenditures		$124,000,000	$63,000,000

Summary of Approach 2 – Targeted improved affordability for consumers earning more than 400 percent FPL				
Outcomes	**ACA Baseline 2021**	**Policy Option T3**	**Policy Option T4**	**Policy Option T5**
Enrollment Increase		**47,000**	**50,000**	**118,000**
<250		*1,000*	*1,000*	*21,000*
250-400		*400*	*400*	*11,000*
400+		*46,000*	*49,000*	*86,000*
Individual Market Take Up Rate	51%	52%	52%	54%
Percent of Enrollees in Silver Coverage or Higher	69%	70%	69%	70%
New State Spending		**$285,000,000**	**$324,000,000**	**$1,456,000,000**
Premium Support		*$285,000*	*$324,000,000*	*None*
Cost Sharing Support		*None*	*None*	*None*
Reinsurance		*None*	*None*	*$1,456,000,000*
Potential State Spending Offsets				
Penalty Revenue		*None*	*None*	*None*
Potential 1332 Funding				$878,000,000
Change in Federal Tax Credit Expenditures		($44,000,000)	($44,000,000)	($878,000,000)

Summary of Approach 2 – Targeted improved affordability for consumers earning less than 600 percent FPL			
Outcomes	**ACA Baseline 2021**	**Policy Option T6**	**Policy Option T7**
Enrollment Increase		**125,000**	**478,000**
<250		*31,000*	*102,000*
250-400		*30,000*	*189,000*
400+		*64,000*	*187,000*
Individual Market Take Up Rate	51%	54%	63%
Percent of Enrollees in Silver Coverage or Higher	69%	72%	68%
New State Spending		**$765,000,000**	**$891,000,000**
Premium Support		*$765,000,000*	*$891,000.000*
Cost Sharing Support		*None*	*None*
Reinsurance		*None*	*None*
Potential State Spending Offsets			
Penalty Revenue		*None*	*$482,000,000*
Potential 1332 Funding			
Change in Federal Tax Credit Expenditures		$45,000,000	$637,000,000

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Potential Impacts Beyond 2021

The outcomes reported for 2021 serve as a basis for understanding potential impacts of the policy options beyond 2021. Specifically, out-year projections will depart from those reported from 2021 in response to three factors: 1) changes in individual market eligibility; 2) residual effects of the zeroing-out of the tax penalty in the baseline; and 3) changes in the macroeconomic environment.

Changes in individual market eligibility capture population growth and wage dynamics associated with statutory increases in the minimum wage. University of California's CalSIM model projects a 1 percent increase in eligibility between 2021 and 2022, which includes a small shift from the <250 percent FPL to the 250-400 percent segment of the eligible population. Per-enrollee premium subsidies associated with the Policy Options are similar across income groups below 400 percent FPL, but larger for individuals earning between 400-600 percent FPL. Taken together, the 1 percent increase in the eligible population between 2021 to 2022 implies that the projected enrollment and budget impacts for 2022 would be roughly 1 percent larger than those reported for 2021. The negligible increases in individual market eligibility between 2022 and 2023 implies that 2023 projections would mirror those from 2022.

It is assumed that most of the impact of the zeroing-out of the tax penalty on enrollment and risk mix (and therefore premiums) will have been realized by 2021, consistent with forecasts published by the Congressional Budget Office and Covered California.[31] The remaining impact of the zero-dollar tax penalty on 2022 enrollment, estimated to be a 1 percent decrease from 2021, would result in a small to negligible increase in premiums between 2021 and 2022, which in turn would have a negligible effect on either enrollment among the unsubsidized consumers, or employer-sponsored insurance offers (which would decrease if premium fell markedly), leaving unaffected the size of the eligible individual market, due to the penalty.

Projected impacts in 2021 and beyond will be sensitive to macroeconomic factors, primarily labor market dynamics and consumer spending patterns. For example, changes in wages, full-time employment, and employer-sponsored insurance offers would shift individuals between the Medicaid, individual, and employer-sponsored markets. This would affect both the size of, and income distribution within, the eligible individual market population with related effects on risk mix and premiums. How evolving macroeconomic conditions alter projected impacts of a given policy option would depend on how particular segments of the individual market are affected. To facilitate the comparison of policy options, the macroeconomic environment is held fixed. An analysis of their impacts under different macroeconomic conditions would require for additional modeling beyond the scope of this study.

IMPLEMENTATION CONSIDERATIONS

This section highlights key issues that would need to be addressed to implement the policy options described above. Note that this section does not address administrative costs for implementation, which would likely be significant, and does not provide an exhaustive list of tasks that would need to be performed by administrative agencies (e.g., developing program regulations, forms, and outreach material). Rather it is meant to highlight key policy and operational decision points that were addressed by the federal government in establishing the Affordable Care Act's individual market structure which would also have to be addressed by the State. In addition, coordination with federal agencies – and potentially federal approval – could be needed.

Implementation Timing

All of the policy options modeled in this Report assume implementation in time for the 2021 plan year. To realize the full benefit of these policies on premiums and enrollment, policies would need to be authorized well in advance. Key dependencies for a 2021 implementation include:

- Systems development: New premium and cost-sharing support programs would need to be integrated into the eligibility system in time for the 2021 renewal period which would begin on or around October 1, 2020. Systems changes can take 12 months or more.
- Benefit development: Benefit designs would need to incorporate new cost-sharing subsidies. Benefit packages for the 2021 plan year will be designed between fall of 2019 and early spring 2020.
- Rate setting: The policies modeled here should be expected to put downward pressure on rates. Health insurance issuers will submit preliminary rates for the 2021 plan year by May of 2020.
- Marketing and outreach campaign development: Marketing and outreach campaigns would need to be adjusted to include new state program benefits. These campaigns are finalized in spring prior to open enrollment.

Note that this discussion only reflects timing considerations for Covered California. Additional considerations should be expected for other impacted state agencies, participating health insurance issuers and enrollment partners, among others.

Premium Subsidies

Key issues related to premium subsidies include eligibility, required contribution levels, and the method for disbursing them to consumers and health plans as discussed below:

- Eligibility and required contribution levels can be adjusted based on policy goals and/or budget constraints. This Report models several eligibility and required contribution levels to demonstrate the range of impacts that can be realized. The Affordable Care Act set up permanent eligibility levels for premium tax credit but does require that the Internal Revenue Service adjust required contribution amounts on an annual basis. This adjustment produces a minor change (usually hundredths of a percentage point) to consumers' required contribution. Fixed eligibility and required contribution levels would simplify program administration

DRAFT

significantly. It is assumed that new premium subsidies would only be available through Covered California.

- Federal premium tax credits are “advanceable” meaning that they are provided upfront to reduce the monthly premium paid by the consumer. Exchanges report enrollment to the federal government, which then reimburses health insuranceissuers for the portion of the premium covered by the tax credit. The enrollment impacts presented in this Report are based on an advanceable premium subsidy. To the extent premium subsides were instead provided as refundable credits after premiums were paid, enrollment would be expected to be much lower because consumers would have to pay the full premium upfront.
- A consumer’s monthly premium tax credit is estimated at the time of application based on the consumer’s projected income for the year. In order to minimize over or underpayments that could negatively affect consumers, exchanges are required to verify income again electronic data sources and make adjustments to premium tax credit amounts if consumers fail to provide adequate justification for their projected income. Given the significant administrative complexity involved in establishing an advanceable credit tax credit, Covered California could leverage and enhance the existing income verification structure to ensure that premium subsidies amounts are accurately determined and updated appropriately to reflect changes in consumer circumstances throughout the year.
- Under the Affordable Care Act, state exchanges report enrollment to the federal government in order to facilitate the payment of advanced premium tax credits to the issuers. A similar structure could be established for a state premium subsidy program in which the eligibility agency – in this case Covered California – could report membership to a separate state agency that would then pay health insurance issuers.

Cost-Sharing Subsidies

Similar to premium subsidies, state policymakers would have to decide which state entity would be responsible for making cost-sharing payments to health insurance issuers. The following additional issues would also need to be addressed:

- The Affordable Care Act established the cost sharing reduction program which specifies the actuarial value of the products available to consumers in specific income ranges. If implemented, the policy options in this report would extend eligibility for certain federally-defined Silver cost-sharing variants and would also define new variants. This program design would need to be harmonized with federal rules for product and rate development as well as federal reporting and claiming. Massachusetts and Vermont have implemented state cost-sharing subsidy programs which could be explored as models (See Selected References).
- The federal cost sharing reduction program was designed to make prospective payments to health insurance issuers on a monthly basis followed by an annual reconciliation. Since the suspension of direct payment by the federal government in 2017, issuers participating in Covered California have been collecting the value of the cost-sharing subsidies through a surcharge on Silver premiums. Implementation of a state cost-sharing program would require consideration both of the payment mechanism for the state cost-sharing subsidy as well as any potential negative consequences for the current surcharge program.

Individual Mandate

Key features of an individual mandate include the definition of qualifying or minimum essential coverage, penalty amounts, and exemptions from the mandate. Because the Affordable Care Act mandate still exists – even though the associated penalty has been set to $0 – policymakers may want to conform a state mandate and penalty to the federal model with a provision to adjust the state penalty amount in the event of the reestablishment of the federal penalty at a future time. As noted above, the modeling of penalty revenue in this Report is based on penalty payment data for California tax filers for the 2016 tax year, the last year for which Internal Revenue Service data is publicly available. A recent publication funded by the Center for Health Policy at Brookings estimated that California could collect approximately $700 million penalty revenue in 2020 based on U.S. Treasury Department estimates produced prior to the zeroing out of the penalty (see Levitis in Selected Resources).

Under the federal mandate, exemptions are granted either by the Internal Revenue Service or federal Department of Health and Human Services depending on the type of exemption. While states have the option of processing certain types of exemptions, most – including California – rely on the Department of Health and Human Services to process exemptions on their behalf. If California wanted to mirror the federal process, the Franchise Tax Board and Covered California could be given responsibility for processing exemptions.

Reinsurance

Several states have implemented reinsurance programs in the three years since the expiration of the federal temporary reinsurance program. Most of these states have modeled their programs on the federal model that reimbursed a specified portion of claims exceeding a certain dollar amount up to a cap. This type of a program is known as attachment point model. An alternative model exists which is based on a predefined list of conditions that qualify for reinsurance payments. Defining a set of qualifying conditions would likely require more time than would definition of the parameters for an attachment point program.

These programs are financed through a combination of state funds and federal funds provided through a state innovation waiver. The state innovation waiver process is defined in Section 1332 of the Affordable Care Act which allows states to waive certain individual market provisions of the law provided that they adhere to statutory requirements to maintain the comprehensiveness, affordability and coverage levels of the pre-waiver market without adding to the federal deficit. Reinsurance programs administered at the state level reduce federal expenditures by reducing gross premiums on which federal premium tax credits are calculated. States can use the Section 1332 waiver process to apply for “pass through” funding equal to the federal savings, which can then be used of offset the state cost of the reinsurance program. This approach is deficit neutral because the federal government spends the same amount it would have spent absent the state reinsurance program.

It is unclear how deficit neutrality would be calculated for a state that simultaneously implemented multiple affordability policies including reinsurance. Taken together, policies may significantly increase the number of subsidized enrollees in the state while still reducing per-enrollee spending on premium

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tax credits through 1) lower gross premiums directly resulting from reinsurance; and 2) lower gross premiums due to improved risk mix in the market. The amount of pass through funding would depend on the extent to which a state would be required to account for the impacts of multiple policy interventions.

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APPENDIX I

STATUTORY LANGUAGE OF AB 1810 (2018)

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

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

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

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

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

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APPENDIX II

STAKEHOLDER WORKGROUP MEMBERS

Alicia Kauk, National Health Law Program
Amber Kemp, California Hospital Association
Beth Capell, Health Access California
Bill Wehrle, Kaiser Permanente
Cary Sanders, California Pan-Ethnic Health Network
Catrina Reyes, California Medical Association
Dave Brabender, California Association of Health Underwriters
Jen Flory, Western Center on Law and Poverty
Marjorie Swartz, Office of Senate President Pro Tempore Toni Atkins
Mary June Flores, Health Access California
Mike Odeh, Children Now
Robert O'Reilly, Molina Healthcare
Robert Spector, Blue Shield of California
Teri Boughton, California State Senate Committee on Health
Wendy Soe, California Association of Health Plans

Covered California Board Member Participants
Jerry Fleming
Sandra Hernandez, M.D.

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

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APPENDIX III

2019 FEDERAL POVERTY LEVEL TABLE

FEDERAL POVERTY LEVEL FOR 2019

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

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APPENDIX IV

2019 PATIENT-CENTERED BENEFIT DESIGNS

2019 Patient-Centered Benefit Designs and Medical Cost Shares

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

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

Drug prices are for a 30 day supply.

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

** Price is after pharmacy deductible amount is met.

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

APPENDIX V

TECHNICAL INFORMATION

To estimate the enrollment and pricing effects of the policies detailed below, we develop and employ a “choice model” using econometric techniques as well as detailed enrollment and rate data from Covered California.

Data

The enrollment data span the years 2014 (the first year the Exchange was operational) through 2018 and contain information on individual characteristics for households who purchased insurance coverage through the Exchange. These characteristics include zip code of residence, household size, household income to poverty ratio, age of each member of the household, gender of each member of the household, household “risk scores,” start -and-end dates of coverage, as well as specific identifiers for the health plans chosen in any given time period. The rate data span 2014-2019, and include information on health plan characteristics, including premiums charged by zip code and year, brand, metal tier, provider network, and actuarial value. In addition, we supplement the Covered California data with data on the uninsured population in California from the American Community Survey and administrative data on medical spending on the Exchange by age, rating region, and plan type from the Integrated Health Association.

Model Setup and Estimation

Using these variables, we construct a dataset of the health plan choices each household has available in each year and zip code between 2014 and 2018. We then model how the plans chosen vary as a function of household characteristics as well as plan characteristics. The model is based on a “utility-maximization” framework, where each household chooses first whether or not to take up insurance through Covered California, given the set of plans available in the Exchange for that household. Next, conditional on choosing to be insured, the household then decides which plan to take up, given the characteristics of those plans. Specifically, we model choices as a function of: premiums, cost-sharing (or actuarial value), carrier brand, and metal tier. We interact these characteristics with the following household characteristics: risk score, age, income, zip code of residence, prior health plan choice, if any.

Estimation involves finding the set of behavioral parameters that rationalize the choices that households are observed to have made with those predicted by the model. Parameters of most interest include dollarized estimates for household price sensitivity, their preferences for brands and tiers, and aversion to cost-sharing. We estimate these parameters separately by household type. Intuitively, if the premium of one plan in a region rises relative to other plans, and we observe younger households in the region switch to other plans in the following year at a greater rate than older households, we can infer that younger households are more price-sensitive and assign a specific dollar-amount threshold that would induce them to switch. Using these estimates, the model is able to predict how households of differing characteristics would react to changes in the insurance environment.

DRAFT

To model premium changes in response to different policy scenarios, we employ a "premium-setting" model that relates observed carrier premiums in a region to characteristics of households enrolled in those carriers' plans and to estimates of medical costs for those households.

Using the combination of our choice model and premium-setting model, we are then able to make predictions on how changes to the insurance environment (e.g., changes to subsidy structure, choices available, mandate penalty, etc.) would affect household enrollment decisions (insured vs. uninsured), household plan choices (e.g., tier level), carrier premium decisions, overall federal premium tax credit spending, and any new spending required to finance the subsidy structure.

Calibration

Although we are able to primarily rely on estimating the parameters specified using data patterns actually observed, we make several calibration assumptions in order to model the policy scenarios detailed in the report. These assumptions are detailed as follows:

Time Period: We model all estimates for a hypothetical year 2021. To do so, we assume, based on actuarial estimates, gross premium increases of 7 percent per year, and nominal income increases of 2 percent per year. We further assume an *additional* 1.25 percent increase in premiums due to the worsened risk mix associated with zeroing-out of the mandate penalty in plan year 2019. (Covered California reports a 2.5-6 percent increase in premiums in 2019 due to the loss of the mandate tax penalty.[32] Finally, we assume that the same carriers and plans who participate in Covered California offer the same products in 2021. Therefore, our model abstracts away from potential carrier entry and exit between 2019 and 2021.

Set of Eligible Households for Coverage: We assume that the set of households eligible for coverage through Covered California include individuals enrolled in Covered California in 2018 and uninsured individuals. To generate the eligible population in 2021, we weight the 2018 eligible population, calibrated to the total eligible non-group population, by income, to estimates produced by the University of California's CalSIM model.

Removing/Reinstating the Mandate Penalty: We assume that removing the mandate penalty affects total enrollment numbers such that it matches Covered California's consumer surveys[33] and budget projections.[34] This implies an approximate 18 percent decline in enrollment by 2021 due to the elimination of the tax penalty. We assume that reinstating the penalty, however, does not yield commensurate enrollment increases due to disenrolled households no longer exhibiting "inertia" from prior enrollment.

Cost Sharing Reduction Subsidies: We assume that cost sharing reduction subsidies enter the model through improvements in the actuarial-value of silver plans for eligible households, but are financed on the back-end so that the benefit does not directly impact premiums of premium tax credits.

Reinsurance: We assume that the reinsurance results in a 10 percent decline in each plans' gross premiums. We assume that the aggregate cost of the reinsurance program is equivalent to a 10 percent

of the claims costs component of *baseline* plan premiums, but of plans chosen in the *simulated* outcome.

Changes to Contribution Caps for Premium Support: In Policy Options that lower the contribution caps, we assume the lower caps are pegged to the second lowest Silver plan. We assume that consumers experience the lower contribution cap as a lower net-of-subsidy premium, where the decrease is equivalent to the dollar difference between consumers' current and modeled premium contribution cap.

Penalty Revenue. For each model forecast, we apply the 2018 mandate tax penalty formula to the remaining uninsured population among consumers eligible for the non-group market. As described above, the eligible non-group population is calibrated to 2021 CalSIM forecasts, and excludes undocumented individuals, individuals over age 65, as well as uninsured in other segments of broader insurance market (e.g. employer sponsored insurance, Medicaid, etc.) We also assume penalty enforcement of 75 percent, similar to federal compliance rates in 2016.

DRAFT

APPENDIX VI

ADDITIONAL INFORMATION FOR APPROACH 1

The premium subsidies modeled in Approach 1 are designed to eliminate the federal premium tax credit cliff by capping the percent of income individuals over 400 percent FPL must pay for a benchmark plan. The new caps over 400 percent FPL – as well as reduction to the Affordable Care Act caps for individuals under 400 percent FPL – are displayed in Table 12. Over 400 percent FPL, these caps are designed to increase from eight to 15 percent of income though it is important to note that premium contribution caps can be set at any value based on policy goals and/or budgetary targets. The effects of the new caps are illustrated in Figures 10 and 11 in which the blue line represents premium costs by FPL under the Affordable Care Act and the blue line represents premiums costs under the proposed premium subsidy policy. Figures 10 illustrates the impact for single individuals purchasing a benchmark plan with either a $700 or an $1,100 monthly premium. With the new cap, a consumer making just over 400 percent FPL would pay eight percent of their income for the benchmark plan. Under the Affordable Care Act, this same consumer does not benefit from a premium contribution cap, so their premium cost equates to about 17 percent of their income for a $700 benchmark plan and 27 percent of their income for a $1,100 benchmark plan. Figure 11 illustrates the same dynamics for a 64-year old couple purchasing two benchmark plans in the most expensive region in California. At the sample premium costs of $700 and $1,100, the share of income devoted to premiums would drop from 25 and 40 percent, respectively, to just over eight percent. Figures 10 and 11 also illustrate the point at which the new subsidies would phase out – meaning that "uncapped" or gross premium costs as a percentage of income would fall below 15 percent. This is reflected in the figures by the peak in the black line.

Table 10. Premium Support to Lower Contribution Caps for Individuals Below 400 Percent FPL and Eliminate the Tax Credit Cliff Above 400 Percent FPL

FPL	Benchmark Premium Contribution Cap (%)	
	ACA Baseline	Proposed
0-138	2.08%	0%
138-150	3.11%-4.15%	0%-0.37%
150-200	4.15%-6.54%	0.37%-1.89%
200-250	6.54%-8.36%	1.89%-3.42%
250-400	8.36-9.86	3.42%-8.00%
400-600	No Cap	8.00%-12.00%
600+	No Cap	12.00%-15.00%

DRAFT

Figure 10. Premium Contributions to Policy Options 1-3

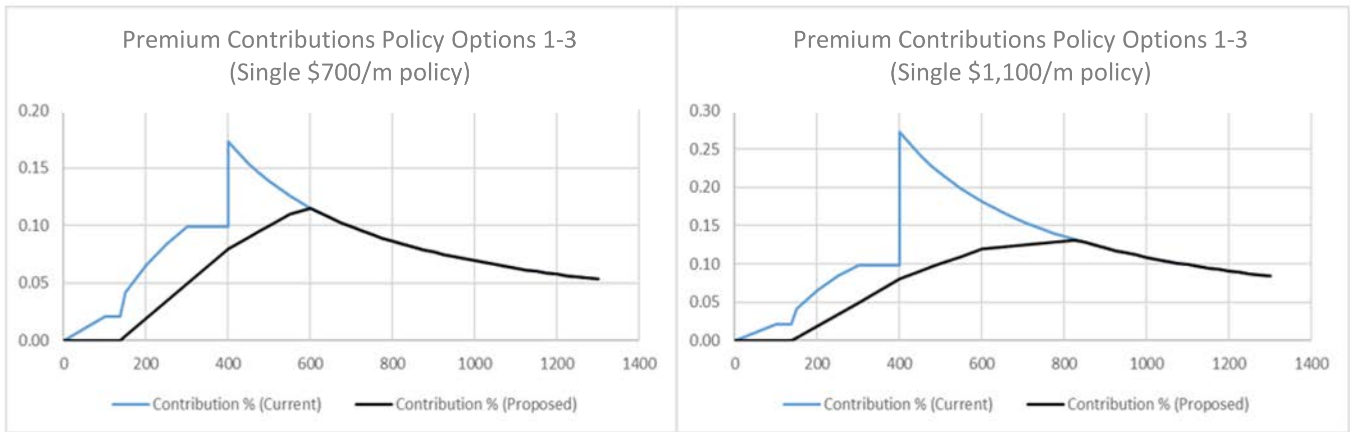

Figure 11. Premium Contributions to Policy Options 1-3

DRAFT

APPENDIX VII

SELECTED RESOURCES

Coverage

Miranda Dietz et al., "California's Health Coverage Gains to Erode Without Further State Action," UCLA Center for Health Policy Research and UC Berkeley Labor Center, November 2018, http://laborcenter.berkeley.edu/ca-coverage-gains-to-erode-without-further-state-action/

Federal and State Individual Shared Responsibility Provisions

Internal Revenue Service Penalty Information: https://www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-calculating-the-payment#Determining if You Need to Make a Payment

Complete Exemption List: https://www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply/

Jason A. Levitis, "State Individual Mandates," USC-Brookings Shaeffer Initiative for Health Policy, October 2018, https://www.brookings.edu/wp-content/uploads/2018/10/Levitis_State-Individual-Mandates_10.29.18.pdf

Jason Levitis, "Model Legislation for State Individual Mandate," February 22, 2018, https://www.shvs.org/resource/model-legislation-for-state-individual-mandate/

Reinsurance

Joel Ario et al., "State Reinsurance Programs: Design, Funding, and 1332 Waiver Considerations for States," Manatt Health, September 2018, https://www.shvs.org/resource/state-reinsurance-programs-design-funding-and-1332-waiver-considerations-for-states/

Application Template for Section 1332 Reinsurance Waiver: https://www.shvs.org/resource/application-template-for-section-1332-reinsurance-waiver

Other States' Affordability Programs

Vermont Health Coverage Map and Program Description, https://info.healthconnect.vermont.gov/sites/hcexchange/files/Health_Coverage_Map-2018Q2.pdf and https://ljfo.vermont.gov/assets/docs/healthcare/Health-Reform-Oversight-Committee/2015_09_15/4d040505fe/Agency-of-Administration-Cost-Sharing-Reduction-Program.pdf

Massachusetts ConnectorCare Health Plan Overview, https://www.mahealthconnector.org/wp-content/uploads/ConnectorCare_Overview-2017.pdf

DRAFT

ENDNOTES

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

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

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

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

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

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

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

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

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

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

[11] Ibid.

[12] Covered California's Health Insurance Companies and Plan Rates for 2019, p.10.

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

[14] Lucia L and Jacobs K, Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment, UC Berkeley Labor Center, March 2018, p.14.

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

[16] Lucia L and Jacobs K, Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment, UC Berkeley Labor Center, March 2018, p.3.

DRAFT

[17] Based on analysis using the California Poverty Measure developed by the Public Policy Institute of California and Stanford Center on Poverty and Inequality (Lucia L and Jacobs K, 2018).

[18] Congressional Budget Office, Repealing the Individual Health Insurance Mandate: An Updated Estimate, November 2017, p.1.

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

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

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

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

[23] UCLA-UC Berkeley CalSIM version 2.2

[24] Brot-Goldberg, Zarek C., Amitabh Chandra, Benjamin R. Handel and Jonathan T. Kolstad "What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics" The Quarterly Journal of Economics, Volume 132, Issue 3, 1 August 2017, Pages 1261–1318.

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

[26] Consumers responding to the mandate tax penalty will typically be healthier than individuals enrolled by choice, resulting in an improved risk mix. Indeed, plans priced in a 2.5 to 6 percent increase in 2019 premiums—with an average of 3.5 percent—in response to anticipated increases in average risk in the first year without the mandate penalty. See Covered California, Covered California Releases 2019 Individual Market Rates: Average Rate Change Will Be 8.7 Percent, With Federal Policies Raising Costs, July, 2018. In the first year of its reinstatement, the penalty would partially reverse this negative risk mix and premium impact, resulting in an estimated 3 percent decrease in premiums.

[27] This assumes that the State enforces tax penalty with the same compliance rate (approximately 75 percent in 2017) as the federal government. See Technical Appendix for more details.

[28] Domurat, Richard, Isaac Menashe and Wesley Yin. "Frictions in Health Insurance Take-up Decisions: Evidence from a Covered California Open Enrollment Field Experiment," April 2018.

[29] As with the contribution caps in primary Policy Options 1-3 in Approach 1, the contribution cap in Policy Option T4 rises to 15 percent at 1200 FPL, roughly where the subsidy would naturally phase out for two-person household purchasing two 64-year old benchmark Silver plans for two 64-year old policies in the most expensive region in California. Above 1200, premium caps remain 15 percent.

[30] As in Policy Options 2 and 3 in Approach 1, estimated penalty revenue reported here comprises tax penalty revenue collected from only the non-group market. We assume that the State enforces tax penalty with the same compliance rate (approximately 75 percent in 2017) as the federal government. See Technical Appendix for more details.

[31] Congressional Budget Office, Repealing the Individual Health Insurance Mandate: An Updated Estimate, November, 2017. And Covered California's budget forecast from Table 3 (Chapter V) in the Budget Book.

[32] See Covered California, Covered California Releases 2019 Individual Market Rates: Average Rate Change Will Be 8.7 Percent, With Federal Policies Raising Costs, July, 2018.

[33] Fung, Vicki, Catherine Y. Liang, Julie Shi, Veri Seo, Lindsay Overhage, William H. Dow, Alan M. Zaslavsky, Bruce Fireman, Stephen F. Derose, Michael E. Chernew, Joseph P. Newhouse, and John Hsu. "Potential Effects Of Eliminating The Individual Mandate Penalty In California" *Health Affairs*, January 2019.

[34] Covered California Fiscal Year 2018-19 Budget, https://hbex.coveredca.com/financial-reports/PDFs/CoveredCA_2018-19_Budget-6-15-18.pdf, June 15, 2018.

DRAFT