Opportunities for California under §1332 of the Affordable Care Act

California has made great progress implementing the Affordable Care Act (ACA), with 6 million people newly enrolled in either Medi-Cal or Covered California since December 2013. The state strives to improve the quality, outcomes and effectiveness of care and the performance of its safety net delivery systems with its recent renewal of its §1115 Medicaid waiver. Beginning in 2017, the ACA offers another major opportunity for states to meet these goals with a §1332 waiver. These broad waivers would allow states the ability to waive several requirements of the ACA to create new and innovative models to improve and expand health coverage.

To create and finance a new coverage framework, a §1332 waiver would allow states to waive four major planks of the ACA:

1. The individual mandate to have health coverage
2. The employer mandate to offer coverage
3. The health benefit exchanges and the essential health benefits requirement
4. The premium and cost-sharing subsidies available through the Exchanges.[1]

The ACA requires that states' §1332 programs would have to exceed or be comparable to the law's standard coverage framework in four ways, so the challenge for California is whether it can design reforms that exceed the following:

1. The number of people covered
2. The scope of health benefits
3. Consumer affordability
4. Containing the cost to the federal government.

In other words, a state's §1332 waiver can cover more people, and/or more services at a lower cost to individuals and equal or lower cost to the federal government. The ACA sets the floor or the minimum that states can use a §1332 waiver to exceed.

States may not waive certain basic rights for all Americans -- the many other insurance market reforms of the ACA, including its guaranteed issue requirement and prohibitions on increasing premiums for consumers with preexisting conditions. In addition, the lifetime and annual coverage limits, coverage of preventive care and dependents up to age 26 may not be subject to a waiver.[2]

To maximize the scope of innovation and to more fully coordinate health coverage programs, States could submit a §1332 waiver in conjunction with a §1115 Medicaid waiver and/or a Medicare waiver to achieve more expansive reforms that involve those programs and their beneficiaries. In fact, the ACA explicitly raises

[1] Centers for Medicare and Medicaid Services. 2015. Section 1332: State Innovation Waivers. Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html#Fact Sheets and United States Department of Health and Human Services and Treasury Department, Guidance on §1332 Waivers for State Innovation (Dec, 16, 2015) at www.federalregister.gov/articles/2015/12/16-3165/waivers

[2] Schubel J, Lueck S. 2015. Understanding the Affordable Care Act's State Innovation ("1332") Waivers (Center on Budget and Policy Priorities). Available at: http://www.cbpp.org/research/understanding-the-affordable-care-acts-state-innovation-1332-waivers

this possibility and instructs the Secretary of Health and Human Services to design a coordinated multi-waiver submission process. This provision of the ACA is "a broad statutory invitation for states to consider many sorts of unprecedented changes to health care policy."[3] A coordinated multi-waiver approach might allow greater alignment of program eligibility and enrollment policies, and parallel value-based purchasing strategies across public and commercial payers.[4] However a state may not use its savings under a §1115 waiver to cross-subsidize its §1332 waiver; in essence aligned savings approaches are permitted and encouraged but not cross-program subsidies.[5]

States will need additional federal guidance about the specific limits of §1332 waivers, and what reforms would require other waivers. For example, while §1332 extends waiver authority to expand essential health benefits within exchanges, some observers do not believe that authority extends to plans outside of that marketplace.[6] Similarly, federal guidance will be necessary regarding the methods for determining whether or not states meet the comparability requirements regarding the number of people covered, the comprehensiveness of benefits, consumer affordability, and impact on the federal budget. For example, if California is now covering 1.5 million Californians in Covered California, is the standard whether it increases that number covered in Covered California or whether it further decreases the numbers of uninsured Californians.

Importantly, §1332 waivers require the passage of state legislation authorizing their reforms in advance of their submission to the federal Departments of Health and Human Services and the Treasury. States could design a waiver in advance of 2017, although it could not take effect before January 1 of that year. States are also able to submit waiver applications at any time after that date.

Under the ACA, California has made major strides to expand and improve health coverage for millions of Californians; the State could use a §1332 waiver to align and advance program and delivery system reforms even further. The ACA largely built around the existing patchwork of health coverage programs that already existed. As a consequence, the landscape became more complicated and confusing for many consumers and providers, despite the expansion of health insurance and consumer protection. Can we use the waiver to make the system simpler and easier to navigate for Californians and their providers? The remainder of this brief explores some ways that California might design a §1332 waiver to make health coverage more consumer-friendly, affordable, and supportive of payment and delivery system reforms that both improve health outcomes and slow the growth in health spending.

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[3] McDonough, J. 2014. Wyden's Waiver: State Innovation on Steroids. Journal of Health Politics, Policy, and Law. May 19. Available: http://jhppl.dukejournals.org/content/early/2014/05/09/03616878-2744824.full.pdf+html

[4] Schubel J, Lueck S. Understanding the Affordable Care Act's State Innovation ("1332") Waivers. Center on Budget and Policy Priorities, 2015. Available at: http://www.cbpp.org/research/understanding-the-affordable-care-acts-state-innovation-1332-waivers

[5] Guidance on §1332 Waivers for State Innovation (Dec, 16, 2015) at www.federalregister.gov/articles/2015/12/16-3165/waivers

[6] Schubel J, Lueck S., Understanding the Affordable Care Act's State Innovation ("1332") Waivers

Affordability

The ACA increases access to more affordable health coverage for millions of Californians. While we lack up-to-date information on the numbers of remaining uninsured Californians, an estimated 30% are eligible for Covered California but not enrolled.[7] The primary reason cited for remaining uninsured was affordability; the second was ineligibility (e.g.documentation).[8] For many households, particularly for older adults with incomes above subsidy eligibility (400% FPL) and no other source of coverage, Covered California plans can still be financially challenging.[9] Another major challenge for households remains the subsidy cliffs -- abrupt increases in cost when their incomes rise above 138% of FPL, above 250% FPL and again above 400% FPL. At 139% of FPL, an individual loses Medi-Cal eligibility and decides between the lower premiums and higher out-of-pocket for bronze tier coverage and an enhanced silver plan (higher premiums and lower cost sharing). ACA cost-sharing subsidies and Medi-Cal eligibility for children both end at about 250% FPL, creating a very marked increase in out of pocket costs for many families at that threshold.

California could seek a §1332 waiver to achieve the goals of greater consumer affordability and predictability in consumer costs. With this opportunity, the State could restructure the sliding scale for subsidies, with the goal of smoothing abrupt increases in premiums and cost sharing as households' income increases. For example, adding cost-sharing subsidies that phase out above 250% FPL and premium subsidies that phase out between 400% and 500% FPL would make those transitions less jarring for households.[10]

In addition, Covered California could offer additional affordable plan choices to consumers. A §1332 waiver could include a new "enhanced Bronze" plan. This option would offer sliding-scale cost-sharing reductions that are parallel to the enhanced Silver plans, but with actuarial values that are 10% lower than the enhanced Silver option.

California could also attempt to eliminate the "family glitch" through a §1332 waiver. Currently, the standard for determining whether or not an offer of coverage is affordable is the cost of *self-only* coverage. If an offer of self-only coverage (and not family coverage) is greater than 9.5% of household income, then it is deemed unaffordable, allowing the individual who was offered employment-based coverage to access premium and cost-sharing subsides through Covered California. At the same time, if an individual worker's self-only coverage is less than 9.5% of his/her household's income, and the worker's employer simultaneously offers family coverage that exceeds that share of household income, even by a considerable amount, that offer of family coverage is considered affordable. This rule prevents the family members from accessing premium and

[7] CalSIM Version 1.91 Statewide Data Book 2015-19 (May 2014) at www.healthpolicy.ucla.edu
[8] DiJulio et al, California's Previously Uninsured After the ACA's Second Enrollment Period (Kaiser Family Foundation, July 30, 2015) http://kff.org/health-reform/report/californias-previously-uninsured-after-the-acas-second-open-enrollment-period/
[9] See Appendix 1, Table 1.
[10] Healthy San Francisco has recently taken steps to improve affordability of premiums and out of pocket responsibilities for city residents. See Wulsin, San Francisco: the Spirit of the Pioneers, Taking Steps to Improve Both Healthy San Francisco and the Affordable Care Act (ITUP, July 30, 2015) at http://itup.org/blog/2015/07/30/san-francisco-the-spirit-of-the-pioneers-taking-steps-to-improve-both-healthy-san-francisco-and-the-aca/

cost-sharing subsidies to purchase a Covered California plan even if the offer of family coverage is very expensive to the household.[11]

The State could elect to change the affordability standard to add a specific threshold for *family coverage.* For example, the State could allow those with an offer of family coverage that exceeds 12% of income to access subsidies through Covered California. This rule change would allow more individuals to take advantage of subsidies to purchase Covered California plans, expanding the reach of health coverage to more Californians.

California could also expand the tax credit for small business to provide greater assistance for those that would like to offer coverage. The ACA's tax credit for small businesses can currently cover up to 50% of premium costs and is available for two years. Qualifying employers must have fewer than 25 employees, average annual employee wages of less than $50,000, and also pay for at least 50% of the cost of premiums for employee coverage through Covered California for Small Business (CCSB), formerly known as SHOP. The State could elect to extend the credit to businesses with more employees and/or for a longer period of time to provide stronger incentives for small employers to offer coverage. This approach, while as yet little used by employers, has some potential to increase the rates of small low wage employers offering coverage, reduce the numbers of uninsured and save federal funds.[12]

Again, to satisfy the requirement that waiver programs not add to the federal deficit, the State would have to take into account costs of financing more generous subsidy structures or allowing more family members to gain access to premium and cost-sharing subsidies. California could contribute some existing state funds currently spent on the uninsured to this project as the need for this particular program spending evaporates. A portion of General Funds, realignment or Proposition 99 funds that the state or the counties use to support care to the higher income uninsured could be redirected to make coverage more affordable to people who are eligible but have not enrolled in Covered California plans due to cost. Rather than financing programs that pay for services to those uninsured who are eligible for Covered California, financing increased premium and cost-sharing reductions to enroll them in Covered California may be a more effective way to apply those resources.[13]

Alternatively, California could finance more generous subsidy structures by establishing an additional tax on the most costly health plans, as the ACA is scheduled to do in 2020. The ACA's "Cadillac Tax" is a 40% excise tax that will apply to plan costs that exceed $10,200 for individual plans and $27,500 for family plans.[14] A California tax could apply to plans with large year over year premium increases, creating the financial incentives to manage their costs more effectively. Such a tax would serve to curb increases in health costs and

[11] Some of the thinking behind the glitch is to keep families in their existing employment-based coverage and to reduce incentives to erode it. If California could design a better financing partnership with employers and employees, it could finance an elimination of the glitch within the limits of budget neutrality required by the ACA.
[12] The opportunity here is to devise a three way financing partnership among small employers, their employees and Covered California that covers more people at a lower cost.
[13] ADAP and Healthy San Francisco have already tested these approaches, and we should assess their effectiveness and as appropriate expand them.
[14] See Peganny, Advancing the Triple Aim for Employment-Based Insurance, Part 3 (ITUP, January 2016) at http://itup.org/itup-latest-news/2016/01/05/advancing-the-triple-aim-for-employer-based-health-insurance/

premiums over time, while making coverage more affordable for more households and allowing more people to purchase coverage.[15]

Under the new guidelines, the United States Treasury Department has stated that states, not the federal government must pay for the administrative costs of any variation from the nationwide tax policies of the Affordable Care Act.[16]

Coverage Requirements

States additionally have the ability to adjust or eliminate both the individual and employer mandate penalties/taxes and exemptions. For example, could the State increase the size of the penalties to motivate more individuals to purchase coverage or more employers to offer? The State could also broaden the number of individuals to which the requirement applies by narrowing the number of current exemptions to the individual requirement in conjunction with improved affordability as discussed above. The State would have to be mindful of, and find offsets for the financial impact of any change that would reduce federal revenue from penalties for individuals who do not have coverage. Furthermore the federal guidance indicates that the State would be responsible for the administrative costs and any changes in penalties would have to be administered at the state level due to federal concerns about maintaining a uniform national tax policy.[17]

Could states also increase or decrease the number of businesses that would be required to offer coverage by adjusting 50-employee threshold currently in place under the ACA?[18] California could also have the ability to broaden or constrict the range of employees to whom businesses would have to offer coverage. For example, the current threshold for full-time employment is 30 hours of work per week. The state could raise or lower that number of hours, which would result in a greater or smaller number of employees receiving an offer of coverage. The State could also change the standard for what would qualify as minimum essential coverage that satisfies the requirement for an employer offer of coverage.

Alternatively, instead of requiring that businesses offer coverage or pay the penalty defined by the ACA, the state could structure employer requirements differently. The State could require that a certain portion of a firm's payroll be dedicated to health care either through coverage or a "fair share" contribution—a model similar to that of Healthy San Francisco.[19] The funds from fair share contributions might then be dedicated to fund additional premium assistance for individuals and families buying insurance through Covered California.

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[15] While many employers and unions are united in opposing the Cadillac benefits tax, they are equally dissatisfied with the inexorable rise in costs and premiums that may be only temporarily in abeyance. The opportunity is to design the right tools and incentives for plans, providers and subscribers to live within a sustainable rate of increase, such as the CPI or CPI plus 1%.
[16] Guidance on §1332 Waivers for State Innovation (Dec, 16, 2015)
[17] Ibid. This could be administered by the Franchise Tax Board or the Employment Development Department as appropriate.
[18] California has a comparatively low rate of individuals with private insurance and might want to seek to increase that rate to the national average or to the levels of other leading states, such as New Jersey, Hawaii and Massachusetts. See http://itup.org/blog/2015/06/23/itup-summary-of-findings-from-the-national-health-insurance-survey/
[19] City and County of San Francisco, Office of Labor Standards Enforcement. 2015. Health Care Security Ordinance. Available at: http://www.sfgsa.org/index.aspx?page=418 These changes would need to be carefully designed to assure their compliance with federal ERISA preemptions.

While some employers may make the calculation that offering health coverage for part timers may be too costly, they might be willing to contribute towards a meaningful portion of their part time employees' premiums. With the State offering a minimum employer contribution as an option, in addition to offering coverage or paying a fine, it may effectively expand coverage, or allow consumers to purchase more comprehensive coverage (e.g., a silver plan instead of a bronze plan). Covered California could also facilitate employer premium contributions by adding employer portals and accounts to its online infrastructure for consumers purchasing individual (or family) plans.

Again, a key consideration with altering either the individual or the employer mandate is ensuring federal budget neutrality and using a state administrative structure. Any policy change that would lessen the amount of penalties or how strictly they are applied would reduce the amount of revenue to the federal government. Therefore, a California §1332 waiver would have to find cost savings elsewhere to compensate for any loss in revenue from relaxing penalties. Increasing penalties could increase the numbers of insured, reduce federal costs and reduce the numbers of remaining uninsured. Providing additional options for employment-based or emplyment-financed coverage also could reduce the numbers of remaining uninsured and reduce federal spending. Relaxing individual and employer requirements could result in fewer people having coverage. Since a §1332 waiver would be required to cover as many people as the ACA, there would have to be a waiver feature that would counteract any reduction in that number (e.g., additional premium subsidies to enhance enrollment or a feature such as annual auto-enrollment with an opt out).

Program Alignment and Simplification

A §1332 waiver submitted in conjunction with a §1115 waiver would allow California to modify both Medi-Cal program and Covered California to create a more aligned program and set of policies that would be friendlier to families with members in both programs, and to individuals who move between the programs. California could design reforms that would blend the programs so that plans could more easily offer coverage in both Medi-Cal and Covered California. Many households experience a great deal of income fluctuation, and the ability to remain in the same plan with the same provider and the same treatment team when moving back and forth between programs could allow for greater continuity of care, better outcomes, lower costs and less risk of spells of uninsurance. This feature is particularly important for patients with complex or chronic illness where continuity is key to the success of treatments.

For example, Arkansas and Iowa already extend coverage to newly eligible Medicaid beneficiaries by enrolling them in their states' marketplace plans. A blended or more unified Medi-Cal and Covered California with a uniform eligibility standard between the programs might allow family members to obtain coverage under the same plan, and if plans offer coverage in both programs, families could keep their provider and plan if their income eligibility churns between them. A move to whole family care and coverage could be particularly beneficial for all family members and their network of providers. Policy alignments that allow more plans and providers to participate in both programs would serve to increase continuity of care and improved outcomes for individual patients and the entire family. Wrap-arounds and supplemental coverage concepts could be used to assure affordable full scope coverage for groups such as children and pregnant women.

California could use a §1332 waiver to design even broader market alignment and delivery system reforms by attracting the individual and small-group commercial markets inside Covered California, and also could allow large employers to purchase through Covered California, and potentially attract the non-self-insured large group commercial market within Covered California. A more consolidated marketplace would allow Covered California, Medi-Cal and their contracting plans to obtain the best values for consumers and facilitate the greatest degree of delivery system reforms. In addition, the shopping process could become and needs to become even more streamlined and consumer-friendly with apples-to-apples comparisons among more plans and carriers.

Some advocates have promoted a §1332 waiver as a means of allowing undocumented immigrants to purchase Covered California plans, albeit without the federal subsidies which will ultimately be needed to promote full enrollment. This could be a stepping-stone.

Value-Based Payment, Cost Containment, and Delivery System Reform

Among Covered California individual market offerings, a §1332 waiver would allow the State wide flexibility to restructure the federal funds used for premium tax credits. For example, the state could adjust tax credits for each plan based on performance in predefined quality or health outcomes metrics.[20] Adding quality as a factor in determining premium assistance available for the different plans would motivate consumers to choose the plans that offer higher value—an approach similar to offering lower or no cost-sharing for higher-value services like preventive care.[21] [22]

A more unified marketplace across health care payers would additionally allow for a more coordinated and concerted push toward higher quality services and cost-containment. If Medi-Cal and Covered California became more unified administrative entities, they would be able to jointly steer the commercial and Medi-Cal delivery systems toward value with parallel or complementary value-based incentives and quality improvement programs. Coordinated contracting strategies are important to enabling providers to participate in both commercial and public coverage markets. Currently, providers must navigate a multiplicity of quality improvement programs and incentives from different health plans and programs. A more aligned set of value-based contracting strategies would help to reduce administrative burdens for providers and prevent various incentives from diluting or detracting from one another.

Further, California could seek to align purchasing strategies of Medi-Cal, commercial, and Medicare Advantage plans by purchasing Medicare Advantage Plans through Covered California as well. To implement this structure, California would need to secure a Medicare waiver along with §1332 and Medicaid §1115 waivers. Bringing Medicare Advantage plans within Covered California would allow it to apply a similar contracting

[20] Bachrach D, Ario J, Kolber M. Thinking Ahead: 1332 State Innovation Waivers. Robert Wood Johnson Foundation. Available at: http://statenetwork.org/wp-content/uploads/2014/12/State-Network-Manatt-1332-State-Innovation-Waivers-Webinar-December-2014.pdf. This could be particularly important in improving health outcomes in communities with the worst risk profiles.
[21] Ibid.
[22] Coleman C, Connolly J. 2014. What's ahead for Covered California? Medium-Term Policy Considerations. ITUP. Available at: http://itup.org/insurance-exchange/2014/10/13/whats-ahead-for-covered-california/

strategy and incentive structure for this market, with the aim of robustly and uniformly motivating plans and providers to prioritize similar quality improvement and cost containment goals.

Other Changes Possible Without a §1332 Waiver

It is also important to note that the ACA also allows states the flexibility to alter several elements of their coverage expansions without seeking a waiver. States have a great amount of flexibility in choosing the benchmark plans that define their essential health benefits packages. A state would only need a waiver if it wanted to significantly modify or seek an exemption from the essential health benefits requirement. In this case, a state would still be required to offer a benefits package that would be as comprehensive as what would have been offered through an ACA-compliant essential health benefits package.

With regard to the value-based purchasing or quality improvement strategies discussed above, Covered California already attaches requirements to its contracts with qualified health plans through its selective contracting process, and it could expand those requirements without a §1332 waiver. Since California's marketplace has the power to exclude plans, it could use its existing authority to implement certain quality improvement programs or payment reforms across participating plans.[23, 24]

The ACA allows the State to merge the Covered California for Small Business (CCSB) and individual markets within Covered California at any time, including either their administration or risk pools, or both.[25,26] In 2017, the ACA also gives Covered California the option to begin allowing businesses with more than 100 employees to purchase coverage through the CCSB, which might greatly broaden the risk pool and purchasing leverage.[27]

Conclusion

In sum, California could reach very broadly across commercial and public insurance markets to make coverage more affordable, consumer-friendly, and high-value if the State pursues a §1332 waiver in coordination with a Medicaid §1115 waiver and a Medicare waiver. This kind of broad, coordinated action across payers could incentivize a large share of California's health care system to increase quality performance and control costs. It

[23] Coleman C, Connolly J. 2014. What's Ahead for Covered California? Medium-Term Policy Considerations. ITUP. Available at: http://itup.org/insurance-exchange/2014/10/13/whats-ahead-for-covered-california/
[24] Bachrach D, Ario J, Kolber M. Thinking Ahead: 1332 State Innovation Waivers. Robert Wood Johnson Foundation. Available at: http://statenetwork.org/wp-content/uploads/2014/12/State-Network-Manatt-1332-State-Innovation-Waivers-Webinar-December-2014.pdf
[25] Ibid. See Peganny, Advancing the Triple Aim for Employment-Based Insurance (ITUP, January 2016) at http://itup.org/itup-latest-news/2016/01/05/advancing-the-triple-aim-for-employer-based-health-insurance/
[26] Ibid; Rosenbaum S, Lopez N, Burke T, Dorley M. 2012. State Health Insurance Exchange Laws: The First Generation. The Commonwealth Fund. Available at: http://publichealth.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/1616_Rosenbaum_state_hlt_ins_exchange_laws_ib.pdf
[27] Kramer, WE. 2012. Large Employers See Scenarios under Which They Could Move Workers and Retirees to Exchanges. Health Affairs 31(2): 299-305.

may additionally allow households with members in multiple forms of coverage to enroll in the same plan, or allow individuals who transition across programs to remain in the same plan.

While the State would not be able to implement a §1332 waiver until 2017, it ought to begin to begin these exploring discussions and the planning process sooner rather than later. A multi-waiver planning process would be complicated and involve a large number and range of stakeholders. Regardless of the specific goals that stakeholders agree to work toward, the State will need time to design its approach, and an earlier waiver submission would allow California to take advantage of the opportunities that coordinated waivers could offer in the nearer term.

In the meantime, the State can also make a number of changes to its coverage framework without a §1332 waiver that could benefit its health care consumers and providers. In 2017 and beyond, the §1332 waiver would allow California to develop a much broader, more comprehensive approach to health reform that could maximize the positive impacts of the ACA.

Figure 1: Summary of Policy Options

Issue	**Policy Options**
Affordability	Smoother, more affordable sliding scale for subsidies
	Add more affordable plan choices (such as "enhanced bronze")
	Eliminate family glitch
	Expand tax credit for small businesses
	Allow state and local funds to help pay premiums for those eligible unenrolled
	Facilitate employer premium contributions for flex workers and dependents
Coverage Requirements	Pilot auto enrollment and consider increasing size of penalties/taxes
	Limit exemptions for individual requirement consistent with affordability improvements
	Adjust the 50-employee threshold
	Adjust the 30-hour threshold
	Restructure employer requirement through coverage or "fair share" contribution
Program Alignment and Simplification	Blend Medi-Cal and Covered California programs so plans can more easily offer coverage in both
	Create uniform eligibility standards between programs – whole family coverage
	Attract individual and small group markets to Covered California
	Allow and attract larger employers to purchase through Covered California
	Allow undocumented individuals to purchase through Covered California (without federal subsidy)
Value-Based Payment, Cost Containment, and Delivery System Reform	Adjust tax credits for each plan based on performance in predefined metrics
	Facilitate Covered California and Medi-Cal in becoming more unified administrative entities
	Create a more aligned set of value-based contracting strategies

	Align purchasing strategies of Medi-Cal, commercial, and Medicare Advantage plans through Covered California
	Establish a Redesigned California Cadillac Tax

Appendix 1: Excerpt from Care, Coverage and Financing for Southern California's Uninsured (ITUP, June, 2015) at http://itup.org/special-features/2015/06/15/care-coverage-and-financing-for-southern-californias-remaining-uninsured/

§1332 waiver

Section 1332 offers California a waiver opportunity to design its own program consistent with the state's priorities. This could be combined with a Section 1115 waiver. The state's waiver cannot spend more than the ACA would otherwise spend – i.e. it must be budget neutral, as would a §1115 waiver. It must cover at least the same numbers of eligible individuals and services and meet the affordability standards of the ACA. This is an opportunity to increase the numbers of enrollees in Covered California and in Medi-Cal. It is not an opportunity to truly cover the undocumented uninsured, but it is a chance to design a better system for Californians. This also could be an opportunity to align Medicare purchasing and reimbursements with the other public programs. This could be an opportunity for California to simplify programs so that they work in the best interest of subscribers, payers and providers.

Hybrid – California could construct a consolidated hybrid program combining some of the best features of Medi-Cal and Covered California. It could seek to offer a broader choice of plans and providers than does Medi-Cal, with lower out of pocket deductibles and co-pays than does Covered California. Subscriber responsibilities could be phased up in a more graduated fashion. Plan offerings could be built on capitation with the same vertically integrated financial incentives for all. Plans could become regional in nature to reflect the underlying health care markets that subscribers use. Prices and quality could be more fully transparent to subscribers so they can make better-informed choices.

Employment based coverage could be offered though the updated Exchange through the same plans and provider networks available to individual subscribers.

Transitions and Churning – There are several key transitions: back and forth between employment-based coverage and Covered California, between Covered California and Medi-Cal and between employment-based coverage and Medi-Cal. There are administrative hurdles at each intersection and choices of different plans and provider networks that end up disrupting continuity of care and medical treatments for subscribers. The goal of this aspect of the waiver could be to make these transitions seamless and prevent the care and treatment disruptions associated with churning.

Affordability Cliffs – There are three abrupt affordability cliffs: 138% of FPL, 250% of FPL and 400% of FPL. See Table 1 to see how these cliffs operate. As individuals reach 138% and transition from Medi-Cal to Covered California, they start to pay premiums, and experience larger copays and deductibles that vary based on their choice of plan and metal tier. At 250% of FPL and then a bit above, the enhanced silver tax credits for copays

and deductibles end, and then so does Medi-Cal coverage for children. At 400% of FPL, tax credits for premium subsidies end causing a large increase in the share of income devoted to premiums for older individuals. California could smooth out these abrupt increases in the affordability of health costs and premiums using a §1332 waiver.

Table 1: Affordability Cliffs (ITUP)

Income	Program eligibility	Benefits	Copays and deductibles	Premiums for eligible individuals (in zip code 90403)
137% of FPL ($15,988)	Medicaid	Full scope Medi-Cal benefits	Nominal copays, no deductibles	No premiums
140% of FPL ($16,338) or ($1361 a month) (Thirty year old)	Covered California	Ten essential health benefits	Bronze: 60/40 Enhanced Silver: 94/6	$3 (lowest priced bronze) $35 (lowest priced silver)
140% of FPL ($16,338) or ($1361 a month) (Sixty year old)	Covered California	Ten essential health benefits	Bronze: 60/40 Enhanced Silver: 94/6	$1 (lowest priced bronze) $19 (lowest priced silver)
251% of FPL ($60,000) or ($5000 a month) Family of four = 40 year old parents 6 and 8 year old children	Covered California for parents Medicaid for children	Full scope Medi-Cal for children; Ten essential health benefits for parents	Bronze: 60/40 Enhanced silver: 73/27 for parents; Nominal copays, no deductibles for children	Medi-Cal for children: $13 per month $281 lowest priced bronze for parents $351 lowest priced silver for parents
273% of FPL ($65,010) or ($5167 monthly) Family of four = 40 year old parents 6 and 8 year old children	Covered California for the entire family	Ten essential health benefits for family	Bronze: 60/40 Silver: 70/30	$322 lowest priced bronze for family $427 lowest priced silver for family
395% of FPL ($46,096) 60 year old adult	Covered California	Ten essential health benefits	Bronze: 60/40 Silver: 70/30	$264 lowest priced bronze $338 lowest priced silver
405% of FPL ($47,263) 60 year old adult	Covered California	Ten essential health benefits	Bronze: 60/40 Silver: 70/30	$450 lowest priced bronze $524 lowest priced silver

405% of FPL ($47,263) 30 year old adult	Covered California	Ten essential health benefits	Bronze: 60/40 Silver: 70/30	$188 lowest priced bronze $219 lowest priced silver

We would recommend a 2, 4, 6, 8 approach in which subscribers' premium contributions for the reference plan are capped at 2% of income below 200% of FPL, 4% below 300% of FPL, 6% below 400% of FPL and 8% above 400% of FPL.

Premium assistance – Premium assistance permits a county, a provider or an employer to pay a part of an individual's premium or to upgrade their coverage from bronze to enhanced silver.[28] Some counties, providers and employers may be interested, and Covered California could be interested as well in testing these concepts. The state is already requiring Covered California to develop this option for certain groups. This approach can be done independently without a §1332 waiver and would be an effective use of local funds.

Enhanced bronze

Nearly all individuals qualifying for subsidies have chosen silver or bronze due to the lower premiums, and the share of individuals choosing bronze are increasing. The enhanced silver helps to pay copays and deductibles and makes the coverage far more meaningful for those who qualify.[29] The low premiums of bronze are very attractive to individuals with little disposable income, but do not afford nearly as much access to health care due to the 60/40 cost sharing. In a §1332 waiver, California could consider an enhanced bronze that parallels enhanced silver, but at 10% lower actuarial value (i.e. if enhanced silver is a 94% of actuarial value for a low-income individual, an enhanced bronze would be at 84% of actuarial value for the same individual). This would allow those low and modest income individuals a better combination of affordable premiums and coverage that allows them to seek needed health care. See Table 1 for the differences in premiums and actuarial values for bronze and silver tiers at 140% and 250% of the federal poverty level.

Other ITUP Reference materials

Coleman, Assistance with Premium Payments and Cost Sharing (ITUP, May, 14, 2015) at http://itup.org/health-financing/2014/05/13/draft-assistance-with-premium-payments-and-cost-sharing-the-non-federal-share/

[28] See Coleman, Assistance with Premium Payments and Cost Sharing (ITUP, May, 14, 2015) at http://itup.org/health-financing/2014/05/13/draft-assistance-with-premium-payments-and-cost-sharing-the-non-federal-share/ and Coleman, Summary of Pregnancy Coverage Trailer Bill (ITUP, June 4, 2014) at http://itup.org/blog/2014/06/04/summary-of-pregnancy-coverage-trailer-bill/

[29] 38% of Covered California subscribers with incomes over 400% of FPL chose bronze; 39% of subscribers with incomes 250-400% of FPL chose bronze; 33% of subscribers with incomes 200-250% (eligible for cost sharing assistance) chose bronze; 17% of subscribers with incomes 150-200% chose bronze; 8% of subscribers with incomes 138-150% chose bronze and 16% of subscribers with incomes less than 138% chose bronze. Covered California Active Member Profile 2015-06-June rev. 2015-10-08.

Peganny, Advancing the Triple Aim for Employment-Based Insurance (ITUP, January 2016) at http://itup.org/itup-latest-news/2016/01/05/advancing-the-triple-aim-for-employer-based-health-insurance/

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