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INFORMATIONAL HEARING

Assembly Health, Assembly Budget Sub. 1,
Senate Health, and Senate Budget Sub. 3 Committees
Health Insurance Affordability Assistance for Californians: Options and Funding

Tuesday, February 12, 2019 ♦ 1:30 p.m.
State Capitol ♦ Room 4202

BACKGROUND

INTRODUCTION

Enacted in March 2010, the federal Patient Protection and Affordable Care Act (ACA) provides the framework, policies, regulations, and guidelines for the implementation of comprehensive health care reform by the states. The ACA expands access to quality, affordable insurance and health care. As of January 1, 2014, insurers are no longer able to deny coverage or charge higher premiums based on preexisting conditions. These aspects of the ACA, along with tax credits for low and middle income people buying insurance on their own in new health benefit exchanges (exchanges), Covered California here in California, make it easier for people with preexisting conditions to gain insurance coverage. California embraced the ACA, and more than 5 million Californians gained coverage through the Medi-Cal expansion and Covered California. The uninsured rate among non-elderly Californians fell from17.6% in 2012 7.2% in 2017. Enrollment in the individual market grew from 1.5 million in 2013 to 2.2 million in 2017 due to California's extensive and effective implementation of the law.

Still, many Californians continue to face difficulties in affording premium and out-of-pocket (OOP) costs. According to UC researchers, affordability challenges can deter enrollment in and retention of coverage, cause financial difficulties for those struggling to pay premiums or medical bills, and decrease access to care. Without further state action, the number of uninsured in the state could rise from 3.5 million in 2016 to 4 million in 2020 and 4.4 million in 2023, in large part due to the zeroing out of the penalty of the individual shared responsibility provision, commonly known as the individual mandate penalty. The Legislature attempted to address these affordability challenges through legislative and budget proposals in 2018.

The purpose of this informational hearing is to examine proposals that will help achieve the goals of providing assistance for Californians when affordability challenges are a barrier to enrollment in the individual market. Potential funding and implementation considerations of these proposals will also be discussed.

THE AFFORDABLE CARE ACT

Benefits and coverage. Prior to the ACA, covered benefits under a health plan or insurance policy varied from policy to policy. The ACA requires all health insurance plans offered in the individual and small group markets to provide a comprehensive package of items and services, known as essential health benefits, with no dollar limits[1]. The ACA also establishes various metal tiers (also known as Actuarial Value [AV]) of health insurance coverage. These tiers are used for three primary purposes: set the minimum amount of coverage many people must have to satisfy the requirement that they be insured or pay a federal tax penalty beginning in 2014; establishes standardized levels of insurance that individuals and small businesses can buy in exchanges or the outside market; and, as benchmarks for premium and cost-sharing subsidies provided to lower and middle income people buying insurance in exchanges.

The goal of the AV tiers is to make it easier for consumers to compare health plans. The four metal tiers required are: Platinum, with an AV of 90% or more; Gold, with an AV of 80% to 90%; Silver, with an AV of 70% to 80%; and, Bronze, with an AV of 60% to 70%. Health plans in the highest tier (Platinum) pay the highest percentage of an individual's expected medical costs (90%) and have higher premiums and lower copays and deductibles. Health plans in the lowest tier (Bronze) pay the lowest allowable percentage of medical expenses (60%) and have lower premiums and higher copays and deductibles.

Federal financial assistance in the individual market. Under the ACA, qualified individuals are able to obtain financial assistance to help pay for health insurance premiums, also known as advance premium tax credits (APTCs) and cost-sharing reductions (CSRs) if health insurance is purchased through an exchange. A person must be a citizen or lawfully present, must have qualifying income (at or below 400% of the federal poverty level (FPL), which is approximately $48,560 for a single individual and $100,400 for a family of four in 2019), and not be eligible for government programs or have affordable coverage through an employer (which is considered affordable if the premium for the employee only, not including dependents, is less than 9.86% of the employee's household income for 2019).

Individual market in California. The ACA required exchanges to be established in every state by January 1, 2014, otherwise the federal government would establish one for the state. The central purpose of these new exchanges is to enable low and moderate income individuals and small employers to obtain affordable health coverage through a variety of insurance exchange models throughout the United States. Each state electing to establish an exchange must adopt the federal standards in law and rule, and have in effect a state law or regulation that implements these standards. The exchanges are required to carry out a number of different functions, including determining eligibility and enrolling individuals in appropriate plans; reporting enrollment to the federal government in order to facilitate the payment of APTC to the health insurance issuers;

[1] These benefits fit into the following 10 categories: i) ambulatory patient services (outpatient care); ii) emergency services; iii) hospitalization; iv) maternity and newborn care; v) mental health and substance use disorder services, including behavioral health treatment; vi) prescription drugs; vii) rehabilitative and habilitative services and devices; viii) laboratory services; ix) preventive and wellness services and chronic disease management; and, x) pediatric services, including dental and vision care.

conducting plan management activities; assisting consumers; ensuring plan accountability; and, providing financial management. Covered California was the first exchange in the nation created under the ACA.

In California, nearly 90%, or 1.2 million, of Covered California enrollees receive federal premium subsidies. ACA tax credits are available in advance, based on income information provided to Covered California, household size, age, and the cost of coverage in the area where individuals live. APTC are reconciled based on actual income when a person files income taxes. Covered California enrollees benefited from $4.7 billion in federal tax credits in 2017. Eligibility under the ACA is calculated by the household modified adjusted gross income (MAGI) which is governed by the Internal Revenue Service, Medicaid, and Treasury regulations. For purposes of determining eligibility for APTC and CSR, Covered California uses an individual's MAGI.

In addition to APTC, low-income enrollees (those with incomes below 250% FPL) qualify for additional subsidies that reduce OOP costs, including deductibles and copayments. In California, these CSRs total over $800 million in 2017. Of the enrollees that receive APTC, 70% have household incomes below 250% FPL, also qualifying them for CSRs.

According to Covered California, subsidized members pay on average $115 per month in premiums, or about 20% of the average gross premium cost of $558 per month. In addition, members enrolled in CSR plans receive reduced deductibles, copayments, and coinsurance estimated to be worth roughly $131 per month on average. Unsubsidized consumers who do not qualify for APTC pay on average about $446 per month in premiums. The difference in average gross premiums between the subsidized and unsubsidized membership is due to the enrollment in Bronze coverage is twice as high among unsubsidized enrollees.

Additionally, unsubsidized enrollees account for a significant population of the individual market. One million Californians are estimated to have been insured in the individual market outside of Covered California in 2017. An additional 160,000 unsubsidized individuals are enrolled through Covered California. While these individuals do not receive APTC or CSRs to lower their monthly costs, Covered California has taken steps to hold down gross premium increases. Each year, Covered California actively negotiates rates and contract terms with health plans and markets the availability of coverage to encourage healthy individuals to sign up. Actions taken by Covered California that lower premium increases directly benefit unsubsidized consumers since health plans must sell standard plan designs for the same price on and off the exchange.

Individual market changes. California has also taken steps toward ensuring a stable individual market in response to recent federal health policy changes. On October 12, 2017, the federal government announced it would no longer provide federal funding for CSR. Rather than rely on federal funding to pay for CSR, Covered California plans added an additional CSR "surcharge" to Silver plan rates for 2018. Covered California structured the surcharge in a way that protects as many consumers as possible from having to pay higher rates. Consumers who receive APTC to help them pay their premiums will receive an even higher amount of tax credit that will offset the surcharge.

Additionally, although the federal requirement for open enrollment is November 1 through December 15, California has maintained a three-month open enrollment period, twice as long as the open enrollment period in the 39 states that rely on the Federal exchange. Covered California spending on ACA marketing and outreach was projected to be 10 times greater than federal government spending in those states in 2018. With the goal of maintaining stability in the individual and small group markets, California also enacted laws in 2018[2] that ban the sale of short-term health plans and limit association health plans, in response to federal rules that expanded options for those types of plans that do not have the ACA's consumer protections.

Furthermore, the Tax Cuts and Jobs Act of 2017 set the tax penalty associated with the individual shared responsibility requirement to zero beginning in 2019. 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. UC researchers using the California Simulation of Insurance Markets microsimulation model projected that 150,000 to 450,000 more Californians will be uninsured in 2020 as a result of the penalty removal. In 2023, that number is expected to grow to between 490,000 and 790,000 more uninsured, compared to the projected number for 2023 had the penalty been maintained. The most substantial enrollment changes will occur in the individual market, where enrollment is projected to decline by 10.1% in 2020 and 14.4% in 2023. UC researchers estimate that, by 2020, approximately 530,000 subsidy-eligible individuals will be uninsured with 70%, or 370,000, having income between 201% and 400% FPL. An additional 500,000 individuals with income above 400% FPL but eligible to purchase coverage in the individual market will also be without coverage. In conjunction with the zero-dollar penalty, rising costs, lack of knowledge of subsidies, and affordability concerns act as deterrents to enrollment.

The individual mandate provision of the ACA requires taxpayers to have qualifying health coverage (also known as minimum essential coverage, [MEC]), qualify for a coverage exemption, or make an individual shared responsibility payment when filing their federal income tax return. All Covered California health plans meet MEC requirements. While the definition of affordability can depend on life circumstances, the ACA has allowed for MEC exemptions in cases where an individual cannot afford coverage because the minimum amount he or she must pay for the premiums is more than a certain percentage of his or her household income. Individuals are exempt from the ACA individual mandate if they lack access to affordable coverage, defined as costing less than 8.16% of household income in 2018. While the penalty associated with the individual mandate was zeroed out effective 2019, taxpayers must continue to report coverage, qualify for an exemption, or make an individual shared responsibility payment for tax years 2017 and 2018. For example, the fee amounts for 2017 was $695 per adult or 2.5% of yearly household income.

[2] SB 910 (Hernandez), Chapter 687, Statutes of 2018, and SB 1375 (Hernandez), Chapter 700, Statutes of 2018

AFFORDABILITY CHALLENGES

A March 2018 report (UC Labor Report), "California Policy Options for Improving Individual Market Affordability and Enrollment," estimates that there are at least 1.2 million Californians who remain uninsured despite being eligible to purchase insurance through Covered California, with or without subsidies. This is the second largest group of uninsured residents in the state, after undocumented residents, who are excluded from the ACA and Medicaid under federal law. In 2014 through 2016, cost was identified as the top reason for lacking insurance among uninsured citizens in California, regardless of income level, according to the California Health Interview Survey. The vast majority of citizens who tried to purchase insurance through Covered California but ultimately remained uninsured said they found it difficult to find an affordable plan. Below are some of the affordability challenges for specific income groups.

Under 400% FPL (under $48,560 for a single individual and $100,400 for a family of four in 2019). Even with ACA subsidies, combined premium and OOP spending in the individual market can exceed 10% of income for some Californians with median OOP spending, and can reach 20% to 30% of income for some with very high medical use. The vast majority of Americans eligible for ACA premium subsidies based on income do not have liquid assets sufficient to cover a $6,300 deductible for a Bronze plan. Research has shown that high OOP costs can be a barrier to care and cause financial problems. OOP costs are a major consideration in an individual's enrollment decisions.

Over 400% FPL (over $48,560 for a single individual and $100,400 for a family of four in 2019). Many middle-class Californians are not protected by the ACA's cap on premium contributions because their income is above the level needed to qualify for APTC. Once household income exceeds 400% of the FPL, 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.

Cost of living. The high cost of living in California and broader financial insecurity may exacerbate health insurance affordability concerns for some individual. ACA premium subsidies are based on the FPL, but the higher cost of living in California may squeeze some families' ability to afford healthcare. The upper income limit for premium subsidies under the ACA, four times the FPL, is equivalent to five times that level in California and six times that level in San Francisco. In all California counties, some individuals face an affordability gap in that they earn too much to qualify for Medi-Cal with no premiums or cost sharing, but do not earn enough to afford Covered California insurance even with subsidies, based on a household budget analysis. Some citizens and lawfully present immigrants lack access to coverage that meets ACA affordability standards. Affordability can be a challenge for people who earn too much to be eligible for premium subsidies, especially for those age 50 or older and those who have family income between $48,240 and $72,360 for a single individual. In every region of California, premiums for some of these individuals exceed the standard of affordability under the

ACA individual mandate. Some Californians have access to neither affordable employer-sponsored insurance nor affordable individual market coverage.

2018 activities. Four bills were introduced in the Legislature in 2018 related to affordability assistance and funding was included in the Assembly's version of the 2018-19 Budget.

The Assembly Budget Subcommittee on Health and Human Services approved a $1 billion package of proposals that included a comprehensive set of reforms to California's health care system to increase insurance coverage and access to care, improve quality of care, and make health care more affordable. The Assembly's proposal included: $300 million to provide enhanced premium assistance to low-income individuals and families covered in California; and $200 to 250 million to establish a refundable tax credit for people with income levels between 400-600% FPL for enrollees in the individual market.

Although no funding was included in the final Budget, AB 1810 (Committee on Budget, Chapter 34, Statutes of 2018), the Budget health trailer bill, included a requirement that Covered California, in consultation with stakeholders and the Legislature, develop options for providing financial assistance to low- and middle-income Californians to help them access health care coverage with respect to individual coverage made available in Covered California. The bill called for Covered California to submit these options to the Legislature, Governor, and Council on Health Care Delivery Systems (also established by AB 1810) by February 1, 2019. Covered California was directed to include in the report options to assist individuals who pay a significant percentage of their income on premiums, even if they receive federal financial assistance, and to include individuals with an annual income of up to 600% FPL. AB 1810 required the options to consider maximizing all available federal funding and determine whether federal financial participation for Medi-Cal would be jeopardized.

The other bill proposals are summarized below.

SB 1255 (Hernandez) would have required Covered California to administer financial assistance to help low- and middle-income Californians access affordable health care coverage with respect to individual coverage made available in Covered California, with priority given to any individual whose premium payment is equal to or greater than 8% of his or her annual household income. The bill would have applied to people with income above and below 400% FPL and would have included as financial assistance, cost sharing reductions as well as premium subsidies. The Senate Appropriations Committee indicated that costs of California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) automation changes, were estimated in the low-mid tens of millions, and there would be significant costs (likely in the low hundreds of millions) in order to identify eligible individuals and administer the financial assistance, which could be in either advanced or refundable credit toward the premium payment, or through cost-sharing. The Senate Appropriations Committee analysis also indicated there could be possible changes to the amount received in federal credit depending on how financial assistance is provided – whether by subsidy or cost-sharing. SB 1255 was held in the Assembly Appropriations Committee.

AB 2459 (Friedman) would have enacted a credit against the personal income tax to subsidize the purchase by income-eligible individuals (income between 400-600% FPL) of health coverage through Covered California. The credit would have been equal to the portion of the cost of health insurance premiums of the lowest cost Bronze plan that exceeds 8% of the taxpayer's MAGI. The bill designated Covered California as the certifying agency for the credit, and required Covered California to send the certification both to the taxpayer and Franchise Tax Board (FTB). According to the Senate Appropriations Committee analysis, the FTB estimated that the bill would have resulted in General Fund (GF) revenue losses of $40 million in 2018-19, $70 million in 2019-20, and $75 million in 2020-21. FTB indicated that it would incur annual administrative costs of $1.4 million to develop, program and test revisions to existing systems, and staff the additional workload. Covered California indicated that the bill would have resulted in one-time information technology costs to make changes to CalHEERS in order to calculate the tax credits, and ongoing operational costs to certify the credit, and provide the certification to both the consumer and the FTB. Covered California anticipated that costs could reach the low millions of dollars. The Senate Appropriations Committee analysis also indicated that an estimated 26,000 individual taxpayers would qualify and the average individual would have received a premium credit of $2,600, resulting in an estimated $67 million in credits generated. AB 2459 was held in the Senate Appropriations Committee.

AB 2565 (Chiu) would have required Covered California to provide enhanced premium assistance on a sliding scale basis to households with income below 400% FPL in addition to APTCs provided under the ACA. According the Senate Appropriations Committee analysis, Covered California estimated a range of several hundred million to $500 million dollars annually with unknown one-time and ongoing operational costs. AB 2565 was held in the Senate Appropriations Committee.

AB 3148 (Arambula) would have required Covered California to offer additional cost sharing financial assistance to those who are otherwise eligible for federal premium Tax Credits and who have incomes determined to be below 400% FPL, such that individuals with incomes between 200-299% FPL would be offered products with an AV of 87%, with the benefit design consistent with the benefit design for cost sharing reduction benefits offered to those with incomes between 150-200% FPL; and, individuals with incomes between 300-400% FPL would be offered products with an AV of 80%, with the benefit design consistent with that of a Gold level of coverage. According to the Assembly Appropriations Committee, the GF costs to provide cost-sharing subsidies would be roughly $500 million annually, according to preliminary estimates from the UC Berkeley Labor Center. This assumes the higher-AV plans specified are offered to individuals at premium levels that would otherwise apply to lower-AV Silver plans. Additionally, there would be unknown, significant one-time and ongoing operational costs to Covered California, including: one-time costs, likely in the millions of dollars for information technology changes to the CalHEERS eligibility and enrollment system, and to create accounting and payment systems to handle subsidy payments; potentially significant, unknown one-time training and outreach costs to agents, enrollers, health plans, counties, and Covered California staff; and, significant, unknown ongoing costs, potentially in the millions of dollars annually, to administer cost-sharing subsidies. AB 3148 was held in the Assembly Appropriations Committee.

This year at least four bills have been introduced and the Governor has included proposals in his proposed 2019-20 budget to address affordability concerns. These bills and the Governor's Budget proposals are summarized below.

SB 65 (Pan) would require Covered California to administer financial assistance to help low-income and middle-income Californians access affordable health care coverage with respect to individual coverage available through Covered California. This bill would require Covered California to implement a maximum premium contribution equal to or lower than 8% of the enrollee's annual household income for an individual whose income is equal to or lower than 400% FPL; and equal to the maximum premium contribution prescribed in the ACA for an individual whose income exceeds 400% FPL. This bill would also reduce copays and deductibles for any individual whose income is between 200-400% FPL.

AB 174 (Wood) would permit, for each taxable year beginning on or after January 1, 2020, a credit under the Personal Income Tax Law in an amount equal to the cost of health insurance premiums of the lowest cost Bronze plan for the qualified individual or the qualified individual's dependent that exceeds 8%, but no more than an unspecified percentage, of the qualified individual's modified adjusted gross income. This bill would also provide a taxpayer with an allowable credit in excess of that liability and requires on or before January 1, 2024, the Legislative Analyst's Office to report on the number of qualified individuals who claimed the credit, the average and median credit amounts claimed, and the effectiveness of the credit in reducing health care costs.

SB 175 (Pan) and AB 414 (Bonta) would enforce the ACA penalty for not having health insurance beginning in 2020 based on the federal methodology that was in place as of December 15, 2017. These bills would require Covered California to determine if a penalty is to be assessed or an exemption granted and requires the Franchise Tax Board to collect the penalty through the tax payment process. These bills also require penalty revenue to be used to improve the affordability of healthcare coverage for Californians.

Included in the 2019-20 budget proposed by Governor Newsom is a proposal to increase subsidies through Covered California for individuals with incomes between 250-400% FPL, and expand subsidies to individuals with incomes between 400-600% FPL to increase coverage and promote affordability. The increased subsidies will be funded by revenues generated by establishing a state individual mandate, modeled on the federal requirement enacted as part of the ACA, to obtain comprehensive health care coverage or pay a penalty. The proposed subsidies and state mandate will promote health care affordability, coverage, and use of preventative care, as well as decrease uncompensated care and county indigent health care costs. The FTB would implement the penalty and Covered California would administer the subsidies.

AB 1810 REPORT

On February 1, 2019, Covered California submitted its report, "Options to Improve Affordability in California's Individual Health Insurance Market," to the Governor and Legislature as required by AB 1810. The report presents policy options based on four elements of the ACA: 1) premium subsidies; 2) cost-sharing subsidies; 3) individual mandate to purchase insurance or pay a penalty; and, 4) reinsurance (which transfers funds to individual market insurance plans with higher-cost enrollees from all individual and group health insurance carriers and third party payers).[3] A brief summary of the options included in the report are below.

Policy Option 1: Enhance and extend premium and cost-sharing support by adjusting the limit on the amount of premium contribution that must be paid by an individual who qualifies for the APTC so that someone with income: between 0-138% FPL pays nothing; between 138-400% FPL has a cap on premium that rises linearly up to 8% of their income; between 400-600% FPL has a cap on premium that rises linearly from 8-12% of their income; and, 600% and above has a cap that rises linearly from 12-15% of their income.

Additionally, cost-sharing support would be expanded such that someone with income between: 150-200% FPL would be able to shift to a plan with 94% AV; 200-250% FPL would be able to shift to a plan with 87% AV; and, 250-400% would be able to shift to a plan with 80% AV. This option significantly increases new enrollment (+290,000) but of the three policy options by the least amount. This option eliminates the APTC cliff, brings in $670 million in APTCs for Californians and reduces premiums for 662,000 people off-exchange on average by $18 less per month and 1.3 million people on-exchange on average by $39 per month. This option shifts more people into higher AV coverage and would result in $2.2 billion in new state spending. Administrative costs to state departments to operationalize these options are not included in the new state spending estimates.

Policy Option 2: The same as Policy Option 1 with the addition of a state-level individual mandate and penalty modeled on the ACA framework in place in 2018. This option significantly increases new enrollment (+648,000) at the lowest amount of new state spending ($2.1 million) because of the mandate to purchase insurance. This option eliminates the APTC cliff, brings in $975 million in APTC for Californians and reduces premiums a bit more than option 1 for 662,000 people off-exchange (on average $41 less per month). This option also shifts more people into higher AV coverage. New state spending is slightly less than Policy Option 1 if costs are offset by revenue generated by people who pay the penalty instead of purchasing health insurance, which is estimated at approximately $441 million. The individual mandate estimate undercounts penalty payers because it is limited to estimates of people in the individual market

[3] This was a temporary federal program that was available from 2014 to 2016. Some states have created their own reinsurance programs funded with a combination of state and federal dollars obtained through state innovation waivers allowed under Section 1332 of the ACA. Section 1332 of the ACA permits a state to apply for a waiver to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.

who are likely not to take up insurance and does not include people with employer based group coverage who opt not to take up coverage.

Policy Option 3: The same as Policy Option 2 with the addition of a reinsurance program modeled on the temporary federal reinsurance program funded at a level that would lower gross premiums by 10%. This option increases new enrollment in the individual market the highest level of the three options (+764,000) because of the reduction in premiums for all. Like the other options it shifts more people into higher AV coverage, and eliminates the APTC cliff. It reduces premiums for the 662,000 people off-exchange on average of $111 per month (the most of all of the three policy options). However, this option would reduce APTCs to Californians by $331 million because reinsurance brings down the premium cost which has a direct impact on APTC amounts. This option subjects Californians to approximately $393 million in penalty payments because of individual mandate. New state spending would be $2.7 billion. The total new spending estimate of $4.2 billion is offset by the penalty revenue and assumes California successfully negotiates with the federal government to maintain $1.1 billion in federal funding under a 1332 waiver.

The AB 1810 report also includes targeted affordability enhancements for three populations: individuals with income under 400% FPL; individuals with income under 600% FPL; individuals with income over 400% FPL; and models the individual mandate without other policy changes.

Targeted Option 1 (T1) is premium support that lowers premium contribution caps so that someone with income: between 0-138% FPL pays nothing; between 138-250% FPL has a cap that rises linearly up to 8% of their income; and between 250-400% FPL has a cap that rises linearly from 8-9% of their income. T1 brings in new enrollment of 70,000 for $425 million in new state spending. This option brings in $125 million in APTC s and reduces off-exchange premiums on average to 807,000 people by $7 per month.

Targeted Option 2 (T2) is cost sharing reductions so that individuals with income between 200-400% FPL get plans with AV of 80%. This brings in new enrollment of 27,000 for $215 million in new state spending. T2 allows 729,000 existing Covered California enrollees to take advantage of new cost-sharing subsidies. This option brings in $63 million in APTC to Californians and reduces off-exchange premiums on average to 807,000 people by $3 per month.

Targeted Option 3 (T3) is premium support up to 600% FPL by creating a contribution cap of 9.86% at 400% FPL rising linearly to 15% at 600% FPL. This option is a combination of T1 and T5. This option brings in new enrollment of 125,000 for $765 million in new state spending. This option brings in $45 million in APTCs to Californians and reduces off-exchange premiums on average to 662,000 people by $14 per month.

Targeted Option 4 (T4) is T3 with an individual mandate. This option brings in new enrollment of 478,000 for $409 million in new state spending. This option brings in $637 million in APTCs to Californians and reduces off-exchange premiums on average to 662,000 people by $31 per month. Californians would be subject to at least $482 million in penalty assessments which could offset total new state spending of $891 million.

Targeted Option 5 (T5) lowers premium contributions for consumers earning between 400-600% FPL. Sets cap at 9.86% of income to align with ACA and cap rises linearly to 15% at 600% FPL. This option brings in new enrollment of 47,000 for $285 million in new state spending. This option reduces APTCs to Californians by $44 million and reduces off-exchange premiums on average to 662,000 people by $5 per month.

Targeted Option 6 (T6) lowers premium contributions for consumers across the income spectrum with a cap of 9.86% for an individual with income at 400% FPL rising linearly to 15% at 1200% and up. This option brings in new enrollment of 50,000 for $324 million in new state spending. This option also reduces APTCs to Californians by $44 million and reduces off-exchange premiums on average to 662,000 people by $5 per month.

Targeted Option 7 (T7) creates a state reinsurance which lowers gross premiums by 10% per year. This option brings in new enrollment of 118,000 for $1.5 billion in new state spending (potentially offset by $878 million if federal 1332 waiver funding estimates are approved by the federal government). This option reduces premiums off-exchange to 807,000 Californians on average by approximately $70 per month. This option reduces APTCs to Californians by $878 million.

Targeted Option 8 (T8) reinstates the individual mandate penalty. This option brings in new enrollment of 359,000 in 2021 with no new state spending (except associated with administrative costs to state agencies). This option reduces off-exchange premiums by $24 per month for 807,000 Californians but also subjects Californians to $526 million in penalty assessments. This option also reduces APTCs to Californians by $426 million.

Note: Individuals affected by the "family glitch" would benefit from lower premiums as a result of many of the modeled policy options presented in the AB 1810 report. However, none of the options model state subsidies for individuals affected by the family glitch. The family glitch is when an employee's spouse and children are not eligible for premium subsidies through Covered California because the employee-only premiums are affordable under the ACA definition for the purposes of determining APTC eligibility.

Implementation considerations. The options in the AB 1810 report assume implementation in 2021. Policymakers will need to evaluate the various policy choices in terms of cost, operational issues, and policy objective. Some considerations include whether or not premium credits are advanceable (which allow monthly premium reductions) or refundable through the income tax system. Additionally, policymakers will need to determine how state subsidies overlay with federal subsidies and how a state individual mandate would interact with the federal mandate if Congress reinstates the penalty at some point in the future. Policymakers should also consider the extent to which the mandate would be applied prior to or at the same time as state subsidies become available.

Other states and localities have implemented premium assistance, reinsurance, and individual health insurance mandates. Premium Payment Subsidies[4] – Massachusetts, Vermont, and San Francisco have existing affordability assistance programs. Massachusetts has zero premium for those at or below 150% FPL; caps premium contributions at 2.90% and 7.45% of income for individuals with income between 150-300% FPL. Vermont reduces premiums using a sliding scale from 75% reduction for individuals with income below 133% FPL to a 16% reduction for individuals with income at 300% FPL. In San Francisco an adult residing in San Francisco with income at or below 500% FPL, enrolled in Covered California, not eligible for Medi-Cal or Medicare whose employer meets City health spending requirement by contributing to City Option, pays 40% of premium after ACA subsidies, or, for an individual with unsubsidized coverage pays 40% of total premium.

Reinsurance – seven states have been approved under the Section 1332 Waiver process. Those states are Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon and Wisconsin. Four out of the seven states received more federal pass through dollars than were estimated. However, three of the states received substantially less than estimated. Minnesota received only 46% of what was anticipated, New Jersey received 83%, and Wisconsin received 77%.

Individual Mandate – Massachusetts had an individual mandate prior to the ACA and continues to have one today. New Jersey, the District of Columbia, and Vermont have enacted legislation to create state individual mandates.

Conclusion

While California has made substantial progress under the ACA in reducing the rate of uninsured and creating more access to health care treatment and prevention services for Californians, recent federal policy changes are having a detrimental impact. Covered California has recently announced a 23.7% drop in the number of new consumers signing up for coverage for 2019. California policymakers have passed many policies in efforts to block what some have characterized as "ACA sabotage." More can and should be done to not only assist Californians in obtaining financial assistance and higher actuarial benefits consistent with the options that will be discussed at this informational hearing but significant efforts must also be targeted at controlling health care costs. Additionally, there may be limits as to how much California policy makers can do to protect Californians from federal policy changes intended to disrupt these successes. Several federal regulatory measures have been initiated that if finalized, will reduce APTC assistance for Californians and could blunt some of the impact of additional state affordability assistance.

[4] California Policy Options for Improving Individual Market Affordability and Enrollment, UC Berkeley Labor Center, March 5, 2018