Impacts on Health Insurance Premiums Resulting From Data Sharing With the Department of Health Care Access and Information (HCAI)

Report to the Governor and the Legislature

Authorized Under Assembly Bill 133

(Committee on Budget, Chapter 143, Statutes of 2021)

Submitted by Covered California

August 1, 2023

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Legislative Mandate

As authorized by Assembly Bill 133 (Committee on Budget, Chapter 143, Statutes of 2021), Covered California receives certain state health care facility discharge data from the Department of Health Care Access and Information (HCAI). This report to the governor and Legislature is provided pursuant to Health and Safety Code § 128730, subdivision (c):

> *(c) The Exchange shall report to the Governor and the Legislature on or before August 1, 2023, on the impacts to the Exchange associated with paragraph (3) of subdivision (a), including the impacts on premium rates for health plans offered through the Exchange. The report shall be submitted in compliance with Section 9795 of the Government Code.*

Additional copies of this report can be obtained from:

Covered California

1601 Exposition Blvd.

Sacramento, CA 95815

This report may also be obtained on Covered California's department website:

https://hbex.coveredca.com/data-research/library/CoveredCA_Report_on_HCAI_Data_Sharing_2023.pdf

Executive Summary

- In the spirit of ensuring that the state of California breaks down data silos to better serve its residents, Assembly Bill 133 (Committee on Budget, Chapter 143, Statutes of 2021) permitted the Department of Health Care Access and Information (HCAI) to share hospital, emergency room and ambulatory surgical center discharge data with Covered California.
- Covered California acts as an active purchaser to manage competition. By negotiating each year to certify and recertify qualified health plans (QHPs) and their features and to determine premium rates, Covered California ensures accurate and competitive pricing.
- The process of setting premium rates for coverage in the individual market is marked by uncertainty given the timeline associated with rate setting. In particular, a high level of churn means that up to one-third of enrollment may have newly entered the marketplace in any given year. Additionally, the dynamics of metal tiers and risk adjustment and very price-sensitive consumers all influence the rate-setting process.
- In the absence of current and credible data, health plan actuaries may lean toward conservative assumptions, which generates upward pressure on premiums.
- Each new year, health plan actuaries project the enrollment level and risk mix for both the group that it has already enrolled and the aforementioned churn membership.
- HCAI data allows Covered California to estimate the number of new enrollees with chronic conditions and use a risk-scoring algorithm to project the relative costs of the newly enrolled population based on specific chronic conditions and overall new enrollee demographics.
- Around 10 percent of the Covered California membership has an inpatient admission or emergency department visit reflected in the HCAI data, yet this population accounts for over 50 percent of the projected cost.
- As analyzed by Covered California, the HCAI data allows health plan issuers to understand how the expected costs of their newly enrolled population compare to those of their already enrolled group. By infusing the rate-setting process with credible data about risk profiles, Covered California believes health plan actuaries are able to more accurately project their risk mix and lower the risk margin needed in their rates to account for uncertainty, thereby lowering premiums for Californians.
- It is difficult to quantify the direct impact of these risk scores on premiums given the broad range of factors that are involved. Generally, Covered California's approach as an active purchaser with a philosophy of managed competition is correlated with an observed 44 percent rate increase over the past decade, compared to 51 percent for the states on the federal exchange and 75 percent for other state-based marketplaces combined.

Background

Pursuant to section 128675, et seq., of the Health and Safety Code, the Department of Health Care Access and Information (HCAI) collects detailed patient-level data from California health care facilities related to patient discharge from hospital admissions, emergency room visits and ambulatory surgery centers.

In 2021, in the spirit of ensuring that the state of California breaks down data silos to better serve its residents and to help Covered California in its aim of lowering premiums, expanding coverage take-up, and improving care, the Legislature passed, and the Governor signed, Assembly Bill 133 (Committee on Budget, Chapter 143, Statutes of 2021), which permitted HCAI to share discharge data with Covered California which permitted HCAI to share discharge data with Covered California (as well as the Department of Health Care Services and the Department of Public Health).

As required under Health and Safety Code § 128730, subdivision (c), this report to the governor and Legislature details how Covered California has used discharge data from HCAI to help ensure that Californians benefit from the lowest possible premiums.

Characteristics of the Individual Market That Affect Setting Premium Rates

The individual market for health insurance (including individual coverage through Covered California on-exchange or direct from issuers off-exchange) has several characteristics that drive uncertainty in the process of setting premium rates for coverage, which may differ from other rate-setting environments (such as for large purchasers in the employer market or Medicaid managed care plans).

1) Churn

A large percentage of people flow into and out of the individual market from employer coverage, Medi-Cal coverage, or uninsured status — a concept referred to as “churn”. In fact, approximately one-third of Covered California’s enrollment might lapse or enter the marketplace in any given year.[1] This can introduce pricing challenges for issuers, particularly relative to populations with more stable year-over-year enrollment, such as for the California Public Employees’ Retirement System (CalPERS) or large employers, because issuers cannot rely as readily on prior enrollee experience to predict future-year costs.

2) Metal Tiers

The Patient Protection and Affordable Care Act (ACA) divides plans into different pre-defined levels of coverage generosity referred to as metal tiers, which conform to specific “actuarial value” ranges that define the average percentage of total health care costs paid by the insurance plan. The remaining health care costs are covered by cost sharing (i.e., member copays and deductibles). These tiers range from Bronze plans that cover on average 60 percent of health care costs (and have lower premiums) to Platinum plans that cover on average 90 percent of health care costs (but have the highest premiums). These plans are selected by enrollees based on their own

[1] E. Wolf, M. Slosar and I. Menashe. Assessment of Churn in Coverage Among California’s Health Insurance Marketplace Enrollees. *JAMA Health Forum.* 2022;3(12):e224484. doi:10.1001/jamahealthforum.2022.4484

knowledge of their health care needs and the relative prices between the tiers. This tier structure creates additional challenges for issuers trying to set prices, compared to traditional family-size tiers in an employer-sponsored insurance setting.

3) Single Risk Pool and Risk Adjustment

The Affordable Care Act implemented two key rules to minimize adverse selection in which issuers seek to enroll primarily healthy consumers. First, the single risk pool requires issuers to consider all of their enrollees, on- and off-exchange and across all products, when setting their rates. Second, risk adjustment is a tool that creates transfer payments between issuers participating in the individual market to ensure that plans that enroll a disproportionate share of the low-utilizing enrollees make payments to the issuers that enrolled a higher share of high-utilizing enrollees, thereby stabilizing premiums to level the playing field and incent all issuers to provide coverage to individuals with higher health care needs and costs. Designed to stabilize the premiums for enrollees broadly, these policies are key considerations for issuers when setting premiums.

4) Price Position and Price Sensitivity

The vast majority of consumers in California's individual on-exchange market are low income, and many are price sensitive. The impact of an issuer's price position is visible each year when the lowest-priced plan in a region tends to pick up the largest share of new enrollees. When issuers bid their rates for the new year, they do not know how their proposed premium rates will compare to their competitors' rates.[2] If these price projections are different than anticipated, such as projecting to be lowest position but actually being in third position, a very material impact on the makeup of the enrollee group that will choose an issuer's plan can occur between risk mix and utilization of services. In turn, this influences what the "right" premium rate should be for that segment, rating region and plan. This in turn creates a multi-year pricing dynamic and contributes to uncertainty for health plan actuaries.

California's Approach to Encourage Lower Premiums in the Individual Market

Under Government Code section 100503, Covered California is charged with certifying and re-certifying qualified health plans (QHPs) that provide the optimum combination of choice, value, quality and service. With this mandate, the exchange operates using the related principles of an active purchaser and managed competition to help control costs in the marketplace.

The certification process is quite extensive and requires health plans to comply with a number of rules and policies that go beyond the minimum ACA requirements that exist for all states. While dozens of health plan issuers operate in California, only 12 offer plans certified by Covered California as qualified health plans in 2023. Several key

[2] Gabel, Jon R, et al. "Consumers Buy Lower-Cost Plans on Covered California, Suggesting Exposure to Premium Increases Is Less Than Commonly Reported," The Commonwealth Fund (January 8, 2017): https://www.commonwealthfund.org/publications/journal-article/2017/jan/consumers-buy-lower-cost-plans-covered-california-suggesting (accessed on July 13, 2023).

aspects of the certification process are important in Covered California's overall strategy to keep premiums low and improve value and choice.

1) Standardized Plan Offerings to Encourage Competition on Value

Covered California requires that all products sold as qualified health plans conform to a standardized benefit design plan (along with "mirrored" versions of these plans off exchange). These standardized plans seek to prevent issuers from offering custom plans that may confuse consumers by being at the same metal level (e.g. "Silver") as a competitor's plan, and appearing to have a less expensive premium, but in actuality offering less-generous coverage.

2) Ensuring Choice in More-Difficult Markets

While bidding, issuers must comply with various rules for bidding on mostly whole geographic rating regions rather than cherry-picking smaller regions, subparts of regions where they have particularly favorable rates with providers or selecting counties that have large market share opportunity given population density. Additionally, Covered California reviews the provider networks to understand how the product offering will create increased access and choice for Californians.

With these and other strategies of "managed competition," Covered California strives to create a competitive market in each region, where pre-screened health plans compete for membership on price and quality. In 2023, over 93 percent of Californians had a choice of at least three or more issuers, and all consumers had a choice of at least two.

3) Active Purchaser Rate Negotiations

As a culminating step of the certification process each spring, Covered California enters active rate negotiation with each issuer on premiums for the coming plan year. In this process, Covered California has the opportunity to leverage information about enrollees and the marketplace to help issuers place the most competitive bids and offer the products that will provide the best choice and value. One component of the data and information exchange leading up to these rate negotiations are the risk scores derived using the HCAI data.

Setting Premium Rates in the Individual Market

With the foregoing in mind as background about the Covered California marketplace, each year health plans and their actuaries must determine how to price a proposed qualified health plan offering, under considerable uncertainty.

In a general way, when pricing commercial health plans, issuers use actual health care cost experience for a base year and apply a range of assumptions and calculations to project future health care costs for the pricing period. Premiums are then "built up" from those expected health care costs to account for administrative costs, various fees, taxes and profit. The overarching goal is to estimate the total cost of providing care to the covered population and set premiums at a level above that to compensate the issuer for bearing risk and ensure that they remain financially sound and continue to participate in the individual market.

The factors that health plan actuaries must account for are numerous but can generally be grouped into three categories, with each category not being an exhaustive list:

1. *Direct impact:* These are factors that affect specific plans either uniquely or at a level that may be different from their competitors. One example of this would be a renegotiation with a major hospital system or provider group (unique to the plan) or the introduction of new pharmaceuticals. Another example — and the focus of this report — is the projected risk mix of the projected enrollee group, which typically affects each plan to a varying degree.
2. *Impact to market segment:* These are factors that may affect all issuers in a particular market segment. Examples are changes to the Covered California standardized benefit designs and major policy or legal shifts, such as the adoption of enhanced subsidies (either at the federal or state level) or the COVID-19 public health emergency (both its implementation and its unwinding), all of which can affect each plan to a varying degree.
3. *Industry or macro impacts:* These influences are often unforeseen but can have major impacts on health care utilization or the health coverage landscape. Medical cost inflation is one key driver in this category. Other shocks can have very material impact; for example, the COVID-19 pandemic had an unusually complicated impact on overall health care costs as demand for most health care services decreased sharply even as the issuers and payers were bearing the substantial financial burden of this disease. Broad economic factors can also affect issuers' health care cost liability, as people flow to employer-based coverage during economic expansions and then to public sources such as Medi-Cal and Covered California with economic slowdowns.

These examples highlight the many challenges health plan actuaries face when setting premiums; the importance of data and information to guide their work cannot be overstated as it is by and large a data-driven body of work. By its very nature, premium setting requires making assumptions regarding the net impact (and often interaction) of several factors. *Most critically, in the absence of very recent or current and credible data, health plan actuaries tend to lean toward conservative assumptions, which generate upward pressure on premiums that compounds over time.*

Insight into California's Risk Mix Is an Essential Tool for Rate Setting

With very high turnover each year and with price-sensitive consumers choosing the lowest-cost plan, health plan actuaries need information to precisely estimate costs for their new enrollee population over the next year, even if they already have perfect data on the experience of the previous year's enrollee group. Health care experience takes time to accumulate, however, and when preliminary proposed rates are due on May 1, health issuers do not yet have enough experience with the newest year's crop of new sign-ups from open enrollment (for which coverage will have begun at the earliest in January). As a result, looking ahead to the next plan year, a plan that already must estimate about the enrollment level and risk mix for the approximately one-third of enrollees who will be new that year must also make assumptions about the risk mix for the group that it has *already enrolled*. This is uniquely different from the traditional

commercial market, where there is a much shorter projection period, a larger and more credible base of membership to smooth out fluctuations, and a more stable risk mix profile.

How HCAI Patient Discharge Data Adds Unique View Into Risk Mix

The HCAI data provides a unique window — available to Covered California, but not the issuers themselves — into the health status of each health plan's newly enrolled set of consumers.

HCAI has been collecting individual-level hospital discharge and emergency department visit data for decades, and it has become a valuable resource for a variety of uses across state agencies and the health services research community in general. Because it has been collected for so long and has been widely used, its quality, accuracy and completeness are well established, and analytics relying on it have been deemed credible by actuaries.

Unlike virtually all health care cost and utilization data, which come from claims data supplied by various payers (Medicare, health issuers, etc.), the HCAI discharge data is collected directly from hospitals. This is particularly valuable for this risk calculation exercise, as it includes all discharges within California hospitals regardless of the individual's insurance status or source of coverage, even if they have no coverage at all. This last piece is extremely helpful since there is no credible issuer experience to draw from when previously uninsured members enroll in coverage through the individual market

Chronic conditions such as diabetes, heart disease, arthritis and some forms of cancer are overwhelmingly the largest drivers of health care costs. According to the CDC, 60 percent of adults have a chronic condition, and 40 percent have more than one.[3] We see this trend among the Covered California population too, where members with at least one chronic disease account for 45 percent of total health care costs. For this reason, the risk profiling exercise conducted by Covered California to inform premium rate setting focuses on prevalence of chronic conditions, especially when chronic conditions are what feeds the risk adjustment program, administered by the Centers for Medicare & Medicaid Services (CMS), which is meant to stabilize the individual market's premiums.

A particularly impactful example of how the HCAI data can provide needed information about a newly enrolled population is where a previously uninsured person visited the emergency room or was admitted to a hospital experiencing a severe diabetic episode. Because this person had been uninsured, the emergency room visit or admission may be the first time they have been diagnosed with diabetes, suggesting that they will likely need costly treatment to bring the disease under control, and once managed, may require the use of expensive medication or other treatment.

[3] "Chronic Diseases in America." CDC's National Center for Chronic Disease Prevention and Health Promotion. (2022). https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm (accessed July 11, 2023).

Without the benefit of the HCAI data, the health plan would have no knowledge about how many of their new members have one or more chronic conditions. The HCAI data allow Covered California to identify the population of members with chronic conditions and use a risk scoring algorithm to project the relative costs of these members based on the specific chronic conditions. Once aggregated and anonymized to reflect the population-level risk mix, this information can directly feed into a health plan actuary's viewpoint on the plan's risk adjustment and subsequently pricing.

Methodology for Implementing Risk Profiling With HCAI Discharge Data

Covered California's approach to leveraging the HCAI discharge data to provide insight into rates was first implemented through an innovative effort developed under guidance from Jim Watkins (then at Department of Health Care Services), Andrew Bindman (University of California San Francisco), and John Bertko (Covered California's former chief actuary).[4] The approach uses the Chronic Illness and Disability Payment System (CDPS), a chronic condition grouper and risk scoring methodology developed by Richard Kronick and Todd Gilmer at University of California San Diego.[5] The CDPS model estimates risk scores based on the relative costs to cover individuals with these conditions in state Medicaid data.

At the close of open enrollment, under the authority granted by the amended Health and Safety Code, Covered California linked enrollment to the latest available HCAI patient level data to identify Covered California members who were previously diagnosed with a chronic disease that is present in the CDPS model during a discharge or emergency department visit. Covered California then ran the CDPS algorithm (augmented with HCAI data) and groups members' chronic conditions using hierarchical chronic condition groupings. Then, risk scores from the CDPS model were applied to provide a concurrent (same year) and prospective (future year) estimate of relative risk based on both a member's chronic conditions and their age and sex. Risk scores based solely on age and sex were then applied for those who either have an encounter in the HCAI facility data that does not contain a diagnosis code used by the CDPS model or who do not match to any encounter in the HCAI data. The latter group constitutes the vast majority of the population, since most residents will not have an emergency room visit or hospital admission in a given year.

With these relative risk scores assigned to the enrollee population, Covered California produced a range of analyses creating summarized, de-identified reports with key metrics to guide the team that conducts certification and rate negotiations, including the chief actuary.

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[4] For background on Covered California's approach, see Bindman, Andrew, et al. "Sorting Out the Health Risk in California's State-Based Marketplace," *Health Services Research* 51, no. 1 (2015), https://doi.org/10.1111/1475-6773.12320 (accessed July 8, 2023).

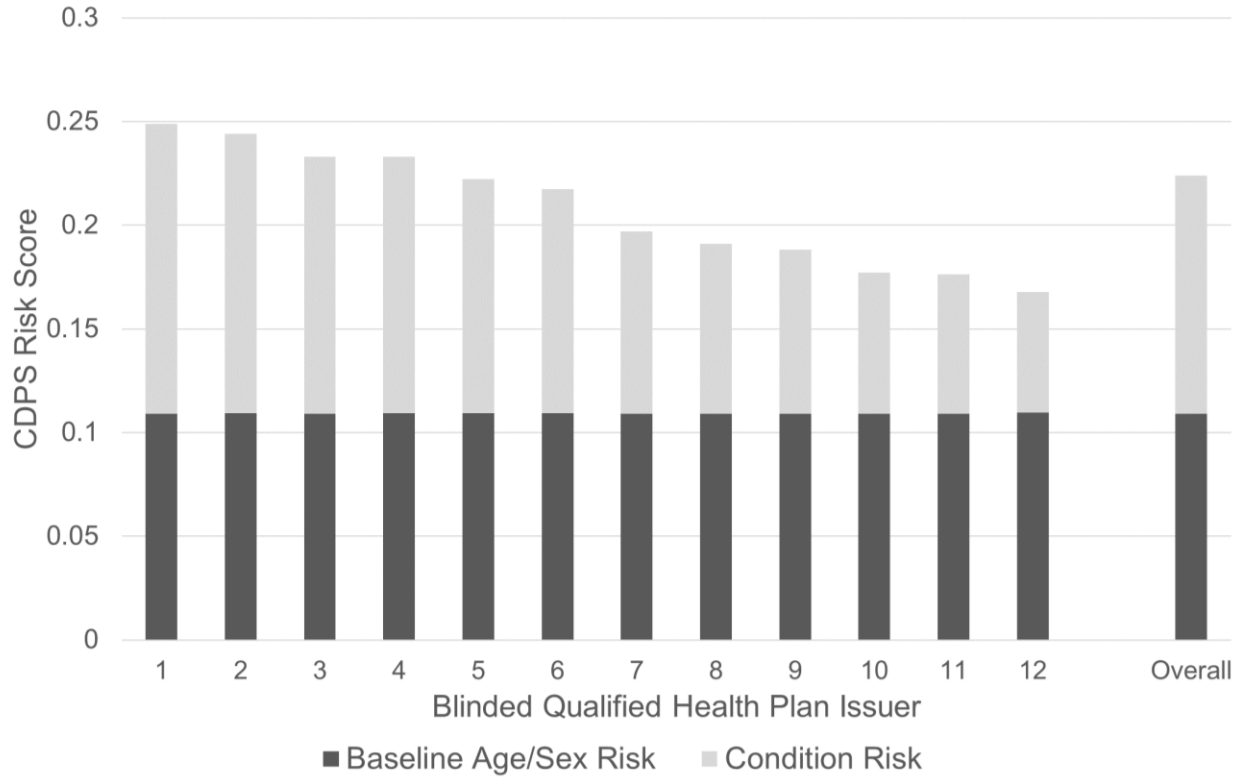
[5] For background on the CDPS, see Kronick, Richard, et al. "Improving health-based payment for Medicaid beneficiaries: CDPS." *Health care financing review* 21, no. 3 (2000): 29, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194678/ (accessed on July 8, 2023).

How Covered California Leveraged HCAI Discharge Data for 2024 Premium Rates

Figure 1 below (stacked column with age, sex and chronic condition diagnosis components of total risk score by blinded issuer) demonstrates the relative impact of chronic conditions on Covered California plans' overall risk profile. This chart is based on the actual total risk score for 2023 enrollment derived from the HCAI analyses using the CDPS model and is similar to an analysis that was provided to plan actuaries this past April prior to 2024 rate discussions. Covered California individually advises the plan actuary which of the de-identified results belongs to their plan.

The lightly shaded portion represents the portion of the total risk (projected costs) due to chronic conditions, which would not have been identified without the use of the HCAI data. Slightly more than 10 percent of the Covered California membership is matched to an HCAI patient data file and thus have chronic condition elements in their risk scores, but they represent 51 percent of the projected cost. The darker shaded portion represents the component of the risk scores driven by enrollee demographics of age and sex.

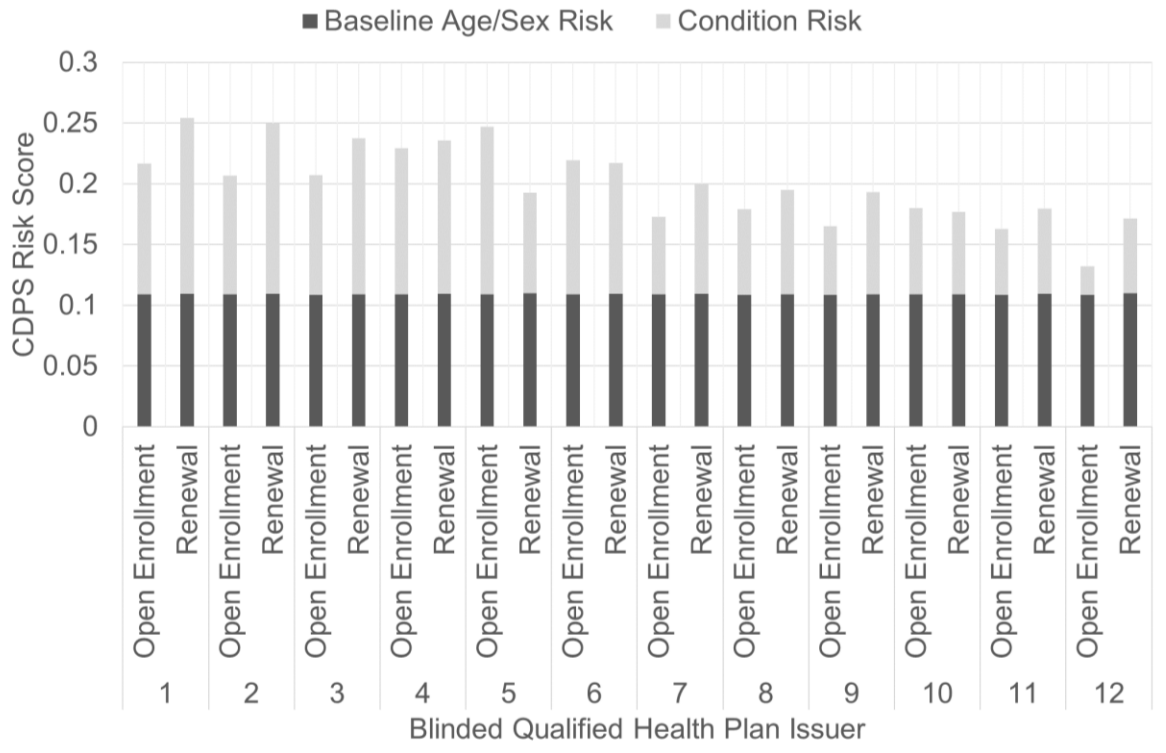
Figure 1: CDPS Risk Scores by Issuer (anonymized), Showing Portion Derived From Chronic Condition Risk v. Baseline Age and Sex Modeling



As a result of these data, plans can also gain insight into where they may have opportunities to control costs for their members or to improve their coding on Bronze or cost-sharing reduction (CSR) Silver membership, both of which heavily play into a plan's risk adjustment results.

Additionally, Covered California conducts other internal risk profiling analyses using the HCAI data, including to better understand the potential risk profile of consumer segments such as new sign-ups versus renewals, open enrollment sign-ups versus special enrollment sign-ups, changes in the risk pool due to new enrollees who joined after the American Rescue Plan Act of 2021 subsidy expansion, those who have enrolled while receiving unemployment insurance or those who may be transitioning from Medicaid to Covered California. The data also inform discussions with the chief actuary and plan actuaries around their opportunities for coding to influence risk adjustment, where the chief actuary can provide insight into where the plan may be experiencing selection or where the plan may be an outlier as it pertains to risk mix. An example of this type of analysis, comparing risk scores for 2023 members enrolled or renewing during open enrollment, is included in Figure 2 below, which shows wide variation in projected costs due to chronic disease between new enrollees (open enrollment) and renewing members, depending on the issuer.

Figure 2: CDPS Risk Scores by Issuer (Anonymized), Showing Risk Profile for New Enrollees (Open Enrollment) v. Renewals



It is difficult to quantify the direct impact of these risk scores on premiums given the broad range of factors that are involved. Covered California's former chief actuary estimates the use of these risk scores lowers gross premium rate increases from 2 percent to 5 percent (meaning, for example, that a 10 percent rate increase becomes instead a 9.8 percent increase under the 2 percent, and a 5 percent savings translates to a final 9.5 percent increase). Based on plan year 2022 premiums, this savings would have translated into $7 million to $20 million saved from premiums and subsequently tax subsidies. It should be noted that the savings are achieved each year with active purchaser rate negotiations, grow dramatically during high rate increase years and compound over time.

More generally, Covered California's approach as an active purchaser utilizing a philosophy of managed competition is correlated with an observed 44 percent rate increase over the past decade, compared to 51 percent for the states on the federal exchange and 75 percent for other state-based marketplaces combined.[6] However, it is critical to note that we do not have evidence to conclude that these differences in premium trends are *caused by* these certification strategies, and given the mix of factors that go into rate setting, it is not possible to precisely quantify the specific impact of the additional data created by the HCAI data linkage and risk profiling.

Conclusion

Pricing health care coverage is a difficult actuarial exercise. The characteristics of the individual market — a high level of churn, the timeline related to forecasting projections, a variety of products, a single risk pool and risk adjustment — make the premium rate setting for Covered California particularly difficult. In the absence of concrete data about risk, health plan actuaries would need to make conservative assumptions about their population's risk. Thanks to new legislative authority under Assembly Bill 133 (Committee on Budget, Chapter 143, Statutes of 2021), Covered California has been able to leverage the unique data collected by the HCAI to provide a better picture of health plan risk during the annual certification of qualified health plans. This work demonstrates the very significant portion of health care costs that are driven by enrollees with chronic conditions, which varies over time given the changing landscape of health care. Furthermore, this analysis gave issuers a window into the projected health care costs of their new enrollees and the difference in risk mix between their new and existing enrollee populations. By infusing the rate-setting process with credible data about risk mix profiles, Covered California believes health plan actuaries are able to lower the risk margin in their rates to account for uncertainty, thereby lowering premiums for Californians.

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[6] Covered California analysis of Kaiser Family Foundation data of benchmark premiums, averages weighted by enrollment. See "Marketplace Average Benchmark Premiums." Kaiser Family Foundation (2022). https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed July 12, 2023).
"2023 Marketplace Open Enrollment Period Public Use Files." Centers for Medicare & Medicaid Services (2023). https://www.cms.gov/research-statistics-data-systems/marketplace-products/2023-marketplace-open-enrollment-period-public-use-files (accessed July 12, 2023).