Covered California and the Affordable Care Act Nationally: Roller-Coaster Reality, Prospects for Stability and the Policy Whirlwind

Charles R. Drew University of Medicine and Science
Dr. M. Alfred Haynes Series

Peter V. Lee
June 15, 2018
### Major Changes to the Health Care System because of the Affordable Care Act

#### Before the Affordable Care Act

- Many consumers denied coverage by insurers because of pre-existing conditions.
- Many consumers with insurance bankrupted by gaps in coverage and annual or lifetime limits.
- Health coverage unaffordable for millions without employer coverage – except the healthy (underwritten) and wealthy (those making enough to foot the bill).
- Insurers could remove young adults from their parents’ policies, leaving them uninsured.
- Children under 19 could be denied coverage because of a chronic condition.
- Medicaid only covered low-income children, pregnant women, elderly and disabled individuals, and some parents, but excluded other low-income adults.

#### Today

- Guaranteed coverage for all — no screening or price differences due to health status.
- Insurers are prohibited from setting lifetime limits on essential health benefits, such as hospital stays.
- Subsidies making coverage affordable to 9 million Americans; 7 million unsubsidized struggling with rising costs.
- Dependent children up to age 26 must be offered coverage under a parent’s insurance plan.
- Insurers may not exclude children under the age of 19 from coverage due to a pre-existing medical condition.
- For Medicaid expansion states, Medicaid covers all adults under 65 with income up to 133 percent of the federal poverty level.
Covered California’s Promise

**Vision:**
To improve the health of all Californians by assuring their access to affordable, high-quality care.

**Mission:**
To increase the number of insured Californians, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

Better Care  •  Healthier People  •  Lower Cost
How Covered California Makes the Promise Real

<table>
<thead>
<tr>
<th>CREATING COMPETITIVE MARKETS</th>
<th>OFFERING AFFORDABLE PRODUCTS</th>
<th>EFFECTIVELY REACHING AND ENROLLING CONSUMERS</th>
<th>ENCOURAGING THE RIGHT CARE AT THE RIGHT TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Plan competition for enrollment (seek at least three plans)</td>
<td>- High enrollment of subsidy eligible to assure good risk mix</td>
<td>- Robust and ongoing marketing</td>
<td>- Benefit design promoting appropriate access</td>
</tr>
<tr>
<td>- Provider-level competition and distinction between plans</td>
<td>- Long term affordability through delivery system changes</td>
<td>- Cost effective enrollment support</td>
<td>- Requirements for plans to promote effective delivery of coordinated care</td>
</tr>
<tr>
<td>- Benefit designs foster informed consumers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Covered California: Building on Central Hypothesis for the Affordable Care Act**

<table>
<thead>
<tr>
<th>Category</th>
<th>Summary</th>
</tr>
</thead>
</table>
| Incentives Matter                             | • Many consumers need financial incentives to be motivated to purchase insurance.  
  • Healthier individuals need greater external incentives, meaning absent robust incentives risk pool will be worse raising costs |
| Insurance Needs to be “Sold”                 | • In absence of mandate, insurance needs to be “sold” to encourage healthier enrollment                                                                                                                  |
| Competition Matters                           | • Competition between plans promotes better value for consumers  
  • Competition between/among providers promotes better value  
  • While some consolidation at the plan AND provider levels can promote efficiencies and better care; it also may foster undue price increases |
| Benefit Designs Matter                        | • The design of health benefits directly impacts both how consumers select and use their health care coverage.  
  • Benefit designs can promote or inhibit “appropriate access” to care  
  • Benefit designs can promote or inhibit retention of better risk pool |
| Cost and Value Depend on the Delivery System  | • Coverage is important, but value and affordability are driven by delivery of care – right care, right setting, right price.  
  • The Triple Aim is more likely to be fostered by payment aligned to value and with narrower/integrated networks (broad networks with FFS payment will not promote value)  
  • There is huge variation in cost and quality at the treatment, provider and facility levels |
| The Fabric of Coverage Spans Public and Private Payment | • New insurance rules and subsidies mean that the spectrum of coverage spans public and private options with increasing movement between them  
  • Expanded coverage has cross-sectoral impacts – increasing coverage through Medicaid and Exchanges reduces costs to employer-coverage and Medicare |
Coverage Expansion Having Dramatic Effects in California

With California's expansion of Medicaid and the creation of a state-based marketplace, the rate of the uninsured has dropped to historic lows. Almost four million new enrollees are in the Medi-Cal program and 1.3 million people are enrolled through Covered California.

Estimated “eligible uninsured” rate, when excluding those ineligible for coverage.

Source: U.S. Centers for Disease Control and Prevention’s National Health Institute Survey
Californians Facing New Opportunities for Coverage

The Affordable Care Act has dramatically changed the health insurance landscape in California with the expansion of Medicaid, Covered California and new protections for all Californians.

California’s 2015 Health Care Market
(in millions — ages 0-64)

- 18.2 employer-based
- 8.7 Medi-Cal
- 18.2 employer-based
- 3.7 Medi-Cal expansion
- 1.3 Covered California
- 1.1 off-exchange
- 1.2 uninsured
- 2.0 other coverage

- As of June 2016, Covered California had approximately 1.4 million members who have active health insurance. California has also enrolled nearly 4 million more into Medi-Cal.

- Consumers in the individual market (off-exchange) can get identical price and benefits as Covered California enrollees.

- From 2013 to 2016, the Centers for Disease Control and Prevention report cutting the rate of uninsured in half (1.5 million are ineligible for Covered California due to immigration status). Not counting those ineligible puts California’s uninsured at 1.2 million.

Estimates based on survey data and adjusted for latest available administrative data, including:
- American Communities Survey, 2015 1-year estimates (Table B27010)
- Covered California Active Member Profile ([http://hbex.coveredca.com/data-research](http://hbex.coveredca.com/data-research))
The Individual Market Was Stabilizing In Plan Year 2017 — Stability Was Becoming The National Norm In 2017

Kaiser Family Foundation analysis\(^1\) of insurer financial data from the first six months of 2017 showed:

- Individual market was stabilizing and on the path to insurer profitability. 2017 rates were estimated to result in “medical loss ratios” of 77 percent through the second quarter of 2017 (down from a high of 93 percent in the second quarter of 2015).

S&P global market analysis\(^2\) found:

- 2016 was the first year since the start of the exchanges that Blue Cross/Blue Shield insurers nationally reported a gross profit (in aggregate) in the individual business line.


The Stability Was Shaken In 2018, But Overall Markets Were Remarkably Steady

Huge uncertainty going into 2018:
• Reduced marketing to consumers living in states supported by the federal marketplace
• Penalty enforcement unclear
• Fall decision to end direct funding of cost-sharing reduction subsidies

Results — huge state-by-state variation, but:
• Much cajoling and nudges kept coverage in all counties, but we now have 30 percent of Americans in marketplaces with only one plan.
• Most states did “CSR work around” — result was DECREASE in premium for those with subsidies (down 3 percent for FFM states) and unsubsidized shielded from the “CSR Surcharge” (unsubsidized premiums up 15 percent or more).
• Spike in earned media coverage filled some of the gap from drop in marketing.
• High reduction in new enrollment and apparently large drop in off-exchange unsubsidized enrollment.
Enrollment Trends 2014 — 2018: Federally Facilitated Marketplace Showing Dramatic Decline in New Enrollment

- Total marketplace enrollment in 2018 declined **4 percent** from 2017 to 2018 and declined by **7 percent** since 2016.

- The FFM has seen a decline of **38 percent** in new enrollments since 2016 — from 4 million to 2.5 million.

- SBM’s overall enrollment has been stable since 2015, with each year attracting about the same number of new enrollees during open enrollment, which helps maintains a healthy risk mix and put downward pressure on premium rates.


Note: The tallies for state-based marketplaces hold constant the number of states currently operating their own marketplace due to some states switching to the federal platform across the years.
Premium Increases Directly Impact the 6 Million Americans Who Do Not Receive Subsidies

Total Individual Market of 15 Million People

Who are the unsubsidized:

- Unsubsidized consumers have an estimated median income of $75,000, compared to an estimated median income of $66,000 for all individuals aged 19 to 64.
- Most are NOT high income individuals and the existing premiums are a struggle for many.
- More likely to have better self-reported health status.

Tax Credits Making Health Care Affordable for Those With Employer-Based Coverage and Subsidized Individuals

Unsubsidized Americans purchasing in the individual market — the only ones not getting a federal leg up

**Covered California Source of Premium Payment**

- Tax Credit (APTC) 78%
- Consumer 22%

**Average Annual Enrollee Premium and Tax Credit**
- Total Premium — $5,868
- Federal Support — $4,596
- Consumer Share of Premium — $1,272

**California Employer-based Coverage Source of Payment**

- Employer 55%
- Tax Break 30%
- Employee 15%

**Average Annual Single Employee Premium and Tax Break**
- Total Premium — $6,284
- Tax Break — $2,721
- Employer Contribution* — $2,789
- Consumer Share of Premium* — $774

* Employer and Consumer shares of premium are implied cost after tax break for employer-based coverage deduction.

Employer-based Coverage Source of Payments reflect Covered California estimate of the value of the employer health coverage deduction based on: data from Kaiser Family Foundation for average national employer-based coverage premium for single policy in 2016 and estimated 3% trend from 2016 to 2017, National Health Interview Survey (2017 release of 2016 survey, to estimate median income of single households with employer-based coverage at $48,000), and various assumptions about marginal tax rates at median income level.
Virtually every Californian knows about covered California

Awareness of Covered California and the ACA continues to rise.

Awareness of Covered California and ACA - 96% Each - 2017

- Heard of
- Haven't heard of

94-97% Brand Recognition
Even With Great Recognition of Our Brand — Ongoing Marketing and Outreach Is Crucial

- 96 percent of those surveyed are aware of Covered California and the Affordable Care Act.
- However, nearly 75 percent of the uninsured don’t know they qualify for subsidies.
- Those who are eligible for a subsidy are twice as likely to enroll.

If consumers know they are subsidy eligible, they are twice as likely to enroll.


Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets

Selling Health Insurance in the Individual Market Is Challenging

Natural biases lead consumers to perceive health insurance as something they do not need and overcoming those barriers requires deep insight and sophisticated marketing:

- Loss Aversion Bias
- Temporal Discounting
- Optimism Bias
- Availability Bias
- Status Quo Bias
- Self-Efficacy

Covered California’s Multi-Segment Targeting

**Total Market:** Uninsured Californians
- Subsidy eligible — Federal Poverty Level (FPL) 138%-400%
- Non-subsidy eligible — FPL +400%

**Media Target:**
- Age/gender: will be ages 26-54 (male/female)
- Household income: 50,000 – 130,000

**Target Segments:**
- Latino (culturally appropriate and in-language)
- Asian-Pacific Islander (culturally appropriate and in-language, in the following: Chinese, Korean, Vietnamese, Filipino, Hmong, Cambodian, Laotian)
- African-American (culturally appropriate)
- Multi-segment

Effective Marketing and Outreach: Multi-Channel Marketing and Multiple Service Channels

- Continued investments for 2018 of over $105 million.
- Investments that for fourth open enrollment meant nearly every Californian was exposed to one of our TV, radio, print, billboards or digital ads on average 49 times, generating nearly 2 billion impressions.
California’s Individual Market Premiums Have Been Stable Since the Launch of Covered California in 2014

- Covered California has held average annual rate increases to about **3.3 percent** after tax credits for subsidized enrollees and **7.2 percent** for unsubsidized enrollees, bringing stability to the individual market.

- The average cost of coverage for subsidized Covered California enrollees that frequently saw high increases in premiums in prior years **decreased 11 percent** in 2018 to $116 per member per month, a decline driven by the increase in the tax credit caused by the cost-sharing reduction surcharge.

- Over 1 million unsubsidized consumers buy coverage either through Covered California or directly from the same carriers in the individual market. For most of these consumers, premiums increased at an estimated average annual rate of **7.2 percent**. While this is a better experience than many had in the pre-Affordable Care Act individual market, an average monthly premium of $503 is still a significant expense for unsubsidized enrollees many of whom are working middle class individuals and families that nationally have a median income of $75,000.

Premiums shown are the actual observed average monthly premiums in Covered California administrative data for renewal and open enrollment plan selections, and the percentage change is the change to the average observed premiums. Year over year, the average premiums shown may be influenced by changes in the population distributions from year to year (such as for region, age, metal tier, etc.). Average premiums for the unsubsidized market are estimated from observed on-exchange unsubsidized premiums: actuals could differ from these estimates to the extent that the off-exchange population and plan choice profiles differ from the Covered California profile. Additionally, the 2018 unsubsidized premiums have been adjusted to remove the Cost Share Reduction "surcharge" in Silver, as off-exchange enrollees do not incur the surcharge and Covered California encouraged its unsubsidized Silver enrollees to move off-exchange to avoid the surcharge in 2018.
Covered California Provides Consumers With Tools to Make Informed Choices Among Plans

### Key Consumer Factors in Choosing a Plan:
- Monthly Premium
- Estimated Total Costs (with out-of-pocket)
- Maximum-Out-of-Pocket
- Amount of Federal Support
- Plan Quality
- Doctor in Plan
- Hospital in Plan
- Drugs Covered

<table>
<thead>
<tr>
<th>Plan</th>
<th>ADD TO CART</th>
<th>VIEW DETAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Gold 80 PPO</td>
<td>ADD TO CART</td>
<td>VIEW DETAIL</td>
</tr>
<tr>
<td>Monthly Premium</td>
<td>GOLD PPO</td>
<td>$421.06 after 2.00 tax credit</td>
</tr>
<tr>
<td>Primary Care Visits</td>
<td>You pay $25</td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>You pay $15</td>
<td></td>
</tr>
<tr>
<td>Yearly Deductible</td>
<td>$0 / $0 (May Not Apply) Non Applicable</td>
<td></td>
</tr>
<tr>
<td>Total Expense Estimate</td>
<td>Higher 🍁</td>
<td></td>
</tr>
<tr>
<td>Quality Rating</td>
<td>★★★★★</td>
<td></td>
</tr>
<tr>
<td>Dr. Hong Mai</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Dr. Andrew Mano...</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Community Hosp...</td>
<td>☑</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oscar Gold 80 EPO</th>
<th>ADD TO CART</th>
<th>VIEW DETAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Premium</td>
<td>GOLD EPO</td>
<td>$448.19 after 2.00 tax credit</td>
</tr>
<tr>
<td>Primary Care Visits</td>
<td>You pay $25</td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>You pay $15</td>
<td></td>
</tr>
<tr>
<td>Yearly Deductible</td>
<td>$0 / $0 (May Not Apply) Non Applicable</td>
<td></td>
</tr>
<tr>
<td>Total Expense Estimate</td>
<td>Higher 🍁</td>
<td></td>
</tr>
<tr>
<td>Quality Rating</td>
<td>★★★★★</td>
<td></td>
</tr>
<tr>
<td>Dr. Hong Mai</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Dr. Andrew Mano...</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Community Hosp...</td>
<td>☑</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Molina Healthcare Platinum 90 HMO</th>
<th>ADD TO CART</th>
<th>VIEW DETAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Premium</td>
<td>PLATINUM HMO</td>
<td>$487.40 after 2.00 tax credit</td>
</tr>
<tr>
<td>Primary Care Visits</td>
<td>You pay $15</td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>You pay $5</td>
<td></td>
</tr>
<tr>
<td>Yearly Deductible</td>
<td>$0 / $0 (May Not Apply) Non Applicable</td>
<td></td>
</tr>
<tr>
<td>Total Expense Estimate</td>
<td>Higher 🍁</td>
<td></td>
</tr>
<tr>
<td>Quality Rating</td>
<td>★★★★★</td>
<td></td>
</tr>
<tr>
<td>Dr. Hong Mai</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Dr. Andrew Mano...</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Community Hosp...</td>
<td>☑</td>
<td></td>
</tr>
</tbody>
</table>

"Default" display of plans is from lowest to highest by total cost (including premium and likely out-of-pocket costs).

Plans are rated on overall quality based on feedback from Covered California members.

Consumers can search to see if a desired physician is in the plan’s network.
Covered California 2017 Patient-Centered Benefit Designs

In California, standard benefit designs allow apples-to-apples plan comparisons and seek to encourage utilization of the right care at the right time with many services that are not subject to a deductible. Benefits below shown in blue are not subject to a deductible.

### 2017 PATIENT-CENTERED BENEFIT DESIGNS BY METAL TIER

<table>
<thead>
<tr>
<th>Coverage Category</th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Wellness Exam</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Primary Care Visit</td>
<td>$75</td>
<td>$35</td>
<td>$30</td>
<td>$15</td>
</tr>
<tr>
<td>Specialty Care Visit</td>
<td>$105</td>
<td>$70</td>
<td>$55</td>
<td>$40</td>
</tr>
<tr>
<td>Urgent Care Visit</td>
<td>$75</td>
<td>$35</td>
<td>$30</td>
<td>$15</td>
</tr>
<tr>
<td>Emergency Room Facility</td>
<td>Full cost until out-of-pocket maximum is met</td>
<td>$350 once medical deductible is met</td>
<td>$325</td>
<td>$150</td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>$40</td>
<td>$35</td>
<td>$35</td>
<td>$20</td>
</tr>
<tr>
<td>X-Ray and Diagnostics</td>
<td>Full cost until out-of-pocket maximum is met</td>
<td>$70</td>
<td>$55</td>
<td>$40</td>
</tr>
</tbody>
</table>

**Deductible**

<table>
<thead>
<tr>
<th>Individual:</th>
<th>$5,300 medical $500 drug Family:</th>
<th>$12,600 medical $1,000 drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>$6,800 individual and $13,600 family</td>
<td>$6,800 individual and $13,600 family</td>
<td>$6,750 individual and $13,500 family</td>
</tr>
<tr>
<td>$8,600 individual and $13,600 family</td>
<td>$8,600 individual and $13,600 family</td>
<td>$4,000 individual and $8,000 family</td>
</tr>
</tbody>
</table>

**Annual Out-of-Pocket Maximum**

Benefits shown in blue are not subject to any deductible. White corner = not subject to a deductible after first three visits. Copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, they will be at full cost until the out-of-pocket-maximum is met.

### 2017 PATIENT-CENTERED BENEFIT DESIGNS BY INCOME

<table>
<thead>
<tr>
<th>Coverage Category</th>
<th>Enhanced Silver 94</th>
<th>Enhanced Silver 87</th>
<th>Enhanced Silver 73</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Based on Income and Premium Assistance</td>
<td>Covers 94% average annual cost</td>
<td>Covers 87% average annual cost</td>
<td>Covers 73% average annual cost</td>
</tr>
<tr>
<td>Single Income Ranges</td>
<td>up to $17,655 (≤100% FPL)</td>
<td>$17,655 to $23,450 (&gt;100% to ≤200% FPL)</td>
<td>$23,451 to $29,425 (&gt;200% to ≤250% FPL)</td>
</tr>
<tr>
<td>Annual Wellness Exam</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Primary Care Visit</td>
<td>$5</td>
<td>$10</td>
<td>$30</td>
</tr>
<tr>
<td>Specialty Care Visit</td>
<td>$8</td>
<td>$25</td>
<td>$55</td>
</tr>
<tr>
<td>Urgent Care Visit</td>
<td>$5</td>
<td>$10</td>
<td>$30</td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>$8</td>
<td>$15</td>
<td>$35</td>
</tr>
<tr>
<td>X-Ray and Diagnostics</td>
<td>$8</td>
<td>$25</td>
<td>$65</td>
</tr>
<tr>
<td>Imaging</td>
<td>$50</td>
<td>$100</td>
<td>$300</td>
</tr>
</tbody>
</table>

**Deductible**

<table>
<thead>
<tr>
<th>Individual: $75 medical Family:</th>
<th>$150 medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>$650 medical $50 drug Family:</td>
<td>$1,300 medical $100 drug</td>
</tr>
<tr>
<td>$2,350 individual and $4,700 family</td>
<td>$2,350 individual and $4,700 family</td>
</tr>
<tr>
<td>$7,000 individual and $11,400 family</td>
<td></td>
</tr>
</tbody>
</table>

Benefits shown in blue are not subject to any deductible.

### DRUG COST SHARES — 30 DAY SUPPLY

<table>
<thead>
<tr>
<th>Category</th>
<th>Full cost up to $500, after deductible is met</th>
<th>Full cost up to $500, after deductible is met</th>
<th>Full cost up to $500, after deductible is met</th>
<th>Full cost up to $500, after deductible is met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs (Tier 1)</td>
<td>$15 or less</td>
<td>$15 or less</td>
<td>$5 or less</td>
<td>$5 or less</td>
</tr>
<tr>
<td>Preferred Drugs (Tier 2)</td>
<td>$55 after drug deductible</td>
<td>$55 after drug deductible</td>
<td>$15 or less</td>
<td>$15 or less</td>
</tr>
<tr>
<td>Non-preferred Drugs (Tier 3)</td>
<td>$80 after drug deductible</td>
<td>$75 or less</td>
<td>$25 or less</td>
<td>$25 or less</td>
</tr>
<tr>
<td>Specialty Drugs (Tier 4)</td>
<td>20% up to $250 after drug deductible</td>
<td>20% up to $250 after drug deductible</td>
<td>10% up to $250</td>
<td>10% up to $250</td>
</tr>
</tbody>
</table>
Covered California Enrollees Able to Choose Both Low Premium and Low Out-of-Pocket Designs

More than 68 percent of Covered California subsidy-eligible enrollees selected a Silver plan, which have NO deductibles for any out-patient services and 56 percent of all subsidy-eligible enrollees qualified for an “Enhanced Silver” plan, which means they benefit for Cost-Sharing Reduction subsidies, leading to lower out-of-pocket costs when accessing services.

2016 Subsidized Enrollment by Metal Tier

- Bronze: 25% (353,000)
- Silver: 12% (167,000)
- Silver Enhanced: 73% (145,000)
- Silver Enhanced: 87% (398,000)
- ENHANCED Silver Enhanced: 84% (237,000)
- Platinum: 3% (40,000)
- Gold: 4% (56,000)

Eliminating the direct federal support for the Cost-Sharing Reduction subsidy would result in federal spending in California of more than $220 million, due to increased APTC.¹

A few notes on monthly premium costs:

- 73 percent pay less than $150 per month per individual.
- More than 192,000 enrollees pay less than $25 per month per individual.
- For consumers enrolled in an Enhanced Silver 94 plan, more than half pay less than $50. In addition, these individuals pay only $3 for doctor visits.

Covered California’s Patient-Centered Benefit Design:

- Bronze — three office visits and lab work, not subject to deductible.
- Silver, Gold, Platinum — no deductibles on any outpatient services.

Source: Covered California enrollment data as of June 2016, including only subsidized enrollees who have paid for coverage.

Assuring Competition, Choice and Affordability

Eleven health plans participate in Covered California in different combinations across 19 rating regions. Covered California is also an entry point to Medi-Cal for those who qualify.
Absent Policy Changes, Premium Increases in 2019 Likely to Range From 12 – 32 Percent; Three Year Cumulative Increases from 36 to 94 Percent

Estimates reflect potential state average increases; some states and individual carriers could be higher or lower. Premium estimates reflect gross premiums and would be fully born by the 6 million Americans who do not receive subsidies. For those who receive subsidies, premium increases would likely be far less.

<table>
<thead>
<tr>
<th>Factors Affecting Premiums</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Trend for Individual Market</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Elimination of Individual Mandate Penalty</td>
<td>+7 to 15%</td>
<td>+2.5 to 10%</td>
<td>+ 2.5 to 10%</td>
</tr>
<tr>
<td>Enrollment effect due to decreases in federally facilitated marketplace states due to less marketing/shortened open-enrollment period</td>
<td>-2% to +9%</td>
<td>0% to +2%</td>
<td>0% to +2%</td>
</tr>
<tr>
<td>Association Health Plans and Short-Term Policies</td>
<td>+0.3% to 1.3%</td>
<td>+0.5 to 2%</td>
<td>+0.5 to 2%</td>
</tr>
<tr>
<td>Total Increase Effect</td>
<td>Range of 12% to 32%</td>
<td>Range of 10% to 21%</td>
<td>Range of 10% to 21%</td>
</tr>
<tr>
<td>Total Cumulative Effect</td>
<td>Range of 36% to 94%</td>
<td>Range of 36% to 94%</td>
<td>Range of 36% to 94%</td>
</tr>
</tbody>
</table>

See: Individual Markets Nationally Face High Premium Increases in Coming Years Absent Federal or State Action, With Wide Variation Among States (http://hbex.coveredca.com/data-research/library/CoveredCA_High_Premium_Increases_3-8-18.pdf)
National Variation in Potential Premium Increases for 2019 to 2021: From Bad to Really Bad

Federal and State Actions that Could Promote Stability Policy Actions That Could Promote Stability for 2019 and Beyond

- **Reinsurance**: State-based and/or national reinsurance programs, could have a dramatic impact on premiums and carrier participation in 2019.

- **Directly Fund Cost-Sharing Reduction (CSR) Subsidies**: Funding CSRs would not directly reduce premiums but would provide needed stability for health plans and reduce federal spending.

- **Increased Subsidies**: Increasing the financial assistance that is available to consumers would help more Americans afford coverage and increase the overall health of the consumer pools.

- **Increased Marketing and Outreach**: Increasing spending on targeting marketing promotes enrollment among healthier individuals and benefits federal taxpayers — who benefit from reduced per-person Advanced Premium Tax Credits — and those who do not receive subsidies and face lower premium increases.

- **State-Based Penalties for Non-Coverage**: States could adopt state-based penalties to promote enrollment.

- **State Regulations on Association Health Plans or Short-Term, Limited-Duration Plans**: States could adopt regulations that limit carriers from offering plans that do not provide comprehensive coverage or protect consumers with pre-existing conditions, which could harm the risk pool in the individual market.

- **Auto-Enrollment**: State or federal policies could promote automatic enrollment of eligible individuals, such as for those who lose employer-based coverage, earn too much for Medicaid or “age out” of coverage eligibility from parents plans.
Covered California is Promoting Improvements in the Delivery of Care

Covered California contract requirements to promote the triple aim of improving health, delivering better care and lowering costs for all Californians include:

**Promoting innovative ways for patients to receive coordinated care, as well as have immediate access to primary care clinicians**
- All Covered California enrollees (HMO and PPO) must have a primary care clinician.
- Plans must promote enrollment in patient-centered medical homes and in integrated healthcare models/Accountable Care Organizations.

**Reducing health disparities and promoting health equity**
- Plans must "track, trend and improve" care across racial/ethnic populations and gender with a specific focus on diabetes, asthma, hypertension and depression.

**Changing payment to move from volume to value**
- Plans must adopt and expand payment strategies that make a business case for physicians and hospitals.

**Assuring high-quality contracted networks**
- Covered California requires plans to select networks on cost and quality and in future years, will require exclusion of "high cost" and "low quality" outliers — allowing health insurance companies to keep outlier providers, but detailing plans for improvement.

Note: for detailed information about improvements in the delivery of care, Covered California requires health insurance companies to abide by Attachment 7 of the model contract. To view Attachment 7, go to [http://hbex.coveredca.com/stakeholders/plan-management/PDFs/Attachment_7_Individual_7-5-2016_Final_Clean.pdf](http://hbex.coveredca.com/stakeholders/plan-management/PDFs/Attachment_7_Individual_7-5-2016_Final_Clean.pdf)

Covered California Enrollees Have a Similar Distribution of Health Care Spend Compared to California Commercial Group Coverage

• A relatively small portion of enrollees account for the majority of health care spend.

• 4.4 percent of Covered California enrollees account for 65 percent of total spend in the 12 months ending September 2017. By comparison, the California commercial group coverage benchmark* shows 9 percent of enrollees accounting for 59 percent of spend.

• Conversely a relatively high portion of enrollees have no healthcare claims.

• One-third of Covered California enrollees did not have a health care claim submitted in the 12 months ending in September 2017. Similarly, 22 percent of California Commercial Group Coverage benchmark* members did not have a claim in the year.

Based on twelve months ending Sept. 2017
* IBM Watson Health MarketScan®, Copyright © 2017 Truven Health Analytics LLC. All rights Reserved.
Each Year, Approximately Forty Percent of the Covered California Individual Market Turns Over*

While Covered California’s consumers experience a high level of coverage transitions, nearly 85 percent of those who leave Covered California report transitioning to other coverage.

* Based on a recently completed Covered California 2016 survey of members (n=8,773) who left ("disenrolled"), the vast majority left for employer-based or other coverage.

California’s Health Care Coverage Transitions (2016 Survey)

- Prior to 2014, Covered California forecasted that about one-third of enrollees would leave coverage on an annual basis.
- During 2015, Covered California covered 1.6 million unique members for at least one month.
- By early 2016, approximately 40% of those 1.6 million (over 600,000) had ‘disenrolled’.
- Of those who left Covered California, most went to employer-based coverage (50%).

- 60% still covered
- 34% other coverage
- 6% uninsured
Coverage Transitions in 2016: Comparing California to FFM Survey Data

While we do not have data on where consumers go when they leave other state-based marketplaces, it is very troubling that the latest data from the Centers for Medicare and Medicaid Services shows that consumers who leave the federal exchange are more than three times as likely to become uninsured as are those leaving Covered California.

Information for consumers
CoveredCA.com

Information on exchange-related activities
hbex.CoveredCA.com