

A STUDY OF AFFORDABLE CARE ACT COMPETITIVENESS IN CALIFORNIA

Micah Weinberg & Patrick Kallerman
Bay Area Council Economic Institute



THE BROOKINGS INSTITUTION
THE ROCKEFELLER INSTITUTE

B | Center for
Health Policy
at BROOKINGS



**THE NELSON A.
ROCKEFELLER INSTITUTE OF GOVERNMENT**
The public policy research arm of the State University of New York



A FIELD RESEARCH REPORT
FEBRUARY 2017

Table of Contents

Section 1 – State Context	3
Section 2 – New Developments Entering the Fourth Open Enrollment Period	6
Section 3 – Selection of Local Sites	7
Section 4 – Methodology	8
Section 5 – Regional Summaries	9
Section 6 – Outcomes of Competition	10
Section 7 – Conclusion	15
Endnotes	17

Section 1 – State Context

California was the first state to pass enabling legislation and create its own insurance marketplace following the passage of the Affordable Care Act (ACA). Since then, the state has been a leader in the implementation of the ACA and has reduced the uninsured rate from 17.2 percent in 2012 to 8.1 percent in 2015 while seeing some of the lowest premium rate increases in the country.¹ Though there have been various technical challenges in implementation—and the law itself is complex in ways that reinforce these difficulties—in many ways Covered California is achieving exactly what was expected for exchange-type marketplaces, as they were conceived for 30 years previous to the passage of health care reform. It is a model of “managed competition” that should be a model for health reformers going forward.

The state made a decision early on to set up Covered California as an “active purchaser,” allowing it to selectively contract with insurers, negotiate rates, standardize benefits, and require programs that promote delivery system improvement. In addition to the relatively large number of enrollees, which has hovered around 1.4 million, as well as the competitive market for individual insurance in the state, this decision to be more than a listing of services for health insurance company products and their prices has contributed to lower premium increases than almost all other states. The weighted average of marketplace plans is set to increase 13.2 percent for the 2017 plan year, which is well above the averages for the first several years.² This one-time bump was expected given the expiration of some of the risk mitigation elements of the Affordable Care Act, and even this comparatively higher rate increase is substantially below the average rate increases in most other states. The expectation was that California would return to modest rate increases in coming plan years as well as aggressively pursue active purchasing policies designed to bring down health care costs and improve the quality of care. But with the move to “repeal and replace” the ACA, the future is now filled with uncertainty.

With nearly 40 million residents, California is the largest state in the nation. It is a very diverse state geographically, economically, and demographically. It is also ethnically diverse, with large numbers of African-Americans and Asian-Americans and a Latino population nearing 40 percent of the state’s total residents. California’s 19 rating regions reflect the diversity of the state as well. The Northern Counties region covers a vast geography of 22 rural counties that have significantly more Caucasian residents, while the populous and ethnically diverse Los Angeles County is split into two regions.

For the 2017 plan year, 11 insurers are participating in the state’s marketplace. This stands in stark contrast to the limited competition in other states. In both cases, this is a reflection, in part, of the competition in these markets before the passage of the ACA. However, California took some affirmative and successful steps to bring in insurers that had traditionally participated only in the Medicaid managed care market, which will be discussed in detail below. Due to this history and these implementation choices, the majority of consumers in California have access to at least three insurers and those in some regions have access to as many as seven choices.

Because of the state’s robust implementation efforts, enrollment in Covered California has been strong. During the first open enrollment period, the state had 1.395 million individuals choose a plan on the

marketplace, and subsequent enrollment periods have held steady. Enrollment in Medi-Cal—California’s Medicaid program—also surged, due to robust implementation and outreach efforts. The program now covers over 13.5 million individuals with more than 4 million people being added to the rolls since 2009.³

The dominance of a few health care systems in Northern California is a perennial concern and a significant driver of rate differences between regions. Insurers have less leverage for negotiating in regions with fewer hospitals and/or places dominated by large medical groups. As a result, rates are often higher in those areas. High levels of provider concentration are partly responsible for rates being 30 percent higher in Northern California versus Southern California. This report on the implementation of the Affordable Care Act in California will assess the interplay among these factors, the choices that the state made in implementation, the underlying market dynamics, and the extent to which the structure of the federal law all contributed to creating these choices for consumers across the many diverse regions of the state.

Figure 1: California Profile, 2010 Census

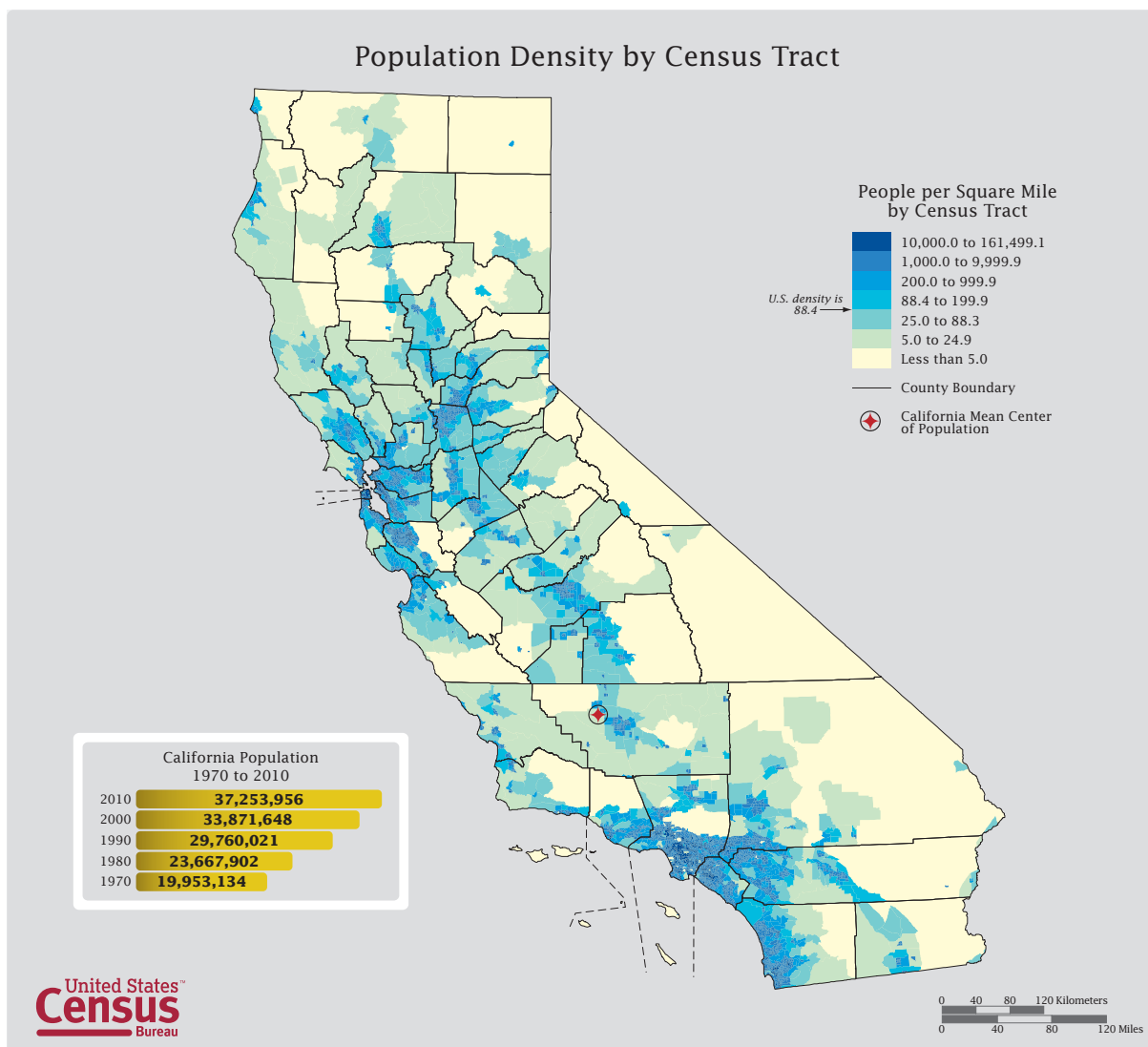


Figure 1: California Profile, 2010 Census (continued)

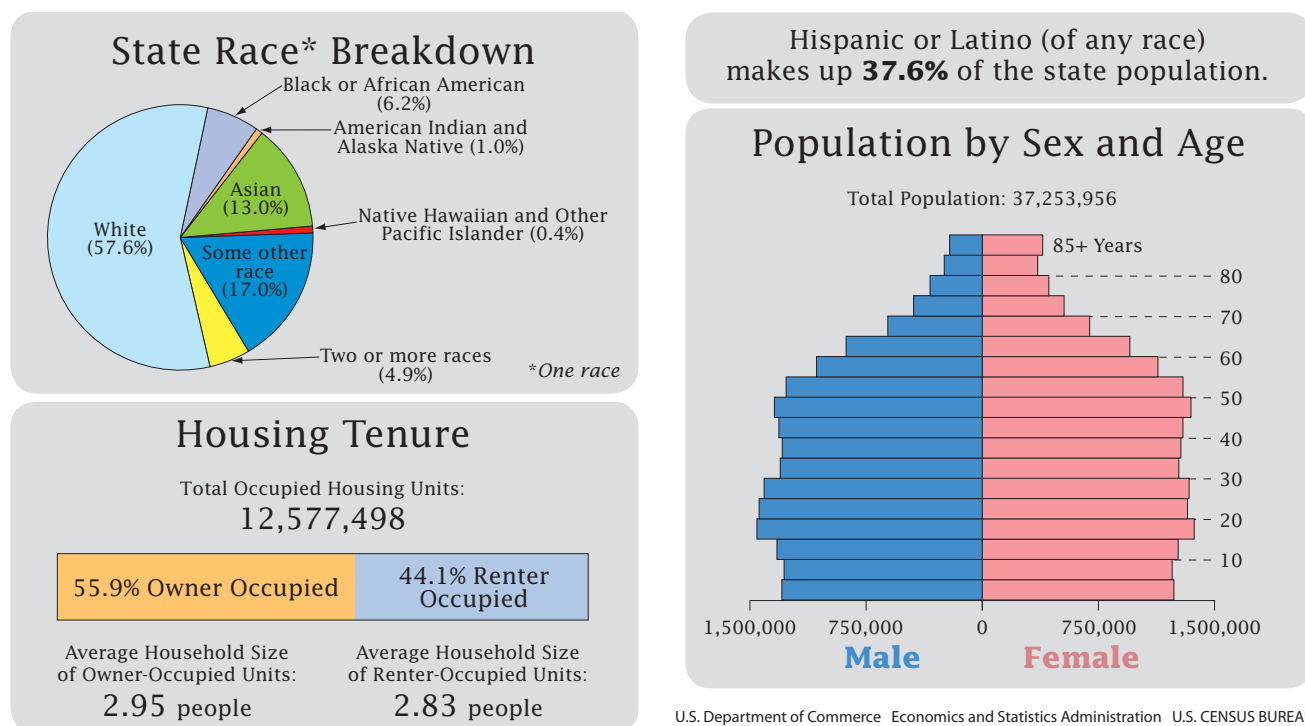


Table 1: Basic State Facts^{4, 5}

California Snapshot	
Type of Exchange	State-based marketplace
Expansion of Medicaid	Yes
Number of Rating Areas	19
Number of Insurers	11 (2017 Plan year)
Net Change in Number of Insurers	-1
Premium Increase (2016, silver plans)	1 percent (10th best)
State Population and Rank	39,144,818 (1st)
State Per Capita Income and Rank	\$53,741 (10th)
Salient Health Facts	California is the 16th healthiest state in the nation, though it has large disparities in health by race, ethnicity, and education level.
Salient Health Policy Information	<p>Uninsured rate, which was previously very high, has come down. Medi-Cal now covers over one-third of the state's population.</p> <p>Marketplace is an active purchaser.</p>

Section 2 – New Developments Entering the Fourth Open Enrollment Period

Due to California's leading role, enthusiastic bipartisan embrace of the ACA, as well as sustained and substantive cooperation across a broad set of stakeholders, enrollment during its first open enrollment period (OEP) for the 2014 plan year was extremely strong, with 1.395 million consumers completing an application and selecting a plan. Enrollment in subsequent OEPs has held steady rather than growing to the extent expected. A total of 495,000 new consumers chose a plan in the second OEP and 439,000 in the third.

Churn into other types of health care coverage—especially Medicaid but also employer sponsored insurance—means that the total number of individuals enrolled has remained essentially stable over three years.⁶ The systems in the state easily support moving people from Covered California coverage into Medicaid, but the transition up into marketplace coverage has been more difficult. California's inability to build significantly on the results of its first open enrollment period is also likely a factor of the difficulty in reaching the remaining uninsured population as well as people at different points in the income spectrum questioning the value of the coverage relative to its cost.

A key question entering the fourth OEP is the long-term viability of insurer participation in ACA marketplaces. Nationally, many major national health insurers are projecting losses on ACA plans for 2016, though there have been other insurers—especially some state and regional Blue plans—that have experienced better returns.⁷ The expiration of the reinsurance program puts increased pressure on the financial performance of insurers in 2017, and significant rate increases are expected nationwide.

Until 2016, insurers in California were performing relatively well on marketplace offerings compared with their national counterparts. The state's three largest insurers were some of the only ones to show profits selling ACA plans.⁸ More recently, however, insurers in California have also begun to lose money on marketplace plans. UnitedHealthcare's announcement to leave the marketplace after only one year of participation—as well as nearly all of the 34 other marketplaces it previously participated in—raises long-term concerns over competition in years to come. Blue Shield of California, the state plan with the highest enrollment as of the end of the third plan year, also announced that it was losing a significant amount of money on this channel after previously reporting favorable returns on business associated with Covered California in the first couple of years of implementation.

The results of the 2016 presidential and congressional elections bring new uncertainty to the fourth open enrollment period for Covered California. The expectation is that the next Congress will pursue a repeal and replace strategy that will leave the current system in place for at least one additional plan year. The state marketplace has pivoted in its marketing efforts to assure customers that it is still open for business. Until its executives learn what the landscape will be going forward and whether state-based exchanges will be a part of this new structure they are continuing to conduct their activities largely as planned, while researching different options for the state under potential new federal laws.

Significantly less clarity exists for the subsequent open enrollment period that begins in November 2017. There were already some questions related to insurer participation in the marketplace in this plan year given financial returns. Substantial additional uncertainty—about, for example, the existence of an individual mandate and the level of subsidies for the purchase of private insurance—threaten a “death spiral” for this marketplace and others around the nation. There is more commitment from California-based insurers to participate in Covered California—and universal, guaranteed issue-based coverage health reform generally—but financial feasibility will ultimately have to guide their decisions as they contemplate an uncertain future.

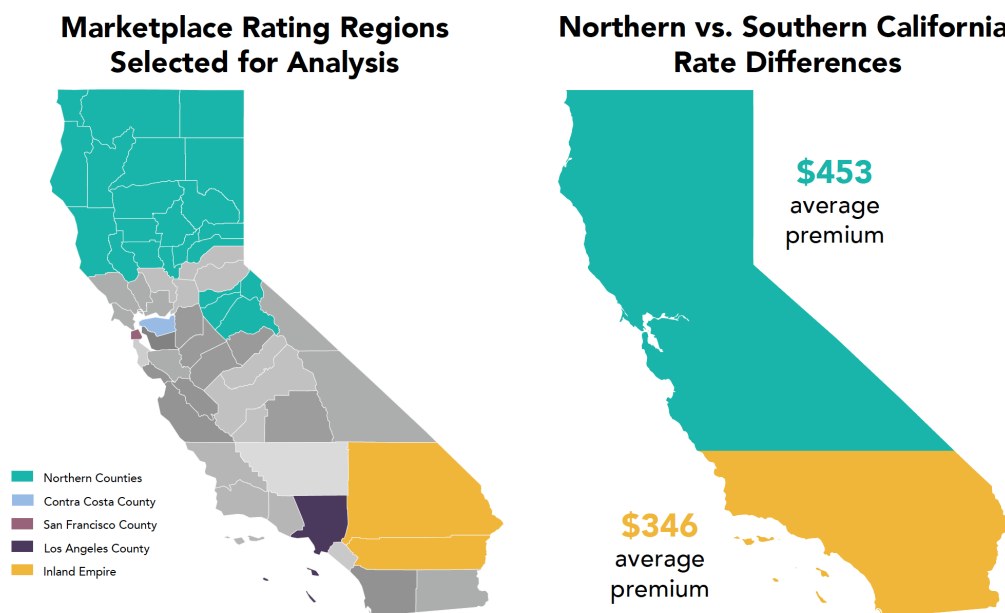
Section 3 – Selection of Local Sites

Five rating regions were chosen for the purposes of this study: the Northern Counties, San Francisco County, Contra Costa County, Los Angeles County (Southwest), and the Inland Empire. They represent the diversity of regions in the state and cover urban, suburban, rural, and mixed geographies, in both the north and south halves of the state. Region 16, the southwestern half of Los Angeles County, represents the most populous region in the state with over 5 million inhabitants, while the Northern Counties region covers 22 sparsely populated counties, one with a total population of only 25,000 people.

Rate increases in the five regions for 2017 are similar, ranging from 10.1 percent in the Inland Empire to 14.8 percent in San Francisco County. However absolute rates vary significantly, with the lowest-cost silver plan for a 40-year-old being \$407 in San Francisco County and \$256 in Los Angeles County and the Inland Empire. Both the similarity of rate increases and the absolute difference in rates has been consistent across the three plan years.

The chosen regions also vary considerably in the market concentration of insurers and providers, important measures that have a significant impact on rates. San Francisco County, Los Angeles County (Southwest), and the Inland Empire all have what are considered moderately concentrated insurance markets.⁹ By comparison, insurance markets in Contra Costa County and, in particular, the Northern Counties region are highly concentrated. The Northern Counties regional insurance market is twice as concentrated as Contra Costa’s market and almost four times as concentrated as Los Angeles County’s market. The concentration in provider markets follow a similar pattern, with those in San Francisco County, Contra Costa County, Los Angeles County (Southwest) and the Inland Empire all falling in the range considered concentrated. The provider market in Los Angeles is the least concentrated.

Figure 2: Regional Variation



Source: Covered California. Health Insurance Companies and Plan Rates for 2017.

Section 4 – Methodology

The methodology for the study included interviews with dozens of health care industry stakeholders, public officials, and academic experts from across the state. In most cases, these interviews were conducted over the phone or in person. Further email conversations often supplemented these initial conversations, which generally took 30 minutes and were structured by the questions provided to the broader research group for the study. The interviewees were promised confidentiality to extract as much candor as possible. These interviews were supplemented by extensive research into media coverage of the implementation of the Affordable Care Act in California as well as analysis of data on enrollment, premiums, and local market dynamics both by this team of researchers and by researchers throughout the state whose studies are cited in this report.

Most of the interviews pertained to multiple rating regions, since most of the larger insurers cover almost all of the rating regions in the state. California is also home to a number of statewide hospital systems and multiregional provider networks. Insurance brokers and navigators, however, tend to be local and provided important intelligence on how these statewide trends were playing out for consumers at the local level. The number and type of interviewees were as follows; they are not broken out by region, because many of the interviews were pertinent to multiple regions: hospital executives (five), health insurance executives (eight), doctors' group executives and physician executives (four), health insurance brokers (six), health insurance navigators (five), leading academics focused on health reform and financing (three), public officials who work for Covered California, the Department of Health Care Services and the Health and Human Services Agency (seven), health care purchaser group executives (two), health care consumer groups (three).

Section 5 – Regional Summaries

RATING REGION 1—NORTHERN COUNTIES

Rate change (weighted average): +12.1 percent

Lowest-price silver plan: +10.8 percent (\$402 for a 40-year-old)

Comprising 22 counties, the Northern Counties rating region is primarily rural, with local health care markets typically dominated by a single hospital. For the 2017 plan year, the region saw an overall rate increase of 12.1 percent (weighted average) and a 10.8 percent increase in rates for the lowest-price silver plan. Four insurers are participating in the region, with two offering coverage to the entire region and two offering only to selected geographies.

The Northern Counties region is tied with Contra Costa County in having the second-highest monthly cost of all five study areas. However, incomes in the Northern Counties are significantly lower than those in Contra Costa County and San Francisco County (the region with the highest cost). Hence, there is generally a higher cost burden for consumers without subsidies. The individual insurance market for Northern California has been dominated by the health insurer Anthem before and after health care reform as well as the Sutter hospital system, though there are other players in certain local markets.

RATING REGION 4—SAN FRANCISCO COUNTY

Rate change (weighted average): +14.8 percent

Lowest-price silver plan: +15.6 percent (\$407 for a 40-year-old)

Comprised of only San Francisco County, the San Francisco rating region is entirely urban, relatively affluent, ethnically diverse, and has multiple hospital systems. For the 2017 plan year, the region saw an overall rate increase of 14.8 percent (weighted average) and a 15.6 percent increase in rates for the lowest-price silver plan. Five insurers are participating in the region and offer coverage to the entire region. San Francisco County has the highest cost of any of the five study areas. This is consistent with the costs for health insurance customers with other types of coverage, including large and small group employer coverage. This is partly a factor of the concentration of providers and partly a factor of the cost of living, which drives up salaries for hospital doctors, nurses and staff, and other providers in the health care system.

RATING REGION 5—CONTRA COSTA COUNTY

Rate change (weighted average): +13.6 percent

Lowest-price silver plan: +11.4 percent (\$402 for a 40-year-old)

Comprised of only Contra Costa County, the Contra Costa rating region is a mix of urban and suburban, is ethnically diverse, and has several hospital systems. For the 2017 plan year, the region saw an overall rate increase of 13.6 percent (weighted average) and a 11.4 percent increase in rates for the lowest-price silver plan. Four insurers are participating in the region and offer coverage to the entire region. The Contra Costa County region is tied with the Northern Counties in having the second-highest monthly cost

of all five study areas. However, incomes in Contra Costa County are higher than those in the Northern Counties. Hence, there is a greater percentage of those who do not receive subsidies and have a lower cost burden relative to their total income.

RATING REGION 16—LOS ANGELES COUNTY (SOUTHWEST)

Rate change (weighted average): +13.9 percent

Lowest-price silver plan: +8.8 percent (\$256 for a 40-year-old)

Comprising the southwestern half of Los Angeles County, this rating region is entirely urban, densely populated, heavily Latino, and has multiple hospital systems. For the 2017 plan year, the region saw an overall rate increase of 13.9 percent (weighted average) and an 8.8 percent increase in rates for the lowest-price silver plan. Seven insurers are participating in the region, with five offering coverage to the entire region and two offering only to selected geographies. Robust competition among insurers and providers in Southern California result in significantly lower rates in Los Angeles County and the Inland Empire than the other study areas. This is consistent with other channels of insurance.

RATING REGION 17—INLAND EMPIRE

Rate change (weighted average): +10.1 percent

Lowest-price silver plan: +5.4 percent (\$256 for a 40-year-old)

Comprised of San Bernardino and Riverside counties, the Inland Empire rating region is a mix of urban, suburban, and rural, with a limited number of hospital systems. For the 2017 plan year, the region saw an overall rate increase of 10.1 percent (weighted average) and a 5.4 percent increase in rates for the lowest-price silver plan. Five insurers are participating in the region, with two offering coverage to the entire region and three offering only to selected geographies. Relatively robust competition among insurers and providers in Southern California result in significantly lower rates in Los Angeles County and the Inland Empire than the other study areas.

Section 6 – Outcomes of Competition

The health insurance marketplaces set up by the ACA were intended to promote competition and transparency among insurers in the individual and small group markets. Subsidies that reduce the cost of premiums would only be available in these marketplaces, incentivizing insurers to participate and gain access to these consumers. In addition, the ACA's reinsurance provision provided insurers further incentive to offer coverage through these marketplaces by using fees collected from all insurers to mitigate potential losses through these channels.

A great deal of the emphasis in analysis of the ACA has focused on competition among insurers as the key to controlling health care costs and improving the quality of health care. However, it is not entirely clear that we should always expect increased competition among insurers to have these effects. Increased competition may have the rate-reducing effect it has had in many other types of markets, as an increased number of participants compete for market share, in part, by lowering prices. It may also have

the opposite effect, though, as an increased number of participants split market share and thereby reduce the ability of any single insurer to negotiate prices with providers, necessitating higher rates. The potential of reduced negotiating ability is of particular concern in California, where certain regions have very high levels of provider concentration. Recent research by Ho and Lee found that the direction of impact that competition had on rates was critically influenced through mechanisms employers and institutions use to constrain rates.¹⁰

In California, these findings are particularly relevant because of the state's decision to structure its marketplace as an active purchaser. This allows the marketplace to selectively contract with insurers, negotiate rates, standardize benefits, and require programs that promote delivery system improvements—the types of activities Ho and Lee found to constrain rates. A 2016 *Health Affairs* examination of market concentration in California and New York found a positive correlation between insurer concentration and rates in New York and a negative correlation in California.¹¹ What this suggests is that it is not competition among insurers but rather other factors—including potentially California's choice to structure its exchange as an active purchaser—that influence these outcomes. California has begun to use its active purchasing powers to select which insurers can participate on the marketplace and to work through and with these insurers to attempt to influence the provider marketplace, including the quality and cost of care.

COMPETITIVENESS OF CHOICE

Twelve insurers participated in California's individual marketplace in 2016. The departure of UnitedHealthcare from the marketplace gained a good deal of attention, but it is not clear this was a significant development. The company was not a player in the individual market before health care reform. Eleven insurers continue to participate in 2017, almost twice the national average of 5.7 insurers.¹² However, the state's large geography means no consumers have access to every insurer. The vast majority of consumers have access to at least three insurers, though those in limited geographies have access to only two and others to as many as seven. Therefore, the choices of consumers vary substantially throughout the state.

While insurer participation has remained relatively stable, the majority of rating regions in the state are still considered “high concentrated,” according to guidelines published by the Federal Trade Commission.¹³ Four insurers—Blue Shield of California, Anthem Blue Cross of California, Kaiser Permanente, and Health Net—accounted for more than 90 percent of enrollment in the first two open enrollment periods.¹⁴ There were signs that this dominance was eroding in the third OEP, however. The Molina health plan, which has traditionally served the Medicaid market in the state, saw substantially increased enrollment, especially in Southern California, likely due to its favorable price position. Generally, it appeared that consumers initially shopped primarily based on the brands with which they were the most familiar, then turned to shopping that was driven largely by the networks offered by the insurers, and finally they have started to appear to be most sensitive to price over other factors. This may be a factor of the conservatism of enrollees as they enter a new marketplace and become accustomed to a new system.

Of the five study areas, the two with the lowest premiums also have some of the highest levels of insurer participation. The Los Angeles region has seven insurers participating, with five offering to the entire region. The Inland Empire region has five insurers participating, with two offering to the entire region,

and three offering only to selected geographies. The lowest-price silver plan for a 40-year-old was \$256 per month in both regions. Despite similarities in the number of insurers and the pricing in plans, these regions are very different in terms of their demographics and geographies, suggesting that these are less important factors than insurer and provider concentration.

With relatively low concentrations of insurers and providers, competition in the marketplace has remained robust in Los Angeles. However, other trends have started to emerge in response to reforms under the ACA. The Los Angeles region's traditionally fragmented health care market is showing signs of coalescing. Numerous hospital systems, physician organizations, and community clinic organizations are coming closer together, and "super group" physician organizations are on the rise, as hospital systems compete with managed care organizations such as Kaiser Permanente.¹⁵

The Inland Empire region has also seen strong competition from insurers in its marketplace and has a similarly concentrated insurance market to Los Angeles. However, provider concentration in the region is much higher, and there are shortages of both hospitals and physicians. The region has not been as successful as Los Angeles in reducing the uninsured rate. The Inland Empire currently has an uninsured rate of 17 percent compared with Los Angeles's 13 percent.

In the two Bay Area regions—San Francisco and Contra Costa counties—participation among insurers remains robust, but heavily concentrated provider markets mean premiums are much higher on average than in Southern California. Lowest-price silver plans are nearly \$150 a month higher in the Bay Area regions than in Los Angeles or the Inland Empire. Regional consolidation among providers has also continued to increase. One of the biggest concerns of the framers of the Affordable Care Act is the extent to which it seems to have accelerated the trend toward consolidation among insurers and providers—or at the least has done little to forestall this trend.

The rural nature of the Northern Counties means that the number of insurers, and therefore competition, is much lower. Only two insurers have offerings that cover the entire region. Provider concentration is also extremely high; hospital concentration in the region is five times higher than that of the Inland Empire, for example. The Northern Counties were one of the regions UnitedHealthcare participated in briefly before pulling out of California completely, citing an inability to make participation in the marketplaces profitable. Generating increased competition, particularly among hospital systems, is more difficult in sparsely populated areas. To the extent there are concerns that lack of competition generates much higher prices within a market-based system, rural California and other similar geographies may have to experiment with new technologies, especially telehealth, to see the benefits of competition among providers.

BROADENING THE MARKET

The advance premium tax credits offered to individuals and families under the ACA are set on a sliding scale based on income. Individuals and families with incomes between 138 and 200 percent of the federal poverty level (FPL) receive subsidies such that their premium contributions do not exceed 2 to 6 percent of their income. For individuals and families with incomes between 200 and 400 percent of the

FPL, premium contributions are a higher share of their income, between 6 and 9.5 percent. This structure means that those in the higher subsidy-eligible income ranges are likely to be more price sensitive to rate increases than those in the lower ranges.

In California, 53 percent of the 3 million potential marketplace enrollees had selected a plan through the end of the third OEP. The majority of enrollees (89 percent) was eligible for subsidies and had incomes toward the lower end of the eligible income ranges. While only 38 percent of the *total* subsidy-eligible population had incomes between 138 and 200 percent of the FPL, 56 percent of *enrollees* had incomes within that range. By contrast 62 percent of the *total* subsidy-eligible population had incomes between 200 and 400 percent of the FPL, though only 44 percent of *enrollees* had incomes within that range.¹⁶ Expanding enrollment above 200 percent of poverty remains a challenge in California. Efforts to reach out to lower-income populations have been improved through the extensive use of navigators as well as community clinics as enrollment sites. The majority of the relatively higher-income enrollees likely came to the marketplace through health insurance agents, who have been responsible for 40 percent of the enrollment on an ongoing basis. Continued downward pressure on commissions for these agents means that California may continue to have difficulties developing a more equal income mix across enrollees.

As expected, there is significant variation among rating regions. Enrollment patterns in Los Angeles County and the Inland Empire are similar to those of the state, with more enrollment in the lower end of the eligible incomes ranges. The Northern Counties, San Francisco County, and Contra Costa County see the reverse, with relatively more enrollees in the higher end of the eligible income ranges than the lower ranges.¹⁷ These trends mostly follow local income distributions, with the exception of the Northern Counties, where there is relatively low enrollment in the lower end of the eligible income ranges. Still, the share of subsidy-eligible enrollment in the higher end of the income ranges in all five study areas is below the eligible share.

BENDING THE COST CURVE

California Rating Region 16, which spans the west half of Los Angeles County, has a population of nearly 5 million and as much enrollment as many state-based exchanges (currently over 200,000 active enrollees.) The dynamics in this rating region are very illuminative of what is going on across the rest of the state, as well as the rest of the nation, in terms of competition among plans and providers and its impact on the cost of health care.

In one major way, Region 16 is an outlier, since there are seven insurance insurers competing for business: major state or national insurers, Blue Shield of California, Anthem and HealthNet, offering PPOs, EPOs, and/or HMOs; the integrated delivery system Kaiser Permanente; two Medicaid managed care plans, LA Care and Molina; and a new tech-savvy entrant, Oscar. This means that western Los Angeles County is a test bed for competition among as broad a range of insurers as anywhere in the nation.

The results of this competition and its impact on the cost of health insurance, as well as the subsidy-adjusted cost paid for by the majority of enrollees in Covered California, is very instructive and has changed significantly at least twice during the four plan years for which we have data. Initially, the plans had very little differentiation in terms of their price points for the benchmark plan; all were within \$50 or

so of each other in terms of premium for a 40-year-old person selecting a silver plan (which was also representative of differences at other actuarial value levels and enrollee types). Generally speaking, the Medicaid managed care plans (LA Care and Molina) were the lowest, with the commercial HMOs in the middle range and the commercial PPOs and EPOs as the most expensive. That pattern persisted across the three years.

Initially, the PPO networks of the commercial insurers were very narrow. As an example, Cedars Sinai Medical Center, the regional facility with a brand that is synonymous globally with high quality care, was only in the network of the HealthNet bronze and catastrophic plans. In subsequent years, the commercial insurers Blue Shield of California and Anthem broadened their networks to include this and other premier hospitals. This led to an even greater difference in premiums between these PPOs and the HMOs that generally had narrower networks, particularly those administered by the Medicaid managed care plans. This also led to a great deal of risk selection across plans, in which patients who had higher health needs and wanted access to premium facilities enrolled in large numbers in these plans. These plans were not able to make up the difference through higher premiums and began to report losses on this channel in years two and, especially three, driven by this and other factors.

In the first two years, more than 90 percent of enrollment in this region, as well as throughout the state, was in the plans of the well-known commercial brands. However, in the 2016 plan year, the third open enrollment, Molina saw a significant spike in enrollment (a 350 percent increase from 2015) largely attributable to its significantly better cost position. LA Care has had trouble getting traction in the market as of yet, but may see significant enrollment for the 2017 plan year due to its low relative price point.

Covered California released rates for the 2017 plan year showing that the gap between the lowest-priced plan and highest-price plan more than tripled in one year. In 2016, Molina's unsubsidized premium was \$278 per month and the premium for the Anthem EPO was \$327 per month for a difference of \$49. In 2017, Molina actually *dropped* its premium to \$253 per month and the Anthem price jumped dramatically to \$415 per month, for a difference of \$162 per month. Given that the subsidized population is highly sensitive to price differences and the cost of the second-lowest silver level plan (LA Care) remained essentially unchanged (it increased \$1 to \$267 per month), we are likely to see continued significant movement into managed care plans with Medicaid-type networks, which in California are very narrow compared with their counterparts and generally do not include prestigious facilities.

In Region 16 in 2017, the benchmark silver plan, LA Care, costs a 40-year-old \$270 a month, or \$3,240 annually. If an enrollee earns \$23,760 (or 200 percent of the FPL), she would be expected to kick in 6.43 percent of her income, or \$1,528, toward insurance ($0.0643 \times \$23,760 = \$1,528$). This means that she will pay \$1,528 annually, or about \$127 a month, for the benchmark plan. If she selects Molina, the cost of the plan to her is the difference versus the benchmark plan (- \$14) for a cost of \$113 per month. If she wants to select the Anthem EPO, the cost of the plan to her is the difference versus the benchmark plan (+ \$151), or \$278 per month. Many analyses have suggested that the premium subsidies are not large enough to adequately incentivize people to purchase even the benchmark plan. Particularly in areas with higher costs of living such as coastal California, that seems to be the case. Given the cost of living,

less than \$24,000 per year are poverty wages. In this case, shelling out up to \$278 per month for health insurance seems beyond reach.

On some level, though, this is exactly how the ACA—and exchanges generally—are supposed to work. Due to regulations of the law that standardize benefit designs as well as the additional standardization imposed by California through its active purchasing role, the cost of insurance is largely a reflection of the cost of the network that is “sold” by the health insurer. There is a vast difference in the cost of these underlying networks, particularly in Los Angeles, where there is a great deal of competition among health systems. As more people enroll in the lower-cost plans, this theoretically puts pressure on providers to lower their costs to continue to be able to attract patients. So, the competition among plans and the competition among health insurers could help in bringing down costs overall.

Ultimately, though, the exchange is just one health insurance sales channel in the state. In spite of its very large size relative to other exchanges and that most of the individual market outside of the exchange is standardized to match exchange offerings, insurers and providers still can choose not to participate in the exchange and charge high rates to other payers. So, the overall impact on bending the cost curve in California has as of yet been limited.

Further, it’s not entirely clear that the only affordable products within the exchange for subsidized populations are of a quality comparable with the networks offered by conventional employer-sponsored insurance. And even the networks offered on the exchange by commercial insurers are narrower than their traditional offerings for employer-sponsored insurance to the extent that they have attracted lawsuits for inadequacy. Finding the right balance is challenging, but California’s role as an active purchaser means that it has had some tools to explicitly address these issues of competitive balance and offerings. The experience of California, and that of Region 16, highlights both some of potential for using these marketplaces to bend the cost curve but also some of its limitations.

Section 7 – Conclusion

There have been many challenges associated with the implementation of health reform in California and there are still many areas to address. However, the experience of the state and of its marketplace, Covered California, are promising in fulfilling the expectations of a system of managed competition in which the underlying cost of the health system consumers are purchasing determines the price of insurance, drives their selection of an insurance plan, and hence drives the cost of health care down without reducing value. Ensuring that the networks are adequate—and that the system of financing continues to support both the safety net as well as the unique offerings of academic medical centers—is something that is necessarily going to be an ongoing dialogue in the state and would have to be supported by administrative actions and, potentially, state or federal legislation.

The trend towards consolidation of both insurers and provider systems is also a threat to this system and one that California is well positioned to understand and, potentially, to address as an active purchaser. The understanding springs from the fact that health insurance premiums are dramatically higher in

northern California for individuals or employers purchasing coverage. This is largely a factor of provider concentration. There are steps the public marketplaces and private employers can take to drive down costs, including strategies such as reference pricing, but it will be difficult to make much headway in the wake of increased provider consolidation.

Another challenge for the state, one that stands in the way of optimizing the consumer experience as well as the system for highest value, is the churn across programs. Income is very volatile for individuals at the threshold of Medicaid, and marketplace coverage and the transition across programs has been very difficult. Developing a single program for the working poor is one opportunity as the nation revisits its health care financing structure in the wake of the 2016 elections. The ACA, for all of its virtues, is a very conservative law that preserves an enormously complicated system largely by layering more complexity on top of it.

Therefore, the lessons learned from California's experience are not always entirely simple. For example, papers across the nation were full of stories about unsubsidized health premiums going up, sometimes by massive amounts year over year. However, given the structure of the law's subsidies, if health insurers raised their rates to roughly the same degree, there would be minimal impact on the 90 percent of marketplace enrollees who received income-adjusted subsidies. Ironically, the fact that a major insurer in Los Angeles (Molina) dropped its premiums while others increased them only modestly had a much larger impact on the pocketbooks of enrollees in this area.

The lessons of California are that fundamentals matter more than implementation actions or partisan preferences. The fundamentals, in this case, are largely the relative concentration of providers and insurers in different regional marketplaces. The differentials in price across these regions swamped the differences that were a factor of government actions, though Covered California was expected to do more to address these issues in the coming years. In this environment of uncertainty, the nation has a great deal to learn from California. Ideally, the analysts who are informing decision makers will dive deeply into what made California's implementation of the Affordable Care Act the most successful in the nation. This report is simply one window into that time period.

Endnotes

1. Centers for Disease Control and Prevention, “National Health Interview Survey,” accessed Jan. 30, 2017, <https://www.cdc.gov/nchs/nhis/>
2. California Health Benefit Exchange, “2017 Product Prices for all Health Insurance Companies,” accessed Jan. 30, 2017, <http://hbex.coveredca.com/data-research/>
3. California Department of Health Care Services, “Medi-Cal Monthly Enrollment Fast Facts, May 2016,” accessed Jan. 30, 2017, http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_May_2016_ADA.pdf
4. Jon R. Gabel, Heidi Whitmore, Adrienne Call, Matthew Green, Rebecca Oran, and Sam Stromberg, “Modest Changes in 2016 Health Insurance Marketplace Premiums and Insurer Participation,” Commonwealth Fund, January 2016, <http://www.commonwealthfund.org/publications/blog/2016/jan/2016-health-insurance-marketplace-premiums>
5. United Health Foundation, “America’s Health Rankings, 2015 Annual Report,” accessed Jan. 30, 2017, <http://www.americashealthrankings.org/learn/reports/2015-annual-report>
6. Kaiser Family Foundation, “Marketplace Plan Selections as a Share of the Potential Marketplace Population,” (November 1, 2015-February 1, 2016), accessed Jan. 30, 2017, <http://kff.org/health-reform/state-indicator/marketplace-plan-selections-as-a-share-of-the-potential-marketplace-population/?currentTimeframe=0>
7. Anna Wilde Mathews, “Aetna Joins Rivals in Projecting Loss on Affordable Care Act Plans for 2016,” *Wall Street Journal*, August 2, 2016, accessed Jan. 30, 2017, <http://www.wsj.com/articles/aetna-tops-views-stops-aca-expansion-plans-1470134736>
8. Chad Terhune, “California’s 3 largest health insurers among few to show Obamacare profit in 2014,” *Los Angeles Times*, December 9, 2015, accessed Jan. 30, 2017, <http://www.latimes.com/business/la-fi-obamacare-profits-20151209-story.html>
9. Market concentrations based on Federal Trade Commission guidelines using the Herfindahl-Hirschman Index as calculated by Richard M. Scheffler, Daniel R. Arnold, Brent D. Fulton, and Sherry A. Glied, “Differing Impacts Of Market Concentration On Affordable Care Act Marketplace Premiums,” *Health Affairs* vol. 3, no. 5, May 2016, <http://content.healthaffairs.org/content/35/5/880.abstract>
10. Kate Ho and Robin S. Lee, “Insurer Competition in Health Care Markets,” NBER Working Paper #19401, September 2013, <http://www.nber.org/papers/w19401>
11. Scheffler et al, “Differing Impacts of Market Concentration on Affordable Care Act Marketplace Premiums.”

12. Kaiser Family Foundation, “Number of Issuers Participating in the Individual Health Insurance Marketplaces,” (2014-2017), accessed Jan. 30, 2017, <http://kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace/?currentTimeframe=0>
13. Scheffler et al, “Differing Impacts of Market Concentration on Affordable Care Act Marketplace Premiums.”
14. California Health Benefit Exchange, “2016 Open Enrollment Plan Selection Profile,” accessed Jan. 30, 2017, <http://hbex.coveredca.com/data-research/>
15. California Health Care Foundation, “Los Angeles: Thriving or Surviving in a Fragmented Market,” September 2016, <http://www.chcf.org/publications/2016/09/regional-market-los-angeles>
16. California Health Benefit Exchange, “2016 Open Enrollment Plan Selection Profile.”
17. UCLA Center for Health Policy Research, “California Health Interview Survey,” accessed Jan. 30, 2017, <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>