



Covered California's First Five Years: Improving Access, Affordability and Accountability



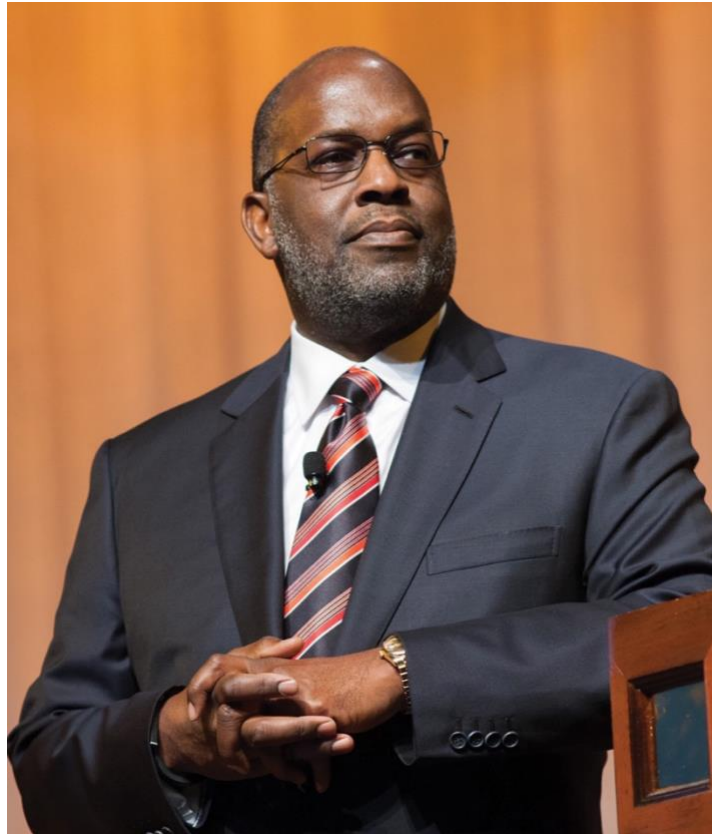
December 2019

Cover Image

This report provides data and analysis on Covered California efforts to improve the performance of California's health care system and to ensure that its members receive affordable, high quality care. The people featured on the cover are individuals who have benefited from these efforts. Their stories — and those of others told here <https://www.coveredca.com/real-stories/> — go beyond the data to provide personal perspectives on what Covered California has achieved over the past five years.

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Dedication



Bernard J. Tyson

January 20, 1959 – November 10, 2019

Covered California dedicates this report to the memory Bernard J. Tyson, chairman and CEO of Kaiser Permanente. Mr. Tyson devoted his life to helping others, leading the way in the state and nation to examine and address health disparities and support the expansion of affordable health care in America. We take inspiration from his leadership and remain committed to his vision ensuring quality health care for all.



Dec. 18, 2019

In 2010, California became the first state in the nation to enact legislation to establish a state-based health insurance exchange under the auspices of the Patient Protection and Affordable Care Act (ACA). Covered California was officially established in 2011 as an independent state entity governed by a Board of Directors, followed by the subsequent development of a vision statement that has guided Covered California since its inception: *To improve the health of all Californians by assuring their access to affordable, high-quality care.*

Covered California was established by California, for Californians, and our independent board has provided critical leadership as we have engaged the range of partners across the state in crafting and implementing the Affordable Care Act. Under the leadership of our board, in particular board chairs Diana Dooley, former Health and Human Services (HHS) Secretary and our current chair, HHS Secretary Mark Ghaly, MD., Covered California has been held to the highest standard of public accountability. With their direction, Covered California has leveraged its role to create and foster a marketplace where plans compete and are held accountable. The guidepost of all of our efforts is what will benefit consumers.

The work of Covered California has been enabled and guided by legislative and executive branch leadership in the state that has fully embraced the Affordable Care Act. In recent years it has sought to actively build on and go beyond the ACA on the path to universal coverage. Almost 10 years ago, the republican governor, Arnold Schwarzenegger, signed into law the establishment of Covered California, laying the groundwork for today's structure of an independent, self-funded advocate for California's consumers. Gov. Jerry Brown used one of the most important tools of the ACA — the ability to expand state Medicaid programs — to bring millions of Californians into coverage through Medi-Cal. And, Gov. Gavin Newsom has launched bold programs that defend consumers in California by reinstating the mandate rolled back nationally. He and the legislature have also built on and gone beyond the ACA to expand financial help to almost 1 million Californians, including first-in-the-nation help for middle class Californians, many whom were paying large portions of their income for health care coverage.

While Covered California has focused on effectively implementing the ACA, we have also been mindful of our responsibility to share data on what is and is not working to inform both our efforts and the work of policymakers in California and nationally. It is in this vein that we release "Covered California's First Five Years: Improving Access, Affordability and Accountability," which provides an overview of Covered California's activities and achievements in its first five years, during which we have provided health insurance to millions of Californians.

There have been many individuals and organizations that have contributed to Covered California's achievements to the benefit of California consumers — policymakers, health insurers, consumer advocates, counties, community-based organizations and agents, to name a few. This said, Covered California specially dedicates this report to Bernard J. Tyson CEO, of Kaiser Permanente, who recently passed away. Bernard embodied unparalleled passion and leadership. His work to transform health care delivery, and his drive for justice in health care and quality have left a lasting imprint on California and the nation.

Sincerely,

Peter V. Lee
Executive Director

Covered California's First Five Years: Improving Access, Affordability and Accountability

Introduction

The United States health care system has long faced serious problems: inadequate access to care, uneven quality, rising costs and persistent racial, ethnic, socioeconomic and geographic disparities. The passage of the Patient Protection and Affordable Care Act in 2010 created an opportunity to address these problems. California has undertaken a range of efforts to implement and even go beyond the Affordable Care Act, such as its early expansion of coverage through its Medicaid program, and, more recently, its decision to provide state-funded subsidies to secure greater affordability as it reintroduces the individual responsibility to have health insurance. These new subsidies supplement federal subsidies and give first-in-the-nation support to middle-class Californians.

In addition to providing resources to expand coverage, the Affordable Care Act authorized the creation of state-based health insurance marketplaces with the capacity and authority to influence how health care is delivered. California was the first state to pass legislation to form a state-based marketplace. Covered California — the largest state-based marketplace in the nation — has worked to leverage its authority and influence to lower health care costs and improve the health and health care not only for its enrollees and those in the individual market, but also for all Californians.¹ Key accomplishments of the past five years are summarized on the following page.

This report describes provides an overview of how California — the state government, Covered California, and other stakeholders — are working together to improve health system performance and the impact that has been achieved over the past five years. A companion report — [Covered California Holding Health Plans Accountable for Quality and Delivery System Reform](#) — describes how Covered California is holding itself and its contracted health insurers accountable for assuring quality care and promoting delivery system reform. It provides detailed descriptions of Covered California's work to assure that its contracted insurers are actively working to deliver high-quality care, address health disparities and promote improvements in how care is delivered.

¹ Beginning with the inaugural 2014 plan year and updated in 2017, Covered California set forth standards and strategies for quality improvement and delivery system reform in its qualified health plan contract, specifically in the section of the contract titled "Attachment 7: Quality, Network Management, Delivery System Standards and Improvement Strategy". See more: https://hbex.coveredca.com/insurance-companies/PDFs/Attachment-7_2020_Clean_Final-Model.pdf. Covered California is in the process of working to update its contract terms for the 2022-24 plan years and is seeking to provide concrete requirements that will address the "Triple Aim" of lowering costs, improving quality and improving health outcomes with a focus on promoting health equity.

California's First Five Years Implementing the Affordable Care Act: Major Impacts in Affordability and Accountability

California was the first state to establish a state-based marketplace — under a Republican governor — and ever since then has sought to implement the Affordable Care Act as effectively as possible for the benefit of the state's consumers. State actions included expanding Medi-Cal, the state Medicaid program; building Covered California as the public entity responsible for creating a consumer-driven marketplace and holding health plans accountable; and most recently, enacting reforms to stabilize insurance markets and further improve affordability. This report, "Covered California's First Five Years: Improving Access, Affordability and Accountability," describes in detail both the strategies and their impacts. Major impacts include:

- Coverage expansion reduced the uninsured rate in California from 17 percent in 2013 to 7.2 percent in 2018, the largest drop in any state.
- Stable participation by health insurers has contributed to robust competition that, along with healthier enrollment, has saved unsubsidized enrollees more than \$1,000 annually, with estimated savings to enrollees and the federal government of \$12.5 billion from 2014 to 2018. At the same time, enrollees remained more satisfied with their health plan and overall health care than those in other states.
- Covered California's 11 health insurance companies are responding to requirements to address disparities in health care, which will likely affect not only their Covered California enrollees, but also their estimated 19.5 million enrollees in California.
- Two health insurance companies with integrated delivery systems, Kaiser Permanente and Sharp Health Plan, are ranked in the top 10 percent of all U.S. health insurers in most measures of quality. Quality performance across the other nine insurers, however, was highly variable and often in need of improvement.
- Covered California's push toward delivery reform to improve value and system performance has resulted in about 25 percent of enrollees being cared for in an Accountable Care Organization (ACO) in 2018, far exceeding state and national benchmarks. Analysis of variation among diverse models should identify best practices and assist ACOs in fulfilling their potential to match the performance of integrated delivery systems.
- By aligning with other stakeholders, Covered California has helped achieve important gains in hospital patient safety, in the prevention and treatment of opioid use disorders and in the reduction of low-risk C-section rates.

This report focuses on the four core approaches Covered California has taken to improving health system performance:

- 1. Create an effective consumer-driven marketplace:** Covered California operates an effective consumer-driven marketplace, creating a level playing field where consumers benefit from meaningful competition and expanded enrollment. High enrollment, a healthier risk mix than is seen nationally and robust competition have helped to slow premium growth and to lower costs, which is likely to have saved enrollees and the U.S. Treasury an estimated \$12.5 billion over the past five years.
- 2. Hold health insurance companies accountable for improving quality and advancing delivery reform:** Covered California holds health insurers accountable through its selection of who can participate in the marketplace and through an array of reporting and performance requirements. Covered California also requires insurers to promote advanced primary care² as well as integrated and coordinated care. There is a documented association of these approaches with better care, and an increasing proportion of Covered California enrollees are receiving care through these approaches. Although meaningful improvement on many key quality measures has been achieved, marked variation in performance across insurers underscores the benefit of care that is integrated and coordinated, and it reveals that much more improvement is possible.³
- 3. Align efforts to foster systemic change:** Covered California recognizes the imperative of working with others to change how care is delivered. By working with other purchasers, providers and consumers, Covered California has helped catalyze major gains in patient safety, maternity care, the prevention and treatment of opioid use, and in performance measurement for both hospitals and physician practices.
- 4. Use data and evidence to drive continuous improvement:** Covered California continuously reviews and reflects on what is working to improve care in order to refine future requirements and inform multi-stakeholder collaborations in ways that will increase impact while reducing burdensome, unnecessary requirements.

² There are several key attributes of advanced primary care models. These models maintain continuous patient-provider relationships. They are person- and family-centered, comprehensive and equitable, team-based and collaborative, and coordinated and integrated, accessible, and high-value. See more: <https://www.pcpcc.org/about/shared-principles>.

³ The details of contract requirements related to improving quality and delivery system reform are set forth in the section of the contract titled "Attachment 7: Quality, Network Management, Delivery System Standards and Improvement Strategy". See more: https://hbex.coveredca.com/insurance-companies/PDFs/Attachment-7_2020_Clean_Final-Model.pdf.

National Context and California Responses

The Affordable Care Act's Core Domains; Recent Federal Actions to Undercut or Reinforce the ACA; and California's Actions to Protect, Reinforce, and Build on the ACA

The Affordable Care Act (the ACA or the Act) has had an indelible impact on the lives of millions of Americans throughout the nation. It has provided a solid and resilient foundation of transformative policies upon which the promise of affordable, high-quality health coverage has been realized by many individuals and families since its enactment nearly 10 years ago. Among its fundamental tenets are four groundbreaking consumer-protective policies that serve as cornerstone principles to successful health reform in our nation:

- **Ensure Meaningful Coverage for Everyone**
- **Concretely Address Consumer Affordability**
- **Foster Consumer Choice**
- **Hold Health Plans Accountable**

When fully and properly implemented, as it has been in California, the ACA has delivered on each of these areas resulting in healthy, stable markets where millions of consumers have gained access to affordable, high-quality coverage that gives them financial protection and peace of mind knowing they can get care when in need. At the same time, some states have chosen to forgo implementation of some of the keystone provisions of the ACA. For example, while the vast majority of states have chosen to expand their Medicaid programs, 14 states⁴ have elected not to expand Medicaid coverage, leaving millions of uninsured, low-income adults without an affordable coverage option. In addition, in the past three years, multiple federal policy actions have diminished the integrity of the Act by reversing key ACA policies; reducing or eliminating federal support designed to improve affordability and maintain healthy, stable enrollment; and, promoting non-ACA-compliant plans that leave consumers vulnerable to exclusion or inadequate coverage when in need of care.

In stark contrast to federal efforts to undo the ACA, California not only continues to fully embrace the Act by taking actions to counter or respond to federal policies, it has also implemented policies that build on the ACA in significant ways to the benefit of consumers. Through the leadership of the Governor and Legislature, the state has made significant investments to bolster affordability and expand access to coverage by offering state subsidies that offer additional financial assistance to those currently receiving federal subsidies and, for the first time in the nation, extend financial assistance to consumers with incomes over 400 percent of the federal poverty level who are not eligible for federal subsidies. Covered California continues to leverage its role to create and foster a marketplace where plans compete and are held accountable to rigorous contractual standards, and to promote healthy, stable enrollment through significant investments in marketing and outreach which helps keep costs low and fosters robust choice among plans. Consumers, both on- and off-exchange, reap the benefits of these efforts through lowered premiums, choice, and quality among plans.

⁴ Status of State Medicaid Expansion Decisions; November 2019; Kaiser Family Foundation <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>

The bulk of this report documents how Covered California has implemented the ACA and displays the results of those actions. Those results are the best evidence available to-date of what happens when states' seek to deliver on the promise of the Affordable Care Act and stand in stark contrast to the results in much of the nation — where millions of low-income Americans have no option for Medicaid, where millions of middle-class Americans have been priced out of coverage, and where there is often limited competition with health plans not being held accountable. Before reviewing these results, however, it is important to put them in the context of: (1) the goals the Affordable Care Act sought to achieve; (2) recent changes in federal policies; and (3) how California has acted to ensure the tools of the ACA are fully used to benefit its consumers.

The following outlines the differences between federal action and that of California to protect and build on the key principles of the ACA:

1. Meaningful Coverage for Everyone

The ACA enacted landmark market reforms to ensure that no one can be turned away from coverage and that once a consumer got coverage, they would have access to affordable high-quality care. It prohibits plans from denying coverage on the basis of pre-existing conditions and from discriminating against consumers based on health status, price, or other factors. It prohibits annual and lifetime coverage limits and requires plans to cover a standard set of 10 essential health benefits to ensure consumers have comprehensive coverage that will protect them when they need care. These policies contrast to those in the individual market prior to the ACA where consumers were either rejected from coverage, or, when they did get coverage, got “swiss-cheese” coverage that failed to offer the care they needed when they sought care. (See Appendix, Chart 1: Meaningful Coverage for Everyone.)

2. Concretely Address Consumer Affordability: The ACA's expansion of Medicaid provided coverage for millions of low-income Americans across the country, and the provision of federal premium and cost-sharing subsidies helped bring coverage within reach of millions more. The Act also set forth critical market stabilization policies designed to foster healthy risk and stable enrollment that help lower premiums such as the individual mandate and penalty, an expanded open enrollment period, risk selection protection (reinsurance, risk adjustment and risk corridors), and marketing and navigator programs to promote enrollment. Offering subsidized enrollment and other policies were key to getting a large and healthy population enrolled in the individual market to keep premiums low for those not eligible for subsidies. In addition to programs targeting the individual market, the ACA also took steps to address underlying health care costs, such as building on payment reforms in Medicare to move away from fee-for-service — which can promote unneeded services — and the establishment of the Center for Medicare and Medicaid Innovation to foster new delivery systems to lower costs both for those enrolled in public programs and those enrolled in the private marketplace. (See Appendix, Chart 2: Consumer Affordability.)

3. Foster Consumer Choice: The ACA aims to harness competition and choice in the market in order to improve coverage, affordability, access to care, and consumer satisfaction. Consumer choice relies on plan participation with the need for a stable market that provides health plans some certainty regarding the number and health status of enrollees being a vital element. The Act also set forward policies such as reinsurance and risk adjustment to

foster plan participation and ensure choice among consumers. (See Appendix, Chart 3: Foster Consumer Choice.)

- 4. Accountability:** Ensuring accountability among plans is a core principle of the ACA which provides tools to ensure plans spend the majority of premiums on health care and meet quality standards. It also provides flexibility for states, like California, to impose rigorous standards for qualified health plans to benefit consumers. (See Appendix, Chart 4: Health Plan Accountability.)

This report and its companion, [Covered California Holding Health Plans Accountable for Quality and Delivery System Reform](#), detail how California and Covered California have worked to both protect and implement the ACA as effectively as possible. It also includes the results of those actions. While it is outside of the scope of this report to assess and analyze how the ACA has been implemented in other states or the results of that implementation, in many ways the indications are clear that states that have taken advantage of and expanded the tools of the ACA have seen greater success in enrollment than those states that have adopted the policies intended to undo the ACA.

California Creating an Effective Consumer-Driven Marketplace

Design Principles and Early Work

California embraced the Affordable Care Act's goal of improving health care coverage by expanding health care access and creating a marketplace that works for consumers. As presented in a 2017 Covered California report, [Key Ingredients to Creating a Viable Individual Market That Works for Consumers: Lessons From California](#), California's success in expanding coverage and creating a competitive marketplace can be attributed to the following actions:

- **Early policy actions that promoted market stability:** Early policy actions were critical to success. Expanding California's Medicaid program, known as Medi-Cal, allowed millions to gain coverage directly, while also benefiting those in the individual market. States that expanded Medicaid have seen a more dramatic reduction in their rates of uninsured residents and have individual market premiums that are 7 percent lower than states that did not expand their Medicaid program.⁵
- **Active negotiation:** Through active and extensive vetting and negotiations with health insurance companies on rates, network composition and delivery-system requirements, Covered California ensures that consumers have a choice among multiple insurers that are stable and provide value.⁶
- **Ensuring that plan designs promote access and enable comparison shopping:** All plans sold in Covered California, and in the off-exchange individual market where the vast majority of enrollment is in plans that "mirror" Covered California plans in benefits

⁵ Sen, A. P., and DeLaria, T. C. (2016). The effect of Medicaid expansion on marketplace premiums. Washington D.C.: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

⁶ Covered California decided against a "clearinghouse" model — in which any health insurance company and plan design is accepted — and instead chose to take a more active role in fostering competition in the marketplace and value among plan choices for consumers.

and price,⁷ are designed to promote access to needed care, including having most outpatient care, such as primary care visits and lab tests, not being subject to any deductible for Silver and higher metal tiers.⁸ Benefit designs and cost-sharing levels are the same across all of Covered California's 11 health insurance companies for each metal tier, which enables apples-to-apples comparison of premiums, providers and quality.

- **Extensive marketing and outreach:** Selling health insurance is uniquely difficult. While sick individuals are motivated to buy health insurance, healthier people need to be reminded of the value of coverage. In [Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets](#), Covered California describes how investments in marketing have attracted a healthier risk pool, helped to lower premiums and encouraged health insurance company participation.

Through the combined effects of these actions, the state of California and Covered California in particular have demonstrated the positive impacts of effective policies and implementation of the Affordable Care Act, including:

- **Biggest drop in uninsured rate in the nation:** The uninsured rate in California has decreased from over 17 percent in 2013 before the implementation of the Affordable Care Act to 7.2 percent in 2018, representing the largest overall drop in the rate of uninsured in the nation.⁹ Because a large portion of California's residents are undocumented, the progress in getting those eligible for state and federal programs covered has been even more striking, with the eligible uninsured rate dropping to about 3 percent in the same period.¹⁰
- **Unsubsidized Californians have some of the lowest premium increases in the nation due to a healthy risk mix:** Covered California has maintained a vibrant and large unsubsidized individual health care market, where those without subsidies benefit from California consistently being among the states enrolling the healthiest risk pool in the nation. Between 2014 and 2019, the average national benchmark premium has increased by over 79 percent, while in California the average premium increase was 45 percent (see Figure 1. California and National Benchmark Premium Growth — 2014 to 2019). Many states across the nation have maintained enrollment of those receiving subsidies, largely from strong renewals, while new enrollment has plummeted and the

⁷ Off-exchange mirror plans are identical to plans sold in Covered California, having the same benefit design and gross premium.

⁸ Outpatient services include primary care visits, specialist visits, urgent care, lab tests, X-rays, imaging and other services. Bronze plan enrollees can have three primary care or specialist visits without needing to satisfy a deductible. Further details on how this alignment of benefit design with delivery reform promotes better care can be found [here](#).

⁹ United States Census Bureau, 2013 American Community Survey (2013). American Community Survey Tables for Health Insurance Coverage. Retrieved from: <https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.2013.html>; and United States Census Bureau, 2018 American Community Survey (2018). American Community Survey Tables for Health Insurance Coverage. Retrieved from: <https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.2018.html>

¹⁰ Dietz, M, Graham-Squire, D, Becker, Chen, X, Lucia, L, and Jacobs, K. (2016, August). Preliminary CalSIM v 2.0 Regional Remaining Uninsured Projections. UCLA Center for Health Policy Research & UC Berkeley Labor Center. Retrieved from: <http://laborcenter.berkeley.edu/pdf/2016/Preliminary-CalSIM-20-Regional-Remaining-Uninsured-2017.pdf>.

unsubsidized enrollment has dropped dramatically.¹¹ Fortunately, this has not been the reality for California's consumers. The steep increases in premiums in the rest of the nation have two main impacts:

- First, there was a dramatic decrease in the number of new enrollments. In the individual markets in the states served by the federal marketplace ("FFM," or federally facilitated marketplace), new enrollment has declined by 38 percent between 2016 and 2018 — dropping from 4 million new enrollees to 2.5 million, while in California new enrollment in the same two years dropped 9 percent (from roughly 425,000 to 388,000).¹² Garnering new enrollment is vital to make sure those who need insurance buy it and to keep the risk pool as healthy as possible (which keeps costs low for those not receiving subsidies and the federal government) since generally healthier individuals are more apt to leave coverage.
- Second, in the same two-year period — from 2016 to 2018 — the national unsubsidized individual market enrollment declined by 2.3 million, a decrease of 44 percent, for the on and off-exchange individual market. However, there was only a 17 percent drop in unsubsidized enrollment in California in those two years (see Figure 2: Unsubsidized Enrollment in Individual Markets – Federally Facilitated Marketplace (FFM) States Compared to California: 2015-2018).¹³ This means that if the nation's rate of coverage were similar to California's, there would be about 1.5 million more Americans with individual market coverage from those two years alone.

By keeping costs down through the relatively healthy risk mix, California has successfully retained a large unsubsidized individual market — almost one million Californians as of 2019 — who are enrolled in good coverage that will meet their needs in the event of major health events.

And additional indication of California's success compared to much of the nation can be found in a recent study conducted on health care costs.¹⁴ This study found that while California was one of the most expensive states in the nation for health care — as measured by the average costs for seven common procedures paid in the commercial market — the 2019 premiums in the individual market were 5 percent lower than the national average, even though in 2015 California individual market premiums were 9 percent higher than the national average.

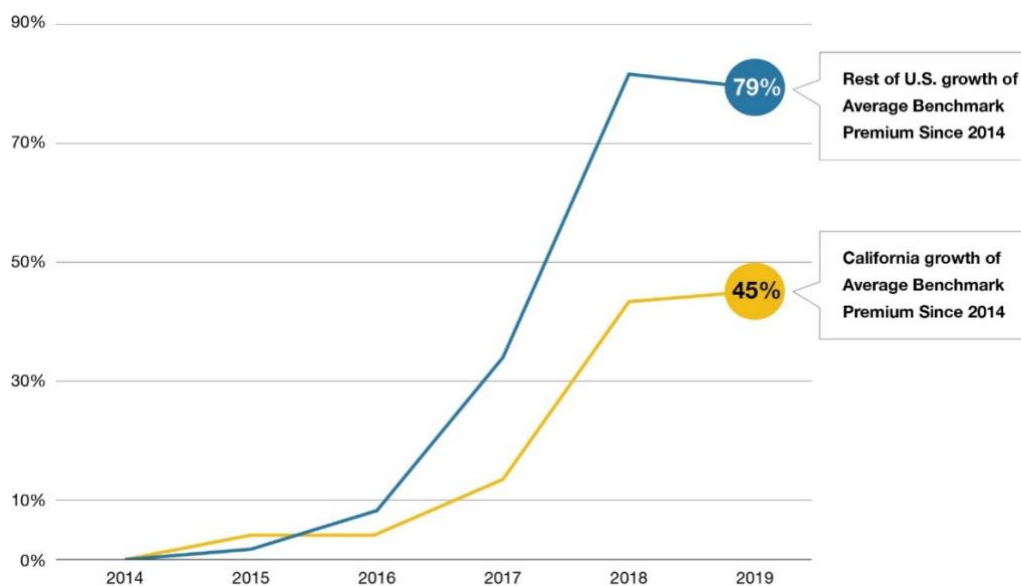
¹¹ Keith, K. (2019, August 13). CMS Issues New Reports on Marketplace Enrollment. Health Affairs blog. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20190813.981115/full/>.

¹² Centers for Medicare and Medicaid Services (CMS). "Marketplace Open Enrollment Period Public Use Files" for 2017, 2018 and 2019: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index>

¹³ Analysis of data from Centers for Medicare and Medicaid Services (CMS). "1 Trends in Subsidized and Unsubsidized Enrollment" (August 12, 2019): <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY17-18.pdf>

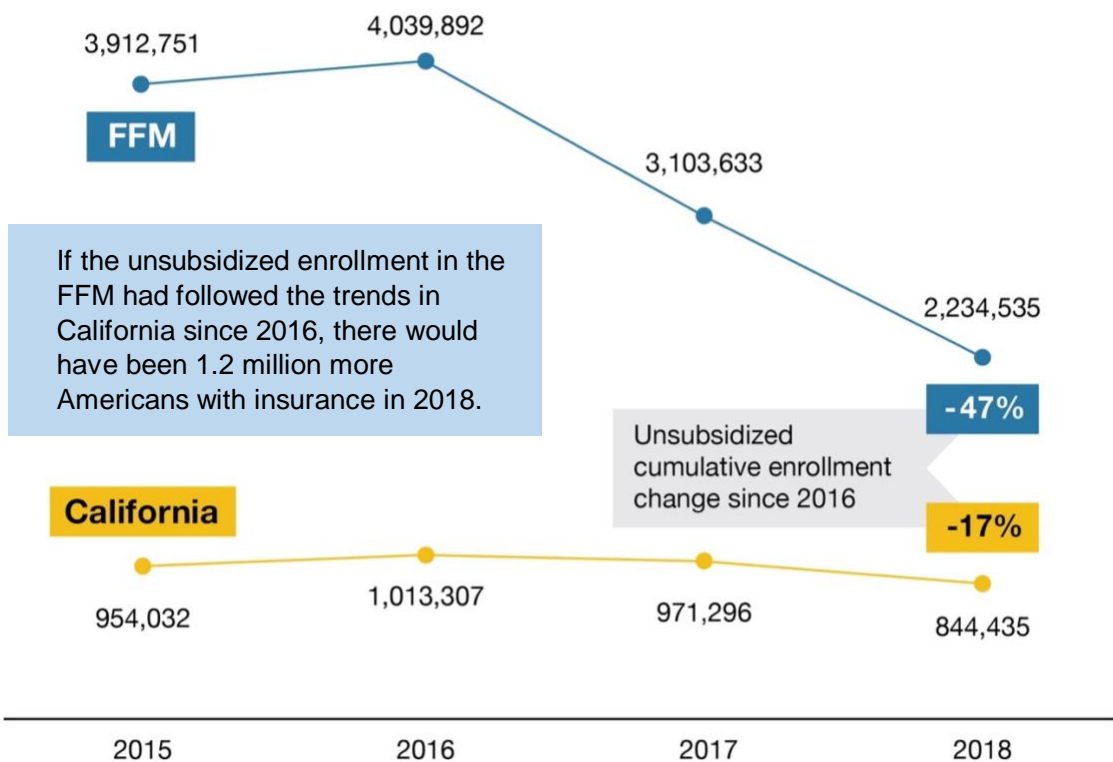
¹⁴ Scheffler, R, Arnold, D and Fulton, B. (October 2019). The Sky's the Limit: Health Care Prices and Market Consolidation in California. California Health Care Foundation. Retrieved from: <https://www.chcf.org/wp-content/uploads/2019/09/SkysLimitPricesMarketConsolidation.pdf>.

Figure 1. California and National Benchmark Premium Growth — 2014 to 2019



Source: Covered California analysis of CMS Data. Retrieved from <https://www.cms.gov/>.

Figure 2: Unsubsidized Enrollment in Individual Markets — Federally Facilitated Marketplace (FFM) States Compared to California: 2015-2018



Source: CMS, Trends in Subsidized and Unsubsidized Enrollment, August 12, 2019.

- **Robust competition driving value for consumers:** Continuous participation by 10 health insurance companies since the launch of Covered California in 2014 and the addition of one insurer in 2016 promotes robust competition in the marketplace, which helps keep premium costs low for consumers. Health insurance companies know that if they are priced significantly higher than their competition, consumers will “vote with their feet.” California’s individual marketplace has been marked by stability and broad choice of insurer, with ten health plans participating in the exchange market place from 2014 through 2020 and a totally of eleven plans now in the market. Economic analysis has demonstrated the effect of increased competition on lowering costs in the individual insurance markets¹⁵ — in California 87 percent of enrollees can choose from at least three insurers, with 56 percent having five or more. The robust competition in California contrasts to many other areas around the nation. The number of issuers participating in exchanges nationally has seen dramatic fluctuation nationally over the past five years, with significant growth in the number of health plans participating in exchanges in the past two years (2019 and 2020). While one-in-ten exchange enrollees nationally will be in markets with only one insurer in 2020, that represents a dramatic decrease from 2018, when 26 percent of enrollees had only one insurer. Nonetheless, most of the nation still suffers from far less consumer power to drive their markets, with 67 percent of enrollees nationally outside of California being able to choose three or more health insurers (and 27 percent five or more).¹⁶ The enrollment within each insurer is a testament to the fact that health care is local, with local health insurance companies often having significant enrollment in the areas they serve — providing important competition (see Table 1. Statewide and Regional Enrollment for Covered California Insurers — 2019).

¹⁵ Unpublished research from Wes Yin, PhD, University of California, Los Angeles, communication, December 2019.

¹⁶ Kaiser Family Foundation analysis downloaded December 2019, with additional analysis by Covered California to separately identify California-specific enrollment options.

Table 1. Statewide and Regional Enrollment for Covered California Insurers — 2019

Health Insurance Company	Total Enrollment	Percent of Statewide Enrollment	Percent of Service Area Enrollment	Service Area Description
Kaiser Permanente	477,683	34.3%	38.2%	Nearly statewide*
Blue Shield of California	428,498	30.8%	30.8%	Statewide
Anthem	64,031	4.6%	35.1%	Northern counties, Santa Clara and Central Valley
Valley Health Plan	16,366	1.2%	28.3%	Santa Clara
LA Care	84,750	6.1%	21.8%	Los Angeles
CCHP	10,013	0.7%	19.7%	San Francisco and San Mateo
Health Net	191,650	13.8%	17.7%	Greater Sacramento Area, North Bay Area, San Francisco, Central California and Southern California
Sharp Health Plan	17,335	1.2%	15.9%	San Diego
Molina Healthcare	56,023	4.0%	7.5%	Southern California
Oscar Health Plan	35,962	2.6%	6.6%	San Francisco, Los Angeles and Orange
Western Health Advantage	9,386	0.7%	7.3%	North Bay Area and Greater Sacramento Area

Note: Service area enrollment is calculated by dividing the insurers' enrollment by the total enrollment in the service area. *Kaiser Permanente has a presence in all regions in California, but in some regions offers partial coverage. Blue Shield of California is the only insurer with a full presence in every ZIP code in California.

- Lower premiums have benefited unsubsidized consumers and the federal Treasury:** Savings in lower per-person premiums have largely benefited unsubsidized California enrollees and the U.S. Treasury. Between 2014 and 2018, Covered California's risk scores were approximately 20 percent below the national average for the individual market, resulting in likely savings of approximately \$2.5 billion per year for enrollees and the U.S. Treasury, which translates to approximately \$12.5 billion in savings over this five-year period (see Figure 3. California's Combined Impact on Lowering Costs in the Individual Market — 2014-2018 [in billions]).^{17,18} The savings to the U.S. Treasury resulting from lower Advanced Premium Tax Credits are important,

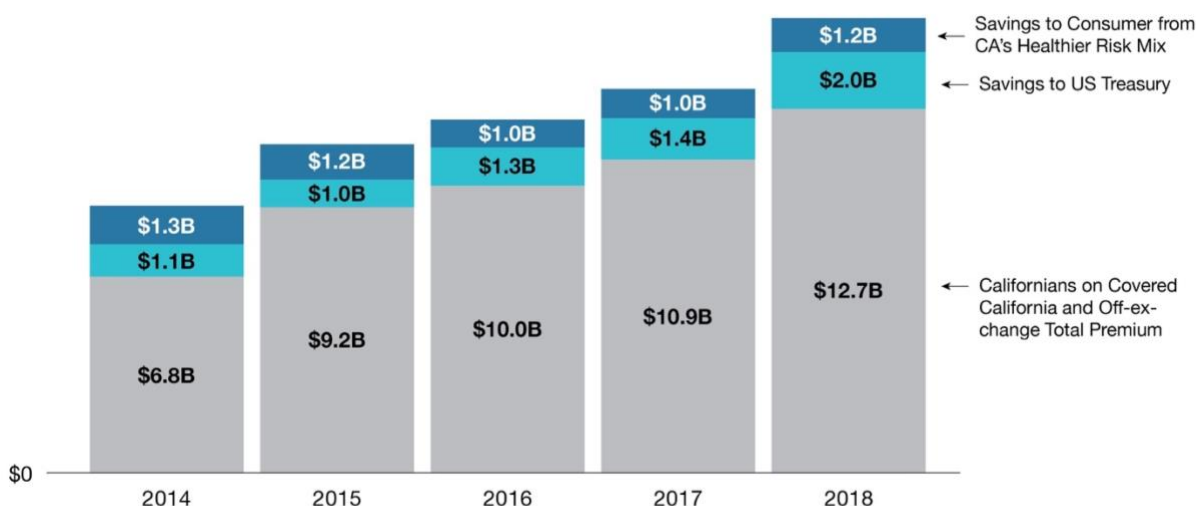
¹⁷ For risk score differences, see: Bingham, A., Cohen M., and Bertko J. (2018). National vs. California Comparison: Detailed Data Help Explain the Risk Differences Which Drive Covered California's Success. Health Affairs blog. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20180710.459445/full/>. Covered California analysis savings derived using data from CCIIO (see [risk-adjustment reports](#)), CMS (effectuated enrollment snapshots, such as [this example](#)), and Covered California's own administrative data. Savings were determined by holding observed enrollment constant and estimating hypothetical premiums if the risk mix in California had mirrored that of the rest of the nation in each of the respective years (using the enrollment-weighted average risk score for all states for which risk adjustment data are reported, excluding California).

¹⁸ The 2018 Covered California Silver-tier gross premium increased by an additional 12.5 percent to provide insurers with funding to pay cost-sharing reductions (CSR) in certain Silver-variant plans because of the end of the CSR payments from Centers for Medicare and Medicaid Services (CMS).

but the lower premium costs for unsubsidized enrollees are especially so. On an annual basis, the lower costs to unsubsidized enrollees mean their average annual premium is \$1,080 to \$1,560 less than those enrollees would have paid if the risk mix had been similar to that seen in the rest of the nation (see Figure 4. California’s Healthier Risk Mix Leads to Lower Premium Costs for Unsubsidized Enrollees).

These reduced costs not only mean real savings for unsubsidized enrollees, but for many, the lower annual costs are the difference between buying insurance and going without coverage. Because those most likely to be financially motivated to drop coverage are healthier individuals, these lower costs encourage healthier individuals to get or retain coverage, which in turn helps foster a healthier risk mix.

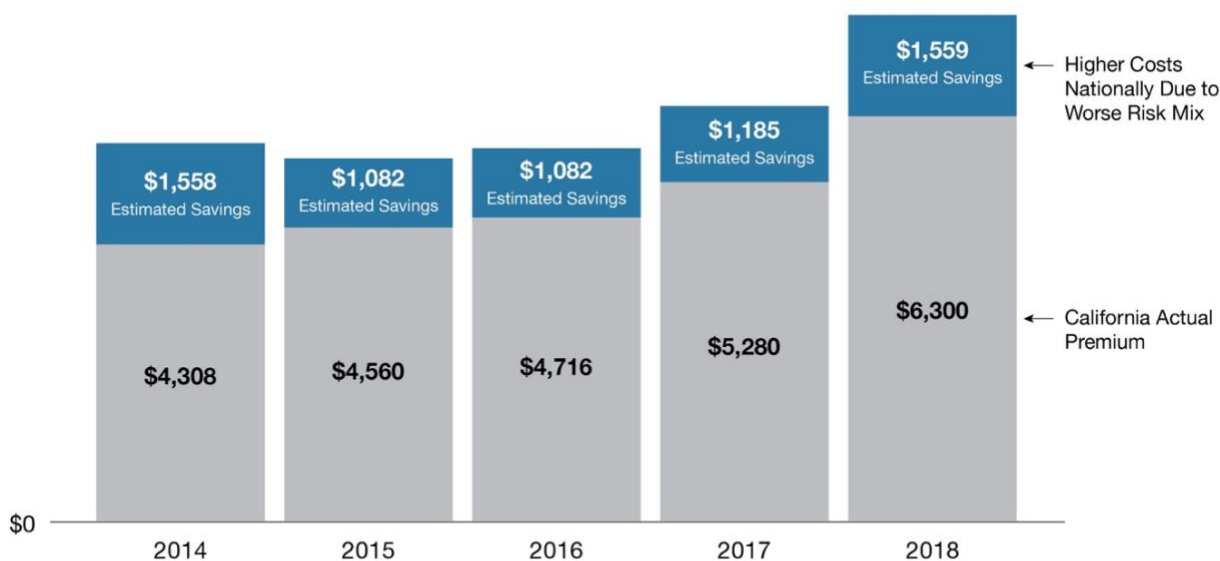
Figure 3. California’s Combined Impact on Lowering Costs in the Individual Market — 2014-2018 (in billions)¹⁹



Note: Across five years, the cumulative savings to consumers was about \$5.7 billion, and to the US Treasury was \$6.8 billion, for a combined savings of \$12.5 billion.

¹⁹ Covered California analysis of data is derived from CCIIO (see [risk-adjustment reports](#)), CMS (effectuated enrollment snapshots, such as [this example](#)), and Covered California’s own administrative data. Savings were determined by holding observed enrollment constant and estimating hypothetical premiums if the risk mix in California had mirrored that of the rest of the nation in each of the respective years (using the enrollment-weighted average risk score for all states for which risk adjustment data are reported, excluding California).

Figure 4. California’s Healthier Risk Mix Leads to Lower Premium Costs for Unsubsidized Enrollees²⁰



Note: In the period from 2014 to 2018, the cumulative average premium increase in California was one-third lower than the increase for the rest of the US: relative to 2014, the average premium in 2018 was 76 percent higher in the rest of the US, compared to 46 percent in California. In 2018, a large average premium increase was driven by the gross premium for the Covered California Silver tier (the most commonly chosen tier) increased by an additional 12.5% due to the elimination of the Cost-Sharing Reduction (CSR) payments from Centers for Medicare and Medicaid Services (CMS).

State Actions for 2020 Promote Affordability and Continued Market Stability

Recent federal policy changes that include zeroing out the individual mandate’s penalty and other changes²¹ have destabilized insurance markets nationwide. Although California’s market has been stable, with robust competition among 11 health insurance companies and premium increases that have been about half of national rates, the Legislature and governor acted in 2019 to assure continued stability and affordability. This effort was accomplished by banning short-term health plans, establishing a California individual mandate and penalty to be in effect while the federal penalty remains set at zero and funding a state subsidy program that expands financial assistance above the Affordable Care Act’s income limits.²²

The new subsidies include first-in-the-nation efforts to build on the Affordable Care Act and provide financial help to the middle class (those with incomes of 400 to 600 percent of the federal poverty level), many of whom have experienced high health care costs with little help.

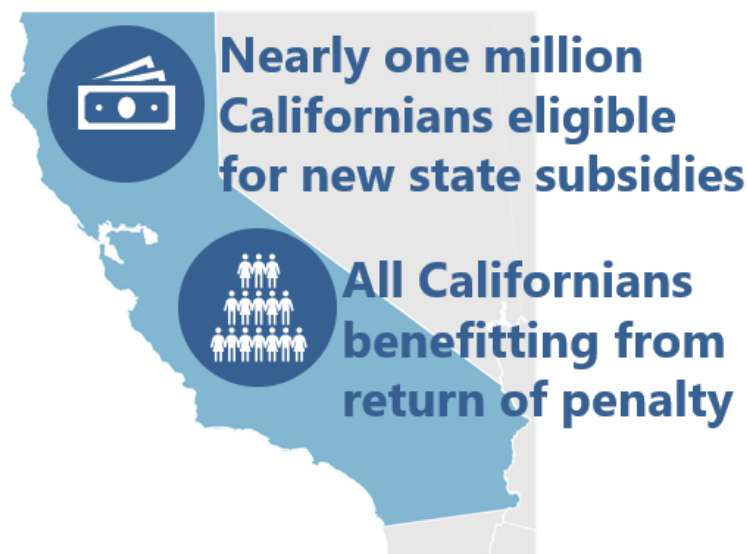
²⁰ Covered California analysis of data is derived from CCIO ([see risk-adjustment reports](#)), CMS (effectuated enrollment snapshots, such as [this example](#)), and Covered California’s own administrative data.

²¹ Other actions include reduced marketing to promote enrollment in the federal marketplace and the promotion of short-term, limited-duration policies that have gaps in covered benefits, underwrite consumers based on health status and that are composed of enrollees who are not part of the common risk pool that helps to foster a healthy risk mix and lower premiums.

²² Senate Bill 106 (Committee on Budget and Fiscal Review, Chapter 55, Statutes of 2019) provides the appropriations for the state subsidy program, along with income eligibility and specified funding allocation by eligibility levels. Senate Bill 78 (Committee on Budget and Fiscal Review, Chapter 38, Statutes of 2019) is the omnibus health trailer bill that establishes the individual mandate and penalty, as well as the requirements for the state subsidy program.

These policies are predicted to result in 229,000 newly insured Californians. They have helped keep premium increases to an all-time low of 0.8 percent for 2020, the lowest since the 2014 launch of Covered California. In contrast to 2020 rate changes in many other parts of the nation — which have largely been attributed to downward adjustments of major over-pricing that occurred over the past two years or the effect of state-administered reinsurance programs — the lower rate increases in California follow years of relatively moderate premium increases (see Figure 5. California's 2020 Policies to Protect and Go Beyond the Affordable Care Act).

Figure 5: California's 2020 Policies to Protect and Go Beyond the Affordable Care Act



Holding Health Insurers Accountable for Improving Quality and Advancing Delivery Reform

Covered California's Approach to Contracting

Covered California has established a rigorous health insurer selection and vetting process focused on how effectively insurers meet consumers' needs. It has specific contractual requirements that health insurance companies must meet to participate in Covered California. The individual market in California is an important and attractive market for health insurance companies considering Covered California's enrollment of about 1.4 million in 2019, of whom about 85 percent receive subsidies. There are also an estimated 850,000 "off-exchange" consumers who purchase directly from health insurance companies and do not receive subsidies but benefit from an effective marketplace. While Covered California has directly addressed consumers' health care costs by promoting healthier enrollment and fostering price competition among its insurers within the marketplace, the agency's contractual expectations have broader impacts and are intended to promote improvement in the underlying cost and quality of health care for all Californians.

The Affordable Care Act established a minimum set of quality standards that "qualified health plans" must meet to be available to consumers who enroll through the marketplace. These include participating in a nationally standardized Quality Rating System and submitting a Quality Improvement Strategy each year. As a state-based marketplace, Covered California went

beyond these standards to select health insurance companies, define contractual requirements and other processes intended to ensure that its contracted insurers meet consumers' needs and contribute to improving health and care delivery for all Californians. These requirements include participation in Covered California's Healthcare Evidence Initiative, a combined medical claims database reflecting the care provided by Covered California's health insurers. This data, which is managed under contract by IBM Watson Health, provides the ability to analyze patterns of utilization and care across and among Covered California's insurers.²³ Examples of other oversight, accountability and improvement processes are:

- **Network composition review:** As part of its annual contracting cycles, Covered California assesses network composition, the number and types of physicians, medical groups and hospitals that are unique to particular health insurers or available through multiple insurers, drive times to hospitals and other indicators of how a health plan's distribution of providers assures consumers have timely access. The health insurance companies also report network changes and financial performance quarterly.
- **Utilization review:** Covered California reviews Healthcare Evidence Initiative claims data with its health insurance companies to identify trends in emergency room, hospital and physician utilization and determine potential areas for improvement or further investigation. Health insurance companies share claims and encounter data with Covered California monthly.
- **Studies for targeted improvement:** Covered California commissions and provides to its health insurance companies analyses of specific areas to better understand cost-drivers and to foster improvement by assessing plan-level variation, such as a review of potentially wasteful prescription drug use and spending and variation in prescribing patterns for diabetes and HIV.
- **Regular meetings with health insurers:** In addition to the annual negotiating sessions, which include a review of quality and cost issues, Covered California holds regular quality-assessment meetings with each health insurance company throughout the year. These meetings, which are chaired by Covered California's chief medical officer, review areas for improvement and opportunities for the insurer to align with other efforts in California (see "Alignment: Working with Others to Promote Improvement" below).

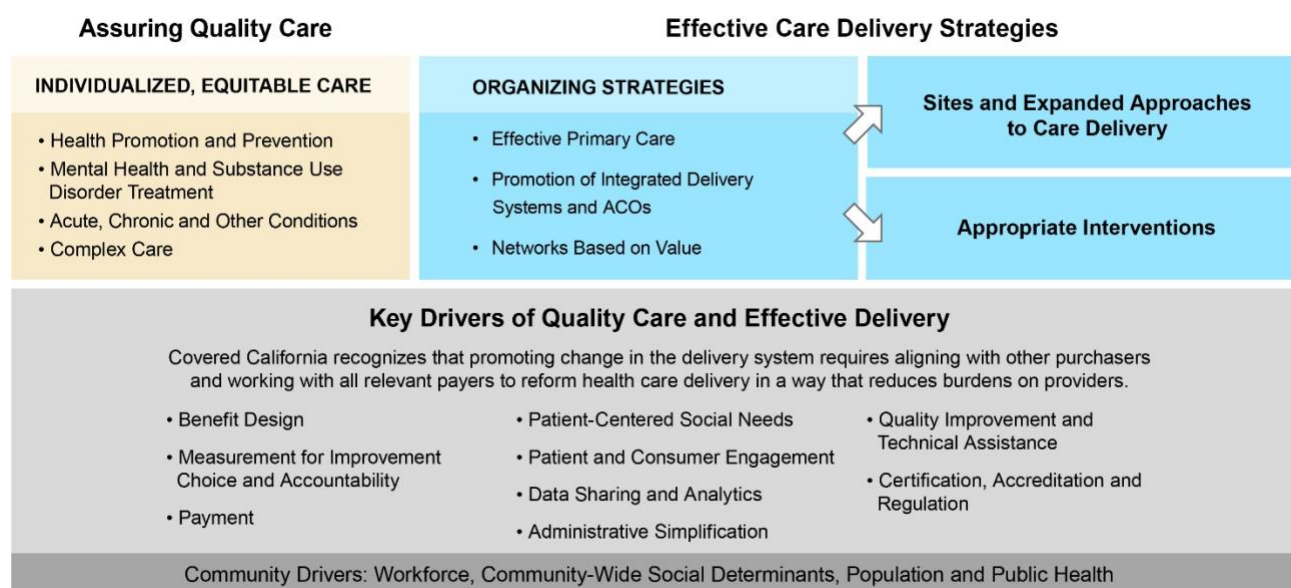
For these areas, Covered California has shared data with its health insurance companies to foster improvement. It intends to release enrollment-wide, and, as appropriate, plan-specific results in the future.

²³ Newly enacted state legislation (Assembly Bill 929, Chapter 812, Statutes of 2019) further clarifies the importance of Covered California using detailed utilization and encounter data to ensure that consumers are able to choose from plans that offer the best value and to evaluate impact on the health delivery system through lower costs, quality improvement, and disparity reductions.

An Overarching Framework Guides Accountability and Improvement Initiatives

These processes have been anchored in the expectations detailed in the contract between Covered California and its health insurance companies (see [Attachment 7: Quality, Network Management, Delivery System Standards and Improvement Strategy](#)). To update its contractual expectations, Covered California has developed a revised comprehensive framework for evaluating and improving health system performance (see Figure 6. Covered California’s Framework for Holding Health Plans Accountable for Quality Care and Delivery Reform). The framework is composed of two main strategies: assuring quality care and effective care delivery. Substantial work under current contract requirements has been accomplished in each of the two strategies and is summarized in this report, with additional details provided in a companion report: [Covered California Holding Health Plans Accountable for Quality and Delivery System Reform](#).

Figure 6. Covered California’s Framework for Holding Health Plans Accountable for Quality Care and Delivery Reform



Assuring Quality Care

Covered California’s overarching goal is to ensure that all Californians — whether they are striving to stay healthy or currently needing treatment — receive individualized, equitable care. Regardless of their circumstances, race, gender, or where they live, health insurers are expected to ensure that every individual receives care that is personalized, delivered in the right setting at the right time, does not cause harm and is as cost-effective as possible.^{24,25} A key

²⁴ In the current contract, Covered California focused health equity efforts on the reduction of health disparities. While inclusive of health-disparities reduction, the revised framework of Individualized Equitable Care is intended to capture the broad goal of care that is individualized to address an individual’s health needs.

²⁵ These goals are consistent with the six attributes of health care quality identified by the Institute of Medicine: safe, timely, effective, efficient, equitable and patient-centered. See more: Committee on Quality Health Care in America, Institute of Medicine, (2001). Crossing the quality chasm: a new health system for the 21st century. Washington, D.C.: National Academy Press.

element of this goal is to identify and reduce racial and ethnic health disparities, which has been central to Covered California's mission since its inception.

Assuring quality care requires a high degree of collaboration among Covered California, health insurance companies and providers. Health insurance companies are required to collect diverse measures²⁶ and implement robust quality improvement strategies. Annually reported quality measures are key to assessing progress and understanding variations in performance across providers and health plans, as well as comparing Covered California health plan performance to marketplace plans nationally. The accompanying report, [Covered California Holding Health Plans Accountable for Quality and Delivery System Reform](#), provides health plan-specific results in multiple domains and presents early findings from an ongoing initiative to understand and reduce racial and ethnic disparities in care.

Insights From Variations and Trends in Measured Performance

One approach to tracking performance has been through the calculation of annual global quality ratings for each plan, which are now summarized in a rating scale of one to five stars. Since 2014, Covered California has included global quality scores in its consumer-facing information, and as of fall 2016, Covered California has used the federal Quality Rating System results, which are based on standard quality of care measures (Healthcare Effectiveness Data Information Set) and patient experience of care measures (Consumer Assessment of Healthcare Providers and Systems).^{27, 28} The Quality Rating System calculates a global star rating and three summary component scores on: medical care, care experience, and plan experience for each health plan based individual market experience compared to a national marketplace benchmark.

Although there have been some changes to the scoring methodology that limit year-to-year comparisons, Covered California's health plans have improved on the marketplace star ratings between the 2016 and 2019 reporting years. There remains, however, substantial variation in scores across insurers with Kaiser Permanente and Sharp Health Plan, two insurers with integrated and coordinated delivery system models, consistently performing among the best in the nation. The performance of physicians and physician organizations that contract with other Covered California insurers varies: some physician organizations perform well, but many have significant opportunity for improvement.

To more sharply focus accountability efforts among health insurers, Covered California examined over 40 measures used by the national marketplace Quality Rating System to determine star ratings. Covered California is proposing to prioritize a subset of 13 measures that were selected based on the following criteria: (1) health impact, (2) extent of health plan

²⁶ Health insurance companies are required to participate in the CMS Marketplace Quality Rating System, which entails the collection of measures from the Healthcare Effectiveness Data Information Set (HEDIS) and Consumer Assessment of Healthcare Provider and Systems (CAHPS).

²⁷ Prior to the launch of the federal Quality Rating System (QRS) in the fall of 2016, Covered California used non-exchange historical performance on patient-experience survey measures (CAHPS) and QRS beta testing results to calculate a Covered California-specific rating using a one to four-star scale.

²⁸ For plan year 2020, the federal marketplace (healthcare.gov) will begin displaying global ratings and the three summary component scores for each qualified health plan. Center for Consumer Information and Insurance Oversight and Center for Clinical Standards and Quality, Centers for Medicaid and Medicare Services. (2019). Quality Rating Information Bulletin. Retrieved from <https://www.cms.gov/>.

variation, (3) performance improvement opportunity, (4) alignment with other California accountability programs, and (5) balance across domains of care, such as prevention, chronic-illness care and behavioral health. Additionally, three of the 13 measures overlap with the measures currently collected by race/ethnicity for health disparities reduction interventions.

Performance trends on these 13 measures are presented in Table 2. Covered California’s Weighted Average Health Plan Performance for Candidate Priority Quality Rating System Measures, 2016-19. Each entry is the weighted average by enrollment for all health plans on the specific measure, and therefore represents the experience of the average enrollee. Entries are color-coded to show where the weighted average falls among national percentiles for marketplace plans. For all measures, a higher rate indicates better quality of care or better patient experience except the All-Cause Hospital Readmissions for which a lower score means better performance.

Table 2. Covered California’s Weighted Average Health Plan Performance for Candidate Priority Quality Rating System Measures, 2016-19

	2016*	2017	2018	2019
Individualized, Equitable Care				
Rating of All Health Care	80	81	83	78
Rating of Health Plan	73	76	78	73
Prevention				
Breast Cancer Screening Ages 50-74	74	70	72	72
Cervical Cancer Screening Ages 21-64	59	62	65	64
Colorectal Cancer Screening Ages 50-75	51	55	58	58
Chronic Illness Care				
Controlling High Blood Pressure	63	63	66	66
Diabetes: Hemoglobin A1c (HbA1c) Control (<8%)	58	60	63	64
Behavioral Health				
Alcohol & Drug Disorders: Initiation & Engagement Ages 13+	21	23	26	25
Antidepressant Medication Management		57	60	61
Follow-up After Hospitalization for Mental Illness	56	60	53	50
Care Coordination and Access to Care				
All-Cause Hospital Readmissions**	86	80	74	71
Care Coordination	81	81	83	79
Access to Care	70	71	77	72
Key: Percentile of U.S. Qualified Health Plan Scores:	< 25	25-50	50-90	≥ 90

*Some measures were not used in the Quality Rating System scoring in 2016 and therefore do not have scores or associated percentiles. **This table mostly reports percent scores. The All-Cause Hospital Readmissions measure is an exception. It is a ratio of the observed rate to the expected rate x100, and therefore a lower score represents better performance; if the observed rate is above expected (poorer performance) the score would exceed 100.

The performance of the 11 health insurance companies in Covered California on these priority measures and on the additional 29 measures as detailed in the report, [Covered California Holding Health Plans Accountable for Quality and Delivery System Reform](#), provide both overall and plan-specific performance information that Covered California and its contracted plans are using to inform quality improvement efforts. Some major observations are:

- **High levels of consumer satisfaction with their health plan and health care:** As evident from the Rating of All Health Care and Rating of Health Plan measures, there is generally high satisfaction among Covered California enrollees with their health plans (with 95 percent of enrollees enrolled in plans with satisfaction that is above the 50th percentile nationally) and with their care (with 75 percent of enrollees enrolled in plans reporting satisfaction that is above the 50th percentile nationally). The data reveal, however, that further improvement remains possible.
- **Wide variation in performance among insurers:** The weighted average of these important measures is a broad indication of how care is being delivered and provides the generally positive news that, for most measures, enrollees in Covered California's plans receive care at or above the national average. The more important finding, however, is that for each measure there is wide variation in the care being delivered among the 11 contracted health insurance companies (see companion report for plan-specific data).
- **Improvement in performance would be potentially life-saving and clinically meaningful for hundreds of thousands of Californians:** The wide variation in performance is particularly meaningful for measures related to managing diabetes and hypertension that help point to important opportunities to reduce the morbidity and mortality attributable to those conditions. Better performance on these indicators means there would be fewer adverse events and more saved lives. Research suggests that a one percent reduction in HbA1c reduces diabetes-related deaths by 21 percent and myocardial infarctions (heart attacks) by 14 percent.²⁹ For every 10 percent reduction in HbA1c (e.g., 10 to 9 or 9 to 8) the risk of progression to blindness fell 44 percent, progression to kidney failure fell 25 percent, and loss of sensation in the feet by 30 percent.³⁰

Another study estimated the effect of having all health plans nationally achieve the levels found at the 90th percentile on measures focused on diabetes and cardiovascular disease (similar to what is seen for Kaiser Permanente in California). This would result in 2.3 million fewer heart attacks (a reduction of 22 percent), 800,000 fewer strokes (a reduction of 12 percent) as well as reduced incidence of several other less common complications over a 10-year period.³¹ The researchers estimated that approximately 4.9 million years of life would have been saved during this same period.

²⁹ Stratton, I. M., Adler, A. I., Neil, H. A., Matthews, D. R., Manley, S. E., Cull, C. A., ... Holman, R. R. (2000). Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. *BMJ (Clinical research ed.)*, 321(7258), 405–412. doi:10.1136/bmj.321.7258.405

³⁰ Nathan, D. M., Bayless, M., Cleary, P., Genuth, S., Gubitosi-Klug, R., Lachin, J. M., ... DCCT/EDIC Research Group (2013). Diabetes control and complications trial/epidemiology of diabetes interventions and complications study at 30 years: advances and contributions. *Diabetes*, 62(12), 3976–3986. doi:10.2337/db13-1093

³¹ Note these estimates are from a 2008 study based on the Archimedes simulation model. At the time, impacts were modeled for the U.S. population of 210 million adults ages 18-85 over a ten-year period, 1995-2005: Eddy, D. M., Pawlson, L. G., Schaaf, D.

- **Strong performance by Kaiser Permanente and Sharp Health Plan underscore potential for improvement and the importance of fostering care that is integrated and well-coordinated:** For most measures, the performance of Kaiser Permanente and often Sharp Health Plan are among the best in the entire nation — scoring in the 90th percentile. This very positive performance is a clear indication of what is possible when care is effectively coordinated. In contrast, the overall performance of the other nine contracted health insurance companies usually falls between the 25th and 90th percentile compared to national performance — with wide variation among insurers and between different measures. Other data has shown that when measuring performance at the level of the medical group, there are groups in California that perform as well as Kaiser Permanente and Sharp Health Plan on clinical performance indicators.³² The high levels of performance observed by some plans and providers reveals what is possible and informs Covered California's high expectations for all its insurers. These findings also underscore the benefits of integrated and coordinated care, which has the potential of being delivered both by integrated delivery systems under a single health insurer's umbrella or through accountable care organizations.
- **Relatively low scores on some consumer-reported experience measures warrant further research and improvement across all insurers:** Covered California identifies four priority CAHPS measures. Of those measures, two that relate to enrollees' overall satisfaction were described above and provide an important positive indicator of overall Covered California health insurer performance. However, Covered California health insurers generally have worse scores than the rest of the nation on the Access to Care and Care Coordination measures, with the majority of insurers below the 25th percentile and none above the 50th.³³ It is important to note that the CAHPS results for marketplace plans nationwide are highly compressed with a difference of only a few points among each percentile, and all results are relatively high compared to other measures. Also, California's demographic diversity includes greater numbers of people in race/ethnicity groups who tend to give plans lower scores. This suggests insurers may not meet the needs of all groups equally. Covered California sees these consumer-experience scores as reason for concern and as an important focus for continuing research. Covered California is working with its health insurance companies to assure improvement in these areas and is seeking to expand the number and sources of measures that can best assess consumers' experience in getting care as it relates to access, care coordination and other important quality domains.
- **Behavioral health presents a significant improvement opportunity:** The relatively low scores in the categories "Engagement of Alcohol & Other Drug Abuse or Dependence Treatment" and "Antidepressant Medication Management" for members with depression highlight important areas for insurer and provider focus. In addition, while the weighted average score for "Follow-Up After Hospitalization for Mental Illness"

³² Integrated Healthcare Association. (2019). Top 10% Performers AMP Commercial HMO (MY 2018). Retrieved from: https://www.iha.org/sites/default/files/resources/my_2018_top_ten_honorees.pdf.

³³ The Access to Care measure indicates whether enrollees had access to urgent care or immediate care as soon as needed and were able to access a specialist when needed. The Care Coordination measure indicates whether the enrollee's experience of receiving care was coordinated across different providers and services.

is above the 50th percentile nationally, the fact that this measure has fallen in the period from 2016 to 2019 warrants attention by Covered California and its contracted insurers to assure appropriate discharge planning and member outreach by care-management teams.

Efforts to Understand and Address Health Disparities

Covered California has the overarching goal of achieving the best possible health and health care for each individual. Achieving this goal requires addressing social and economic disparities. Covered California is therefore working with its health insurance companies to reduce health disparities and promote health equity on four fronts: (1) identifying the race/ethnicity of all enrollees, (2) measuring how quality varies by race/ethnicity, (3) conducting population-health improvement activities and interventions to narrow observed disparities in care, and (4) promoting community health initiatives that foster better health and healthier environments and promote healthy behaviors.

Several of Covered California's contracted health insurance companies have been actively engaged in efforts to understand and address health care disparities for many years. Four of Covered California's health insurance companies, Health Net, Kaiser Foundation Health Plan of Southern California, L.A. Care, and Molina Healthcare representing 36 percent (503,220 out of 1,384,030) of enrollment in 2018 earned the National Committee for Quality Assurance's (NCQA) Distinction in Multicultural Health Care (MHC), a program that recognizes organizations that provide culturally and linguistically sensitive services and work to reduce disparities in health and health care.

Covered California is in its third year of a multiyear initiative to measure how quality varies by race/ethnicity and by insurer. In recognition that care patterns based on race/ethnicity — and the interventions to address gaps — likely need to cut across where consumers get their coverage and to overcome small sample sizes, health insurance companies have submitted data for their entire population under age 65 including their other commercial and Medi-Cal populations. This approach to data collection makes direct comparison of scores between insurers unreliable since their populations and data quality differ. Baseline data, however, has revealed important and actionable variation based on race/ethnicity for each insurer. Additionally, even accounting for differences in measurement and populations, the findings suggest that on at least some measures, the health insurers with integrated delivery systems report better quality scores for all groups — to levels that are among the best in the country. While some of these insurers have long invested in and hired staff to support culturally competent care, this finding suggests that integrated and coordinated approaches to care delivery may improve care for those at greatest risk and help to reduce racial or ethnic disparities in quality.

Given the need to look at health care disparities and health equity across the entire population and to promote interventions that apply to racial and ethnic populations regardless of their source of insurance coverage, Covered California is working to expand its disparities-reduction work with other purchasers, particularly Medi-Cal.

Delivery System Reform: Promoting Effective Care Delivery Strategies

The second pillar of Covered California's strategy is to hold health insurance companies accountable for adopting effective care delivery strategies. As indicated above, this focus is based on evidence showing that how care is organized and paid for can contribute to higher-

quality care. For any given hospital or physician practice, only a relatively small percentage of their patients are Covered California enrollees and those enrolled through Covered California today may be covered through an employer, Medicare or Medi-Cal next year. Because of these dynamics, Covered California seeks to promote changes in how care is delivered for its enrollees in ways that can also promote better care for all Californians who use the providers in Covered California's health plans.

Covered California's efforts focus on three organizing strategies: (1) Effective Primary Care, (2) Integrated Delivery Systems and Accountable Care Organizations and (3) Networks Based on Value. These strategies are expected to encourage providers and insurers to help patients choose the settings that are best for them (e.g., substituting safer outpatient or home-based care for hospital-based care) and to choose the best treatment for that patient. Choosing the "best" treatment means ensuring patients are offered evidence-based treatments and, where more than one treatment is clinically reasonable, ensuring that the decision about which treatment to provide is rooted in an understanding of the patient's values and preferences. What follows is an overview of Covered California's initiatives related to the three organizing strategies.

Effective Primary Care

The benefits of strong and effective primary care to both health and health care have long been recognized.³⁴ Covered California is striving to ensure that all enrollees can experience the benefits of strong primary care systems through several approaches. In California and in much of the nation, virtually all consumers enrolled in a health maintenance organization (HMO) are matched with a primary care physician; however, this is not the case for those enrolled in other types of plans — preferred provider organizations (PPO) or exclusive provider organizations (EPO). In January 2017, Covered California required that all enrollees be matched to a primary care physician or other primary care clinician, such as a nurse practitioner.³⁵ The purpose was to bring the primary care physician match concept to the PPO and EPO environment so that all consumers benefit from a single point of contact to help them navigate the health care system. A primary care physician can provide continuity, address most health care needs, help consumers select the proper specialist, coordinate their care with other providers and ensure that they understand their treatment options.

By the end of 2017 and each year since then, virtually all consumers enrolled in a Covered California health plan either selected or were matched with a primary care physician. For EPO and PPO products, this means that about 500,000 enrollees in Covered California are now matched and provided direct access to a primary care clinician upon enrollment. While there are a few large employers that have implemented similar programs, this is the largest effort of this type in the nation, and Covered California is working with health insurers to help all enrollees

³⁴ A major report by the Institute of Medicine underscored the importance and value of primary care in the 1990s: Donaldson, M. S., Jordy, K. D., Lohr, K. N., and Vanselow, N. A. (Eds.). (1996). *Primary care: America's health in a new era*. National Academies Press. A more recent summary of the evidence for primary care is: Starfield, B., Shi, L., and Macinko, J. (2005). Contribution of primary care to health systems and health. *The Milbank quarterly*, 83(3), 457-502.

³⁵ While having a primary care physician is important, enrollees in PPO plans can still choose to navigate the health care system on their own and do not need permission from their primary care physician to seek treatment or a referral to see a specialist.

understand the value of primary care and to evaluate the impact of primary care physician matching on utilization, cost and quality.

Covered California also encourages its health insurers to move away from fee-for-service and toward payment approaches that support primary care and reward improved care and lower overall costs. While payment strategies to primary care physicians vary widely, significant increases were observed for shared savings and capitation-based payments between 2015 and 2018.³⁶ By 2018, 10 health insurance companies were initiating deployment of such payment models to primary care physicians.³⁷

Finally, a growing body of evidence shows that advanced models of primary care greatly improve the care delivered to patients. The percentage of Covered California enrollees cared for by patient-centered medical home-recognized practices (PCMH) grew by the end of 2018 to 560,000 representing 40 percent of all enrollees. While a substantial portion of that enrollment is credited to the wide adoption of the PCMH model within the Kaiser Permanente system, even outside of that system, PCMH enrollment increased from 3 percent to 11 percent.

Beyond formal PCMH recognition, several health insurers are supporting clinical transformation to advanced primary care that emphasizes accessible, data-driven, team-based care.³⁸ The biggest barrier to full adoption of advanced primary care, despite the structural changes to payment described above, remains inadequate revenue to support well-rounded care teams, underscoring the importance of continued efforts to reform primary care payment. For health insurers to make these investments, performance measurement will likely need to go beyond PCMH recognition-process measures to include outcomes that reflect the impact advanced primary care can have on improving quality and reducing the total cost of care.

Promotion of Integrated Delivery Systems and Accountable Care Organizations

Integrated and coordinated care is widely recognized as a vital contributor to delivering good outcomes and high quality at an affordable cost³⁹ and Covered California has worked with insurers to expand enrollment in integrated models of care. Nationally, the Centers for Medicare and Medicaid Services (CMS) is leading a drive to implement value-based payment models including integrated and coordinated delivery models such as ACOs.

Leavitt Partners tracks the growth and spread of ACOs, including the new models supported by CMS and their commercial and Medicaid analogs.⁴⁰ As of 2018, 10 percent of the U.S. population, or 32.7 million Americans, were cared for in ACOs in commercial, Medicaid and Medicare markets. This includes every state, with penetration ranging from 2 percent to more

³⁶ Covered California notes that capitation to medical groups does not always cascade to individual providers who remain paid FFS.

³⁷ The total number of unique health insurance companies in Covered California is 11. However, this measure considers 12 health insurers because Health Net reports data separately for its Health Net CA and Health Net Life products.

³⁸ There are several key attributes of advanced primary care models, including: person and family-centered; maintain continuous patient-provider relationships; comprehensive and equitable; team-based and collaborative; and coordinated and integrated; accessible; and high-value. See more: <https://www.pcpcc.org/about/shared-principles>

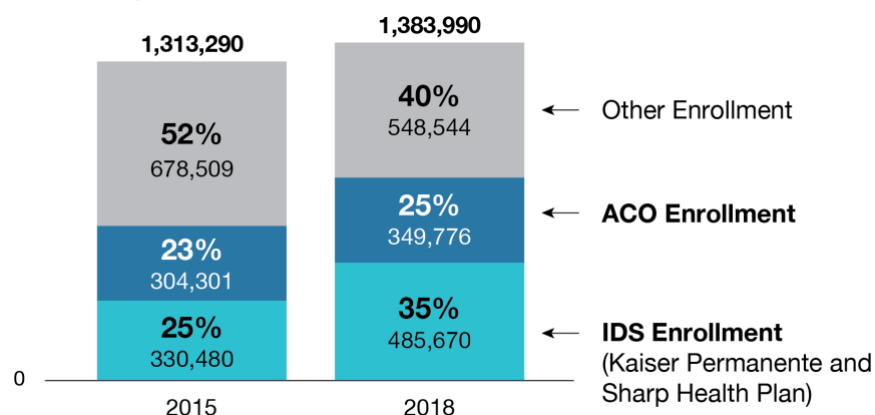
³⁹ Among the best studies providing evidence is based on the Atlas compiled by the Integrated Healthcare Association: <https://atlas.iha.org/>

⁴⁰ Muhlestein et al. (2018). Recent Progress in The Value Journey: Growth of ACOs and Value-Based Payment Models in 2018. Health Affairs blog. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20180810.481968/full/>.

than 20 percent. Leavitt Partners reports that between 10 to 15 percent of Californians are cared for in such models.

In 2018, 60 percent of Covered California enrollees were cared for in an integrated delivery system or an accountable care organization, which represents a 12-percentage point increase from 2015. While much of this growth is due to enrollment in Kaiser Permanente's and Sharp Health Plan's integrated delivery systems, even after excluding these two systems, 25 percent of Covered California enrollees were cared for in an ACO in 2018, which equates to 350,000 consumers and a 2-percentage point increase from 2015 (see Figure 7. Covered California Enrollment in Integrated Delivery Systems [IDS] or Accountable Care Organizations [ACO], 2015 and 2018). It is this latter statistic that is most comparable to the national data from Leavitt Partners; based on this report, California has greater penetration of these new models than the overall U.S. Covered California not only has an ACO enrollment that is more than two-times the national average, but that even in California it appears that Covered California enrollees are far more likely to be enrolled in ACOs than are Californians with other sources of coverage (with 25 percent enrollment when excluding those enrolled with Kaiser Permanente or Sharp Health Plan, compared to the Leavitt Partners estimate of California enrollment of 10 to 15 percent).

Figure 7. Covered California Enrollment in Integrated Delivery Systems (IDS) or Accountable Care Organizations (ACO), 2015 and 2018



Health insurance companies are supporting integrated care in other ways. Nine health insurers reported offering technical support, data-sharing support, or promotion of participation in health information exchanges for providers in 2018, an increase from four health insurers in 2015. Covered California has also seen a steady increase in the number of insurers using other common components of integrated coordinated care such as population health management support. Insurers are also required to report performance of different ACO models using the Integrated Healthcare Association's (IHA) Align Measure Perform Commercial ACO Measure Set starting in 2019. IHA has reported the first results under this measure set, showing that a mix of ACOs, built on both HMO and PPO platforms, while varying significantly, are performing about as well as capitated physician organizations in HMOs and significantly better than regional aggregates of PPO providers. Covered California is beginning to use this data to identify best practices and inform future contract requirements.

Networks Based on Value

Access, affordability and consistent quality performance are core to Covered California's mission to expand the availability of coverage and improve health and health care while

lowering costs. A starting point of Covered California's assessment is to go beyond the well-established network adequacy provisions for all plans in California that are set and overseen by the California Department of Managed Health Care and, for a very small portion of enrollees, the California Department of Insurance. Covered California assesses the number and types of providers and facilities including the mix of providers, the unique providers across plans and access to essential community providers.

Covered California looks beyond standard access measures because of the wide variation in unit price and total costs of care charged by providers, with some providers charging far more for care irrespective of quality, contributing to the high cost of care — with little documented correlation between higher cost and better quality. To help enrollees understand their out-of-pocket costs, 10 of the 11 health insurance companies provide online cost transparency tools. This means that 99 percent of Covered California enrollees have access to tools that aide in their health care decision making process. These tools offer information ranging from provider-specific cost shares of common inpatient and outpatient elective procedures to real-time tracking of their out-of-pocket costs to prescription drug prices. However, utilization of these tools is low, ranging from less than 1 percent to 39 percent among all insurers. More research is needed to understand the low utilization rates. Encouragingly, insurers are focused on increasing the use of these cost transparency tools through patient outreach and education.

On the quality front, while a number of physicians, physician organizations and hospitals provide outstanding care, some lag significantly. Covered California holds insurers accountable to manage this variation and promote improvements across all contracted providers.

For selecting providers, most insurers reported using HEDIS quality of care measures, in addition to considering provider credentialing, member satisfaction results, and grievance and appeals data. While most insurers participate in the Integrated Healthcare Association's Align Measure Perform performance-improvement program, few reported using results to inform provider selection. In contracting with hospitals, most health insurance companies reported reviewing and tracking publicly reported data from The Leapfrog Group, CMS Hospital Compare, and other quality-based organizations, but few actively considered this data in network design.

Covered California required its health insurance companies to describe how they consider quality and cost in their design of networks and to consider establishing policies to exclude hospitals that are low-performing "outliers" (whether low quality or high cost). To support health insurers in meeting the requirement to exclude outlier poor performers that are not improving, Covered California has worked with Cal Hospital Compare to track and trend performance and to define outlier poor performance for hospitals in a way that can be implemented consistently across all health insurance companies. Importantly, all 11 Covered California health insurers aligned around a common set of measures of cost and quality, which sends a clear message to hospitals on the need to reduce variation to assure a common standard of safety.⁴¹

Going forward, Covered California is partnering with the Integrated Healthcare Association's California Regional Health Care Cost and Quality Atlas to profile provider networks for variation in clinical quality, satisfaction, and total cost of care. Health insurance companies and providers

⁴¹ Initial hospital measures included five hospital acquired infections and low risk C-section rates.

are looking to Covered California to work through appropriate multi-stakeholder processes to define low-quality and high-cost providers. Covered California’s goal is to influence providers to improve their performance. The first report on how the contractual expectation that insurers either exclude or justify continued contracting with outlier poor performers is currently planned to be released by year-end 2020, which will inform future contract expectations for how insurers address outlier hospitals and other providers that are low quality or high cost, or both.

Alignment: Covered California Working With Other Purchasers, Insurers and Providers to Accelerate Improvement

Meaningful improvement is difficult when health insurance companies and providers are faced with diverse incentives, inconsistent performance measures, and conflicting priorities from public and private purchasers. Covered California is working to accelerate improvement in three ways: (1) working with other payers and purchasers to align payment models so that hospitals, medical groups and clinicians participate in uniform, value-enhancing financial incentives (discussed above); (2) working to align performance measures across health insurers and purchasers, both to focus priorities and reduce burden on hospitals and clinicians; and (3) encouraging or requiring health insurers to ensure that the providers in their networks are participating in the major quality improvement collaboratives in California.

Covered California is playing an active role by participating in governance structures of quality improvement collaboratives and requiring or encouraging insurers to mandate provider participation in range of collaboratives (see Table 3. Major Quality Improvement Collaboratives in which Covered California Participates). These quality improvement collaboratives seek to improve care for all Californians, so benefits will accrue not only to Covered California’s enrollees, but also to those with employer-based coverage, Medi-Cal and Medicare.

Table 3. Major Quality Improvement Collaboratives in which Covered California Participates

Program	Purpose
The Integrated Healthcare Association	Aggregates data to promote and support performance measurement and improvement of physician organizations and ACOs.
California Quality Collaborative	Leads collaborative quality improvement initiatives, most prominently in chronic disease management, advanced primary care and behavioral health integration.
Cal Hospital Compare	Publishes and tracks hospital performance measures and has created a new patient safety honor roll aligned with metrics important to Covered California.
Partnership for Patients	A federally funded program that focuses on reducing infections and other avoidable complications in hospitals through supporting designated Hospital Improvement Innovation Networks.
The California Maternal Quality Care Collaborative	Leads the state’s effort to achieve the Healthy People 2020 goal of no more than a 23.9 percent low-risk C-section rate.
Smart Care California	A multi-stakeholder initiative led by California state purchasers to reduce avoidable low-risk C-sections and address the opioid epidemic through payment reform, sharing best practices and an honor roll.

Based on data reported to Covered California, health insurer participation and active engagement by insurers to foster greater hospital and provider participation in these quality improvement collaboratives have increased substantially over the past four years. For example, Smart Care California collaborative participation increased from six to all 11 health insurers since 2016. Similarly, the number of health insurers that worked to engage their contracted hospitals in the Partnership for Patients collaborative increased from two to 10 health insurers since 2016.

These initiatives are having an important impact.

- The California Maternal Quality Care Collaborative and Smart Care California C-section initiatives have helped hospitals achieve a 12-percentage point reduction in C-sections among low-risk women, avoiding an estimated 7,200 C-sections through year-end 2018.
- The Partnership for Patients program, in which Covered California's contracting helped assure broader participation, has helped hospitals reduce the incidence of hospital associated infections by more than 20 percent between 2015 and 2018, the last year for which data is available. With the improvement in reducing hospital associated infections, best estimates are that 3,392 infections were avoided resulting in 251 California lives and \$62 million saved in a 12-month period between 2017 and 2018.⁴²
- Through Smart Care California, Covered California and other state purchasers have worked with their health insurers to foster adoption of proven approaches to addressing the opioid crisis. Each day in 2017 about 13 Californians died from a drug overdose with opioids accounting for half of those deaths (primarily prescription pain relievers, heroin and fentanyl).⁴³ Opioid prescriptions are falling and prescriptions for Medication Assisted Treatment are rising through the widespread implementation of Smart Care guidelines for health insurers and purchasers that include best practices for formulary management and network management.⁴⁴ However, deaths have not fallen, as too many people previously dependent on prescription opioids have turned to street drugs.^{45,46} Much more needs to be done to support providers in reducing opioid prescriptions safely and expanding access to medication-assisted treatment.

Additional details on these initiatives are provided in the full companion report, [Covered California Holding Health Plans Accountable for Quality and Delivery System Reform](#).

⁴² Cal Hospital Compare, with support from IBM Watson, calculated the mortality rates of hospital acquired infections and the usual costs of caring for those infections based on evidence from the literature for four of the targeted infections. Full report available on request.

⁴³ Centers for Disease Control and Prevention. (2017). Drug Overdose Deaths. Retrieved from: <https://www.cdc.gov/drugoverdose/data/statedeaths.html>.

⁴⁴ Integrated Healthcare Association. (2019). Curbing the Opioid Epidemic Checklist for Health Plans and Purchasers. Retrieved from: https://www.ihc.org/sites/default/files/files/page/pdf_healthplansopioidchecklist.pdf.

⁴⁵ The California Department of Public Health. (2019). Retrieved from: www.cdph.ca.gov/opioiddashboard

⁴⁶ Josh Katz. (2017). Short Answers to Hard Questions About the Opioid Crisis. The New York Times. Retrieved from: <https://www.nytimes.com/interactive/2017/08/03/upshot/opioid-drug-overdose-epidemic.html>.

Continuous Improvement: Refining the Quality Care and Delivery Reform Strategy

Although the findings presented above point to meaningful progress on many fronts, the data documents variation in performance across plans and providers that reveals a substantial gap between current performance and what is possible. Much more needs to be done to understand the underlying causes of the variation, identify and test approaches to improvement, and work with both providers and insurers to ensure that progress continues. Covered California continues to work with all stakeholders to refine its approach to assuring quality and promoting effective delivery reform. Covered California draws on multiple sources of information and insight for this work, including ongoing meetings with health insurance companies to review their quality improvement initiatives, identify challenges they face and clarify opportunities to do better based on ongoing reviews of evidence in the field.⁴⁷

Examples of insights and areas for targeted improvement identified by Covered California based on the range of data sources it relies on are:

- **The need to identify and engage enrollees who could benefit from preventive and wellness services:** Although smoking cessation and obesity management are critical to population health improvement, several insurers were unable to collect meaningful data, primarily due to the lack of access to clinical data or a practical way to implement universal health risk assessments. Ongoing efforts to update plan requirements are examining both the feasibility of collecting clinical data to improve identification and better tracking of program availability and participation rates.
- **Performance of many health plans needs to improve in multiple domains:** Covered California contracted health plans generally perform well overall on the Quality Rating System measures, typically in the 25th to 90th percentile range nationally. However, there are some measures that several plans perform poorly on, scoring below the 25th percentile, such as Breast Cancer Screening, Antidepressant Medication Management, and Care Coordination. While most of the measures for which Covered California health plans perform relatively poorly are not among those identified as priority measures for Covered California, the ability of integrated systems, such as Kaiser Permanente and Sharp Health Plan, to achieve scores consistently in the 50th to 90th percentile range is a clear indicator of what is possible with well-coordinated and integrated care. Covered California is working to assess what factors contribute to better performance among non-integrated plans and how the performance of integrated systems can be replicated across California with the goal of ensuring that all plans in California deliver care that is as good or better than national benchmark performance.

⁴⁷ To gain additional insights, Covered California regularly engages outside experts. Recently, it engaged two outside consulting firms to review its strategic approaches, the measures used, and the evidence of impact of different strategies to improve care. The firms also offered guidance on how to increase the effectiveness and impact of Covered California's accountability initiatives. Health Management Associates and PricewaterhouseCoopers delivered two reports that were released in July 2019, [Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform](#) and [Health Purchaser Strategies for Improving Quality of Care and Delivery System Reform](#). Covered California is using this material as it continues its stakeholder engagement with health insurance companies, providers, consumer advocates, and the broader public to help inform which efforts Covered California should continue, discontinue or revise in the upcoming 2022-24 health plan contract.

- **The need to improve access to and quality of behavioral health services:** Health insurance companies reported a range of activities to improve access to behavioral health services, including increasing provider capacity, implementing telehealth services, and adopting new billing codes that support care collaboration. Health insurance companies also described a broad spectrum of integration efforts, from increased coordination with carve-out vendors to embedded behavioral health staff in primary care clinics.

While there appears to be an increase in the percentage of enrollees cared for in integrated behavioral health models between 2015 and 2018, Covered California observed data inconsistencies. Requirements are being updated to require better standardization to support meaningful tracking and trending of behavioral health integration. Because monitoring outcomes for behavioral health is a major gap, Covered California is considering requiring the use of patient-reported outcome measures, such as the use of Patient Health Questionnaire-9 (PHQ-9) to screen for and monitor depression. Covered California is also more closely tracking opioid use and medication assisted treatment through its Healthcare Evidence Initiative database.

- **Better measurement is needed related to the care for patients with complex needs:** There are no standard quality measures for complex care. Most health insurance companies reported identifying at-risk enrollees with algorithms and other proprietary technology based on claims and utilization data. Based on current best evidence, Covered California is considering a hybrid method of population stratification starting with automated data to identify high-cost enrollees combined with survey data such as health risk assessments, behavioral health screening, screening for social needs or measuring patient activation to determine enrollees who are likely to continue to be high risk and high cost. Covered California is also considering using its own claims data warehouse to track rates of inpatient and Emergency Department use, Emergency Department follow-up among complex-care patients, and the use of the Transition of Care HEDIS measure, which would require collection of discharge information that includes test results.

Conclusion

Serious problems with the performance of the U.S. health care system persist 20 years after two major reports called attention to the significant gaps in quality and safety confronting the United States and 10 years after passage of the Affordable Care Act, which was intended to expand coverage and improve health care. Health care costs continue to rise,⁴⁸ the quality and safety of care is uneven^{49,50} and while many patients still fail to receive needed, evidence-based care,⁵¹ waste and overuse continue to be widespread.^{52,53}

As is summarized in this report, Covered California has been engaged in efforts to help expand coverage, assure quality and promote delivery reform since its inception and is now engaged in a multi-year process to work with others across the state to address these challenges and improve health and health care for all Californians. While there has been progress, there have also been challenges — as should be expected given the size and complexity of the health care system and the position of Covered California within that system.

At the same time, California has made substantial progress through approaches that can inform the strategies of other public and private purchasers, states and the federal government. This progress was achieved thanks to policy changes enacted by the California Legislature, to specific actions taken by Covered California, and, importantly, to the willingness on the part of health insurers and providers in California to join in this work.

Much remains to be done and in the full companion report, [Covered California Holding Health Plans Accountable for Quality and Delivery System Reform](#), each section highlights implications for the future. These implications include the finding that further advances in performance measurement will be important in order to better identify opportunities for improvement, particularly for behavioral health and complex patients. Continued work to align public and private payers can help to strengthen incentives and reduce administrative burdens on providers and plans. Continued efforts to strengthen primary care and transition toward integrated delivery systems and ACOs are likely to offer benefits to both enrollees and providers. Most importantly, however, data and evidence should help guide decisions about how best to improve the performance of the health care system.

Covered California is committed to working collaboratively and transparently to ensure that it contributes to a state where “Health Care for All” means that all Californians receive the best possible care.

⁴⁸ Hartman, M., Martin, A. B., Espinosa, N., Catlin, A., and National Health Expenditure Accounts Team. (2017). National health care spending in 2016: spending and enrollment growth slow after initial coverage expansions. *Health Affairs*, 37(1), 150-160.

⁴⁹ Birkmeyer, J. D., Finks, J. F., O'Reilly, A., Oerline, M., Carlin, A. M., Nunn, A. R., ... and Birkmeyer, N. J. (2013). Surgical skill and complication rates after bariatric surgery. *New England Journal of Medicine*, 369(15), 1434-1442.

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⁵² Berwick, D. M., & Hackbarth, A. D. (2012). Eliminating waste in US health care. *Jama*, 307(14), 1513-1516.

⁵³ Korenstein, D., Falk, R., Howell, E. A., Bishop, T., and Keyhani, S. (2012). Overuse of health care services in the United States: an understudied problem. *Archives of internal medicine*, 172(2), 171-178.

Appendix: The Affordable Care Act’s Tools, Recent Federal Actions and California’s Steps to Protect and Build Towards Universal Coverage

Chart 1. Meaningful Coverage for Everyone	
Key ACA Provisions	
<p>Guaranteed Issue and Renewal: Requires plans to enroll consumers regardless of health status, age, gender, or other factors.</p> <p>Protections for Pre-Existing Conditions: Plans cannot exclude, deny coverage, or charge more based on pre-existing conditions.</p> <p>Standard Comprehensive Benefits: Requires plans to cover categories of essential health benefits ensuring comprehensive coverage when care is needed.</p> <p>No Annual or Lifetime Limits on Benefits</p> <p>Actuarial Value: Standardizes value of coverage by tiers so consumers know on average how much their plan will pay for health care costs.</p>	
Federal Policy Actions	California Policy Actions
<p>Promote plans and arrangements that can exclude consumers based on health status and pre-existing conditions, set coverage limits, and exclude benefits, not cover all essential health benefits:</p> <ul style="list-style-type: none"> • Short-term, limited-duration insurance, including urging Navigators to promote short-term plans rather than directing consumers to comprehensive coverage through the federal Exchange. • Unregulated health care sharing ministries • Association Health Plans which do not have to meet essential health benefit and other requirements. <p>Proposals to ability of consumers to automatically renew their coverage – a longstanding standard practice in the insurance industry – forcing consumers to reapply for coverage each year.</p> <p>Pulled back from planned federal efforts under prior administration to promote better standardization of benefit designs to protect consumers and foster competition on cost/value.</p>	<p>Ban the sale of short-term, limited duration insurance.</p> <p>Require agents certified by Covered California to disclose to consumers a comparison of protections of ACA coverage and risks of health care sharing ministries; Require agents to disclose number of health care sharing ministries sold.</p> <p>Prohibit small businesses and self-employed with no employees from enrolling in Association Health Plans.</p> <p>Require Patient-Centered Benefit Designs not only covering all essential health benefits but enhancing value and access to care by eliminating deductibles for outpatient services for most enrollees.</p>

Appendix: The Affordable Care Act’s Tools, Recent Federal Actions and California’s Steps to Protect and Build Towards Universal Coverage

Chart 2. Consumer Affordability

Key ACA Provisions

Medicaid Expansion: Providing coverage to millions of low-income Americans.

Financial Support to Help Americans Afford Coverage:

- Premium Tax Credits to help subsidize monthly premiums
- Cost-Sharing Reductions: Reduces out-of-pocket costs for certain low-income consumers.

Individual Mandate and Penalty: Requires consumers to maintain coverage if “affordable” to them or pay a penalty, which fosters healthier enrollment lowering costs for all consumers.

Open Enrollment Period: Protects health of the market by ensuring consumers don’t enroll into coverage only when they need it.

Support marketing and outreach: Advertising and navigator promotion are done nationally and required elements of state “blueprints” to operate as state-based marketplaces o promote enrollment and foster healthy market risk mix.

Enacted federal reinsurance: To help lower premiums, foster plan participation, and maintain a healthy risk mix.

Federal Policy Actions

Promote policies that may encourage barriers to Medicaid enrollment such as work requirements, while 14 states have not expanded Medicaid

Nullified the individual mandate by reducing the penalty to \$0 effective 2019.

Eliminated direct funding for the ACA-required Cost-Sharing Reductions subsidy program (and appears to be considering denying states’ abilities to have the effective workarounds that deliver the greatest benefit to consumers).

Virtual elimination of Marketing spending and large reductions in Navigator support: Cut federal funding for federal exchange and Navigators minimizing promotion of enrollment, comprehensive coverage, and awareness of federal subsidies.

Maintain a short six-week open enrollment period: (from Nov. 1 to Dec. 15 in contrast to enrollment period of Nov. 1 to Jan. 31 implemented in 2016 to 2017)

No support for federal reinsurance: States may apply for reinsurance waivers, but significant state funding required to initiate and maintain a state-based reinsurance program.

Areas in which federal action have continued, reinforced and potentially sought to go beyond the ACA include:

- Continued support for Medicare payment changes to reward value over volume
- Support for CMMI’s piloting of payment changes
- Consideration of federal policies to limit consumer-exposure to surprise billing and policies to directly address high pharmaceutical costs

California Policy Actions

Expanded Medicaid: California has both used the ACA and done state-only expansion of its Medi-Cal program.

Enacted State Mandate: Restored the penalty effective 2020, resulting in lower premiums and greater stability in the market.

Implemented Silver-Loading CSR Workaround: Established an effective workaround to the elimination of direct federal funding – which many other states also implemented – resulting in increased federal spending and likely marginally larger subsidies for some groups.

Significant investments in Marketing and Outreach: to promote stable enrollment, foster a healthy risk mix, and lower premiums, Covered California directly spends over \$100 million to promote stable enrollment leading to healthy risk mix; funds a network of over 100 community groups through its Navigator Program; and coordinates with contracted health plans to maximize their marketing and agent commission payments.

Full three-month open enrollment: Operates a longer open enrollment period, for 2020 running through Jan. 31, to promote enrollment (with coverage effective Feb. 1 even for consumers enrolling near the deadline)

Going Beyond the ACA: Established new state subsidies in 2020 for low- and middle-income Californians to make coverage more affordable.

- Low-income Californians will get financial help in addition to federal subsidies
- For the first time, middle-income Californians will receive subsidies to help with premium costs.

Appendix: The Affordable Care Act’s Tools, Recent Federal Actions and California’s Steps to Protect and Build Towards Universal Coverage

Chart 3. Consumer Choice	
Federal Policy Actions	California Policy Actions
<p>No reinstatement of federal reinsurance program</p> <ul style="list-style-type: none"> • States with may apply for state-based reinsurance program, however, need for state resource investments may be cost-prohibitive and/or difficult to sustain over the long-term. <p>Fostered instability and uncertainty through various policy actions:</p> <ul style="list-style-type: none"> • Elimination of direct funding for cost-sharing reductions. • Reduction of individual mandate penalty to \$0. • Encouraging and promoting enrollment in non-ACA compliant plans which can result in less healthy risk in the market and can add costs when consumers cannot get care covered. • Cut marketing and outreach funding 	<p>Require standard benefit designs both on Covered California and in the off-Exchange market</p> <ul style="list-style-type: none"> • Creates parity and stability across the entire individual market. • Requires plans to compete on price, networks, and service to consumers. <p>Negotiate with plans premiums, network design and other key areas.</p> <ul style="list-style-type: none"> • Improves affordability across the market as Covered California negotiated prices are available both on- and off-Exchange <p>Help plans understand the risk mix and to price right.</p> <ul style="list-style-type: none"> • Aids in fostering competition, affordability, and ensuring plans bring value to consumers.

Appendix: The Affordable Care Act’s Tools, Recent Federal Actions and California’s Steps to Protect and Build Towards Universal Coverage

Chart 4. Health Plan Accountability	
Federal Policy Actions	California Policy Actions
<p>Allow states to lower Medi-Cal Loss Ratios (allowing plans to spend less on health care costs and more on administration and profit) under certain circumstances.</p> <p>Stated requirement on plans to reduce disparities, but minimal oversight or guidance given to plan on how to meet quality domain standards.</p> <p>Continues to allow any plan to participate in a marketplace irrespective of value brought to the market.</p>	<p>Selective contracting with plans.</p> <ul style="list-style-type: none"> • Covered California qualified health plans must meet rigorous standards and demonstrate value to consumers. • Rejects QHP applicants that do not demonstrate they can meet standards or bring sufficient market value to consumers. <p>Actively Negotiating with plans.</p> <ul style="list-style-type: none"> • Help plans understand the risk mix and to price right. • Has rejected QHP applicants. • Required network design changes <p>Covered California’s contracts include rigorous quality standards and requires selected QHPs to adopt Quality Improvement activities selected in collaboration with stakeholders, including:</p> <ul style="list-style-type: none"> • Selecting providers based on quality • Measuring and narrowing disparities in care • Supporting advanced primary care and integrated/coordinated care models • Promoting quality improvement initiative addressing hospital quality, maternity care and the opioid epidemic

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