# Options To Improve Affordability In California's Individual Health Insurance Market

COVERED CALIFORNIA™

February 1, 2019

The Honorable Gavin Newsom
Governor, State of California
State Capitol, Suite 1173
Sacramento, CA 95814

The Honorable Toni G. Atkins
California State Senate President Pro Tempore
State Capitol, Room 205
Sacramento, CA 95814

The Honorable Anthony Rendon
California State Assembly Speaker
State Capitol, Room 219
Sacramento, CA 95814

Feb. 1, 2019

To Governor Gavin Newsom and members of the California State Legislature:

On behalf of the governing board of Covered California, and pursuant to Government Code Section 100503.3, I am pleased to present to the Governor, California Legislature, and Council on Health Care Delivery Systems "Options to Improve Affordability in California's Individual Health Insurance Market."

This report was prepared pursuant to AB 1810 (Committee on Budget, Chapter 34, Statutes of 2018), which required Covered California to develop options to improve affordability for low- and middle-income consumers. Over the past several months, Covered California has worked with academic experts and a workgroup composed of stakeholders and legislative staff to produce this report, and it is our hope that it will serve to inform ongoing policy discussions on health care affordability.

The Patient Protection and Affordable Care Act has transformed health care coverage across America, but it has been particularly effective in states such as California that have embraced its provisions to expand coverage and protect consumers. Using the tools of the Affordable Care Act, California has dramatically reduced the number of the uninsured and made coverage more affordable for millions of Californians. However, research shows that affordability remains a top concern for consumers who purchase coverage today — with or without federal support — and many who are eligible for help today remain uninsured. The release of this report comes at a time of important discussion on health coverage affordability at the state and national levels. In California, the Governor and Legislature have proposed significant policy changes that would expand financial support for Californians to get and keep coverage and reverse coverage losses that are already beginning due to the federal elimination of the individual mandate penalty. At the same time, despite policy actions by the federal administration that have chipped away at


BOARD MEMBERS Michael Wilkening, Chair Paul Fearer Jerry Fleming Dr. Sandra Hernandez Art Torres EXEC. DIRECTOR Peter V. Lee

the integrity of the Affordable Care Act, there is increasing bipartisan interest in building on its foundation to improve affordability and care across America.

This report presents a range of policy options for enhancing the financial support provided by the Affordable Care Act and estimates the enrollment increases and consumer cost reductions that could be gained by Californians if such policies were enacted. The options include both a comprehensive market-wide approach as well several discrete options that could be targeted to different segments of the market based on policy priorities and budget limitations. The report highlights the cost-effectiveness of reestablishing a penalty for not maintaining coverage as well as the importance of increasing financial support to lower premiums and out-of-pocket costs. These options could induce hundreds of thousands of Californians to get coverage and make coverage more affordable for the more than 1 million Californians who are purchasing purchase today. California's leadership in this area could also serve as a national model for enhancements to the Affordable Care Act that could benefit millions of Americans.

It is important to note that all the policy options presented in this report could be taken up at the federal level. The Affordable Care Act is the most significant piece of health care coverage legislation enacted into law since the establishment of Medicare and Medicaid in 1965. Like Medicare, the Affordable Care Act was not perfect and had many areas worthy of improvement and revision. For example, in the 10 years after Medicare was enacted, Congress amended and revised the law multiple times including acting to add coverage for people with long-term disabilities and with end-stage renal disease. Unfortunately, unlike Medicare, in the eight years since the Affordable Care Act was passed, the debate has all too often been about "repeal and replace," not improve and revise. While the proposals in this report are addressed to California's leadership, they can and should also inform federal discussions since these options could benefit Americans across the country if adopted at the federal level.

By legislative charge, this report only addresses affordability challenges in California's individual market and does not consider the important issues of underlying cost increases in health care and the role of group and government-sponsored insurance or other factors in achieving universal coverage. Nevertheless, Covered California is proud to be a part of the ongoing effort to provide Californians with affordable coverage as we strive to realize the triple aim of lowering costs, improving quality and improving health outcomes for all consumers.

Finally, I want to acknowledge and appreciate the thoughtful contributions of the members of the AB 1810 Affordability Workgroup and in particular the contributions of Katie Ravel, Covered California's Director of Policy, Eligibility and Research; and economists Wesley Yin, PhD, University of California at Los Angeles, and Nicholas Tilipman, PhD, University of Illinois at Chicago for preparing this report.

We stand ready to work with the Governor, California Legislature, and Council on Health Care Delivery Systems to advance affordability for Californians.

Sincerely,

Peter V. Lee
Executive Director

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

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## 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 Feb. 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 premiums. 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 and a link to the workgroup webpage.) In addition, Covered California presented a draft version of this report at its Jan. 17, 2019, public board meeting and solicited feedback from the public.

This report is organized into three main sections. The first section describes the tools of the Patient Protection and 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 to get coverage today 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 reform insurance markets, stabilize the individual market and provide financial support to low- and middle-income consumers who previously had no help paying for coverage. These include requirements that health insurance issuers accept all individuals irrespective of health status, risk stabilization mechanisms, "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. Today these policies are providing direct financial assistance to 1.2 million consumers enrolled through Covered California, the state's health benefit exchange, and are moderating premium increases for an additional 1 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 for many Californians. 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. Despite these subsidies, enrollment among the consumers who are currently eligible for federal subsidies is only slightly above 70 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

otherwise 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 and 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. The first approach, "Comprehensive Market-Wide Affordability Enhancements," presents three policy options that build upon each other with the goal of enhancing affordability for all individual market enrollees. The first, known as "Option 1," eliminates the tax-credit cliff and significantly expands cost-sharing subsidies; Option 2 adds the individual mandate penalty to Option 1; and Option 3 adds a reinsurance program to Option 2. The second approach, "Targeted Affordability Enhancements," presents several discrete 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. All models assess potential enrollment impacts in 2021 and compare the policy options to the projected likely enrollment at that point absent intervention.

Full implementation of Approach 1 would achieve significant coverage gains. It would also cap and reduce premium contributions, make care more affordable and lower premiums market-wide. Enrollment would increase by about 764,000 Californians, increasing take-up in the individual market from 51 percent to 70 percent. The increase in cost-sharing generosity would increase enrollment in higher value (Silver-tier or higher) plans by 10 percentage points. Californians who otherwise would have individual market coverage would also experience reductions in their premium payments and cost-sharing. If all offsets were applied, net new spending would be approximately $2.7 billion in Option 3.

| Summary of Approach 1: Comprehensive Market-Wide Affordability Enhancements | | | |
|---|---|---|---|
| | **Option 1: Premium and Cost Sharing Support** | **Option 2: Premium and Cost Sharing Support with Penalty** | **Option 3: Premium and Cost Sharing Support, Penalty and Reinsurance** |
| **New Enrollment** | **290,000** | **648,000** | **764,000** |
| *<250% FPL* | *66,000* | *120,000* | *139,000* |
| *250-400% FPL* | *153,000* | *342,000* | *358,000* |
| *400%+ FPL* | *71,000* | *187,000* | *267,000* |
| Individual Market Take-up Rate* | 58% | 67% | 70% |
| Percent of Enrollees in Silver Coverage or Higher** | 79% | 77% | 79% |
| **Benefits to Existing Enrollees** | | | |
| On-Exchange Number Benefitting | 1,292,000 | 1,292,000 | 1,292,000 |
| On-Exchange Average Monthly Premium Reduction | $39/m | $39/m | $39/m |
| Off-Exchange Number Benefitting | 662,000 | 662,000 | 662,000 |
| Off-Exchange Average Monthly Premium Reduction | $18/m | $41/m | $111/m |
| **Spending Impacts** | | | |
| New State Spending | **$2,190,000,00** | **$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* | *$629,000,000* | *$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** |
| Potential Net State Spending*** | **$2,190,000,00** | **$2,121,000,000** | **$2,676,000,000** |
| Change in Federal Tax Credit Expenditures | $670,000,000 | $975,000,000 | ($331,000,000) |

* 51% under Affordable Care Act Baseline 2021
** 69% under Affordable Care Act Baseline 2021
*** Net State Spending assumes all offsets are applied to reduce State expenditures

Approach 2 estimates the impact of targeted affordability enhancements on four populations of interest: 1) consumers under 400 percent federal poverty level (FPL), 2) consumers under 600 percent FPL, 3) consumers over 400 percent FPL and 4) all consumers through reinstatement of the individual mandate penalty. The options are labeled “T” for targeted and numbered one through eight. 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 an individual mandate penalty could be offset by 1332 waiver funding or penalty revenue, respectively. The range of enrollment and state budget impacts are reported 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 less than 600% FPL | **T3. Premium support** that lowers premium contributions for consumers earning between 0 and 600 percent FPL | 125,000 | $765,000,000 |
| | **T4. 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)* |
| Targeted improved affordability for consumers earning more than 400% FPL | **T5. Premium support** that lowers premium contributions for consumers earning between 400 and 600 percent FPL | 47,000 | $285,000,000 |
| | **T6. Premium support** that lowers premium contributions for consumers earning more than 400 percent FPL | 50,000 | $324,000,000 |
| | **T7. Reinsurance** that lowers gross 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 all consumers generated by reinstating the mandate penalty | **T8. Reinstate individual mandate penalty** which increases enrollment and lowers premiums by improving the risk mix in the individual market | 359,000 | *($526,000,000 potential penalty revenue)* |

## IMPLEMENTATION CONSIDERATIONS

The options modeled in this report 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. This report concludes with a discussion of key decisions that would need to be made to implement each policy option:

- 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 affecting the current federal financing approach.
- Determining how to conform a state individual mandate and penalty to the federal individual mandate.
- Developing a 1332 waiver strategy, if a reinsurance program is considered, that would include pursing federal offset funding.

Each option would require decisions about which state agencies will be responsible for its various administrative components. Other state agencies, health insurance issuers and enrollment entities, among others, will have additional implementation considerations. They likely would have similar needs to embark on planning and implementation work in 2019.

# 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 location. 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 full-scope Medicaid, the Children's Health Insurance Program (CHIP), 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 insurance companies 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 10 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 average portion of the total health care costs that are covered by the health insurance issuer versus the portion covered by a consumer paying out-of-pocket costs. The remaining portion is collected through consumer cost-sharing in the form of deductibles, copays 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.

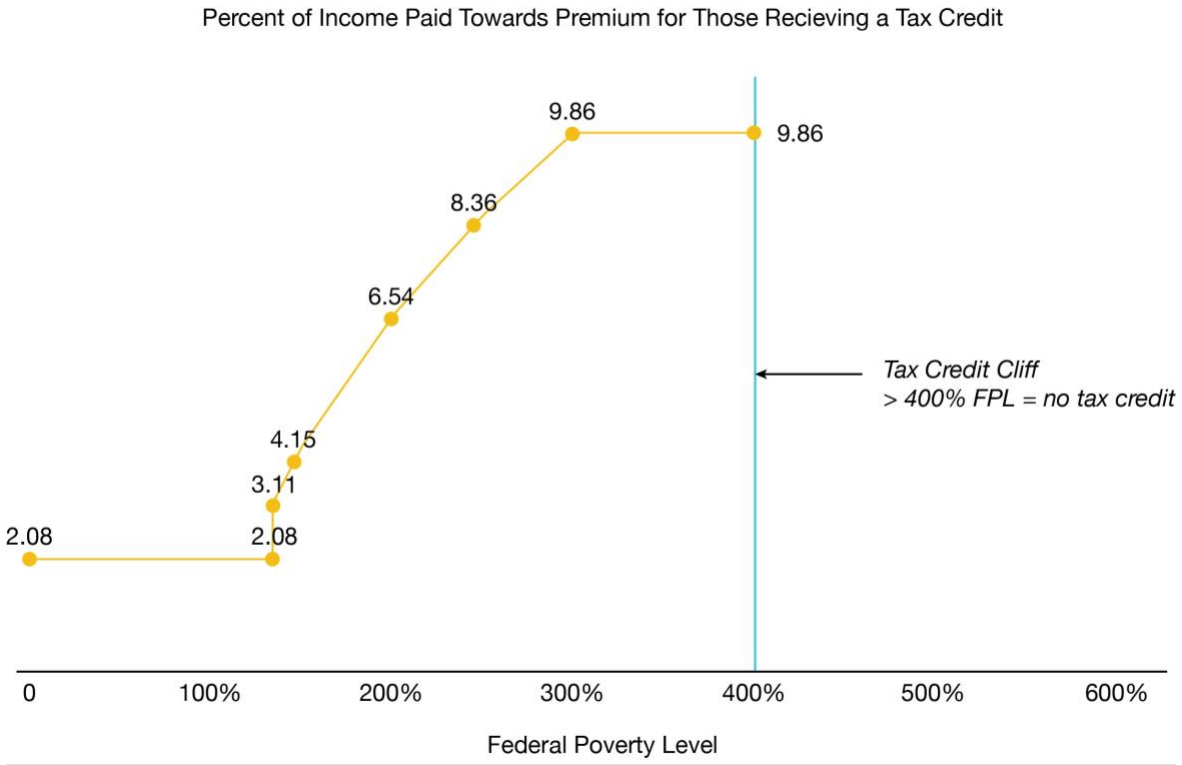
Covered California, in close collaboration with stakeholders, has developed patient-centered benefit designs for each metal tier with the goal of ensuring that cost-sharing does not prevent members from accessing necessary services. For Silver-tier coverage and higher, outpatient care is not subject 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, 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 FPL who buy coverage through exchanges and are not eligible for full-scope Medicaid, the Children's Health Insurance Program (CHIP), affordable employer-sponsored insurance or other coverage. The premium tax-credit structure caps the amount individuals have to pay for their monthly premiums. The member share, referred to as a required contribution, ranges from approximately 2 to 10 percent of household income depending on the individual's FPL (see Figure 1). Note that while eligibility for Covered California begins for most people at 138 percent FPL, certain lawfully present immigrants are eligible for premium tax credits between 0 and 138 percent FPL if they are not eligible for full-scope Medi-Cal, are over age 21 or are not pregnant.

**Figure 1.** Affordable Care Act-Required Contribution Percentages for Benchmark Coverage 2019




The premium tax-credit amount is calculated as the difference between the second-lowest-cost Silver plan available to the individual and the individual's 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. The reconciliation process results in consumers either receiving an additional tax credit if they overestimated their income or owning money to the Internal Revenue Service if they underestimated their income.

Because gross premiums can vary by age and region, but consumers' premium contributions are capped based on income, 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. For example, the average Silver plan premium for 21-year-olds is $333. At that premium, the typical 21-year-old pays $63 per month and the premium tax credit covers the difference. For a 64-year-old, the average Silver premium rises to $1,034. At that premium, the typical 64-year-old enrollee pays only $160, net of the premium tax credit of $603, which offsets the higher age-rated premium.

Figure 3 shows how the value of the premium tax adjusts to account for regional premium differences. While the average Silver premium in Northern California is 30 percent higher than in Southern California, enrollee net premiums after premium tax credits are comparable.[2]

Finally, 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 their income, 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 Credits

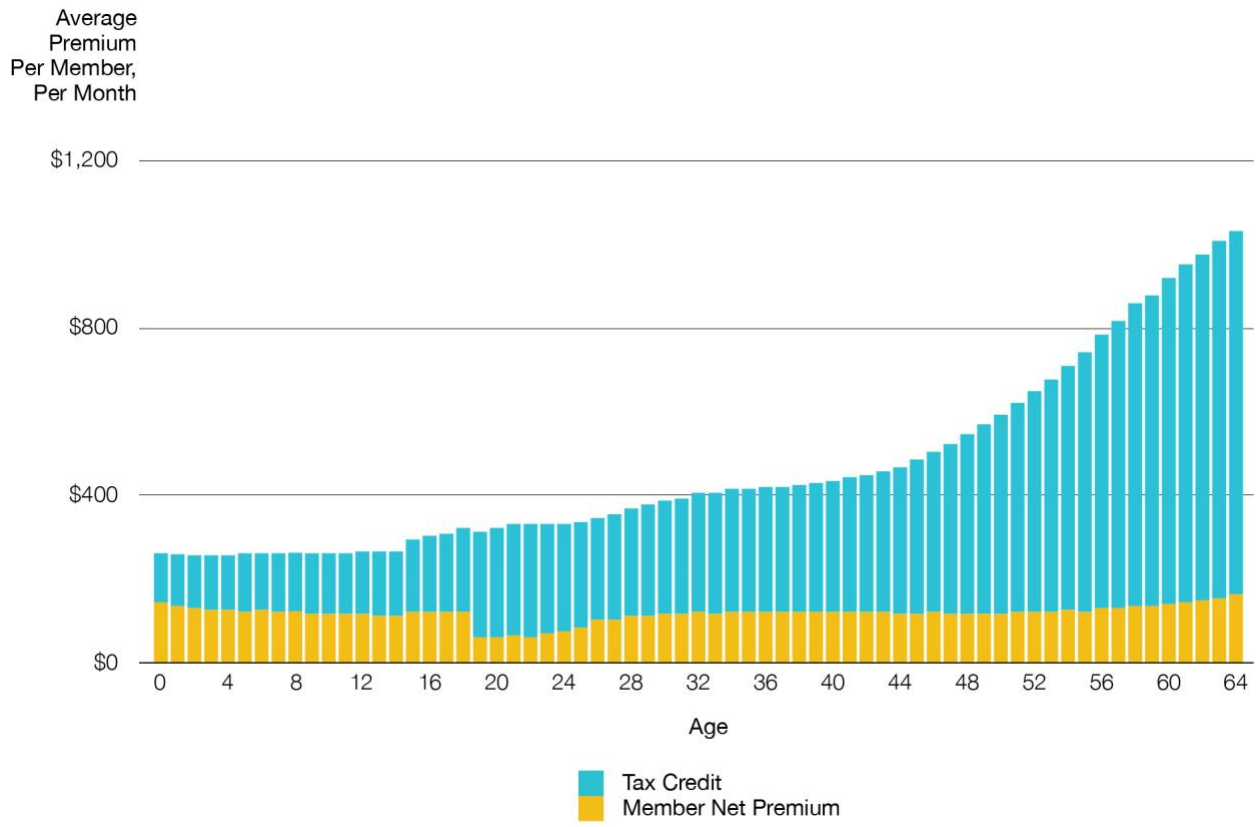
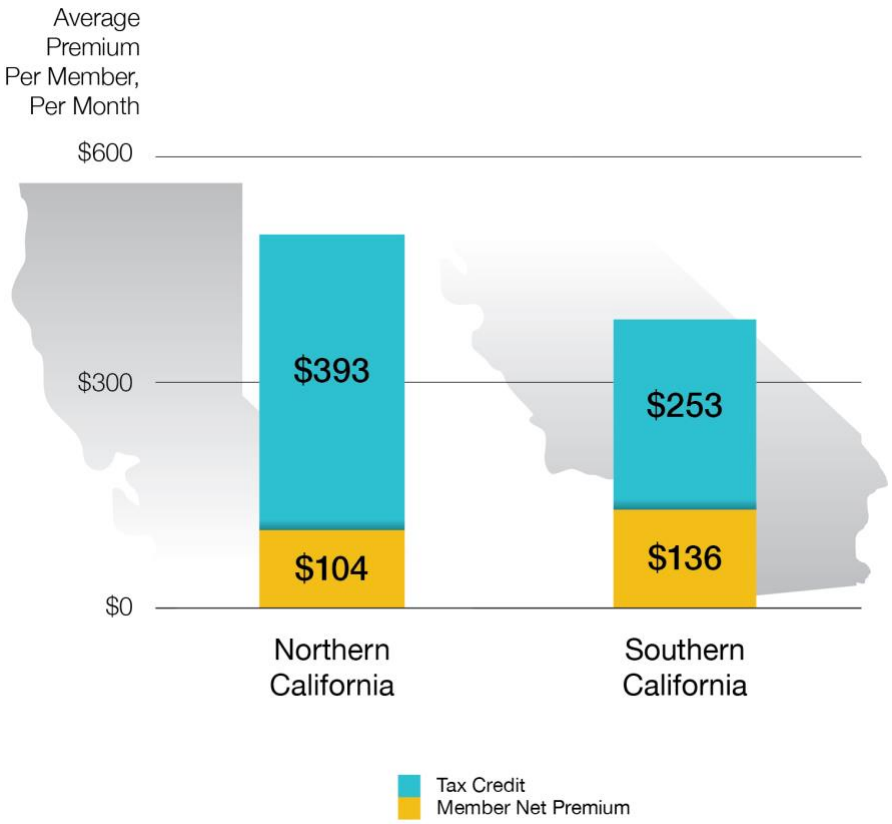


**Figure 3.** Average Premiums for Subsidy-Eligible Silver Plan Enrollees in Northern and Southern California in 2018, Showing Portion Paid by Enrollee and Portion Covered by Premium Tax Credits




## *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 2019 Silver 70 plan design 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 (also 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.** Comparison of Selected Silver Plan Deductibles and Cost Shares in Covered California's 2019 Patient-Centered Benefit Designs

| | | Silver Cost-Sharing Variants | | |
|---|---|---|---|---|
| | **Silver 70** | **Silver 73** 200-250% FPL | **Silver 87** 150-200% FPL | **Silver 94** Up to 150% FPL |
| Actuarial Value (AV) | 70% AV | 73% AV | 87% AV | 94% AV |
| Individual Deductible Medical / Pharmacy | $2,500 / $200 | $2,200 / $175 | $650 / $50 | $75 / $0 |
| Office Visit | $40 | $35 | $15 | $5 |
| Tier 1 Prescription Drugs | $15 after $200 pharmacy deductible | $15 after $175 pharmacy deductible | $5 | $3 |

### *Individual Shared Responsibility Provision*

The Affordable Care Act's individual mandate requires that individuals maintain "minimum essential coverage" or pay a 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).
- 2.5 percent 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 each year for 2014, 2015 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 high-cost claims. Reinsurance offers a direct mechanism to assist consumers who are ineligible or not qualified 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, resulting in lower gross premiums for all plans sold in the individual market. Since the expiration of the program, seven states have implemented

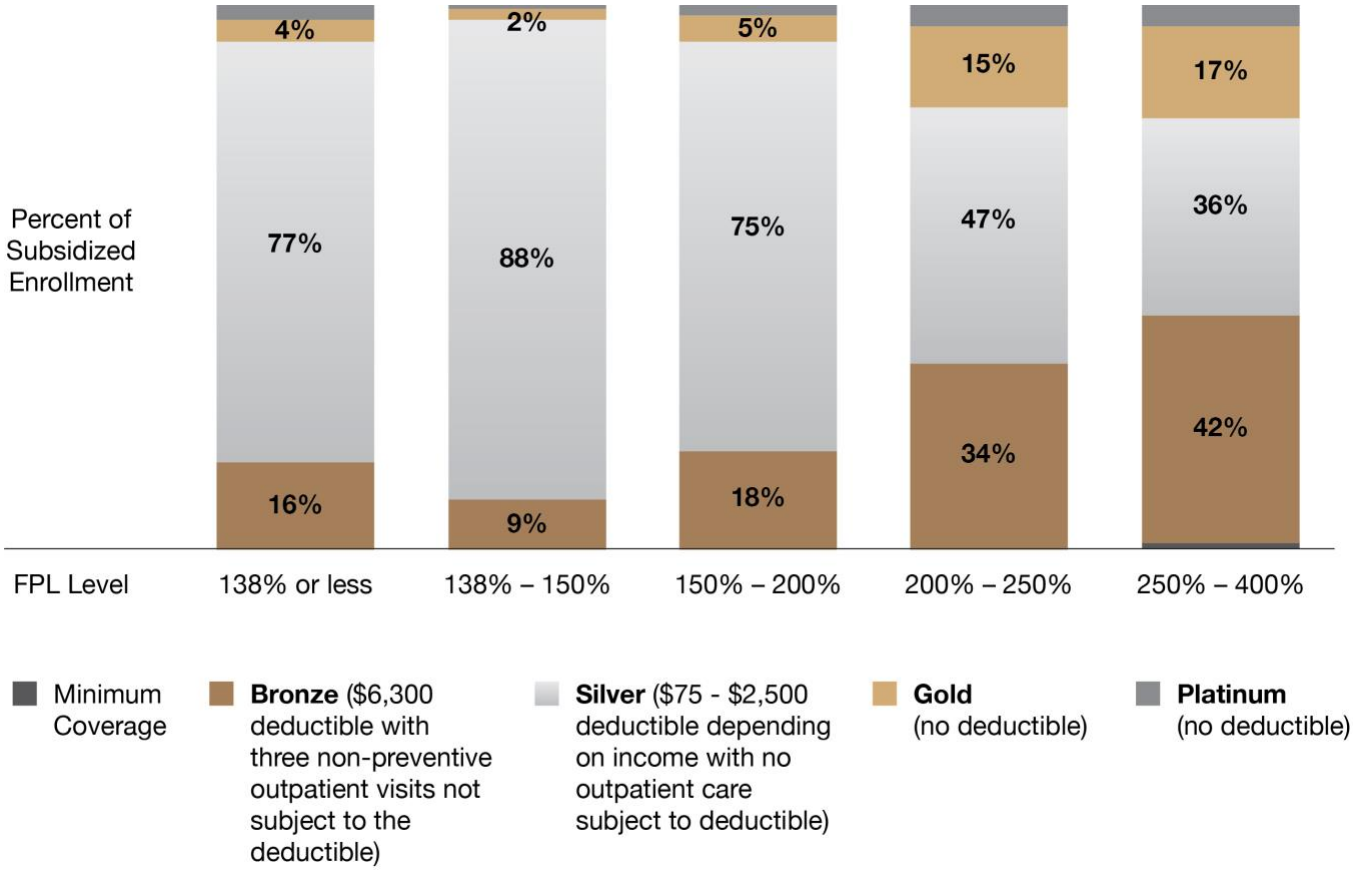
reinsurance programs to stabilize premium increases in their individual markets using the federal Section 1332 “state innovation” waiver process.

The Affordable Care Act also includes a 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. This permanent component of the Affordable Care Act is federally administered and continues to provide stability to the market.

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

In order to evaluate opportunities to enhance affordability for the individual market, it is important to understand the profile of enrollees today. As of 2018, Covered California had approximately 1.4 million enrollees, of whom nearly 90 percent — or 1.2 million — received premium tax credits. Two-thirds of enrollees have household incomes below 250 percent FPL, and half of Covered California's subsidized enrollees purchase a cost-sharing reduction plan. The distribution of metal tier choice varies significantly between income groups as shown in Figure 4, with the percentage enrolled in the Silver tier or higher dropping as income rises and cost-sharing subsidies phase out.

**Figure 4.** Covered California 2018 Subsidized 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 2018 Enrollment by Age and Subsidy Status

| | Subsidized | | Unsubsidized | | Total | |
|---|---|---|---|---|---|---|
| **Age Bracket** | Enrollees | (column %) | Enrollees | (column %) | Enrollees | (column %) |
| Age 17 or less | 65,190 | 5.3% | 29,440 | 18.4% | **94,630** | **6.8%** |
| Age 18 to 25 | 128,580 | 10.5% | 10,620 | 6.6% | **139,200** | **10.1%** |
| Age 26 to 34 | 191,950 | 15.7% | 34,154 | 21.3% | **226,100** | **16.34%** |
| Age 35 to 44 | 177,830 | 14.5% | 29,590 | 18.5% | **207,420** | **15.0%** |
| Age 45 to 54 | 282,190 | 23.1% | 28,300 | 17.7% | **310,490** | **22.4%** |
| Age 55 to 64 | 369,270 | 30.2% | 27,430 | 17.1% | **396,700** | **28.7%** |
| Age 65+ | 8,130 | 0.7% | 690 | 0.4% | **8,820** | **0.6%** |
| **Grand Total** | **1,223,140** | **100.0%** | **160,210** | **100.0%** | **1,383,350** | **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 2018 gross premium cost of $558 per month, as shown in Table 3. In addition, members enrolled in cost-sharing reduction plans receive reduced deductibles, copays 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 the proportion of enrollment in Bronze coverage is twice as high among unsubsidized enrollees as it is among subsidized enrollees.[3]

**Table 3.** Covered California 2018 Average Monthly Premiums, Average APTC, and Average Net Premiums by Subsidy Status

| | Subsidized | Unsubsidized | Total |
|---|---|---|---|
| **Enrollment Metrics** | | | |
| Policies | 841,000 | 110,180 | **951,180** |
| Members Per Policy (average) | 1.45 | 1.45 | **1.45** |
| Gross Premium Per Member Per Month (average) | $558 | $446 | **$543** |
| Net Premium Per Member Per Month (average) | $115 | $446 | **$151** |
| APTC Per Member Per Month (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 insurance companies 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, the decision to require health insurance companies to bring their non-grandfathered individual market products into compliance with Affordable Care Act standards, and the recent decision to prohibit the sale of short-term, limited-duration health plans. 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.[4]

California's actions to promote 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 8 percent.[5] Broadly, the California individual market has a healthy "risk mix," which has consistently ranked in the lowest 10 percent of states.[6] Recent research suggests that premiums in California would have been 20 percent higher if California's risk mix mirrored the national average.[7]

## 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 the uninsured and making high-quality health care coverage more affordable. Despite this significant progress, many Californians insured through or eligible for individual market coverage 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 incomes below 400 percent federal poverty level, take-up of coverage among those who are eligible for premium tax credits is just slightly above 70 percent,[8] and affordability is cited as the top reason for lacking insurance among the uninsured eligible for Covered California.[9]

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.[10] 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.[11]

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. Additionally, those in Bronze plans with incomes 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.[12] In addition, recent research shows that cost-sharing burden reduces utilization, including high-value medical care.[13]

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 through its patient-centered benefit designs, by making the first three visits for primary care, specialty care and urgent care not subject to a deductible, thus helping consumers access needed outpatient care.[14] The burden of a Bronze deductible is still significant, however.

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, but for a Silver 70 plan it costs $40 (see Appendix IV).

Enrollment in Bronze plans increases as the generosity of cost-sharing reductions deceases, as shown in Figure 4, Covered California 2018 Subsidized Enrollment by Income and Metal Tier.

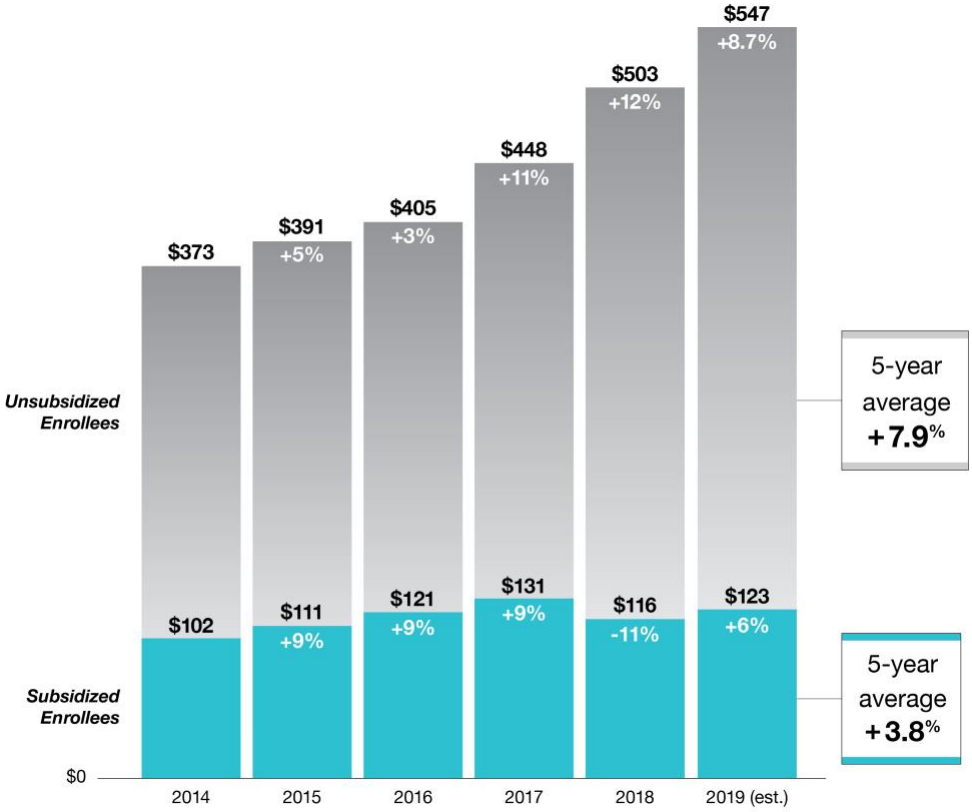
Challenges in paying premiums and out-of-pockets costs can lead to lower utilization. Recent survey results showed that nearly 25 percent of enrollees in the individual market reported that they delayed or avoided medical care due to cost.[15] Even with federal premium assistance, the combination of 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.[16]

### *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 exceeds the qualifying threshold for premium tax credits. Premium tax credits are available to eligible individuals with household incomes up to 400 percent FPL, which is just over $48,000 for an individual, $65,000 for a couple 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, 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 versus 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 coverage who have incomes above 400 percent FPL reported having "some" or "a lot" of difficulty paying their monthly premiums.[17]

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




The premium tax-credit cliff disproportionately affects individuals 50 and older and individuals with income between 400 and 600 percent FPL.[18] Analysis by researchers at the University of California shows that factoring in the local cost of living, the premium assistance provided to 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.[19] Even while choosing the lowest-cost Bronze plan available with a $6,300 individual medical deductible, many 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 the surcharge raised gross premiums for Silver plans, premium tax credits increased by a similar amount. This action produced an 11 percent reduction in average net premiums for subsidized enrollees in 2018, as shown in Figure 5. In addition, Covered California directed its health insurance companies to offer a nearly identical Silver product off the exchange that does

not include the surcharge, giving unsubsidized consumers an opportunity to purchase a nearly identical product off exchange at a lower premium.

While this workaround has protected consumers and provided market stability, it has created a price differential between on- and off-exchange Silver plans that implementing state legislation sought to avoid. The pricing difference between these products is discussed later in this report as a factor to consider when contemplating potential cost-sharing reduction options.

In late 2017, the Tax Cuts and Jobs Act set the 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.[20] Likewise, researchers publishing in Health Affairs estimated that California specifically could see a 4 to 7 percent premium increase due to the zero-dollar penalty.[21]

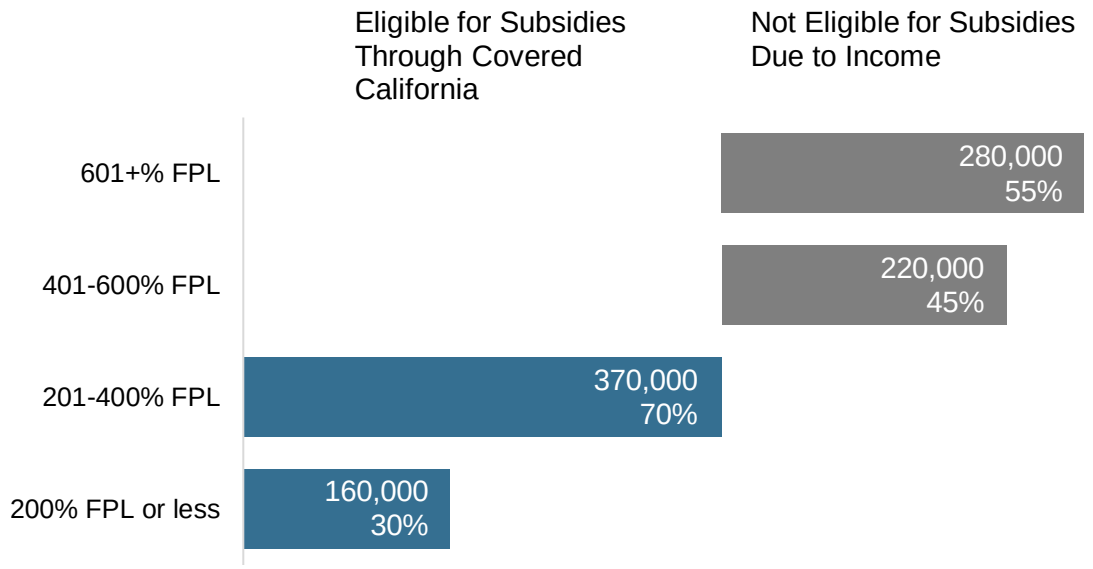
Although the consequences of this federal action within each state will vary based on a variety of factors (including the health of the state's risk pool, carrier competition and the strength of marketing and outreach efforts), reduced enrollment in the individual market will have direct consequences, 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 $0 penalty, although the full impact will take months or even years to assess fully. University of California 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, project that 150,000 to 450,000 more Californians will be uninsured in 2020 because of the penalty removal. In total, approximately 1.2 million Californians will be eligible for individual market coverage but will be uninsured in 2020, as shown in Figure 6.

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.[22]

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 an income between 201 and 400 percent FPL. An additional 500,000 individuals with an income above 400 percent FPL but eligible to purchase coverage in the individual market will also be without coverage.[23] In conjunction with the zero-dollar penalty, rising costs, affordability concerns and lack of knowledge of subsidies act as deterrents to enrollment.[24]

**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 Feb. 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 incomes 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 detail later in this report, to reflect the potential impacts various policy proposals have on the health care marketplace, including impacts to enrollment, consumer health spending and public spending.

To carry out its legislative mandate, Covered California created a stakeholder workgroup. Known as the AB 1810 Affordability Workgroup, membership was composed of partners including health care advocates, health insurance issuers, representatives from key health care associations, and legislative staff. 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.) Covered California presented a draft version of this report at its Jan. 17, 2019, public board meeting and solicited feedback from the public.

The legislation also specifies that the report's options should consider maximizing all available federal funding, determine whether federal financial participation for the Medi-Cal program would otherwise be jeopardized, and include options that do not require a Section 1332 federal waiver. Covered California worked with the Department of Health Care Services to ensure that federal funding for Medi-Cal programs would not be compromised by the policy options modeled. This report includes a variety of affordability options, only one of which, reinsurance, would require a Section 1332 federal waiver.

## 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 providing stability in 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:

- ***Premium 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 or extend the contribution cap to higher income levels, or both. Similar to the Affordable Care Act framework, it is assumed that premium subsidies are only available through Covered California.
- ***Cost-sharing subsidies:*** These options enhance the value of cost-sharing subsidies for currently eligible individuals up to 250 percent FPL or extend eligibility for cost-sharing subsidies to individuals up to 400 percent FPL, or both. It is assumed that cost-sharing subsidies are only available through Covered California. Cost-sharing subsidies reduce copays, deductibles and other out-of-pocket costs, but they do not reduce premiums.
- ***Individual mandate penalty:*** This option models the impact of a reinstatement of an individual mandate penalty. The impacts of this policy option could be achieved by either a state-level individual mandate and penalty or a reinstatement of the federal penalty.
- ***Reinsurance:*** This option models the impact of a reinsurance program to reduce individual market gross premiums.

This report presents two approaches to enhancing affordability. The first approach, Comprehensive Market-Wide Affordability Enhancements, presents three options that build on each other with the goal of enhancing affordability for all individual market enrollees by 1) lowering premium contributions for individuals below 400 percent FPL, eliminating the tax-credit cliff and significantly expanding cost-sharing subsidies; 2) adding an individual mandate penalty to Option 1; and 3) and adding a state reinsurance program to Option 2.

The second approach, Targeted Affordability Enhancements, presents several discrete 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. Spending outcomes are for consumer benefits only and do not include any administrative costs. The modeling assumes implementation of the policy options in 2021. (See "Implementation Timing" on page 46 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 literature to estimate how health insurance issuers would adjust premiums in response to changes in market risk. The new premium reductions and plan characteristics (such as cost-sharing subsidies) proposed in each policy option are imposed onto the model to simulate premium, enrollment and plan-choice responses, as well as the resulting impacts on consumer premium spending and government outlays.

For all analyses, the baseline model was calibrated to the year 2021. 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. Also assumed is the continued $0 federal penalty for 2019, 2020 and 2021. Its impact on enrollment is calibrated using estimates from the literature, Covered California budget estimates and consumer surveys. (See Appendix V for more details on model assumptions and calibrations.)

## APPROACH 1: COMPREHENSIVE MARKET-WIDE AFFORDABILITY ENHANCEMENTS

Approach 1 presents three options that build upon each other with the goal of enhancing affordability for all individual market enrollees. The policy options modeled in Approach 1 are summarized in Table 4. The aggregate impacts of these policies are then discussed and summarized followed by a presentation of consumer scenarios.

**Table 4.** Summary of Approach 1 Policy Options

| Policy Option | Description | Policy Objectives |
|---|---|---|
| **Option 1:** Enhance and extend premium and cost-sharing support | Lower and extend required contribution cap:<br>• 0-138% FPL: 0% cap<br>• 138-400% FPL: cap rises linearly from 0 to 8%<br>• 400-600% FPL: cap rises linearly from 8 to 12%<br>• 600%+ FPL: cap rises linearly from 12 to 15%<br><br>Expand eligibility for, and generosity of, cost-sharing support:<br>• 150-200% FPL: 87 to 94<br>• 200-250% FPL: 73 to 87<br>• 250-400% FPL: 70 to 80 | • Significantly increase enrollment among those eligible for individual market coverage<br>• Cap premium contributions for all individual market enrollees by eliminating the tax credit cliff<br>• Make care more affordable for all enrollees under 400 percent FPL |
| **Option 2:** Enhance and extend premium and cost-sharing support plus individual mandate penalty | Option 1 plus reinstatement of individual mandate penalty | • All Option 1 objectives<br>• Restore a significant share of projected enrollment loss in the individual market due to zero-dollar federal penalty<br>• Lower gross premiums through improved risk mix |
| **Option 3:** Enhance and extend premium and cost-sharing support plus individual mandate penalty plus reinsurance | Option 2 plus funding for a reinsurance program modeled on the temporary federal reinsurance program funded at the level required to lower gross premiums by 10 percent per year | • All Option 2 objectives<br>• Reduce individual market gross 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*

### ***Option 1: Enhance and Extend Premium and Cost-Sharing Support***

Option 1 caps benchmark premium contributions on a sliding scale between 0 and 15 percent of income for eligible Californians. This approach eliminates the tax-credit cliff 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 today and are not otherwise eligible for full-scope Medi-Cal in accordance with state policy and requirements. Figure 7 shows the reduction in consumer-required contribution under Approach 1 relative to the current required contributions under the Affordable Care Act for 2019. Option 1 produces three enrollment outcomes that are summarized below: 1) It induces new enrollment among the uninsured, 2) it improves affordability for current enrollees and 3) it leads to a shift in enrollment away from Bronze to higher metal-tier plans.

**Figure 7.** Comparison of Approach 1 Required-Contribution Percentages for Benchmark-Plan Premium to Affordable Care Act 2019 Percentages

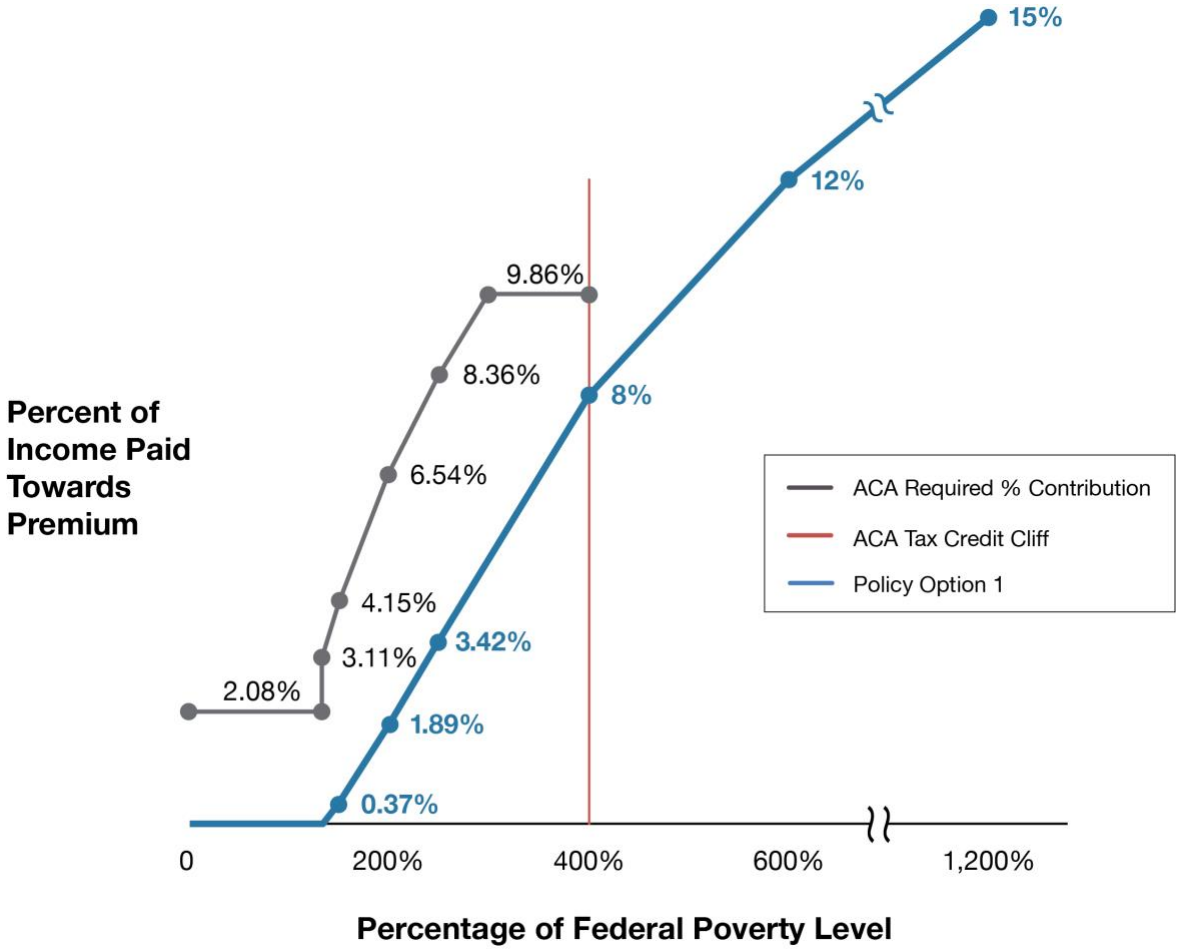


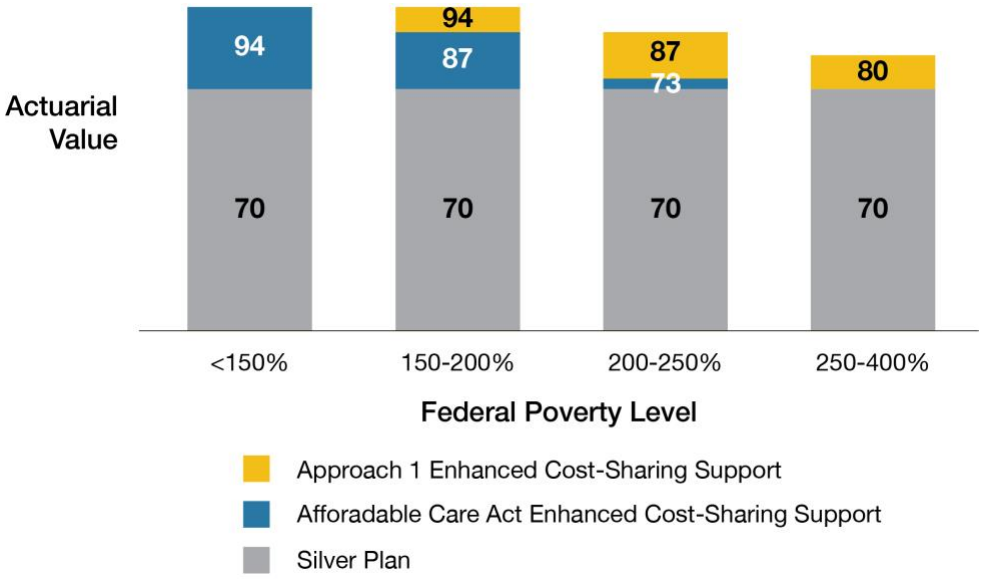
Table 5 converts the required contribution percentages into dollar ranges that individuals would pay for benchmark coverage under Approach 1 as compared to the Affordable Care Act.[25] For example, an individual with income at 150 percent of the federal poverty level would pay a $63 monthly premium for a benchmark plan under the Affordable Care Act and only $6 per month under this option. While these premium contributions would be available for benchmark or second-lowest-cost Silver plans, it is important to note that consumers' actual premiums will depend on the metal tier and plan they choose.

**Table 5.** Monthly Benchmark Premium Contributions Under the Affordable Care Act and Approach 1 Based on the 2019 Federal Poverty Level

| Percent of Income | Affordable Care Act Required Contribution (monthly expense per individual) | Approach 1 Required Contribution (monthly expense per individual) |
|---|---|---|
| 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 |

As shown in Figure 8, Option 1 would also markedly reduce the cost-sharing burden for low- and middle-income individuals by providing enhanced cost-sharing support for copays, deductibles and other out-of-pocket costs for individuals at or below 400 percent FPL. Under this option, all Covered California enrollees under 400 percent FPL would be eligible for cost-sharing support at the Gold level or higher for the price of a Silver-level plan. For comparison, a study conducted in 2011 found that the average employer-sponsored plan had a median actuarial value of 83 percent.[26]

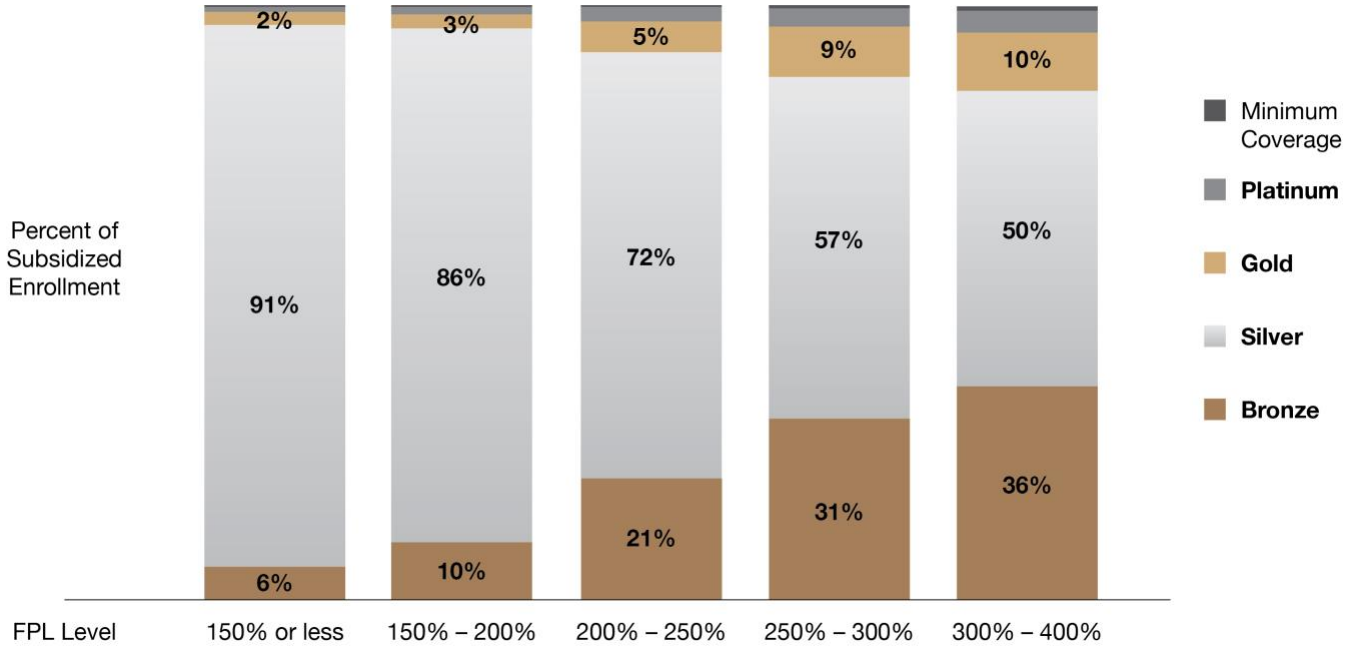
**Figure 8.** Comparison of Cost-Sharing Reductions Under Approach 1 and the Affordable Care Act




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. Also noted in Table 6 are the benefits to existing individual market enrollees. Option 1 would directly benefit 1.3 million existing Covered California enrollees.[27] Average net premiums paid would drop by $39 monthly for these enrollees. This average takes into account the fact that some enrollees will realize larger net premium reductions by choosing the benchmark plan or a less expensive plan while many enrollees will choose to use the higher premium subsidy to purchase a more expensive plan in the Silver tier or higher. 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.

Option 1 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.[28] By design, the enhanced cost-sharing reduction benefit increases Silver plan actuarial value from 7 to 14 percentage points for eligible consumers earning between 150 and 400 percent FPL. The market share of Silver plans (or higher) increases from 69 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.

**Figure 9.** Projected Enrollment by Metal Tier and Income Under Option 1




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.[29] This enrollment increase includes new off-exchange enrollment, captured in the total enrollment increases reported in Table 6. The 662,000 existing off-exchange enrollees — those expected to be covered even absent new state subsidies — also benefit from the improved risk mix and are expected to pay on average $18 less per month due to this dynamic.

Among subsidy-eligible consumers, lower premiums would trigger equal reductions in federal premium tax credits per enrollee. By contrast, subsidy-*ineligible* consumers would experience the full benefit of any premium reduction.

In total, Option 1 transfers roughly $2.1 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.

### *Option 2: Enhance and Extend Premium and Cost-Sharing Support With Reinstatement of an Individual Mandate Penalty*

Option 2 adds to Option 1 a reinstatement of the individual mandate penalty. Compared to Option 1, reinstating the penalty raises enrollment in the individual market by 663,000, or 375,000 more than Option 1. The increased enrollment over Option 1 comes from two related effects: the reinstatement of the penalty itself and lower premiums associated with the improved risk mix because of this new enrollment. This is estimated to lower gross premiums by an

additional 3 percent over Option 1, generating further enrollment increases and a greater reduction in monthly premiums for off-exchange enrollees compared to Option 1 ($41 versus $18).[30] 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 Option 1. This is due to relatively healthy enrollees induced into coverage by the mandate penalty choosing Bronze plans.

Compared to Option 1, Option 2 results in $459 million (or 22 percent) more in new premium support and cost-sharing subsidy spending per year. However, when projected penalty revenue from within the individual market is accounted for, Option 2 would require $88 million *less* spending.[31] Note that this revenue projection underestimates the full potential penalty revenue, which would include individuals who do not take up offers of employer-sponsored coverage or other coverage for which they are eligible and instead pay the penalty.[32] Moreover, this option induces $305 million *more* in annual federal transfers to the state because many new enrollees would qualify for federal premium tax credits and cost-sharing subsidies, further highlighting the projected impact of reinstating the 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.

### *Option 3: Enhance and Extend Premium and Cost-Sharing Support With Reinstatement of an Individual Mandate Penalty and a Reinsurance Program*

Option 3 adds to Option 2 by implementing a reinsurance program funded at the level needed to reduce premiums by 10 percent per year. The goal of this option 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 options 1 and 2. Premiums for off-exchange enrollees would fall by an average of $111 per month. In this option, enrollment in the individual market would increase by 764,000. As expected, almost all of the enrollment gains over Option 2 come from individuals who do not qualify, or are ineligible, for federal or new state premium subsidies. The increase in enrollment over Option 2 also leads to lower revenue from the penalty.

For the subsidized market, the benefits of gross premium reductions are realized as lower subsidy spending. Indeed, the federal premium tax-credit 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-through” funding were 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

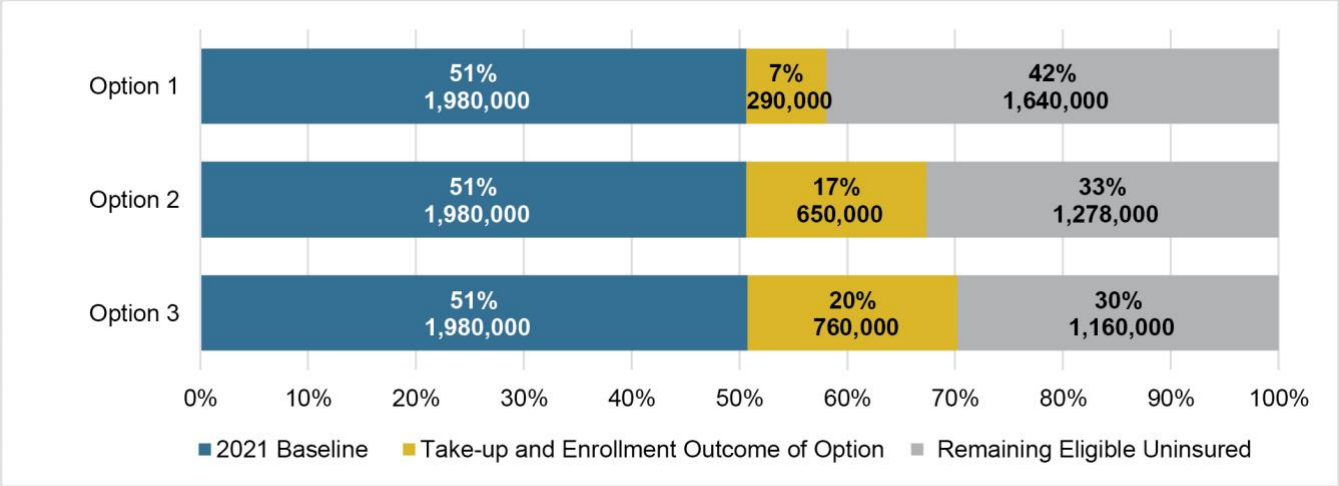
| Summary of Approach 1: Comprehensive Market-Wide Affordability Enhancements | | | |
|---|---|---|---|
| | **Option 1: Premium and Cost-Sharing Support** | **Option 2: Premium and Cost-Sharing Support with Penalty** | **Option 3: Premium and Cost-Sharing Support with Penalty and Reinsurance** |
| **New Enrollment** | **290,000** | **648,000** | **764,000** |
| *<250% FPL* | *66,000* | *120,000* | *139,000* |
| *250-400% FPL* | *153,000* | *342,000* | *358,000* |
| *400%+ FPL* | *71,000* | *187,000* | *267,000* |
| Individual Market Take-up Rate* | 58% | 67% | 70% |
| Percent of Enrollees in Silver Coverage or Higher** | 79% | 77% | 79% |
| **Benefits to Existing Enrollees** | | | |
| On-Exchange Number Benefitting | 1,292,000 | 1,292,000 | 1,292,000 |
| On-Exchange Average Monthly Premium Reduction | $39/m | $39/m | $39/m |
| Off-Exchange Number Benefitting | 662,000 | 662,000 | 662,000 |
| Off-Exchange Average Monthly Premium Reduction | $18/m | $41/m | $111/m |
| **Spending Impacts** | | | |
| New State Spending | **$2,190,000,00** | **$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* | *$629,000,000* | *$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** |
| Potential Net State Spending*** | **$2,190,000,00** | **$2,121,000,000** | **$2,676,000,000** |
| Change in Federal Tax Credit Expenditures | $670,000,000 | $975,000,000 | ($331,000,000) |

* 51% under ACA Baseline 2021
** 69% under ACA Baseline 2021
*** Net State Spending assumes all offsets are applied to reduce State expenditures

## *Impact on Enrollment Gains, Take-Up and the Remaining Uninsured*

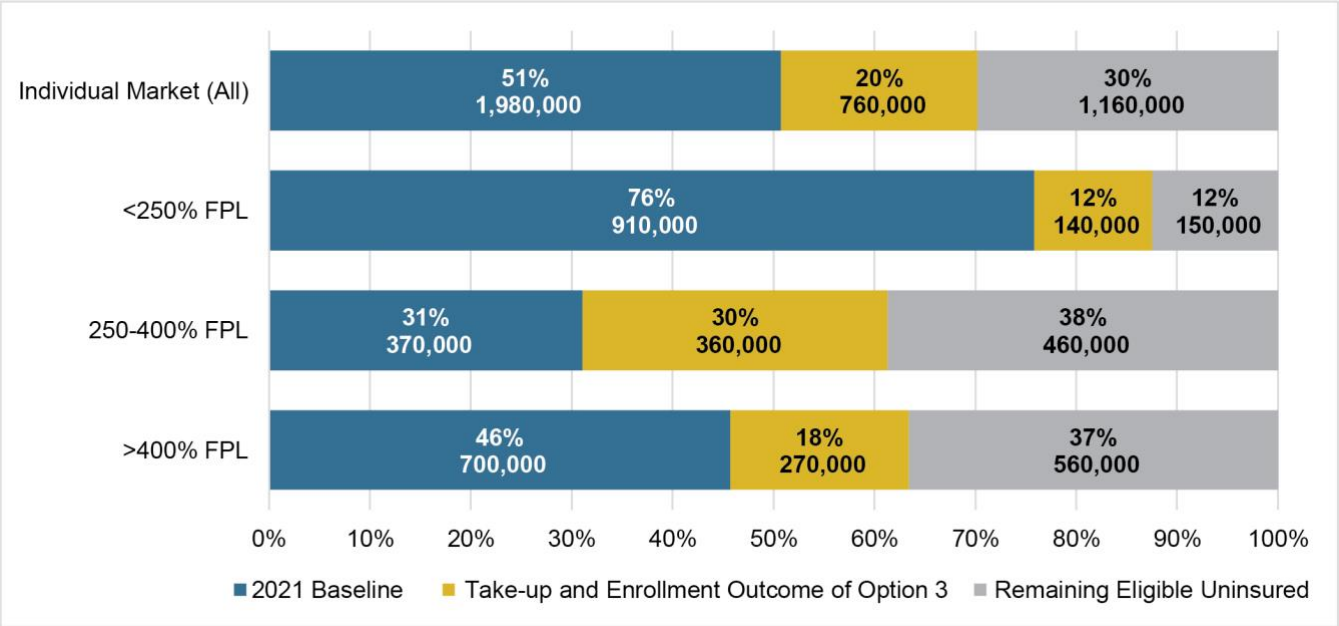
Of the three options, Option 3 generates the largest increases in enrollment, bringing coverage rates in the individual market to just over 70 percent, as shown in Figure 10. Figure 11 shows the impact of Option 3 on coverage rates and the remaining uninsured by income. For those below 250 percent FPL, take-up increases from 78 to 88 percent, which is the highest take-up by income; however, the biggest increase in coverage is among those between 250 and 400 percent FPL, for whom take-up doubles.

**Figure 10.** Comparative Effects of Options 1, 2 and 3 on New Enrollment, Take-Up Rate and Remaining Uninsured Among Eligible Individuals




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

**Figure 11.** Effect of Option 3 on New Enrollment, Take-Up and Remaining Uninsured Among Eligible Individuals by Income




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

### *Approach 1: Consumer Scenarios*

Tables 7a and 7b provide hypothetical scenarios to illustrate the monthly and annual impacts, respectively, of 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 (SLS) plan, Alfonso currently would have to pay $136 per month, after receiving $214 in federal premium tax credits. Under Option 1, Alfonso's monthly premiums would drop by $97, lowering his contribution to $39 per month. Option 2 highlights the individual mandate penalty Alfonso would face if he did not obtain minimum coverage. Option 2 also shows how further reduction in premiums due to improved risk mix (estimated to be about 5 percent) lowers federal subsidies while leaving state subsidies unchanged. A similar effect happens in response to state reinsurance. Moving to Option 3, premiums fall by another 10 percent, generating an equal reduction in Alfonso's premium tax credit while keeping his premium contribution the same. Alfonso also benefits from increased cost-sharing benefits provided under options 1 through 3. The actuarial value of a Silver plan under these scenarios increases from 73 to 87. Using Covered California's 2019 benefit designs for comparison, this change would lower Alfonso's Silver plan deductible by $1,550 (from $2,200 to $650), and primary care office copays by $20 (from $35 to $15).

***Bianca*** illustrates the benefits to consumers earning between 250 and 400 percent FPL, who, in addition to new premium subsidies, newly receive cost-sharing reduction benefits. Bianca earns slightly more than Alfonso does, so would currently contribute no more than 9.86 percent of her annual income towards premiums. Under options 1 through 3, Bianca would receive an 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 cost-sharing support, which is expanded to consumers earning between 250 and 400 percent FPL. Under options 1 through 3, the actuarial value of a Silver plan increases from 70 to 80, which would eliminate the deductible requirement (assuming the current benefit design for AV 80) and lower primary care office visit copays 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 premium tax-credit cliff. The premium contribution cap in options 1 through 3 dramatically lowers her monthly premiums. Cara's case also highlights how reductions in gross premiums associated with either improved risk mix or reinsurance trigger 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 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, evident in the decline in his net premium.

***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 Silver 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 under options 1 through 3. 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's premiums would remain $578 for two policies across options 1 through 3.

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

| | Alfonso | | Baseline | Option 1 | Option 2 | 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 |
| | | Prorated Monthly Penalty | None | None | $58 | $58 |

| | Bianca | | Baseline | Option 1 | Option 2 | 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[33] | $2,500 | None | None | None |
| | | Prorated Monthly Penalty | None | None | $58 | $58 |

| | Cara | | Baseline | Option 1 | Option 2 | 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 |
| | | Prorated Monthly Penalty | None | None | $79 | $79 |

| | Don | | Baseline | Option 1 | Option 2 | 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 |
| | | Prorated Monthly Penalty | None | None | $142 | $142 |

| | Erin and Francis | | Baseline | Option 1 | Option 2 | 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 |
| | | Prorated Monthly Penalty | None | None | $263 | $263 |

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

| | Alfonso | | Baseline | Option 1 | Option 2 | 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 | Option 1 | Option 2 | 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 | Option 1 | Option 2 | 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 | Option 1 | Option 2 | 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 | Option 1 | Option 2 | 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 |

***Note About Policy Limitations***

While the coverage gains projected in the first approach 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. While significant coverage gains are projected under Option 3 that would raise take up from 51 percent in 2021 under the baseline scenario to 70 percent, individual market take up would still lag in enrollment in employer-sponsored insurance and Medi-Cal.[34]

Despite the generosity of the premium and cost-sharing subsidies modeled here, individual premium contributions will still be required, which may hinder take up. Consumers may also lack awareness of subsidy benefits or may be discouraged from enrolling due to inattention, hassle costs or other behavioral frictions.[35] This suggests that 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.

## APPROACH 2: TARGETED AFFORDABILITY ENHANCEMENT

Approach 2 estimates the impact of targeted affordability enhancements for four populations of interest: 1) consumers under 400 percent federal poverty level, 2) consumers under 600 percent FPL, 3) consumers over 400 percent FPL, and 4) all consumers through reinstatement of the individual mandate penalty. The policy options are labeled “T” for targeted and numbered one through eight. Table 8 presents a summary of T1 through T8, 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% FPL | T1 | **Premium support** that lowers premium contribution caps<br>• 0-138% FPL, 0%<br>• 138-250% FPL, new caps rise linearly from 0-8%<br>• 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 less than 600% FPL | T3 | **Premium support** that lowers premium contribution caps and extends the cliff to 600% FPL<br>• Option T1 for people below 400% FPL<br>• 400-600% FPL, caps rise from 9% to 15% at 600% FPL | $765,000,000 |
| | T4 | **Premium support and penalty reinstatement**<br>• Option T3<br>• Reinstate individual mandate penalty | $891,000,000<br>*($482,000,000 potential offset from penalty revenue)* |
| Targeted improved affordability for consumers earning more than 400% FPL | T5 | **Premium support between 400 and 600% FPL** that extends the cliff<br>• Contribution cap is 9.86% at 400% FPL<br>• Rises linearly to 15% at 600% FPL | $285,000,000 |
| | T6 | **Premium support above 400% FPL** that eliminates the cliff<br>• Contribution cap is 9.86% at 400% FPL<br>• Rises linearly to 15% at 1200% FPL, 15% thereafter | $324,000,000 |
| | T7 | **Reinsurance** that lowers premiums by 10 percent per year | $1,456,000,000<br>*($878,000,000 potential offset from 1332 reinsurance waiver)* |
| Targeted improved affordability for all consumers generated by reinstating the mandate penalty | T8 | **Reinstate individual mandate penalty** | *($526,000,000 potential penalty revenue)* |

### *Discussion of Projected Aggregate Impacts of Policy Options Under Approach 2*

#### Option T1: Targeted Premium Subsidies Below 400 Percent FPL

Option T1 aims to increase the affordability of plans for individuals earning less than 400 percent FPL and eligible to receive federal premium tax credits. Under this option, the state would lower premium contribution caps, scaled back relative to the premium subsidies modeled in Approach 1, above, so that the maximum premium contribution for a benchmark plan would not exceed 9 percent of income.

This 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 option targets premium subsidies. Approximately 1.1 million existing enrollees also benefit from lower net premiums, which are projected to fall by an average of $20 per month under this option. Declines in premiums due to modest improvements in the risk mix would lead to an increase in enrollment among the unsubsidized segments of the market, as well as modest premium reductions for existing off-exchange enrollees.

The increased subsidies for lower-income consumers also cause 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 would switch to Bronze plans, while some would 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 plans that are more generous. This option would require roughly $425 million per year in state spending. It would induce about $125 million in additional federal premium subsidies due to increased enrollment.

#### Option T2: Enhanced and Expanded Cost-Sharing Reductions Between 200 and 400 Percent FPL

Option T2 aims to lower the cost-sharing burden for consumers earning between 200 and 400 percent federal poverty level. Currently, consumers earning between 200 and 250 percent FPL can enroll in an Enhanced Silver plan with an actuarial value of 73, higher than the typical Silver AV of 70. Under this option, 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 and 400 percent FPL, also making their Silver plans 80 AV.

Option T2 would cause enrollment to increase by nearly 27,000 people, primarily among consumers earning between 200 and 400 percent FPL. Beyond increases in enrollment, this option would also result 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.

Approximately 729,000 existing Covered California consumers would be eligible to take advantage of the new cost-sharing subsidies. In addition, off-exchange enrollees would experience a slight premium reduction on average due to the better risk mix. This option would require $215 million per year in new state spending and is expected to increase federal premium subsidies by $63 million per year.

### Option T3: Targeted Premium Subsidies Below 600 Percent FPL

Option T3 aims to increase affordability of plans for individuals earning less than 600 percent FPL. This option would lower premium contribution caps, effectively a combination of options T1 and T5 (but with a slight adjustment around 400 percent FPL to eliminate the small discontinuity). Compared to the contribution caps in Approach 1, Option T3 finances smaller reductions in consumer premium contribution so that the impact on state spending is roughly $765 million per year. This option does not include cost-sharing benefits.

Option T3 causes total individual 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 option would occur among consumers between 400 and 600 percent FPL.

As in Option T1, the increased subsidies would 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 to downgrade metal tier and others to shift to more generous Silver or higher plans. The net effect is an increase in coverage in plans that are more generous.

Option T3 would reduce premiums by $21 per month on average for approximately 1.3 million existing Covered California enrollees who benefit from new premium subsidies. Approximately 662,000 existing off-exchange enrollee would also experience a decline in premiums of $14 per month on average due to the improved risk mix from new enrollment.

### Option T4: Targeted Premium Subsidies Below 600 Percent FPL With Penalty

Option T4 aims to achieve significant coverage expansion but at lower cost to the state than in Approach 1. To this end, Option T4 institutes the same contribution caps as in Option T3 but reinstates the individual mandate penalty in order to generate greater enrollment and penalty income.

This option would increase enrollment by nearly 478,000, or roughly 350,000 more than the enrollment gain generated by Option T3. The impact in comparison to Option T3 illustrates two related effects of the mandate penalty: the institution of the penalty itself and the improved risk mix associated with this new enrollment (estimated to lower gross premiums by an additional 3 percent over Option T3), which generates further enrollment increases.

Option T4 would reduce premiums by $21 per month on average for approximately 1.3 million existing Covered California enrollees who benefit from new premium subsidies. Approximately 662,000 existing off-exchange enrollees would also experience a decline in premiums of $31 per month on average due to the substantially improved risk mix from new enrollment.

Net of penalty revenues, Option T4 would result in net state spending of approximately $410 million per year, or $356 million *less* than T3.[36] Moreover, T4 would result in an increase of $590 million in federal subsidies over T3, net of 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.

### Option T5: Targeted Premium Subsidies Between 400 and 600 Percent FPL

Option T5 aims to increase the affordability of plans for individuals who currently receive no federal tax credits earning above 400 percent FPL. Under this option, the state would finance premium support to cap premium contribution for consumers earning between 400 and 600 percent FPL. The cap at 400 percent FPL would be set at 9.86 percent of income to align with the Affordable Care Act cap 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.

Option T5 would cause enrollment to increase by 47,000. Compared to T1, targeting higher income consumers in Option T5 has a similar per-new state-subsidy dollar impact on enrollment. This would seem to go against conventional wisdom, in that 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 share of the funding required by Option T1 goes toward lowering consumer premium contributions of *existing* enrollees.

Other impacts of this model include average premium reductions of approximately $93 per month for 199,000 existing Covered California enrollees and modest premium declines for off-exchange enrollees due to small improvements in the risk mix associated with increased enrollment. The small reduction in the total federal premium tax-credit expenditure is a byproduct of the decline in gross premiums due to the improvement in risk mix.

### Option T6: Targeted Premium Subsidies Above 400 Percent FPL

Option T6 is similar to Option T5, except that new premium support is extended to all consumers, not just to those between 400 to 600 percent FPL. Under this option, the state would finance premium support to cap premium contribution for consumers earning more than 400 percent FPL. The cap at 400 percent FPL would be set at 9.86 percent of income and rise linearly to a maximum of 15 percent at 1,200 percent FPL and remain 15 percent above that.[37] This would eliminate the subsidy cliff and institute a premium cap for all eligible consumers.

Option T6 would cause enrollment to increase by 51,000. The increase in enrollment over Option T5 is primarily composed of older consumers purchasing multi-person policies and older consumers residing in high health care cost areas who would benefit from the elimination of the subsidy cliff at 600 FPL. Existing Covered California enrollees in this income range would benefit from average premium reductions of $122 under this option. Here, too, the small reduction in off-exchange premiums and federal 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.

### Option T7: Reinsurance

Option T7 offers an alternative to Options T5 and T6 to increase affordability for all consumers who are either ineligible or not qualified for federal subsidies. Under this option, the state would finance a reinsurance program that lowers gross 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.

Option T7 would lower 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. For existing off-exchange enrollees, premiums are projected to decline about $70 per month. Among subsidy-eligible consumers, lower gross premiums trigger a commensurate decrease in federal tax credits, leaving net-of-subsidy premiums unchanged. Total federal savings are 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 option.

### Option T8: Reinstate the Individual Mandate Penalty

Option T8 increases enrollment by 359,000 in 2021 by reinstating the individual mandate penalty. The share of enrollees with Silver tier or higher coverage drops slightly because new enrollees induced into coverage by the mandate are projected to be healthier on average and more likely to choose Bronze-tier plans. The improved risk mix would lower gross premiums, which would benefit approximately 807,000 off-exchange enrollees who experience average premium reductions of $24 per month. The federal government realizes the benefit of lower gross premiums for existing subsidized enrollees through lower premium-tax credit outlays. As with all the options modeled in this report, spending impacts do not include administrative costs that would be required to implement the policy options.

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

| 9a. Summary of Approach 2: Targeted Improved Affordability for Consumers Earning Less Than 400 Percent FPL | | |
|---|---|---|
| **Enrollment Outcomes** | **Option T1 Premium Subsidies** | **Option T2 Cost Sharing Subsidies** |
| **New Enrollment** | **70,000** | **27,000** |
| *<250% FPL* | *29,000* | *4,000* |
| *250-400% FPL* | *29,000* | *18,000* |
| *400%+ FPL* | *11,000* | *4,000* |
| Individual Market Take-Up Rate* | 52% | 51% |
| Percent of Enrollees in Silver Coverage or Higher** | 72% | 73% |
| **Benefits to Existing Enrollees** | | |
| On-Exchange Number Benefitting | 1,100,000 | 729,000 |
| On-Exchange Average Monthly Premium Reduction | $20/m | |
| Off-Exchange Number Benefitting | 807,000 | 807,000 |
| Off-Exchange Average Monthly Premium Reduction | $7/m | $3/m |
| **Spending Outcomes** | | |
| 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 |

| 9b. Summary of Approach 2: Targeted Improved Affordability for Consumers Earning Less Than 600 Percent FPL | | |
|---|---|---|
| **Enrollment Outcomes** | **Option T3 Premium Subsidies** | **Option T4 Premium Subsidies Plus Penalty** |
| **New Enrollment** | **125,000** | **478,000** |
| *<250% FPL* | *31,000* | *102,000* |
| *250-400% FPL* | *30,000* | *189,000* |
| *400%+ FPL* | *64,000* | *187,000* |
| Individual Market Take-Up Rate* | 54% | 63% |
| Percent of Enrollees in Silver Coverage or Higher** | 72% | 68% |
| **Benefits to Existing Enrollees** | | |
| On-Exchange Number Benefitting | 1,289,000 | 1,289,000 |
| On-Exchange Average Monthly Premium Reduction | $21/m | $21/m |
| Off-Exchange Number Benefitting | 662,000 | 662,000 |
| Off-Exchange Average Monthly Premium Reduction | $14/m | $31/m |
| **Spending Impacts** | | |
| 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 |

| 9c. Summary of Approach 2: Targeted Improved Affordability for Consumers Earning More Than 400 Percent FPL | | | |
|---|---|---|---|
| **Enrollment Outcomes** | **Option T5 Premium Subsidies 400-600 Percent FPL** | **Option T6 Premium Subsidies over 400 Percent FPL** | **Option T7 Reinsurance** |
| **New Enrollment** | **47,000** | **50,000** | **118,000** |
| *<250% FPL* | *1,000* | *1,000* | *21,000* |
| *250-400% FPL* | *400* | *400* | *11,000* |
| *400%+ FPL* | *46,000* | *49,000* | *86,000* |
| Individual Market Take-Up Rate* | 52% | 52% | 54% |
| Percent of Enrollees in Silver Coverage or Higher** | 70% | 69% | 70% |
| **Benefits to Existing Enrollees** | | | |
| On-Exchange Number Benefitting | 199,000 | 206,000 | 818,000 |
| On-Exchange Average Monthly Premium Reduction | $93/m | $122/m | $0/m |
| Off-Exchange Number Benefitting | 662,000 | 662,000 | 807,000 |
| Off-Exchange Average Monthly Premium Reduction | $5/m | $5/m | $70/m |
| **Spending Impacts** | | | |
| New State Spending | **$285,000,000** | **$324,000,000** | **$1,456,000,000** |
| *Premium Support* | *$285,000,000* | *$324,000,000* | *None* |
| *Cost Sharing Support* | *None* | *None* | *None* |
| *Reinsurance* | *None* | *None* | *$878,000,000* |
| 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) |

| 9d. Summary of Approach 2: Targeted Improved Affordability For All Consumers Generated by Reestablishing a Penalty | |
|---|---|
| Enrollment Outcomes | Option T8 Penalty |
| New Enrollment | 359,000 |
| <250% FPL | 86,000 |
| 250-400% FPL | 149,000 |
| 400%+ FPL | 125,000 |
| Individual Market Take-Up Rate* | 60% |
| Percent of Enrollees in Silver Coverage or Higher** | 67% |
| Benefits to Existing Enrollees | |
| On-Exchange Number Benefitting | N/A |
| On-Exchange Average Monthly Premium Reduction | N/A |
| Off-Exchange Number Benefitting | 807,000 |
| Off-Exchange Average Monthly Premium Reduction | $24/m |
| Spending Impacts | |
| New State Spending | None |
| Premium Support | None |
| Cost Sharing Support | None |
| Reinsurance | None |
| Potential State Spending Offsets | |
| Penalty Revenue | $526,000,000 |
| Potential 1332 Funding | |
| Change in Federal Tax Credit Expenditures | ($486,000,000) |

* 51% under Affordable Care Act Baseline 2021
** 69% under Affordable Care Act Baseline 2021

*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 five factors: 1) changes in medical costs, 2) changes in individual market eligibility, 3) residual effects of the zeroing-out of the penalty in the baseline scenario, 4) changes in the macroeconomic environment and 5) effects of penalty reinstatement.

**Changes in medical costs:** Nominal gross premiums in the individual market have increased by an average of 7 percent per year in recent years, largely due to medical price growth. Increases in premiums between 2021 and later years will have the largest influence on projected budgetary impacts of modeled policy options. It is illustrative to consider a 7 percent increase in gross premiums between 2021 and 2022, in keeping with past medical cost inflation. For subsidy-eligible consumers, any increase in gross premiums above the rate of income growth is offset by a commensurate increase in federal subsidies. Assuming federal poverty lines increase 2 percent between 2021 and 2022, a 7 percent increase in gross premiums would result in a 5 percent increase in federal premium tax credits in the 2022 "baseline" scenario, as well as all policy options.

*Increases* in federal premium tax credits due to modeled policy options would also be approximately 5 percent larger than those reported above for 2021. A similar logic applies to new state spending, where a 7 percent increase in gross premiums, and a 2 percent increase in FPL thresholds, would lead to an approximate 5 percent increase new state spending, as compared to the 2021 projections given in this report. However, because reinsurance is not linked to FPL thresholds, a 7 percent increase in gross premiums would require a 7 percent increase in new state funding to finance the same 10 percent reduction in premiums proposed in the modeled policy options.

**Changes in individual market eligibility**: Population growth and wage dynamics associated with statutory increases in the minimum wage will affect individual market eligibility. University of California's CalSIM model projects a 1 percent increase in eligibility between 2021 and 2022, which includes a small shift from the less than 250 percent FPL to the 250 to 400 percent FPL segment of the eligible population. Per-enrollee premium subsidies associated with the options are similar across income groups below 400 percent FPL, but larger for individuals earning between 400 and 600 percent FPL.

Taken together, the 1 percent increase in the eligible population from 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.

**Effect of penalty removal after 2021:** It is assumed that most of the impact of the zeroing-out of the 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.[38] The remaining impact of the zero-dollar 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. This increase would in turn 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.

**Macroeconomic factors:** 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.

**Effect of penalty reinstatement:** In options that include a penalty, the model assumes a 75 percent recovery of enrollment lost due to its zeroing-out. The effect of the penalty on enrollment would likely grow in the years following its reinstatement, resulting in larger enrollment increases than those reported for 2021. The full effect of the penalty could be realized by as many as five years after its implementation, resulting in budget estimates then that are roughly 30 percent larger than reported impacts for 2021, on top of other adjustments discussed previously.

## IMPLEMENTATION CONSIDERATIONS

This section highlights key issues that would need to be addressed to implement the policy options described in this report. 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 Covered California (e.g., developing program regulations, forms and marketing and outreach materials). Rather, it is meant to highlight key policy and operational decision points that would need to be addressed in establishing the program parameters for these options. In addition, some of the policy options would require coordination with (and potentially approval by) federal agencies.

*Implementation Timing*

All policy options modeled in this report assume implementation for the 2021 plan year. 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 that would begin on or around Oct. 1, 2020.
- Benefit development: Benefit designs would need to incorporate new cost-sharing subsidies. Benefit packages for the 2021 plan year will be designed between the 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 the spring prior to open enrollment.

To the extent policies were implemented for 2020, additional modeling would be needed and the dependencies would need to be advanced one year. 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 subsidies to consumers and health insurance issuers:

- Eligibility and required contribution levels can be adjusted based on policy goals or budget constraints, or both. 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 credits, but it 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 contributions. Fixed eligibility and required contribution levels would

simplify program administration 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 up front to reduce the monthly premium paid by the consumer. Exchanges report enrollment to the federal government, which then reimburses health insurance issuers 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, new enrollment would be much lower because consumers would have to pay the full premium up front.
- Consumers' monthly premium tax credit is estimated at the time of application based on their projected income for the year. In order to minimize overpayments or underpayments that could negatively affect consumers at tax time, exchanges are required to verify income again via electronic data sources and adjust premium tax-credit amounts if consumers fail to provide adequate justification for their projected income. Covered California could leverage and enhance the existing income verification structure to ensure that premium subsidy 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 health insurance 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 the issuers.

*Cost-Sharing Subsidies*

State policymakers would have to address the following issues related to a cost-sharing subsidy program:

- The Affordable Care Act established the cost-sharing reduction program that specifies the actuarial value of the products available to consumers in specific income ranges. If implemented, the options in this report would extend eligibility for federally defined Silver cost-sharing reductions 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 that could be explored as models (see Appendix VII for Selected Resources).
- 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 Penalty*

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 that would adjust the state penalty amount in the event of the reinstatement 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. The penalty revenue estimates provided in this Report do not include revenue that would be collected from individuals who have offers of employer-sponsored or other coverage but do not enroll. The revenue estimates provided in this report are therefore understated because they do not include payments that would be made by uninsured individuals eligible for employer-sponsored or other types of coverage. A recent publication funded by the Center for Health Policy at Brookings estimated that California could collect in total approximately $700 million in penalty revenue in 2020 based on U.S. Treasury Department estimates produced prior to the zeroing-out of the penalty (see Levitis in Appendix VII, Selected Resources). In addition, revenue estimates provided in this report assume a federal penalty compliance rate that was approximately 75 percent in 2017. Modeling differences in penalty enforcement practices are beyond the scope of this report.

Under the federal mandate, exemptions are granted by either 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 program that reimbursed a 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 program start-up time than would definition of the parameters for an attachment point program.

State reinsurance programs are financed through a combination of state and federal funds provided through a state innovation waiver. The state innovation waiver process is defined in Section 1332 of the Affordable Care Act. It 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 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 implemented simultaneously.

## 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.

## 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

## 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 |

# APPENDIX IV

## 2019 PATIENT-CENTERED BENEFIT DESIGNS

COVERED CALIFORNIA

### 2019 Patient-Centered Benefit Designs and Medical Cost Shares

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

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

Drug prices are for a 30 day supply.

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

** Price is after pharmacy deductible amount is met.

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

https://www.coveredca.com/PDFs/2019-Health-Benefits-table.pdf

# APPENDIX V

## TECHNICAL INFORMATION

To estimate the enrollment and pricing effects of the policies modeled in this report, 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 Covered California was operational) through 2018 and contain information on individual characteristics for households that purchased insurance coverage through Covered California. These characteristics include ZIP code of residence, household size, household income to poverty ratio, the age of each member of the household, the 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 to 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.

### *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 to take up insurance through Covered California, given the set of plans available 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 and 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 that younger households in the region switch to other plans in the following year at a greater rate than older households do, we can infer that younger households are more price-sensitive and assign a specific dollar-amount threshold that would induce them to switch plans. Using these estimates, the model is able to predict how households of differing characteristics would react to prospective changes in the insurance environment.

To model premium changes in response to different policy options, we employ a “premium-setting” model that relates observed health insurance issuer 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 rely primarily on estimating the parameters specified using data patterns actually observed, we make several calibration assumptions in order to model the policy options detailed in this report.

*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 to 6 percent increase in premiums in 2019 due to the zeroing-out of the penalty.)[39] Finally, we assume that the same carriers and plans that 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 includes 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 individual market population, by income, to estimates produced by the University of California's CalSIM model.

*Removing/reinstating the mandate penalty*: We assume that zeroing out the mandate penalty affects total enrollment numbers such that it matches consumer survey data[40] and budget projections.[41] This implies an approximate 18 percent decline in enrollment by 2021 due to the elimination of the penalty. We assume that reinstating the penalty, however, does not yield commensurate enrollment increases in year one of a state penalty 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 affect premiums or premium tax credits.

*Reinsurance*: We assume that the reinsurance results in a 10 percent decline in each plan's gross premiums. We assume that the aggregate cost of the reinsurance program is equivalent to 10 percent of the claims cost's component of *baseline* plan premiums, but of plans chosen in the *simulated* outcome.

*Changes to required contribution caps for premium support:* In policy options that lower the required 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 penalty formula to the remaining uninsured population among consumers eligible for the individual market. As described above, the eligible individual market population is calibrated to 2021 CalSIM forecasts, and excludes undocumented individuals, individuals over age 65 and 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.

For this reason, our estimate of potential penalty revenue naturally understates the total penalty revenue the state could expect to collect. Because the microsimulation model used for this Report only includes data for individual market-eligible individuals, modeling total state penalty revenue across all coverage segments is beyond the scope of this Report.

We also assume penalty enforcement reflecting the federal collection rates. In the most recent study, the "tax gap" on federal taxes owed is estimated to be 18 percent.[42] Potentially weaker enforcement of the federal individual mandate penalty — due to the IRS's inability to file a notice of lien for mandate penalty evasion,[43] and allowing "silent returns" that do not include proof of health insurance coverage[44] — suggests a larger tax gap for the federal tax penalty.[45] Therefore, we assume similar enforcement by the state would collect 75 percent of penalties owed.

## 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. It is important to note that premium contribution caps can be set at any value based on policy goals and/or budgetary targets. What follows is a discussion of the particular structure that was chosen for Approach 1. The Approach 1 required contribution cap over 400 percent FPL — as well as reduction to the Affordable Care Act cap for individuals under 400 percent FPL — is displayed in Table 9. Over 400 percent FPL, the cap is designed to increase from 8 to 15 percent of income. The effects of the new caps are illustrated in Figures 12 and 13, 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 in Approach 1.

Figure 12 illustrates the impact for single individuals purchasing a benchmark plan with either a $700 or a $1,100 monthly premium. With the new cap, consumers making just over 400 percent FPL would pay 8 percent of their income for the benchmark plan. Under the Affordable Care Act, these same consumers do 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 13 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 8 percent. Figures 12 and 13 also illustrate the point at which the new subsidies would phase out — meaning that “uncapped” or gross premiums as a percentage of income would fall below 15 percent. This is reflected in the figures by the peak in the black line.

**Table 9.** 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 (%) | |
|---|---|---|
| | Affordable Care Act 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% |

**Figure 12.** Premium Contributions to Options 1 Through 3

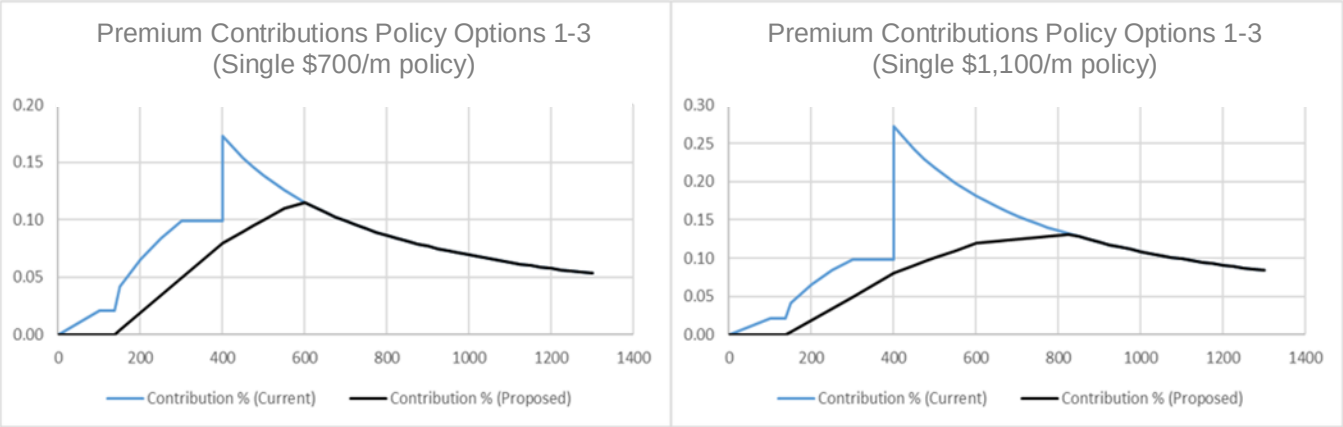
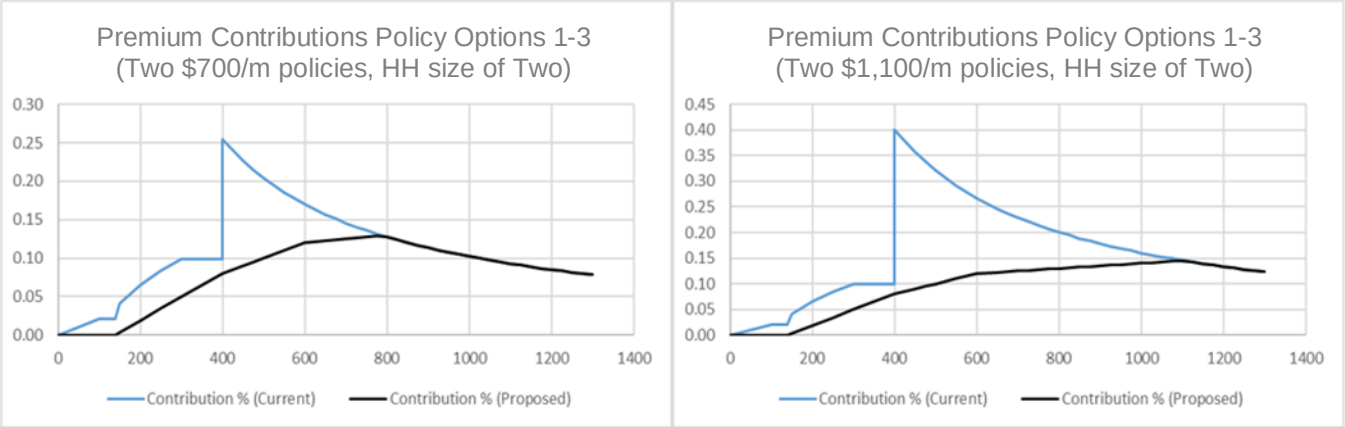



**Figure 13.** Premium Contributions to Options 1 Through 3



## APPENDIX VII

### SELECTED RESOURCES

#### 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/

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/

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 A. Levitis, "Model Legislation for State Individual Mandate," Feb. 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

#### State Affordability Programs and Options

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

Laurel Lucia and Ken Jacobs. March 2018. Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment. UC Berkeley Labor Center. http://laborcenter.berkeley.edu/pdf/2018/CA-policy-options-individual-market-affordability.pdf.

# ENDNOTES

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

[2] While the Affordable Care Act's premium tax credit structure is designed to ensure that consumers at the same federal poverty level will pay the same amount for a benchmark plan regardless of their age or where they live, actual average enrollee prices like those shown in Figures 2 and 3 can vary. This can occur if average member income differs between age groups or regions which would change the average member premium contribution or if enrollees in a certain age group or region are more likely to "buy down" to the least expensive Silver plan or "buy up" to a more expensive Silver plan than their counterparts.

[3] Covered California Active Member Profile, Statewide Metal Tier by Subsidy Eligibility, September 2018. https://hbex.coveredca.com/data-research/.

[4] 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.

[5] Covered California's Health Insurance Companies and Plan Rates for 2019. p.7. https://www.coveredca.com/newsroom/PDFs/CoveredCA_2019_Plans_and_Rates.pdf.

[6] Bingham A, Cohen M, Bertko J. July 11, 2018. National vs. California Comparison: Detailed Data Help Explain the Risk Differences Which Drive Covered California's Success. https://www.healthaffairs.org/do/10.1377/hblog20180710.459445/full/.

[7] Ibid.

[8] 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]).

[9] Lucia L and Jacobs K. March 2018. Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment. UC Berkeley Labor Center. p.2. http://laborcenter.berkeley.edu/pdf/2018/CA-policy-options-individual-market-affordability.pdf.

[10] Fung V, Liang C, Hsu J. May 31, 2018. Perceptions Among Individual Insurance Market Enrollees in California in 2017. California Health Care Foundation. https://www.chcf.org/publication/perceptions-affordability-among-individual-market-enrollees-california-2017/.

[11] Ibid.

[12] Ibid.

[13] Brot-Goldberg Z, Chandra A, Handel B, Kolstad J. August 1, 2017. 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, p. 1261–1318. https://academic.oup.com/qje/article/132/3/1261/3769421.

[14] Covered California's Health Insurance Companies and Plan Rates for 2019. p.10. https://www.coveredca.com/newsroom/PDFs/CoveredCA_2019_Plans_and_Rates.pdf.

[15] Fung V, Liang C, Hsu J. May 31, 2018. Perceptions Among Individual Insurance Market Enrollees in California in 2017. California Health Care Foundation. https://www.chcf.org/publication/perceptions-affordability-among-individual-market-enrollees-california-2017/.

[16] Lucia L and Jacobs K. March 2018. Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment. UC Berkeley Labor Center. p.14. http://laborcenter.berkeley.edu/pdf/2018/CA-policy-options-individual-market-affordability.pdf.

[17] Fung V, Liang C, Hsu J. May 31, 2018. Perceptions Among Individual Insurance Market Enrollees in California in 2017. California Health Care Foundation. https://www.chcf.org/publication/perceptions-affordability-among-individual-market-enrollees-california-2017/.

[18] Lucia L and Jacobs K. March 2018. Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment. UC Berkeley Labor Center. p.3. http://laborcenter.berkeley.edu/pdf/2018/CA-policy-options-individual-market-affordability.pdf.

[19] 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).

[20] Congressional Budget Office. November 2017. Repealing the Individual Health Insurance Mandate: An Updated Estimate. p.1. https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.

[21] Fung V, Liang C, Shi J, et al. January 2019. Potential Effects of Eliminating the Individual Mandate Penalty in California. Health Affairs, Vol 38:1. https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05161.

[22] Dietz M, Lucia L, Roby D, et al. November 2018. California's Health Coverage Gains to Erode Without Further State Action. p.7. http://laborcenter.berkeley.edu/pdf/2018/CA-Coverage-Gains-To-Erode-Without-Further-State-Action.pdf.

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

[24] Dietz M, Lucia L, Roby D, et al. November 2018. California's Health Coverage Gains to Erode Without Further State Action. p.2. http://laborcenter.berkeley.edu/pdf/2018/CA-Coverage-Gains-To-Erode-Without-Further-State-Action.pdf.

[25] For simplicity we use 2019 federal poverty level to calculate the required contribution for benchmark coverage. These values will change based on annual updates to the federal poverty level.

[26] Gabel J, Lore R, McDevitt R, et al. More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014. Health Affairs Web First. May 23, 2012. https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.1082

[27] The term "existing enrollees" includes three groups of consumers who are expected to have individual market coverage in 2021 even absent new state subsidies: 1) renewing consumers who are expected to be enrolled through Covered California; 2) consumers who would have purchased coverage off-exchange in 2021 but who would switch to Covered California in 2021 to avail themselves of the new subsidies; and 3) new Covered California enrollees who would have signed up with Covered California even absent state subsidies. The third group represents those who "churn" through Covered California each year as they experience a life change and seek subsidized coverage.

[28] Brot-Goldberg Z, Chandra A, Handel B, Kolstad J. August 1, 2017. 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, p. 1261–1318. https://academic.oup.com/qje/article/132/3/1261/3769421.

[29] 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 to lower premiums in both individual markets, equally.

[30] Consumers responding to the mandate 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. (Covered California News Release. July 2018. Covered California Releases 2019 Individual Market Rates: Average Rate Change Will Be 8.7 Percent, With Federal Policies Raising Costs.) In the first year of its reinstatement, the penalty would partially reverse this negative risk mix and premium impact, resulting in an estimated three percent decrease in premiums.

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

[32] Because the microsimulation model used for this project only includes data for individual market-eligible individuals, modeling total state penalty revenue across all coverage segments is beyond the scope of this Report.

[33] In this scenario, Bianca is eligible for new state cost sharing subsidies through a plan with an actuarial value of 80. Covered California's 2019 Gold plan design does not have a deductible, so for purposes of illustration, Options 1 through 3 show Bianca without a deductible.

[34] Gabel J, Whitmore H. June 2018. California Employer Health Benefits: Workers Shoulder More Costs. Slide 7. https://www.chcf.org/publication/california-employer-health-benefits-workers-shoulder-more-costs/. Dietz M, Lucia L, Roby D, et al. November 2018. California's Health Coverage Gains to Erode Without Further State Action. p.11. http://laborcenter.berkeley.edu/pdf/2018/CA-Coverage-Gains-To-Erode-Without-Further-State-Action.pdf.

[35] Domurat, R, Menashe I, Yin W. April 2018. Frictions in Health Insurance Take-up Decisions: Evidence from a Covered California Open Enrollment Field Experiment.

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

[37] As with the contribution caps in primary Options 1 through 3 in Approach 1, the contribution cap in Option T6 rises to 15 percent at 1200 percent 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 percent FPL, premium caps remain 15 percent.

[38] Congressional Budget Office. November 2017. Repealing the Individual Health Insurance Mandate: An Updated Estimate. https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf. Also see Covered California Fiscal Year 2018-2019 Projected Budget. May 2018. Table 3, p.14. https://board.coveredca.com/meetings/2018/05-17/CoveredCA_2018-19_Proposed_Budget-5-17-18.pdf.

[39] Covered California News Release. July 2018. Covered California Releases 2019 Individual Market Rates: Average Rate Change Will Be 8.7 Percent, With Federal Policies Raising Costs. https://www.coveredca.com/newsroom/news-releases/2018/07/19/Covered-California-Releases-2019-Individual-Market-Rates-Average-Rate-Change-Will-Be-8-7-Percent-With-Federal-Policies-Raising-Costs/.

[40] Fung, V, Liang C, Shi J, et al. January 2019. Potential Effects of Eliminating the Individual Mandate Penalty in California. *Health Affairs* vol 38, no 1. https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05161.

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

[42] Internal Revenue Service, Research, Analysis and Statistics. 2016. "Federal Tax Compliance Research: Tax Gap Estimates for Tax Years 2008–10." Publication 1415 (Rev 5–2016). Washington, DC: Internal Revenue Service. https://www.irs.gov/newsroom/the-tax-gap.

[43] Annie L. Mach, Individual Mandate Under the ACA (Congressional Research Service, May 13, 2015), https://fas.org/sgp/crs/misc/R41331.pdf

[44] Thomson Reuters, "IRS Won't Reject Returns That Are Silent Regarding Compliance with ACA Individual Mandate," Thomson Reuters Tax and Accounting News, Feb. 16, 2017, https://tax.thomsonreuters.com/media-resources/news-media-resources/checkpoint-news/daily-newsstand/irs-wont-reject-returns-that-are-silent-regarding-compliance-with-aca-individual-mandate/

[45] Eibner, Christine and Sarah Nowak. "The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors" The Commonwealth Fund. July 11, 2018. https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors