Bringing Care within Reach: Options to Promote California Marketplace Affordability and Improve Access to Care in 2023 and Beyond Using State and Federal Funding

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Note for reviews: feedback on this draft report should be sent policy@covered.ca.gov by Thursday, December 16, 2021. Covered California intends to finalize and submit the report in the week of December 20, 2021.

TABLE OF CONTENTS

Executive Summary 4

Introduction 7

Options for a Cost-Sharing Reduction Program 15

Potential State Options if American Rescue Plan Premium Subsidies are Not Extended 24

Operational Assessment for Implementation of a Cost-Sharing Reduction Program in 2023 26

Appendices 31

EXECUTIVE SUMMARY

Marketplace Coverage, Covered California and Ongoing Efforts to Increase Affordability

The Affordable Care Act reformed the individual health insurance market and established insurance Marketplaces that offer comprehensive insurance plans with income-based financial assistance for individuals who do not have affordable coverage through an employer, Medicaid or Medicare. Covered California is California's insurance Marketplace. Despite federal support to reduce Marketplace premiums and out-of-pocket costs such as copayments and deductibles, with the original Affordable Care Act subsidies many consumers still struggled to afford needed care due to both their required premium contributions and their out-of-pocket costs. To address remaining affordability concerns, California implemented a premium subsidy program in 2020 to reduce premium costs for low-income enrollees and expand eligibility to middle-income individuals who were not eligible for help under the Affordable Care Act. In 2021, the American Rescue Plan provided a significant increase in premium assistance through 2022, which effectively ended the state premium subsidy program. The Build Back Better Act (H.R. 5376) as passed by the House of Representatives on November 19, 2021, would both extend American Rescue Plan premium subsidies through 2025 and would provide $10 billion annually from 2023 through 2025 that would be allocated to states to use to reduce consumer costs including out-of-pocket spending.

Potential State and Federal Funding to Reduce Cost-Sharing for Marketplace Enrollees

In response to the American Rescue Plan, the 2021-2022 State Budget (Assembly Bill 128) and Health Omnibus trailer bill (Assembly Bill 133) redirected $333.4 million from the General Fund that would have been spent on state premium subsidies to a newly established Health Care Affordability Reserve Fund to be used for affordability programs operated by Covered California starting in plan year 2023. That legislation also called on Covered California to report on options for how state subsidies could reduce out-of-pocket costs for consumers. This report responds to that legislation. Most of the analytic work conducted by Covered California that was called for by AB 133 was performed in the context of how new state cost-sharing subsidies could complement the American Rescue Plan, which provided enhanced premium subsidies but did not provide additional cost-sharing support. Covered California added additional cost-sharing reduction options for consideration in the context of new potential federal funding to reduce consumer cost sharing as proposed in the Build Back Better Act (H.R. 5376). The full set of options presented in this report can be used by policymakers under several possible scenarios:

- **Scenario 1. The Build Back Better Act extends American Rescue Plan premium subsidies WITHOUT adding new cost sharing support:** Under this scenario, only state funding would be available for a cost-sharing reduction program. Most of the options in this report were developed for this scenario.

- **Scenario 2. The American Rescue Plan premium subsidies expire after 2022:** Under this scenario, the state would face a policy tradeoff between using state funding to reduce cost sharing or to address dramatic reductions in premium subsidies, that would take the state (and the nation) back to the original Affordable Care Act subsidy levels that were the basis of California's state-based premium support program instituted in 2020. This scenario is discussed below. See Potential State Options if American Rescue Plan Premium Subsidies Are Not Extended.
- **Scenario 3. The Build Back Better Act is enacted with additional cost sharing support:** Under this scenario, California would receive a portion of the national $10 billion in funding per year from 2023 through 2025 to lower consumer cost sharing. While additional modeling would undoubtedly be needed, we have included in this report a preliminary set of options for lowering cost-sharing based on likely federal funding levels. Covered California has not modeled additional options that would combine state and federal funding to further reduce consumer cost sharing under this scenario.

Options for a State Cost-Sharing Reduction Program

To produce this report, Covered California developed a variety of cost-sharing reduction options and commissioned the actuarial firm Milliman to estimate the cost of those options. Options were drawn from the AB 133 legislation, an extensive working group process that engaged a range of stakeholders (see Appendix I), other state-based cost-sharing reduction programs, and a cost-sharing reduction proposal modeled recently at the national level. This report presents Covered California's summary of the options and operational assessment for implementing either a state or new federal cost-sharing reduction program in 2023. Full details of the modeling developed by Milliman are available as a companion to this report.[1]

Options presented in this report would reduce out-of-pocket costs for low- and middle-income Californians enrolled through Covered California. Most options would expand eligibility for cost-sharing support above the current income limits. Many would also increase the actuarial value of plan designs for middle-income enrollees to match or exceed the generosity of Gold and Platinum plans, making these plans similar to or richer than the average actuarial value coverage provided for employer-sponsored coverage which is about 85. For the state-funded options presented, costs range from a low of $37 million per year to a high of $450 million per year. Federal funding through the Build Back Better Act would significantly expand the range of options that could be considered, as we estimate that under the proposal in H.R. 5376, approximately $1 billion would be available annually from 2023 to 2025 to reduce cost-sharing for California consumers. Table 1 presents a selection of three of the four options modeled for a state-funded cost-sharing reduction program and, for reference, one of the three options modeled if California were to use the federal funds under consideration in H.R. 5376. Additional detail on these and other options modeled is provided in the report that follows.

[1] *Bringing Care Within Reach – Milliman Companion Report*. December 6, 2021. https://www.hbex.ca.gov/stakeholders/AB_133_Health_Care_Affordability_Working_Group/Attachment-1_Bringing-Care-Within-Reach_Milliman-Companion_Report-12-06-21.pdf

Table 1. Summary of Selected Cost-Sharing Reduction Options Under State- or Federally-Funded Scenarios

Selected Options	Up to 150% FPL	150-200% FPL	200-250% FPL	250-300% FPL	300-400% FPL	400-600% FPL	Annual Cost of Option Based on CSR Plan Enrollment Scenarios		
							Current	Some Switching to CSR Plans	More Switching to CSR Plans
Cost-Sharing Reduction Plans under Current Law	*94*	*87*	*73*	*70*	*70*	*70*			
ACA CSR plans with no deductibles (Option 1)	**94**	**87**	**73**	**73**	**73**	**70**	$37	$45	$55
ACA CSR plans with no deductibles and Gold AV for 200-400% FPL (Option 2)	**94**	**87**	**80**	**80**	**80**	**70**	$128	$154	$189
ACA CSR plan upgrade with no deductibles and Gold AV for 250-400% FPL (Option 4)	**94**	**94**	**87**	**80**	**80**	**70**	$362	$403	$452
AV 95/90/85/80 with no deductibles (Option 9)	**95**	**95**	**90**	**90**	**85**	**80**	$475	$542	$626

Source: Table presents a selection of the 11 options modeled to show a range of options possible with state or federal funding. Full detail on all options modeled is available in Table 5 and Appendix C1 in the companion Milliman report.

Notes: ACA = Affordable Care Act, AV = actuarial value, CSR = cost-sharing reduction, FPL = federal poverty level. Enrollment scenarios reflect a range of switching among current Covered California members into CSR plans to take advantage of enhanced benefits. Green shading indicates richer CSR plan provided in the option compared to the Affordable Care Act.

Potential State Options if American Rescue Plan Premium Subsidies Are Not Extended

The American Rescue Plan significantly increased and expanded premium assistance for Marketplace enrollees nationwide for benefit years 2021 and 2022 by lowering premium contributions for Marketplace enrollees with income under 400 percent of the FPL and expanding premium subsidies to individuals with income above 400 percent of the FPL so that no Marketplace enrollee has to pay more than 8.5 percent of their income for coverage. If federal action is not taken to extend American Rescue Plan premium subsidies beyond 2022, Californians receiving these benefits through Covered California would lose approximately $1.6 billion annually in premium assistance. In that event, many thousands of the roughly 2.2 million Californians who receive coverage in the individual market might drop coverage.[2] Should this occur, California policy-makers would need to consider whether the Health Care Affordability Reserve Fund would be best used to partially address the shortfall by reinstating the California premium subsidy program.

[2] The Congressional Budget Office originally projected that approximately 1.3 million uninsured (nationally) would temporarily take-up new coverage under the American Rescue Plan; suggesting that roughly eight percent of current nongroup enrollment might be at risk of returning to being uninsured. See Congressional Budget Office (2021). CBO Cost Estimate: Reconciliation Recommendations of the House Committee on Ways & Means, February 2021: https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf.

Operational Assessment for Implementation of a Cost-Sharing Reduction Program in 2023

Launching a state cost-sharing reduction program in 2023 would require a significant amount of work on a compressed timeline. Program design and operations would need to closely follow the federal model and decisions would be needed as early as possible in calendar year 2022. We note that the statute that established the Health Care Affordability Reserve Fund does not specify an ongoing funding source. The workload associated with implementing a state cost-sharing program will divert Covered California staff from other policy and consumer experience priorities. These tradeoffs should be strongly considered if federal funding for cost-sharing support is not made available and a multi-year program cannot be financed with state funds.

INTRODUCTION

MARKETPLACE COVERAGE, COVERED CALIFORNIA AND ONGOING EFFORTS TO INCREASE AFFORDABILITY

Section in brief:

- *The Affordable Care Act reformed the individual health insurance market and established insurance Marketplaces that offer comprehensive insurance plans with income-based financial assistance for individuals who do not have affordable coverage through an employer, Medicaid or Medicare. Covered California is California's insurance Marketplace.*
- *Covered California uses the framework and tools of the Affordable Care Act to create benefit plans that reduce financial barriers to accessing needed health care services.*
- *In recent years, state and federal efforts have improved affordability of Marketplace coverage by increasing financial assistance to reduce monthly premiums for Marketplace coverage.*
- *While affordability of premiums has improved significantly, federal support to reduce out-of-pocket costs such as copays and deductibles is limited to the lowest-income Marketplace enrollees, and some still struggle to afford needed care.*

Affordable Care Act Marketplaces

The Affordable Care Act, passed in 2010, dramatically changed the individual health insurance market by implementing key reforms such as banning coverage exclusions for preexisting conditions; standardizing benefit and coverage levels; and creating insurance Marketplaces where eligible individuals can buy health insurance plans with federal financial assistance to lower monthly premiums and out-of-pocket costs. Covered California is California's health insurance Marketplace established under the Affordable Care Act. Through Covered California, eligible individuals buy Qualified Health Plans (QHPs) from brand-name health insurance issuers that are certified by Covered California for meeting state and federal standards.

Marketplace Benefits and Coverage Levels

The Affordable Care Act requires that plans sold in the individual market cover ten essential health benefit (EHB) categories. [3] The Affordable Care Act defines four "metal tiers" of coverage for these benefits that vary by actuarial value (AV), or the average amount of a member's health care cost that is paid by the health plan. The remaining cost is paid by the individual in the form of deductibles, copayments, and coinsurance which is referred to as member cost sharing. Plans with a lower AV generally have lower monthly premiums but higher cost-sharing. The four metal tiers are Bronze (60 percent of cost paid by the plan),

[3] Essential health benefits include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including oral and vision care.

Silver (70 percent of cost paid by the plan), Gold (80 percent of cost paid by the plan) and Platinum (90 percent of cost paid by the plan). Covered California takes an additional important step of in standardizing the benefit designs within in each metal tier in order to simplify consumer plan choice and encourage the use of high-value services, through in a benefit design process that is described in detail below (see Covered California's Patient-Centered Benefit Design Principles and Development Process).

Marketplace Eligibility and Financial Assistance

To purchase coverage through a Marketplace, individuals must meet federal eligibility requirements for citizenship or immigration status and state residency. Eligible individuals who do not have affordable coverage through an employer, Medicaid, Medicare or other qualifying program receive income-based financial assistance to lower their monthly premiums and cost-sharing.

- **Premium assistance:** Marketplace premium assistance under the Affordable Care Act is available to individuals with income above Medicaid eligibility levels. Appendix II shows California's eligibility levels for Medi-Cal – California's Medicaid program – and Marketplace coverage. Marketplace premium assistance takes the form of an income-based tax credit that can be taken in advance of tax filing to lower monthly premiums. Marketplace enrollees make a monthly required contribution toward their premium costs which ranges between zero to 8.5 percent of their income based on their federal poverty level, and the premium tax credits covers the remaining cost of the premium.[4] Recent state and federal policies described below have significantly increased premium assistance by expanding eligibility for assistance and reducing enrollee contributions toward monthly premiums.

- **Cost-sharing assistance:** The Affordable Care Act requires QHP issuers to reduce out-of-pocket maximums and cost-sharing amounts for consumers with income at or below 250 percent of the FPL, which is $32,200 for an individual and $66,250 for a family of four.[5] Marketplace enrollees access these benefits by enrolling in what are known as cost-sharing reduction (CSR) plans built on Silver-level coverage. For the lowest-income enrollees, CSR plans provide coverage near or above the Platinum level for Silver premium prices.

  CSR plans significantly reduce out-of-pocket costs at the point of care. For example, in Covered California's 2022 Silver 70 plan design, a primary care office visit costs $35, but in a Silver 94 plan the same visit costs $5. CSR plans also reduce the Maximum-Out-of-Pocket (MOOP) limit on cost-sharing for a benefit year. The MOOP in the most generous cost-sharing for an enrollee with income CSR plan eligibility and selected benefit information is presented in Table 2. It is important to note that consumers forego their CSR benefits if they enroll in coverage tiers other than Silver.

[4] These required contributions were implemented with the American Rescue Plan as discussed below. Under the Affordable Care Act, premium contributions ranged from approximately two to 10 percent of income, and individuals with income above 400 percent of the FPL were not eligible for premium assistance.
[5] QHP issuers are compensated by the federal government for reducing member cost sharing in accordance with federal requirements. Payment processes are discussed in the Operational Assessment section.

Table 2. Eligibility for Cost-Sharing Reduction Plans and Selected 2022 Cost-Sharing Amounts

Cost-Sharing Reduction Plan	Income Eligibility by Federal Poverty Level	Deductibles Individual / Family			Maximum Out-of-Pocket Limit	Primary Care Office Visit	Generic Drugs
		Outpatient Care	Drugs	Inpatient Care			
Silver 94	Up to 150%	$0 / $0	$0 / $0	$75 / $150	$800 / $1,600	$5	$3
Silver 87	151-200%	$0 / $0	$0 / $0	$800 / $1,600	$2,850 / $5,700	$15	$5
Silver 73	201-250%	$0 / $0	$10 / $20	$3,700 / $7,400	$6,300 / $12,600	$35	$15*
Silver 70	N/A	$0 / $0	$10 / $20	$3,700 / $7,400	$8,200 / $16,400	$35	$15*

*Price after drug deductible is met.

Covered California's Patient-Centered Benefit Design Principles and Development Process

Two key Affordable Care Act market reforms – requiring essential health benefits and standardized coverage tiers – work in concert to ensure consumers can shop with confidence for comprehensive coverage with clear distinctions based on plan generosity. The addition of cost-sharing supports is critical for low-income Marketplace enrollees to afford the care they need. But these elements are not sufficient to ensure that consumers do not face an overwhelming number of benefit designs that are difficult to understand and create unnecessary financial risk and barriers to accessing care. To address these issues, Covered California develops standard benefit designs – known as Patient Centered Benefit Designs – for all metal tiers and CSR plans. These designs are crafted to remove as many financial barriers as possible to consumers receiving needed care as possible, enable apples-to-apples comparisons between product offerings, and incentivize insurers to compete on factors like network composition, service, and quality rather than enrollee risk selection. See Appendix III for Covered California's 2022 Patient-Centered Benefit Designs.

Each year, Covered California partners with consumer advocates, Qualified Health Plan issuers, providers, hospital associations, and regulators to update the benefit designs to meet annual actuarial value requirements. In this process, Covered California incorporates the following benefit design principles to reduce financial barriers to care:

1. Emphasize first dollar coverage for most outpatient services in the Silver, Gold and Platinum plans. Enrollees with Bronze coverage have a copayment for the first three non-preventive office visits before the deductible applies. With key primary care benefits not subject to the deductible, Patient-Centered Benefit Designs offer greater access to care.
2. Implement cost-sharing caps for expensive Tier 4 specialty drugs ($250 for Silver, Gold, and Platinum; $500 for Bronze).
3. Use of copayments versus coinsurance for several benefit categories and in particular to promote higher value care like primary care visits and generic medications.
4. Integrate the maximum out-of-pocket limit for health and pediatric dental benefits.

If a state cost-sharing reduction program were implemented, Covered California would use its existing benefit design process to ensure that additional funding is applied in a way that maximizes consumer value. Considerations for this process are included in the Operational Assessment section of this report.

REMAINING AFFORDABILITY CHALLENGES

Most efforts to address Marketplace affordability have centered on increasing premium subsidies, as premiums represent the initial barrier to coverage take-up. However, consumers' perceptions of plan value include both premium and out-of-pocket costs, with enrollment and utilization decisions reflecting their perceived affordability of both.

Low-income enrollees face high costs with higher utilization

With enhanced premium subsidies available through the American Rescue Plan, individuals with incomes under 200 percent of the FPL contribute up to two percent of their income for their benchmark CSR plan; individuals with incomes under 150 percent of the FPL are also eligible for $0 Silver 94 CSR plans. While enhanced subsidies increase affordability of premiums for these individuals, some low-income consumers can still face high cost-sharing relative to their monthly incomes. Evidence suggests that most individuals accrue their total out-of-pocket costs for the year in just one or two health encounters, which could create significant financial shocks for lower-income enrollees.[6] For example, an individual enrolled in a Silver 87 plan attending an annual check-up with an accompanying follow-up appointment, lab work, and a medication, could total almost four percent of their monthly income – nearly double their monthly premium cost - for this single encounter.[7] While generally considered affordable for most enrollees, individuals with more complex health needs will face greater cost burdens to access needed care.

Little to no cost-sharing support for other consumers

The federal cost-sharing program significantly increases the generosity of Silver plans for the Marketplaces' enrollees at the lowest income levels, but there is little or no cost-sharing support for those with incomes over 200 percent of the FPL. While individuals with incomes between 200 and 250 percent of the FPL do qualify for the Silver 73 CSR plan, these benefit designs are nearly identical to the standard Silver 70 plan, offering little costs-sharing support at these incomes. In addition, while federally-defined maximum out-of-pocket limits provide important financial protection for enrollees who need high cost care like inpatient hospitalization and specialty drugs, those limits remain high as a percentage of income for groups that receive little or no federal cost-sharing support as shown in Table 3.

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[6] Steven Chen et al., Annual Out-of-Pocket Spending Clusters Within Short Time Intervals: Implications for Health Care Affordability, *Health Affairs* Volume 40, Number 2, February 2021.

[7] See Covered California October 14, 2021 AB 133 Health Care Affordability Working Group Meeting materials, Slide 10: Lucia L. Oct 2021. Encounter scenario assumes out-of-pocket costs total $60 for an individual with an income of $1,620.
https://hbex.coveredca.com/stakeholders/AB_133_Health_Care_Affordability_Working_Group/Final_10.14.21.pdf

Table 3. 2022 Maximum out-of-pocket limits as a percentage of annual household income

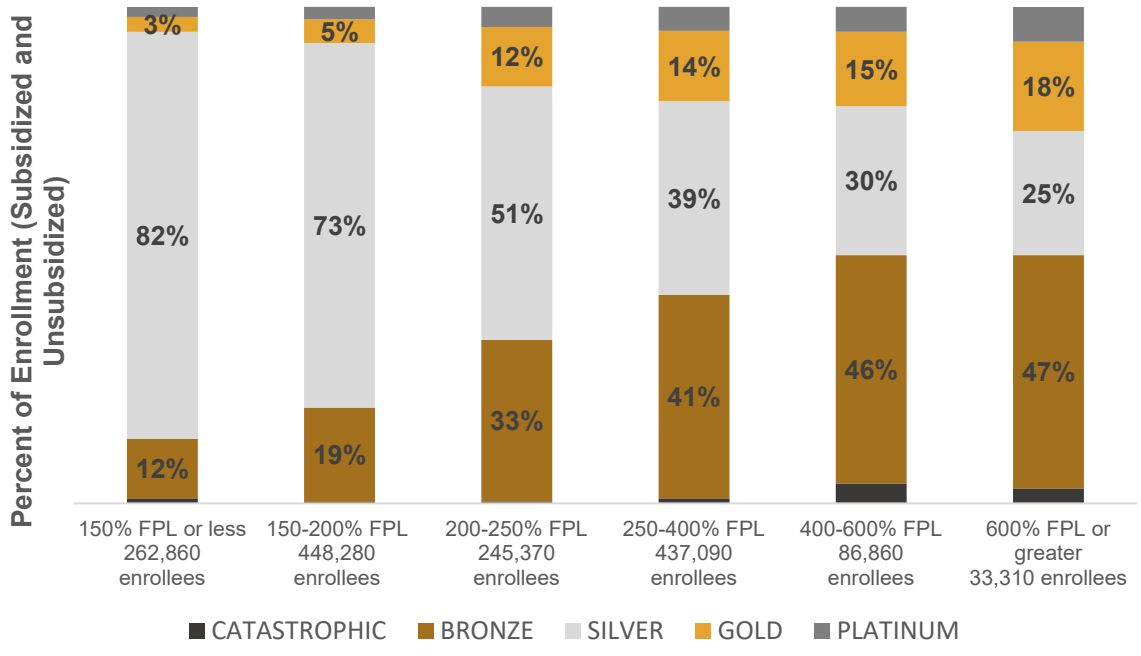
Income Eligibility by Federal Poverty Level	Cost-Sharing Reduction Plan Actuarial Value	Maximum Out-of-Pocket Limit		Maximum Out-of-Pocket Limit as a Percent of Annual Income	
		Individual	Family	Individual	Family of Four
Up to 150%	Silver 94	$800	$1,600	4-6%*	4-6%*
151-200%	Silver 87	$2,850	$5,700	11-15%	11-14%
201-250%	Silver 73	$6,300	$12,600	20-24%	19-24%
251-400%	Silver 70	$8,200	$16,400	16-25%	15-25%

*Range calculated for income at 100 and 150 percent of the federal poverty level.

Implications for take-up and utilization

Affordability issues have implications for take-up, plan choice, and enrollee health care utilization. As shown in Figure 1, take-up of Silver plans among Covered California enrollees decreases as income increase (and Silver actuarial value decreases), while enrollment in Bronze plans increases as income increases. While only 12 to 19 percent of enrollees choose Bronze plans when income is below 200 percent of the FPL, the share of Bronze enrollees by income group jumps to 33 percent for those between 200 to 250 percent of the FPL and 46 percent for middle-income consumers. As enhanced cost-sharing support declines, consumers at higher incomes opt for the lower premiums of Bronze plans at higher rates.

FIGURE 1. Distribution of Metal Tier Choice, by Federal Poverty Level Bracket



Source: Covered California Active Member Profile, June 2021. Available at: https://www.hbex.ca.gov/data-research/

Perceptions of plan affordability also limit Marketplace coverage take-up among the uninsured, with many unaware of available financial assistance.[8] However, lack of awareness of subsidies and premium costs are not the only reasons individuals remain uninsured. Many uninsured individuals report preferring not to enroll in a plan with subsidized premiums if the plan comes with high out-of-pocket costs. National survey data indicate that 75 percent of uninsured individuals would not be interested in enrolling in a Bronze plan with a $0 monthly premium if accompanied with an annual deductible that exceeds $5,000.[9]

Covered California Bronze enrollees face much higher cost-sharing, including a $6,300 individual medical deductible, which may influence enrollees' decisions to seek care. In 2018, three in 10 Bronze enrollees reported delaying care to costs, compared to less than one in 10 enrollees in the Silver 94 CSR plan. The rate of delaying care due to costs for enrollees in the Silver 70 plan was more than twice the rate of enrollees in the Silver 94 CSR plan.

Finally, implementation of the enhanced premium subsidies under the American Rescue Plan has highlighted the significant financial implications of foregoing CSR plans in order to enroll in Platinum, Gold or Bronze plans. Individuals eligible for the richest CSR plans who instead choose Platinum or Gold plans pay higher monthly premiums and copayments than they would in a CSR plan and have significantly higher maximum out-of-pocket limits.[10] Also, with the American Rescue Plan premium subsidies, many low-income enrollees in Bronze plans could pay the same amount in monthly premium for a generous CSR plan.

Measuring Affordability

In an effort to measure these various affordability concerns, researchers at The Commonwealth Fund defined metrics of "underinsurance" in which an individual has health coverage but faces steep out-of-pocket costs that make care unaffordable. Based on out-of-pocket costs, an individual is considered underinsured if:

1. Deductibles equal five percent or more of a person's income, or
2. Out-of-pocket costs (excluding premiums) total 10 percent or more for an individual with an income greater than 200 percent of the FPL or more than five percent for lower-income individuals (below 200 percent of the FPL).

[8] Jennifer M. Haley et al. Many Uninsured Adults Have Not Tried to Enroll in Medicaid or Marketplace Coverage. Urban Institute, January 2021.
[9] Karen Pollitz et al. Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need. Henry J. Kaiser Family Foundation, August 2020.
[10] For a discussion of such "choice errors" in California, see Feher, Andrew, and Isaac Menashe. "Using Email And Letters To Reduce Choice Errors Among ACA Marketplace Enrollees." Health Affairs 40, no. 5 (2021): 812-819.

By these metrics, 42 percent of individual market enrollees nationally are considered underinsured.[11] One limitation of this underinsured metric is that Covered California's standard benefit designs maximize first dollar coverage for most outpatient services in the Silver metal tier, but a higher deductible is required for inpatient care and skilled nursing care to achieve this. Nevertheless, as California explores options to reduce cost-sharing for Covered California enrollees, these or similar metrics may be helpful in evaluating policy options.

EFFORTS TO INCREASE AFFORDABILITY OF MARKETPLACE COVERAGE

State and federal efforts over the last several years have built on the foundation of the Affordable Care Act to increase affordability for Marketplace enrollees:

- **In 2020, California established a state-funded premium subsidy program to complement the Affordable Care Act for low- and middle-income Californians:** California established a three-year pilot program to provide new and enhanced premium subsidies to Covered California enrollees. The program was the first in the nation to provide premium subsidies to middle-income individuals with income between 400 and 600 percent of the federal poverty level. The program took effect in in 2020, along with the state individual mandate to have coverage. As a result of these policies, Covered California saw a dramatic increase in new sign-ups during the open enrollment period for 2020 compared with 2019.[12] While the program was authorized through 2022, it was effectively ended in 2021 with the enactment of the federal American Rescue Plan.

- **In 2021, the American Rescue Plan significantly increased and expanded federal premium assistance for Marketplace enrollees nationwide**. Among its many provisions, the American Rescue Plan increased and expanded Marketplace premium assistance for 2021 and 2022 by lowering required premium contributions for Marketplace enrollees earning less than 400 percent of the FPL and expanding premium subsidies to individuals earning more than 400 percent of the FPL, so that no Marketplace enrollee pays more than 8.5 percent of their income for a benchmark plan. Appendix IV provides a comparison of premium subsidies under the Affordable Care Act and the American Rescue Plan.

  The American Rescue Plan significantly increased financial support for Covered California enrollees. Average household subsidies increased by over $100 per month, bringing the average monthly premium subsidy to $704 and the average household net premium to $109. Notably, more than half of households enrolled through Covered California in 2021 had a $1 per member per month premium after implementation of the American Rescue Plan, compared to only 11 percent of households under the Affordable Care Act subsidies.

[11] Sara R. Collins et al. U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability. Commonwealth Fund, August 2020.

[12] Covered California (2020). New California Policies Make Huge Difference, Increasing New Signups During Covered California's Open Enrollment by 41 Percent (February 18, 2020): https://www.coveredca.com/newsroom/news-releases/2020/02/18/new-california-policies-make-huge-difference-increasing-new-signups-during-covered-californias-open-enrollment-by-41-percent/.

While the American Rescue Plan made significant increases in support for consumers' premiums, it did not increase cost-sharing support or lower consumers out-of-pocket costs at their point of service.

- **The Build Back Better Act would extend the American Rescue Plan premium subsidies through 2025 and provide states funding to further lower costs for Marketplace enrollees:** The Build Back Better Act (H.R. 5376, as passed by the House or Representatives on November 19, 2021) includes several provisions that would increase affordability of Marketplace coverage by: (1) extending the American Rescue Plan premium subsidies through 2025; (2) establishing an affordability fund that would provide $10 billion per year between 2023 and 2025 for Marketplaces to lower enrollee costs including by reducing cost-sharing such as copayment and deductibles; and (3) enhancing benefits for individuals with income at or below 138 percent of the FPL who do not qualify for Medicaid coverage. These provisions are discussed below along with a preliminary set of cost-sharing reduction options that could be considered if federal funding is made available.

OPTIONS FOR A STATE COST-SHARING REDUCTION PROGRAM

Section in brief:

- *Covered California developed a **variety of options** for a state cost-sharing reduction program that would reduce out-of-pocket costs for low- and middle-income Californians enrolled through Covered California.*
- *Several options would increase the actuarial value of plan designs for middle-income enrollees to **match or exceed the generosity of Gold and Platinum plans**, making these plans similar or richer than the average actuarial value of 85 percent for employer-sponsored coverage.*
- *Federal funding through the **Build Back Better Act would significantly expand the range of options** that could be considered.*

CONTEXT FOR REVIEWING COST-SHARING REDUCTION OPTIONS

Enactment of the Build Back Better Act (H.R. 5376) as passed by the House of Representatives on November 19, 2021, would significantly expand the range of the options that could be considered for an enhanced cost-sharing reduction program relative to what would be possible with state funding. Options should be reviewed in the context of the following federal funding scenarios for 2023.

- **Scenario 1. The Build Back Better Act extends American Rescue Plan WITHOUT new cost sharing support:** Under this scenario, only state funding would be available for a cost-sharing reduction program. Most of the options in this report were developed for this scenario.
- **Scenario 2. The American Rescue Plan premium subsidies expire after 2022:** Under this scenario, the state would face a policy tradeoff between using state funding to reduce cost sharing or to address dramatic reductions in premium subsidies, that would take the state (and the nation) back to the original Affordable Care Act subsidy levels that were the basis of California's state-based premium support program instituted in 2020. This scenario is discussed below. See Potential State Options if American Rescue Plan Premium Subsidies Are Not Extended.
- **Scenario 3. The Build Back Better Act is enacted with new cost sharing support:** Under this scenario, California would receive a portion of the national $10 billion in funding per year from 2023 through 2025 to lower consumer cost sharing. While additional modeling would undoubtedly be needed, we have included in this report a preliminary set of options for lowering cost-sharing based on likely federal funding levels. Covered California has not modeled additional options that would combine state and federal funding to further reduce consumer cost sharing under this scenario.

SUMMARY OF OPTIONS MODELED

Covered California developed a variety of cost-sharing reduction options and commissioned Milliman to estimate the cost of those options. This section summarizes the options and key considerations for program design. Full details of the modeling developed by Milliman are available as a companion to this report.[13]

Options were modeled using the following steps:

1. **Developed plan designs.** Covered California provided Milliman with twelve plan designs to model – four existing and eight illustrative. Deductibles were eliminated in all illustrative plan designs, and copayment and coinsurance amounts were significantly reduced in many designs. Plan design detail is displayed in Table 4 and can be summarized as follows:
    - Plans 1, 3, 7 and 10 are the existing Silver CSR plans for 2022.
    - Plans 2, 4, 8 and 11 are the existing Silver CSR plans for 2022, with the deductibles removed (e.g., eliminating the $3,700 inpatient deductible and $10 drug deductible from the Silver 73 plan design).
    - Plans 5, 6, 9 and 12 were chosen to target a desired actuarial value (e.g. Silver 80). Covered California provided the plan designs to use in order to achieve the target actuarial value.

2. **Estimated per member per month costs for each plan design.** Milliman modeled the marginal per member per month (PMPM) cost the state would have to pay to provide each of the modeled plan designs based on enrollee income group (e.g., it would cost approximately $48 PMPM to provide a Silver 94 plan to enrollees currently eligible for a Silver 87 plan). Average marginal PMPM costs are reported at a statewide level and separately for Northern and Southern California. See Tables 2, A1 and A2 of the Milliman report for full detail.

3. **Estimated the cost of several cost-sharing reduction program options.** At Covered California's direction, Milliman estimated the total costs of 11 program design options that differ by the plan design and enrollee income group. Options were drawn from the AB 133 legislation and working group process which requires Covered California to:
    - "Include options for all Covered California enrollees with income up to 400 percent of the FPL to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs."
    - "Include options to provide zero deductibles for all Covered California enrollees with income under 400 percent of the FPL and upgrading those with income between 200 percent and 400 percent, inclusive, of the FPL to gold-tier cost sharing."

[13] *Bringing Care Within Reach – Milliman Companion Report*. December 6, 2021. https://www.hbex.ca.gov/stakeholders/AB_133_Health_Care_Affordability_Working_Group/Attachment-1_Bringing-Care-Within-Reach_Milliman-Companion_Report-12-06-21.pdf

Several options are based on other state-based cost-sharing reduction programs[14] and a cost-sharing reduction proposal modeled recently at the national level by researchers at the Urban Institute.[15]

Table 5 presents the four options modeled for a state-funded cost-sharing reduction program and a selection of the options modeled if California were to use the federal funds under consideration in H.R. 5376. Detail for all 11 options modeling is available in the companion Milliman report.

For each option, at each income level, the table shows the proposed actuarial value for the Silver product proposed, and denotes the combination of benefit and eligibility improvements proposed as follows:

- Improved cost-sharing relative to current eligibility under the Affordable Care Act, through either:
  - CSR "upgrades" that further reduce cost-sharing for those who are already eligible for some cost-sharing assistance at or below 250 percent of the FPL;
  - Expansion of new eligibility for a group with income above 250 percent of the FPL that is ineligible for a cost-sharing plan under the Affordable Care Act.
- Elimination of deductibles.

Table 5 also provides a cost range for each option based on one of three "tier switching" enrollment scenarios under which some percentage of Covered California members are assumed to switch from either the Platinum, Gold, or Bronze tiers to take advantage of the enhanced cost-sharing subsidies at the Silver tier. See Tables 3, 4, and 6 of the Milliman report for full detail. All estimates use 2021 enrollment and would need to be updated in 2022 to reflect projected 2023 enrollment, including any changes in either Covered California's total enrollment or changes in metal tier choice.

[14] Massachusetts, Vermont and Colorado operate state-level cost-sharing reduction programs within their Marketplace programs. See Appendix V for additional information.

[15] Linda J. Blumberg et al. Cost and Coverage Implications of Five Options for Increasing Marketplace Subsidy Generosity. Urban Institute, February 2021. Accessed on December 7, 2021. https://www.urban.org/sites/default/files/publication/103604/cost-and-coverage-implications-of-five-options-for-increasing-marketplace-subsidy-generosity_0.pdf

Table 4: Key Components of Existing 2022 Covered California Plan Designs and Illustrative Plan Designs

Plan	Plan Description	Existing or Illustrative	Deductible			MOOP	Copays			Federal Actuarial Value
			Inpatient [2]	Outpatient	Drug		PCP	X-Ray	Drugs [4]	
1	Individual Silver 70	Existing	$3,700	$0	$10	$8,200	$35	$85	$15/55/85/20%	71.5%
2	Individual Silver 70 with Deductibles Removed	Illustrative[1]	$0	$0	$0	$8,200	$35	$85	$15/55/85/20%	74.3%
3	73 Silver	Existing	$3,700	$0	$10	$6,300	$35	$85	$15/55/85/20%	73.9%
4	73 Silver with Deductibles Removed	Illustrative[1]	$0	$0	$0	$6,300	$35	$85	$15/55/85/20%	76.3%
5	80 Silver	Illustrative	$0	$0	$0	$8,200	$35	$75	$15/55/85/20%	79.8%
6	85 Silver	Illustrative	$0	$0	$0	$5,200	$15	$40	$5/25/45/15%	85.0%
7	87 Silver	Existing	$800	$0	$0	$2,850	$15	$40	$5/25/45/15%	87.9%
8	87 Silver with Deductibles Removed	Illustrative[1]	$0	$0	$0	$2,850	$15	$40	$5/25/45/15%	88.3%
9	90 Silver	Illustrative	$0	$0	$0	$4,500	$15	$30	$5/15/25/10%	89.3%
10	94 Silver	Existing	$75	$0	$0	$800	$5	$8	$3/10/15/10%	94.7%
11	94 Silver with Deductibles Removed [3]	Illustrative[1]	$0	$0	$0	$800	$5	$8	$3/10/15/10%	94.9%
12	99 Silver	Illustrative	$0	$0	$0	$250	$0	$0	$0/10/10/10	99.7%

Source: This table was reproduced from Table 1 in the companion Milliman report.

Notes:

[1]Illustrative plans titled "with Deductibles Removed" are modified versions of existing plans (i.e., the deductibles are removed). For ease of reference, we used the parallel naming convention for these illustrative plans, however the AVs are different due to the changes made. For example, 73 Silver with Deductible Removed (Illustrative) has an AV that is higher than 73%.

[2]The inpatient deductible applies to both inpatient facility and skilled nursing facilities.

[3]The plan 94 Silver with Deductibles Removed is also referred to as 95 Silver in this report.

[4] Cost sharing for drugs is shown as Tier 1 / Tier 2 / Tier 3 / Tier 4. Tier 1 is most generic drugs and low-cost preferred brands. Tier 2 is non-preferred generics and preferred brand drugs. Tier 3 is non-preferred brand drugs. Tier 4 is specialty drugs and biologics.

Table 5. Summary of Key Elements of Selected Cost-Sharing Reduction Options Modeled

= richer CSR support

	Option	Summary	Description	Up to 150% FPL		150-200% FPL		200-250% FPL		250-300% FPL		300-400% FPL		400-600% FPL		Annual Cost by Tier Switching Scenarios 1, 2, and 3 (millions)		
				CSR Upgrade	No Deductible	CSR Upgrade	No Deductible	CSR Upgrade	No Deductible	New CSR Eligibility	No Deductible	New CSR Eligibility	No Deductible	New CSR Eligibility	No Deductible	Current	Some Tier Switching	More Tier Switching
	N/A	***Current CSR Eligibility***		*CSR Eligible*						*CSR Ineligible*								
		AV of ACA Silver Products		*94*		*87*		*73*		*70*		*70*		*70*				
AB 133 Statute and Working Group	1	**ACA CSR plans with no Deductibles**	Existing CSR products across the income spectrum. No deductibles at any income below 400% FPL.	**94**	✓	**87**	✓	**73**	✓	**73**	✓	**73**	✓	**70**		$37	$45	$55
	2	**ACA CSR plans with no Deductibles and Gold AV for 200-400% FPL**	New CSR product (AV 80) for 200% FPL. No deductibles at any income below 400% FPL.	**94**	✓	**87**	✓	**80**	✓ ✓	**80**	✓ ✓	**80**	✓ ✓	**70**		$128	$154	$189
	3	**ACA CSR plan upgrade for 150-250% FPL**	Richer CSR below 250% FPL, moving Silver 87 to Silver 94 and Silver 73 to Silver 87.	**94**		**94**	✓	**87**	✓	**70**		**70**		**70**		$278	$299	$322
	4	**ACA CSR plan upgrade with no deductibles and Gold AV for 250-400% FPL**	New eligibility for CSR up to 400% FPL. New CSR products (min AV 80) up to 400% FPL.	**94**	✓	**94**	✓ ✓	**87**	✓ ✓	**80**	✓ ✓	**80**	✓ ✓	**70**		$362	$403	$452
Selected Build Back Better Options	8	**AV 95/90/85 with no deductibles**	New eligibility for CSR up to 400% FPL. New products (min AV 85) under 400% FPL. No deductibles at any income below 400% FPL	**95**	✓	**95**	✓ ✓	**90**	✓ ✓	**90**	✓ ✓	**85**	✓ ✓	**70**		$463	$526	$604
	9	**AV 95/90/85/80 with no deductibles**	New eligibility for CSR up to 600% FPL. New products (min AV 80) under 600% FPL. No deductibles at any income below 600% FPL	**95**	✓	**95**	✓ ✓	**90**	✓ ✓	**90**	✓ ✓	**85**	✓ ✓	**80**	✓ ✓	$475	$542	$626
	11	**ACA CSR plan upgrade with no deductibles and Gold AV for 300-400% FPL**	New eligibility for CSR up to 400% FPL. New CSR products (min AV 80) up to 400% FPL.	**94**	✓	**94**	✓ ✓	**87**	✓ ✓	**87**	✓ ✓	**80**	✓ ✓	**70**		$386	$433	$489

Source: Adapted from Table 5 and Appendix C1 in the companion Milliman report. Table 5 in the Milliman report also includes modeling of cost-sharing reduction programs in Colorado, Massachusetts and Vermont (Options 4-7). Appendix C1 also includes modeling of an additional option for Build Back Better funding (Option 10).

Notes: ACA = Affordable Care Act, AV = actuarial value, CSR = cost-sharing reduction, FPL = federal poverty level.

Option 1: Affordable Care Act CSR plans with no deductibles ($37 – $55 million). In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. State funding would be used to eliminate deductibles in existing CSR plans and upgrade the Silver base plan for individuals between 250 and 400 percent of the FPL.

Option 2: Affordable Care Act CSR plans with no deductibles and Gold AV for individuals between 200 and 400 percent of the FPL ($128 – $189 million). In this option, CSR support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 200 and 400 percent of the FPL would receive a new Silver 80 plan. Deductibles would also be eliminated as in Option 1.

Option 3: Affordable Care Act CSR plan upgrade for individuals between 150 and 250 percent of the FPL ($278 – $322 million). In this option, eligibility for CSR plans would remain at 250 percent of the FPL but individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to an existing Silver 94 plan and individuals between 200 and 250 percent of the FPL would be upgraded from a Silver 73 to existing Silver 87 plan. Deductibles would not be eliminated in this option which would prevent the need for benefit design changes.

Option 4: Affordable Care Act CSR plan upgrade with no deductibles and Gold AV for individuals between 250 and 400 percent of the FPL ($362 – $452 million). In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to an existing Silver 94 plan and individuals between 200 and 250 percent of the FPL would be upgraded from a Silver 73 to a Silver 87 plan. Individuals between 250 and 400 percent of the FPL would receive a new Silver 80 plan. Deductibles would be eliminated as in Option 1.

Option 8: AV 95/90/85 with no deductibles ($463 – $604 million). In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. Coverage generosity would be increased with new CSR plan actuarial values set to 95, 90 and 85. All individuals above 150 percent of FPL would be upgraded from their existing plans. Deductibles would be eliminated as in Option 1.

Option 9: AV 95/90/85/80 with no deductibles ($475 – $626 million). In this option, cost-sharing reduction support would be expanded to all enrollees up to 600 percent of the FPL. Coverage generosity would be increased with new CSR plan actuarial values set to 95, 90, 85 and 80. All individuals above 150 percent of FPL would be upgraded from their existing plans. Deductibles would be eliminated as in Option 1. Note that this is the only modeled option that incorporates CSR enhancements above 400 percent of FPL.

Option 11: Affordable Care Act CSR plan upgrade with no deductibles and Gold AV for individuals between 300 and 400 percent of the FPL ($386 – $489 million). In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to a Silver 94 plan with no deductibles and individuals between 200 and 300 percent of the FPL would be upgraded from a Silver 73 to a Silver 87 plan with no deductibles. Individuals between 300 and 400 percent of the FPL would receive a new Silver 80 plan that has no deductibles. Deductibles would be eliminated as in Option 1.

BENEFIT AND PROGRAM DESIGN CONSIDERATIONS

While Covered California will provide technical assistance during the development of any state cost-sharing reduction proposal, we offer several program design considerations to inform initial policy discussions.

- **Integration of state cost-sharing reduction funding into Covered California's program:** For this modeling effort, Covered California assumed that a state cost-sharing reduction program would operate similarly to the federal cost-sharing reduction program in which the statute defines both the income-based eligibility for CSR plans and the actuarial value that those plans would have to meet for each income group. We further assumed that Covered California would produce one standard CSR plan for each income group that would combine federal and state cost-sharing support. Actual plan designs developed for a state cost-sharing reduction program could differ from those modeled for this report based on federal actuarial value requirements for the 2023 benefit year and benefit design choices (e.g., requiring copayments versus coinsurance for certain services). Qualified Health Plan issuers would be compensated for the federal portion of the cost-sharing reduction through the Silver loading process and for the state portion through a direct payment made by the state. Operational considerations for payment are described below.

- **Impact of deductibles.** The marginal cost of eliminating deductibles in Silver plans is small because deductibles are only applied to inpatient hospital and skilled nursing services, for which members very often hit their maximum out-of-pocket limit. While the direct financial impact of this option is relatively low, eliminating deductibles may have other important impacts on consumer take-up of coverage and access and use of care, including:
    - Removing a potential enrollment barrier for consumers who are eligible for CSR plans but are deterred from enrolling based on real or perceived financial risk, or a judgement that a product with a deductible does not provide adequate value for the cost of the plan; or
    - Removing a potential barrier for seeking care due to perceived cost for those who are enrolled, yet not aware that their plan's medical deductible only applies to inpatient services.

  These secondary impacts were not modeled in the analysis by Milliman.

- **Required updates to cost and enrollment estimates to develop state budget estimates:** As noted above, the costs of the options presented in this report are preliminary and only address tier switching among current members. Costs will need to be updated in 2022 to reflect projected enrollment and benefit costs for 2023.

- **Actuarial Value Comparisons to Employer-Sponsored Coverage.** Several options modeled would increase the actuarial value of plan designs for middle-income enrollees to match or exceed the generosity of Gold and Platinum plans, making these plans similar or richer than the average actuarial value of 85 percent for employer-sponsored coverage.[16] Recent research indicates that a growing share (85 percent) of individuals with employer-sponsored coverage are enrolled in plans with a general annual deductible with an average amount of nearly $1,700 for single-coverage. Nearly all employer plans require additional cost-sharing for physician and specialist visits, and most enrollees face additional cost-sharing for outpatient surgery and hospital admissions.[17]

POTENTIAL IMPLICATIONS OF FEDERAL BUILD BACK BETTER LEGISLATION

As noted above, the Build Back Better Act (H.R. 5376) as passed by the House of Representatives on November 19, 2021, would provide $10 billion in funding in each benefit year from 2023 through 2025 for Marketplaces that could be used to reduce member cost-sharing. While Covered California is still reviewing the allocation methodology in the proposed legislation, if funding were allocated proportionally based on recent CSR enrollment, California might receive $1.2 to $1.4 billion. This potential funding for cost-sharing would significantly exceed the amount of state funding in the Health Care Affordability Reserve Fund.[18] Should this provision be enacted into law, Covered California would need to engage in a review of options for uses of the funding and would likely need to develop additional modeling for cost-sharing or other affordability options. However, given the potential federal action to increase cost-sharing assistance, Covered California requested that Milliman enhance several of the options developed for this report to provide a preliminary set of options that might be more appropriate for the federal funding level. Those options are summarized in Table 4 and Appendix C in the Milliman report. We did not model additional options that would combine state and federal funding to reduce consumer cost sharing.

[16] See for example Rae, M., Copeland, R., and Cox, C. (2019). Tracking the rise in premium contributions and cost-sharing for families with large employer coverage. *Kaiser Family Foundation* https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/. See also Thomas G. Moehrle, "Measuring the generosity of employer-sponsored health plans: an actuarial-value approach," Monthly Labor Review, U.S. Bureau of Labor Statistics, June 2015, https://doi.org/10.21916/mlr.2015.16. Available at: https://www.bls.gov/opub/mlr/2015/article/measuring-the-generosity-of-employer-sponsored-health-plans.htm.

[17] 2021 Employer Benefits Survey. Kaiser Family Foundation (2021). https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf

[18] In a recent effectuated enrollment snapshot (for the month of February 2021), California comprised 12.3 percent of all CSR effectuated enrollment, and 14.0 percent of total marketplace enrollment. See Centers for Medicare and Medicaid Services (2021). Effectuated Enrollment: Early 2021 Snapshot and Full Year 2020 Average (June 5, 2021). https://www.cms.gov/document/Early-2021-2020-Effectuated-Enrollment-Report.pdf

Finally, the provision of the Build Back Better Act that is intended to expand health care coverage in states that did not expand their Medicaid programs would provide special benefits for all individuals under 138 percent of the federal poverty level who qualify for Marketplace coverage and do not qualify for Medicaid.[19] In addition to enhanced premium subsidies that would be available in 2022, these individuals would be eligible for a new CSR plan with an actuarial value of 99 percent for benefit years 2023 through 2025. Plan design and PMPM costs for an illustrative Silver 99 plan design are available in the Milliman report.

[19] This generally includes individuals with household income under the federal poverty level who do not qualify for Medicaid for reasons other than immigration status.

POTENTIAL STATE OPTIONS IF AMERICAN RESCUE PLAN PREMIUM SUBSIDIES ARE NOT EXTENDED

Section in brief:

- *If federal action is not taken to extend American Rescue Plan premium subsidies beyond 2022, Covered California* ***enrollees will lose approximately $1.6 billion annually in premium assistance.***
- *Should this occur, the Health Care Affordability Reserve Fund could be used to* ***partially address the shortfall*** *by reinstating the California premium subsidy program*

The Build Back Better Act would extend the American Rescue Plan premium subsidy levels through 2025. If federal action is not taken to extend American Rescue Plan premium subsidies beyond 2022, Californians receiving these benefits through Covered California would lose approximately $1.6 billion annually in premium assistance. In that event, many thousands of the roughly 2.2 million Californians who receive coverage in the individual market might drop coverage.[20]

Should the American Rescue Plan subsidies expire at the end of 2022, California policy-makers would need to consider whether the Health Care Affordability Reserve Fund would be best used to partially address the shortfall by reinstating the California premium subsidy program. We note that the estimated annual value of the American Rescue Plan premium subsidies is more than four times the amount that was appropriated the state premium subsidy program.[21]

Table 6 shows the increased premium assistance that Covered California enrollees will receive under the American Rescue Plan in 2022 by income group. We note that this estimate does not include the potential value of the American Rescue Plan subsidies for eligible but unenrolled Californians. This group consists primarily of uninsured individuals and those enrolled in the individual market outside of Covered California.[22]

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[20] The Congressional Budget Office originally projected that approximately 1.3 million uninsured (nationally) would temporarily take-up new coverage under the American Rescue Plan; suggesting that roughly eight percent of current nongroup enrollment might be at risk of returning to being uninsured. See Congressional Budget Office (2021). CBO Cost Estimate: Reconciliation Recommendations of the House Committee on Ways & Means, February 2021: https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf.

[21] For the plan years 2020 and 2021, $428,629,00 and $348,939,000, respectively, was appropriated for the state premium subsidy program.

[22] An estimated 810,000 uninsured individuals and 270,000 individuals enrolled in the individual marketplace outside of Covered California could benefit from marketplace subsidies. See Covered California April 8, 2021 Board Meeting Materials, Slide 3. Covered California Policy and Action Items. https://board.coveredca.com/meetings/2021/april/meeting-materials/Policy-and-Action-April-2021-Final.pdf.

Table 6. Estimated 2022 American Rescue Plan premium subsidies for Covered California enrollees by income group

Enrollee Income Range (by FPL Bracket)	Annual Value of American Rescue Plan Premium Subsidies in 2022	Count of Covered California Enrollees
0-150% FPL	$160,000,000	270,000
0-200% FPL	$565,000,000	706,000
0-250% FPL	$861,000,000	955,000
0-300% FPL	$1,098,000,000	1,171,000
0-400% FPL	$1,286,000,000	1,395,000
0-600% FPL	$1,575,000,000	1,484,000
All Enrollees	$ 1,617,000,000	1,519,000

OPERATIONAL ASSESSMENT FOR IMPLEMENTATION OF A COST-SHARING REDUCTION PROGRAM IN 2023

Section in brief:

- *Launching a state cost-sharing reduction program in 2023 would require a **significant workload on a compressed timeline**. Program design and operations will need to closely follow the federal model and **decisions will be needed as early as possible in calendar year 2022**.*
- *The workload associated with implementing a state cost-sharing program will divert Covered California staff from other policy and consumer experience priorities. These **tradeoffs should be strongly considered if a multi-year state program cannot be financed**.*

In addition to modeling options for enhanced cost-sharing support, AB 133 also requires Covered California to develop an operational assessment for implementing a state cost-sharing reduction program for benefit year 2023. This section describes operational work streams and key activities that Covered California would need to undertake to launch a state cost-sharing program on that timeframe.

COVERED CALIFORNIA OPERATIONAL WORK STREAMS

Described below are nine major operational work streams for implementing a state cost-sharing program with detail about key activities and considerations within each work stream.

- **Benefit design**: As discussed above, state funding to reduce member cost-sharing could be used to expand income-based eligibility for existing CSR plans, increase the generosity of one or more of the existing income-based CSR plans, or both. Expanding income-based eligibility for one or more existing CSR plans would be simpler to operationalize because Covered California would not have to develop new CSR benefit designs. Modifying one or more of the existing CSR plans to increase generosity would require plan design changes and actuarial analysis that would have to be incorporated into the benefit design approval process, which is described below.

  Benefit designs are developed between November and January for the next full benefit year (e.g., 2023 benefit designs will be developed between November 2021 and January 2022). Benefit designs are approved by the Covered California Board in a two-step process that usually occurs at the January and March Board meetings. As such, the annual benefit design process is completed several months before the statutory deadline for the adoption of the state budget. This creates significant operational risk that will have to be mitigated if a program is authorized for 2023.

- **Payment methodology**: Covered California would have to develop a payment methodology to compensate QHP issuers for reducing member cost-sharing in accordance with the state program design. Covered California assessed two potential payment methodologies, which are summarized below. These options are based on those previously developed by the U.S. Department of Health and Human Services to make cost-sharing reduction payments to QHP issuers under the federal cost-sharing reduction program. Covered California will not direct QHP issuers to "load" the cost of a state program into plan premiums, a practice that is currently in use to fund the federal cost-sharing reduction program due to elimination of direct payments in 2017.[23]
    1. A prospective per member per month payment methodology in which the marginal cost to the QHP issuer to reduce member cost-sharing in accordance with the state program design would be calculated as a per member per month (PMPM) amount. The PMPM amount(s) would be set in advance of the benefit year (thus "prospective"), and would be paid to QHP issuers throughout the benefit year for all eligible members. Modeling performed by Milliman assumed that a PMPM payment methodology would be used. This methodology is similar to the methodology that was in place for the federal cost-sharing reduction program between 2014 and 2017.
    2. A claims-based reconciliation methodology in which QHP issuers would receive prospective payments throughout the benefit year similar to option 1 but would have to reconcile prospective payments to actual cost at the end of the benefit year. This methodology was required for benefit year 2017 and beyond for the federal program but was shortly thereafter negated due to the elimination of direct payments in the federal cost-sharing reduction program. A claims-based reconciliation methodology would require significant development time and resources for QHP issuers and Covered California, and QHP issuers may need to make modifications throughout the claims processing workflow.

  Due to the complexity of the claims-based reconciliation methodology, Covered California could only support the prospective PMPM payment methodology for 2023. As noted by Milliman, the initial modeling assumed a PMPM payment methodology in which the marginal cost to the QHP issuer to administer a richer plan design would be set based on each member's income category and that the program cost would be based on Northern versus Southern California average costs. Covered California would have to decide whether to include other factors in the methodology such as region, QHP issuer, or enrollee risk.

- **Enrollment forecasting and budgeting**: Estimates developed by Milliman for this report are preliminary and are intended to provide a reasonable estimate of program costs but will certainly vary based on enrollment and program design decisions. As noted above, costs will need to be updated in 2022 to reflect projected enrollment and benefit costs for 2023.

[23] This elimination of direct payments resulted in "silver loading", a response by health plan issuers to cost-sharing reduction payments ending in 2017. The issuers raised Silver plans' premium costs to offset the uncompensated cost of continuing to provide cost-sharing reduction subsidies. Federal premium tax credit expenditures also rose due to the increase in Silver plan premiums.

- **Eligibility determination process**: Covered California would have to make system changes to CalHEERS, Covered California's eligibility and enrollment system, to define the income ranges and associated Cost Sharing (CS) levels for the state program design. CS levels are briefly explained in Appendix VI. Initial planning can begin prior to approval of a state cost-sharing reduction program, but program design decisions will be needed by late spring 2022 in order to finalize system development and testing within and between Covered California and the QHP issuers' enrollment systems in time for the 2023 benefit year.

- **Enrollment process**: Beginning October 1, 2022, Covered California would have to display the appropriate benefit plans to consumers based on state cost-sharing reduction program design. Consistent with current processes, Covered California would automatically move existing enrollees in the Silver metal tier to the appropriate CSR plan if they did not actively renew their coverage for 2023. Covered California could also consider various policies to encourage the selection of CSR plans among new and renewing members. For example, Covered California could consider adding decision support information to the plan shopping experience in CalHEERS to encourage selection of CSR plans by new members and those who actively renew. Covered California could also consider automatically moving existing enrollees in the Bronze, Gold and Platinum coverage levels into CSR plans at renewal to increase the number of consumers who take advantage of the benefits.[24]

- **Education and outreach**: Covered California would have to develop plans for education and outreach to applicants, members, and enrollment partners. These activities would take place throughout the summer of 2022 in preparation for open enrollment and renewal for the 2023 benefit year.

- **Carrier payment process**: Covered California would have to work with the State Controller's Office to develop a process to make state cost-sharing reduction payments to carriers. Covered California would likely make payments monthly but would have to determine whether payments would be made prospectively or retrospectively for the month. Regardless of that decision, payments to QHP issuers would be reconciled to actual membership through Covered California's regular issuer reconciliation processes.

- **Risk adjustment**: Covered California would have to consider whether or not to layer a state-specific risk adjustment calculation on top the state cost-sharing reduction program. Since risk adjustment is operated at the federal level, there is no built-in mechanism for making an adjustment for the impact of the state cost-sharing reduction program on risk selection. At least one other state, Colorado, has decided not to layer on a state-specific risk adjustment calculation with their state CSR program. An analysis has not yet been done to determine the potential relative impact of this on carriers.

[24] Beginning plan year 2022, Covered California will automatically select Bronze plan enrollees into an Enhanced Silver 94 plan with the same issuer in the same product to help them take advantage of significant cost-sharing support and $0 net premiums available through the American Rescue Plan.

- **Plan renaming**: Covered California could assess the feasibility of renaming CSR plans as early as 2023 to reduce consumer confusion and better communicate the value of these plans. New plan names would likely be needed by March of 2022 to meet operational timeframes for the 2023 benefit year. Plan renaming would impact issuers' regulatory filings and development of member material. Covered California would also have to assess the need for changes to the plan shopping experience in CalHEERS to accommodate new names, particularly if the metal tier was eliminated from the plan name.

KEY PLANNING MILESTONES FOR THE 2023 BENEFIT YEAR

Planning for a benefit year begins approximately 12 months in advance of open enrollment for that benefit year. Key milestones and timeframes for the 2023 benefit year are listed in Table 7. While there is some flexibility to modify the timeframes below, Covered California, QHP issuers and the health insurance regulators will need parameters of a state cost-sharing reduction program as early in the planning process as possible to ensure that key milestones are met. As noted above, the annual state budget process lags behind Covered California's benefit year planning process by several months.

Table 7. Key planning milestones for 2023 benefit year

Milestone	Estimated Timeframe
Plan Management Advisory: Benefit Design & Certification Policy Recommendation	January 2022
January Board Meeting: Discussion of Benefit Design & Certification Policy Recommendation	January 2022
Final AV Calculator Released*	February 2022
QHP & QDP Applications Open	March 1, 2022
March Board Meeting: Anticipated approval of 2022 Patient-Centered Benefit Plan Designs & Certification Policy	March 2022
May Board Meeting: Discussion of 2022-23 Covered California Budget	May 2022
June Board Meeting: Anticipated approval of 2022-23 Covered California Budget	June 2022
QHP Negotiations	June 2022
Public Posting of Proposed Rates	July 2022
Carrier Integration Testing for 2023 Plan Year	July – August 2022
CalHEERS Release for 2023 Plan Year	September 2022
Public Posting of Final Rates	September – October 2022

OPERATIONAL PLANNING ASSUMPTIONS

Launching a state cost-sharing reduction program in 2023 would require a significant workload on a compressed timeline. In developing this operational assessment, Covered California made the following planning assumptions that will need to hold true to minimize operational risk and prevent disruption for consumers:

1. State CSR plans would be offered to all renewing and newly applying members for a full benefit year, meaning that products would need to be available for shopping beginning October 1, 2022.
2. Individuals would have to meet eligibility requirements for federal premium tax credits to be eligible for the state cost-sharing reduction program. It would not be possible to make changes to eligibility rules to provide state cost-sharing reductions to individuals currently ineligible for APTC prior to the 2023 benefit year.
3. Given the compressed timeframe, the program would need to leverage existing business processes wherever possible.
4. State CSR plans would be offered only at the Silver metal tier and would be developed by enhancing the actuarial value of the benefit plan consistent with the federal cost-sharing reduction program.
5. Payments for a state cost-sharing reduction program would be made directly by the state to the carrier. The cost of a state cost-sharing reduction program would not be "loaded" on premium rates, as it is now with the federal CSR program.

CONSIDERATIONS FOR A SINGLE-YEAR VERSUS A MULTI-YEAR STATE PROGRAM

The statute that established the Health Care Affordability Reserve Fund does not specify an ongoing funding source. The workload associated with implementing a state cost-sharing program will divert Covered California staff from other policy and consumer experience priorities. These tradeoffs should be strongly considered if federal funding for cost-sharing support is not made available and a multi-year program cannot be financed with state funds. We also note that Covered California would have to tailor its member communication and marketing approach to be clear at the time of application or renewal that enhanced benefits would expire at the end of the 2023 benefit year.

Appendix I. Statutory Language of AB 133, Working Group Members and Meeting Material

Government Code: TITLE 22. California Health Benefit Exchange [100500 - 100522]

100520.5. (a) The Health Care Affordability Reserve Fund is hereby created in the State Treasury.
Government Code section 100520.5. (a) The Health Care Affordability Reserve Fund is hereby created in the State Treasury.

(b) Notwithstanding any other law, the Controller may use the funds in the Health Care Affordability Reserve Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381.

(c) Upon the enactment of the Budget Act of 2021, and upon order of the Director of Finance, the Controller shall transfer three hundred thirty-three million four hundred thirty-nine thousand dollars ($333,439,000) from the General Fund to the Health Care Affordability Reserve Fund.

(d) Upon appropriation by the Legislature, the Health Care Affordability Reserve Fund shall be utilized, in addition to any other appropriations made by the Legislature for the same purpose, for the purpose of health care affordability programs operated by the California Health Benefit Exchange.

(e) (1) The California Health Benefit Exchange shall, in consultation with stakeholders and the Legislature, develop options for providing cost sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians. On or before January 1, 2022, the Exchange shall report those developed options to the Legislature, Governor, and the Healthy California for All Commission, established pursuant to Section 1001 of the Health and Safety Code, for consideration in the 2022–23 budget process.

(2) In developing the options, the Exchange shall do all of the following:

(A) Include options for all Covered California enrollees with income up to 400 percent of the federal poverty level to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs.

(B) Include options to provide zero deductibles for all Covered California enrollees with income under 400 percent of the federal poverty level and upgrading those with income between 200 percent and 400 percent, inclusive, of the federal poverty level to gold-tier cost sharing.

(C) Address any operational issues that might impede implementation of enhanced cost-sharing reductions for the 2023 calendar year.

(D) Maximize federal funding and address interactions with federal law regarding federal cost-sharing reduction subsidies.

(3) The Exchange shall make the report publicly available on its internet website.

(4) The Exchange shall submit the report in compliance with Section 9795 of the Government Code.

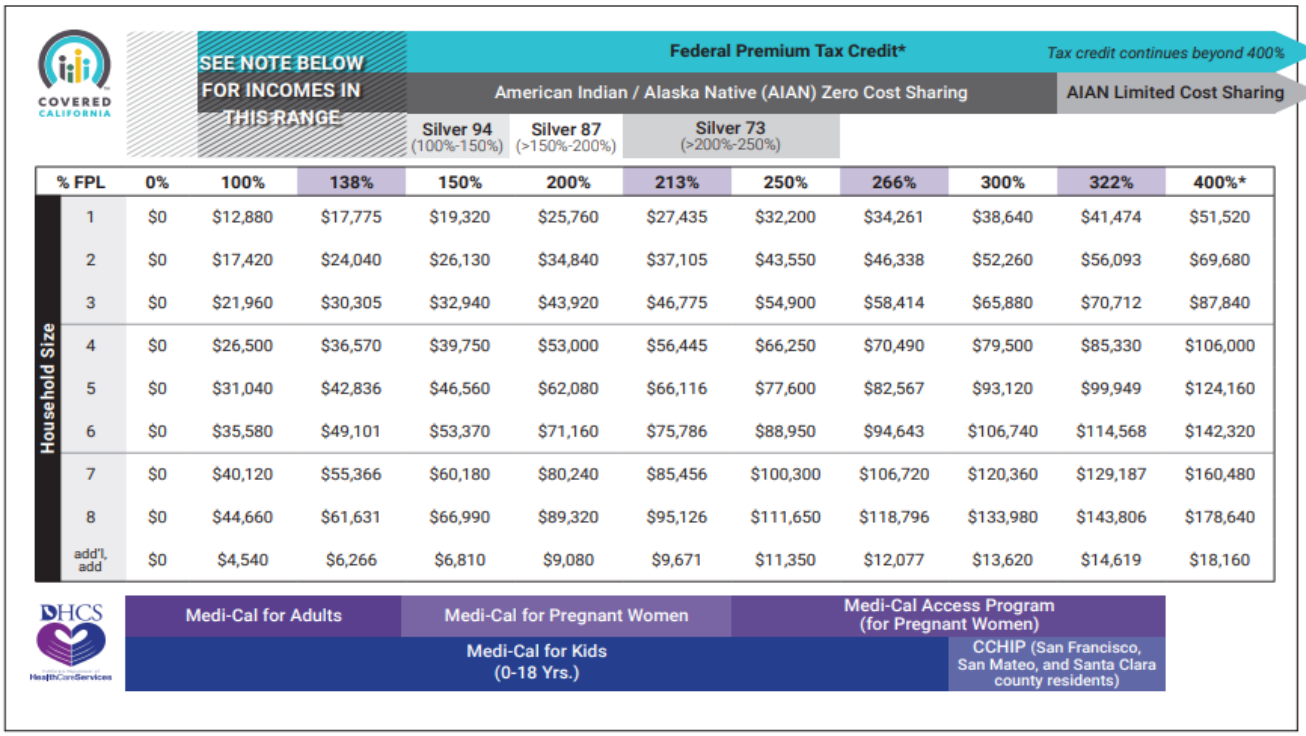
Covered California thanks the working group for their valuable contributions to this project.

Working Group Member	Organization
Dawn McFarland	Agent
Rick Krum	Anthem
Robert Spector	Blue Shield
Anete Millers	California Association of Health Plans
Faith Borges	California Association of Health Underwriters
Stesha Hodges	California Department of Insurance
Janice Rocco	California Medical Association
Cary Sanders	California Pan-Ethnic Health Network
Mike Odeh	Children Now
Diana Douglas	Health Access
Amy Frith	Health Net of California
John Newman	Kaiser
Alicia Emanuel	National Health Law Program
Marjorie Swartz	Policy Consultant to Senate President Pro Tempore Toni Atkins at California State Senate
Cicely Rucker	Sharp
Jen Flory	Western Center on Law and Poverty
Jerry Fleming	Covered California Board Member
Jarrett Tomás Barrios	Covered California Board Member
Teri Boughton	Senate Committee on Health
Ryan Witz	California Hospital Association
Doreena Wong	Asian Resources
Anika Lee	California Consortium of Urban Indian Health Consortium

AB 133 working group website and meeting materials:
https://hbex.coveredca.com/stakeholders/AB_133_Health_Care_Affordability_Working_Group/

Appendix II: Eligibility Limits for Medicaid and Marketplace Coverage in California in 2022

Medi-Cal, California's Medicaid program, provides coverage for adults with income at or below 138 percent of the federal poverty level. Medi-Cal eligibility limits are higher for pregnant women and children as shown below.



Note: Most consumers up to 138% FPL will be eligible for Medi-Cal. If ineligible for Medi-Cal, consumers may qualify for a Covered California health plan with financial help including: federal premium tax credit, Silver (94, 87, 73) plans and Zero Cost Sharing and Limited Cost Sharing AIAN plans.

Silver 94, 87 and 73 plans provide lower deductibles, co-pays, and out-of-pocket maximum costs.

* Consumers at 400% FPL or higher may receive a federal premium tax credit to lower their premium to a maximum of 8.5 percent of their income based on the second-lowest-cost Silver plan in their area. See the chart on page 2 for more information.

Appendix III. Covered California's 2022 Patient-Centered Benefit Designs

2022 Patient-Centered Benefit Designs and Medical Cost Shares

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

Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers **0%** until out-of-pocket maximum is met	Covers **60%** average annual cost	Covers **70%** average annual cost	Covers **73%** average annual cost	Covers **87%** average annual cost	Covers **94%** average annual cost	Covers **80%** average annual cost	Covers **90%** average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	**$25,761 to $32,200 (>200% to ≤250% FPL)**	**$19,321 to $25,760 (>150% to ≤200% FPL)**	**up to $19,320 (100% to ≤150% FPL)**	N/A	N/A
Annual Wellness Exam	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Vist	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	$65*	$35	$35	$15	$5	$35	$15
Urgent Care		$65*	$35	$35	$15	$5	$35	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$95*	$70	$70	$25	$8	$65	$30
Emergency Room Facility		40% after deductible is met	$400	$400	$150	$50	$350	$150
Laboratory Tests		$40	$40	$40	$20	$8	$40	$15
X-Rays and Diagnostics		40% after deductible is met	$85	$85	$40	$8	$75	$30
Imaging			$325	$325	$100	$50	$150 copay or 20% coinsurance***	$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	$18**	$15**	$15**	$5	$3	$15	$5
Tier 2 (Preferred Drugs)		40% up to $500 per script after drug deductible is met	$55**	$55**	$25	$10	$55	$15
Tier 3 (Non-preferred Drugs)			$85**	$85**	$45	$15	$80	$25
Tier 4 (Specialty Drugs)			20% up to $250** per script	20% up to $250** per script	15% up to $150 per script	10% up to $150 per script	20% up to $250 per script	10% up to $250 per script
Medical Deductible	N/A	Individual: $6,300 Family: $12,600	Individual: $3,700 Family: $7,400	Individual: $3,700 Family: $7,400	Individual: $800 Family: $1,600	Individual: $75 Family: $150	N/A	N/A
Pharmacy Deductible	N/A	Individual: $500 Family: $1,000	Individual: $10 Family: $20	Individual: $10 Family: $20	N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$8,700 individual $17,400 family	$8,200 individual $16,400 family	$8,200 individual $16,400 family	$6,300 individual $12,600 family	$2,850 individual $5,700 family	$800 individual $1,600 family	$8,200 individual $16,400 family	$4,500 individual $9,000 family

Drug prices are for a 30 day supply.

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

** Price is after pharmacy deductible amount is met.

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

Appendix IV: Comparison of percentage of income paid for a Marketplace benchmark plan under the Affordable Care Act, the California Premium Subsidy Program, and the American Rescue Plan

Income Range		Required Premium Contribution		
Income As Percent of Federal Poverty Level (FPL)	**Income** for Single Household[25]	**Affordable Care Act**	**California State Subsidy Program**	**American Rescue Plan**
Under 138%	$0 to $17,609	2.07%	0%	0%
138% – 150%	$17,609 to $19,140	3.10% – 4.14%	N/A	0%
150% – 200%	$19,140 to $25,520	4.14% – 6.52%	N/A	0% – 2.0%
200% – 250%	$25,520 to $31,900	6.52% – 8.33%	6.24% – 7.80%	2.0% – 4.0%
250% – 300%	$31,900 to $38,280	8.33% – 9.83%	7.80% – 8.90%	4.0% – 6.0%
300% – 400%	$38,280 to $51,040	9.83%	8.90% – 9.68%	6.0% – 8.5%
Over 400%	$51,040 and up	Not eligible for subsidies	9.68% – 18.0%	8.5%

[25] Income limits for additional household sizes can be found www.coveredca.com/pdfs/FPL-chart.pdf.

Appendix V. Information about Cost-Sharing Reduction Programs Operated by Other State Exchanges

	Actuarial Value of State Cost-Sharing Reduction Plans					
	Enrollee Income Range					
	<100% FPL*	100-150% FPL	150-200% FPL	200-250% FPL	250-300% FPL	300-400% FPL
AV of ACA Silver Products	*94%*	*94%*	*87%*	*73%*	N/A (70%)	N/A (70%)
Massachusetts	99.7%	95%	95%	92%	92%	N/A (70%)
Colorado	N/A (94%)	94%	94%	73%	N/A (70%)	N/A (70%)
Vermont	N/A (94%)	94%	87%	77%	73%	N/A (70%)

Adapted from [insert citation and link to Jason's slides]

* Individuals under 100 percent of the federal poverty level are generally eligible for cost-sharing reduction plans only if "lawfully present" immigrants subject to the so-called five-year bar from accessing Medicaid benefits.

Resources

Massachusetts Health Connector, 2021, https://www.mahealthconnector.org/wp-content/uploads/MA-Cost-Sharing-Subsidies-in-ConnectorCare-Brief-083021.pdf]

Oliver Wyman, 2021, https://hbex.coveredca.com/stakeholders/AB_133_Health_Care_Affordability_Working_Group/Colorado-Enhanced-Support-Payment-Options-Final.pdf]

Vermont General Assembly, 2021, https://legislature.vermont.gov/statutes/section/33/018/01812

See also "Introduction to State Cost-Sharing Subsidies" presentation by Jason Levitis to the AB 133 working group.

Appendix VI. Marketplace Qualified Health Plan Identifiers

HIOS ID and Cost Sharing Levels: Each plan has a CMS approved 14-digit Health Insurance Oversight System (HIOS) identification number with a 2-digit extension, or CS level, to identify the cost-sharing variation from the baseline plan. Below are the definitions for the CS levels and eligible populations.

CS Level	Cost-Sharing Reduction Plan	Eligible Population
01	Standard plan with no cost-sharing reduction (all metal tiers and catastrophic)	All consumers
02	Zero cost-sharing AI/AN	AI/AN below 300% FPL – Bronze tier only
03	Limited cost-sharing AI/AN	AI/AN above 300% FPL – all tiers
04	CSR 73%	200 to 250% FPL – silver tier only
05	CSR 87%	150 to 200% FPL – silver tier only
06	CSR 94%	Up to 150% FPL – silver tier only