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Health Care Reform in the Balance: California and the Future of the Affordable Care Act

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California got off on the right foot in implementing the Affordable Care Act (ACA). This means it has more leeway to make adjustments to the program than do many smaller states, which will need greater assistance from federal policy changes and higher government spending to stabilize their individual marketplaces. However, if Congress continues to dismantle or underfund the program in coming years, California will have to decide whether to recreate features of the ACA, such as the individual mandate, at the state level, modify the ACA, or move toward other ways to finance healthcare access for the state's residents. This report traces how California successfully built an ACA marketplace and what its options are in this period of retrenchment.

Building a Stable Foundation

A Strong State Commitment to Healthcare Reform

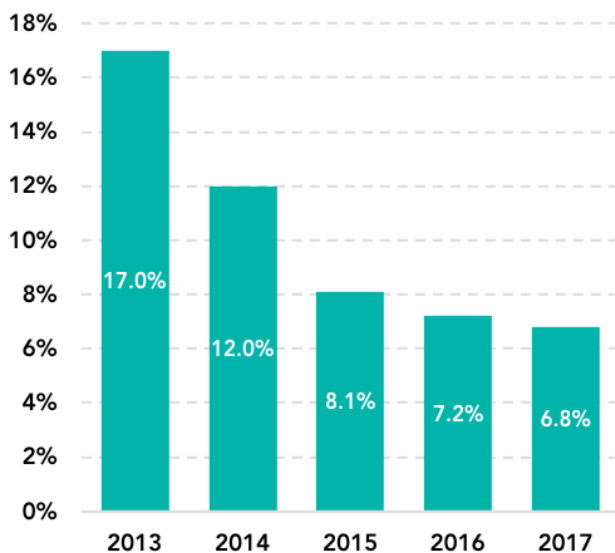
Implementing the Affordable Care Act in California posed many significant challenges. The state had millions of uninsured individuals who spoke a wide variety of languages and were spread out over an enormous geography. Stakeholders from many different

regional healthcare markets had to come together to effectively manage the implementation of a very complex law on an aggressive timeline. Nevertheless, soon after the passage of the federal Affordable Care Act (ACA) in 2010, California's Secretary of Health and Human Services, Diana Dooley, remarked that California wanted to be the lead car, not a pace car, in implementing the reforms.¹

That goal was achieved. California was the first state to establish an individual exchange, or marketplace, under the terms of the ACA. Unlike the website serving federally-run plans and those in many state-run marketplaces, California's web portal was serviceable from the outset. The state drew on ample federal funding to help establish its health insurance marketplace, which it named Covered California.²

From establishing standardized plan designs to negotiating these designs with insurers, Covered California took the most innovative position in the country with respect to designing its healthcare market to promote value for consumer spending. In recent years, the marketplace has become financially self-sustaining thanks to an annual tax levied on health plans. Through the effective use of a federal waiver, California also handled the law's expansion of

CA Uninsured Rate Since Enactment of the ACA



Source: Centers for Disease Control and Prevention (CDC), National Health Interview Survey; Laurel Lucia, UC Berkeley Labor Center, "Uninsurance in California," ITUP 22nd Annual Conference

Medicaid—"Medi-Cal" in California—more smoothly than in most other states that chose to expand the program.

Enrollment numbers have been strong with between 1.2 and 1.5 million Californians enrolled in Covered California at any given point in the last five years and more than five million Californians having had coverage through the marketplace since the passage of the ACA. Almost five million more are newly enrolled in Medi-Cal.³ Approximately 600,000 people have selected off-exchange coverage and now fall into the same pool of risk as those selecting plans inside the marketplace. The percentage of uninsured in California has fallen from 17 percent in 2013, when the first open enrollment period began, to just 6.8 percent by late in 2017.⁴

California's experience shows that the basic design of the ACA can function effectively when a state is committed to its implementation. Nevertheless, at the end of the ACA's fifth enrollment period, its future in California, as elsewhere, is in considerable doubt. President Donald Trump's administration and Congressional Republicans have made repeated efforts first to repeal Obamacare and then to undermine or

roll back features of the law that, in the eyes of most analysts, stabilize the individual markets while protecting individual consumers.⁵

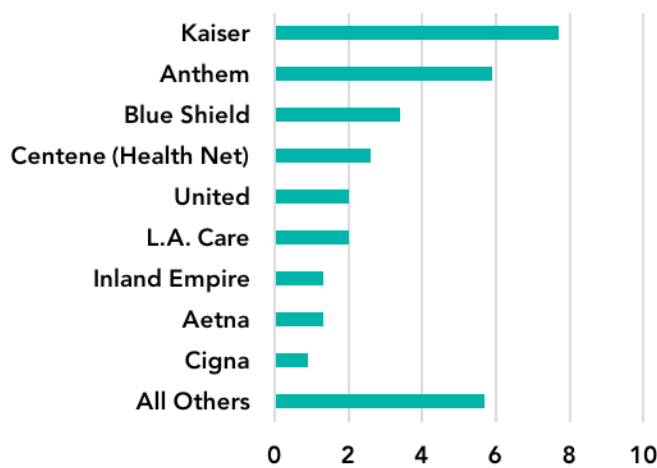
After several years of modest premium growth in the low single digits, among the lowest in the nation, California experienced double-digit increases in 2016-17, in significant part because of the sunsetting of a provision that reduced risk for insurers. Premiums for the 2017-18 cycle also rose substantially—an average of 12.5 percent—in large measure because of the decision by President Trump to end Cost-Sharing Reduction Payments to insurers. This rise in premiums especially affects unsubsidized individual purchasers (10-15 percent of exchange membership, plus those buying products off-exchange) who pay full freight rather than having the cost of the policies capped at a percentage of their income. The potential impact of the elimination of the penalty for failing to have ACA-compliant coverage, as well as the implications of the loosening of regulations around short-term and association health plans, is also likely to be substantial.

California's Health Care Marketplace: Large Scale, Long Experience

The number of participants in California's health insurance market played a large role in getting the Affordable Care Act off the ground. Thirty-two insurers, most of them local and regional, considered participating in the first open enrollment cycle, attracted by the potentially large size of the marketplace. Twelve eventually reached an agreement with Covered California to participate. This number has remained steady over time—eleven participated in the most recent open enrollment period—though smaller carriers have left or rejoined the marketplace. Four insurers—Anthem, Blue Shield of California, Kaiser, and HealthNet—have held the lion's share of the market throughout, both in Covered California and off-exchange, though plans such as LA Care and Molina have gained enrollment in recent years, mostly at the expense of Anthem, which has been reducing its market footprint.

United Healthcare, Aetna, and Cigna, three large insurers which pulled out of many states in subsequent enrollment periods, registered barely a toehold in

Total California Enrollment by Insurer, 2016 (in millions)



Source: California Health Care Foundation, California Health Insurance Enrollment 2016

California's individual and small group marketplaces.⁶ After failing to reach an agreement during the first open enrollment period, United Healthcare returned in 2016-17, almost exclusively in rural areas such as Northern California and the Sierra region, and left again after one year.

California's experience with comparable designs for exchanges also helped make ACA implementation successful in the state. CalPERS, the retirement system for the state's public employees, has been running a large health plan with exchange-like features for decades, serving some 1.4 million retirees.⁷ And California's children's health insurance program, administered by the Managed Risk Medical Insurance Board, has put in place many consumer-friendly market features while working with many of the private plans that served that market.

California also had prior experience with a public small group purchasing marketplace, HIPC/PacAdvantage, which was run by a state agency from 1986 to 1992 and by a non-profit coalition of large purchasers, the Pacific Business Group on Health, from 1992 to 2006, when it folded. A substantial reason for its demise was that brokers tended to offer healthier groups better deals outside PacAdvantage while steering less healthy groups toward exchange products, creating an

adverse selection spiral that the marketplace could not overcome.⁸

This experience helped frame a number of the early decisions made by California's marketplace. In particular, it spoke to the need to ensure that the rules inside and outside the exchange were the same, the imperative to swiftly cancel "grandmothered," non-compliant plans, the need for close partnership with insurers, the importance of outreach, and the value of manageable choice.

Health Reform Momentum in California

The debate over state-based comprehensive health care reform in California, which preceded federal reform, was in effect a dry run for the subsequent federal reforms that led to the passage of the ACA. The Massachusetts reform effort deeply influenced the California process. The federal bill, however, more closely resembled the structure of the California bill that passed the California House but not the Senate in early 2008 than it did other state-based reform bills. California's own process, in addition to familiarizing legislators, stakeholders, and the public with the terms of the debate—"exchanges," mandates, and the like—created regular contact between stakeholders with different interests, in particular the hospital sector, insurers, and consumer activists. These established partnerships greatly smoothed the path for ACA implementation. Moreover, this multi-year debate drew from almost a century of independent statewide reforms and reform proposals in California.⁹

Arnold Schwarzenegger, the GOP governor of California from 2003 to 2011, was unpopular by the end of his final term. But the fact that the marketplace was endorsed and to a considerable degree designed and implemented by his Republican administration did much to provide the bipartisan cover that was so sorely lacking at the federal level of ACA implementation. For instance, issues such as delayed vendor payments and initial enrollment hitting the low end of expectations could easily have become public embarrassments and prompted negative media coverage. However, most politicians and virtually all stakeholders worked together to resolve these problems rather than turning them into political footballs.

Pragmatic Governance

The small independent board of Covered California numbers just five members. This limited size and collegial quality of its members, along with public vetting of issues with stakeholders, allowed the board to make quick and pragmatic decisions in response to operational issues during the implementation of the federal law. This helped the marketplace succeed.

For instance, the staff leadership and board were lukewarm at first toward the thousands of private insurance brokers in the state marketplace. They focused a great deal of effort instead on the certification and funding of “navigators” drawn largely from the not-for-profit and advocacy sectors. As the challenge of selling policies became more apparent, the board reached out to and embraced brokers, who now sell almost half of the individual policies on the exchange. Moreover, despite a strong rhetorical commitment to its companion, SHOP (Small Business Health Options Program), a small group marketplace established alongside the individual market by the ACA, Covered California chose to promote the individual markets and downplay SHOP, upsetting some small business leaders but probably making the best use of available resources.¹⁰

The Board remained flexible and responsive throughout implementation. African-American and Latino state legislators, upset by lagging and what they saw as ineffective outreach in their constituencies, came in person to board meetings to express their concerns. Covered California adjusted its outreach strategies to respond to these criticisms, with considerable success. Despite the board’s commitment to outreach, however, it cut funding for marketing in the most recent enrollment cycle to make sure it did not overspend.

Policy Innovation: Active Purchasing, Standardized Plans, and Simple Choice

While the scale of California’s insurance markets and the absence of political headwinds ensured that ACA implementation could succeed, deliberate policy innovation was also critical to getting the marketplace off the ground. Taking advantage of these favorable conditions, the leadership of Covered California

decided to act aggressively in shaping the insurance marketplace rather than accepting all carriers who passed a minimal regulatory threshold. The aim of these innovations was to lower premiums, improve the “shopping experience” for consumers, and to nudge the healthcare delivery system in California toward delivering better health outcomes rather than a higher volume of services.

Most ACA state marketplaces—usually out of necessity because of the lack of competing insurers—operate in effect on a “clearinghouse” model. All insurers that clear a relatively low regulatory threshold offer a variety of products, with varying cost-sharing and deductibles, across the different metal tiers established by the law. The result, as one analyst points out, is a “buyer beware” model that puts the onus of choice on the consumer, who frequently has little ability to distinguish between a bewildering variety of products.¹¹

As Covered California executive director Peter Lee wrote, the marketplace “extracts concessions on price and product design as a condition for having access to the largest pool of new enrollees in the state. It has excluded plans that have not demonstrated the administrative capability, prices, networks, or product designs that improve consumer value...[T]he exchange first jawbones down premiums to the extent it can, leveraging its private information on risk mix, competitor rates, and the price elasticity of demand.”¹²

In effect, the marketplace calculated what set of criteria would yield an insurer a modest profit and invited them to partner based on these expectations. It is impossible to know precisely how much this approach lowered premiums relative to states that took a more passive approach, or compared to other strategies such as widening the risk pool due to marketing and outreach, but studies conducted by a number of analysts, both affiliated with and independent of Covered California, drew favorable conclusions.¹³

Consistent with this philosophy of structured choice, California standardized benefits at each tier (platinum, gold, silver and bronze) of coverage. Deductibles, co-pays, and co-insurance are required to be the same for each insurer within a small number of plan types. The aim is that the shopper is choosing based on price and physician network alone, not trying to compare complex

benefit designs that have the same actuarial value.¹⁴ The flip side, of course, is that more choices may result in an insurance product that more precisely matches an individual’s circumstances. These designs were nationally influential and became the model for “Simple Choice Plans” that were first offered on the federally-run insurance exchanges in 2017.¹⁵

Covered California has also instituted a large number of consumer-friendly requirements that aim to entice purchasers, who might otherwise feel their insurance was of little practical value, into taking steps toward better health. For instance, outpatient care at the higher metal tier levels is not subject to a deductible. And all plans at all tiers have a monthly cap on how much patients pay for drugs.

The exchange has also pushed to demand higher quality from physicians and hospitals. Health plans are required to identify doctors and hospitals who perform poorly on a variety of metrics, identify steps to reduce ethnic and geographic differences in quality of care, and ensure that every enrollee be assigned a primary care doctor.¹⁶ Among many other delivery system reform activities, Covered California became a member of Choosing Wisely, a national initiative aimed at reducing medical waste and low-value care.

Planning and Executing Successful Outreach

Buying health insurance, former Massachusetts exchange administrator Jon Kingsdale wisely observed, is a “grudge purchase.” Even if residents are eligible for coverage and enjoined to purchase it, the policies still need to be sold actively. The Covered California model took this admonition very seriously from the outset. Many full board meetings focused on outreach before the launch and policy and practice decisions were backed up by extensive market surveys and expert analysis. Covered California spent 27 percent of its initial funding on outreach, far above the average for state-run exchanges.

As noted earlier, private insurance brokers became an important part—arguably the most important service channel—of promoting and selling policies.¹⁷ Navigators, the class of not-for-profit outreach assisters created by the ACA, were also heavily used alongside the brokers. Covered California has enlisted call centers to handle demand. It has advertised heavily at sporting events, in neighborhoods, and on television and radio. Each year, the executive staff of the marketplace barnstorms the state on a bus tour, stopping in many of California counties and conducting special events with local legislators,

Potential Return on Covered California's Marketing Investment – 2015 and 2016			
	2015	2016	Two-Year Impact
Gross Premiums			
Covered California	\$6 billion	\$6.5 billion	\$12.5 billion
Average Risk Scores			
FFM States	1.69	1.69	–
California	1.34	1.36	–
Estimated Covered California Gross Premiums if California had FFM Risk Scores			
Covered California gross premiums	\$7.26 billion	\$7.8 billion	\$15.1 billion
Difference	\$1.26 billion	\$1.3 billion	\$2.56 billion
Assumption: Premium Savings Due to Marketing and Outreach			
If marketing explains 1/3 of gross premium difference (\$1.3 billion)	\$420 million	\$433 million	\$853 million
If marketing explains half of gross premium difference (\$1.3 billion)	\$630 million	\$650 million	\$1.3 billion
Covered California Marketing and Outreach Investments			
Covered California	\$143 million	\$122 million	\$265 million
Return on Marketing Investment			
If marketing explains 1/3 of gross premium difference (\$1.3 billion)	194%	255%	222%
If marketing explains half of gross premium difference (\$1.3 billion)	341%	433%	383%
Source: Covered California, Marketing Matters: Lessons from California to Promote Stability and Lower Costs in National and State Individual Insurance Markets			

entertainment figures, and community organizers. From the second enrollment period on, Covered California focused on geographic areas in which individuals were more likely to be uninsured and on potentially subsidy-eligible individuals who were not enrolled.¹⁸

This commitment to well-informed and well-executed outreach strategies seems to have paid dividends. Out of all exchanges, Covered California has had among the best “risk mix” of enrollees, some 20 percent more healthy than the national average, and one of the highest ratios of younger enrollees aged 26-34, again substantially better—in terms of mix of enrollees—than the national norm. While the marketplace and insurers spent an estimated \$255 million on marketing and outreach in 2017-18, Covered California calculates that it has a better than three-to-one return on marketing investment, judged by the premium savings created by having a larger and healthier risk pool.¹⁹

The importance of outreach is magnified by the fact that the ACA marketplace experiences considerable “churn” as entrants leave and enter Covered California. Most of the short-term members tend to be healthier and move into employer-based coverage, so that if the program were limited to those who stayed year to year a much worse risk mix would result. During the most recent sign-up period, the marketplace recruited over 420,000 new enrollees, a comparable number to previous years.

Tackling Underinsurance and Narrow Networks

The principal source of dissatisfaction with Obamacare—as President Obama himself acknowledged in an article for the *Journal of American Medicine*—is that for many it still failed to make health care affordable.²⁰ This is especially true for those not receiving subsidies, but exposure to high cost-sharing and deductibles in addition to premiums causes affordability challenges for subsidized enrollees as well. Medical deductibles for a Bronze plan in California can reach \$6,300 for an individual and \$12,600 for a family.²¹ More than one-third of Covered CA enrollees with incomes between 200 and 400 percent of FPL, the higher range of the subsidized population under the ACA, have Bronze plans with a deductible of \$6300 or more.²² (By contrast, 66%

of California workers had a deductible of over \$2000 for their employer-based coverage, still a very high number.²³) National surveys suggest that two-thirds of U.S. households in that income range lack sufficient liquid assets to cover a deductible of that size.²⁴ According to researchers at UC Berkeley, “Even with ACA subsidies, combined premium and out-of-pocket spending in the individual market can exceed 10% of income for some Californians with median out-of-pocket spending, and can reach 20% to 30% of income for some with very high medical use.”²⁵

One source of ongoing confusion is that the higher deductible health plans offered through ACA marketplaces have higher premiums than what seemed to be comparable plans offered before the passage of the law. Much of this difference stems from the different composition of the risk pool when coverage is guaranteed, as well as the more comprehensive coverage (such as “essential benefits”) that the ACA requires. The higher premiums also reflect vital protections that many consumers overlook: the end of caps on lifetime coverage and the end of the risk that one could fail to find coverage after illness or a lapse in coverage. On the whole, the ACA appears to have reduced the number of Americans with medical debt and debt-related bankruptcy, one of its main accomplishments.²⁶

Another source of concern, in California and elsewhere, has been the growth of “narrow networks” which exclude hospitals and physician groups that charge higher prices in order to keep premiums down. As with managed care, paring down networks to reduce premiums is a natural strategy for insurers who can no longer compete on benefits or on their skill in underwriting, as well as a reasonable choice for an informed consumer. It becomes a problem when consumers are not aware that they are purchasing a trimmed-down product, cannot find a specialist, or wrongly believe that their doctor is included in the network. In spite of some initial well-publicized consternation about these issues, though, it is not clear that these plan designs have had substantial negative effects. A study of plans with narrow hospital networks in California found no significant drop-off in quality among most narrow networks, raising concerns only about extremely limited networks that included just one to

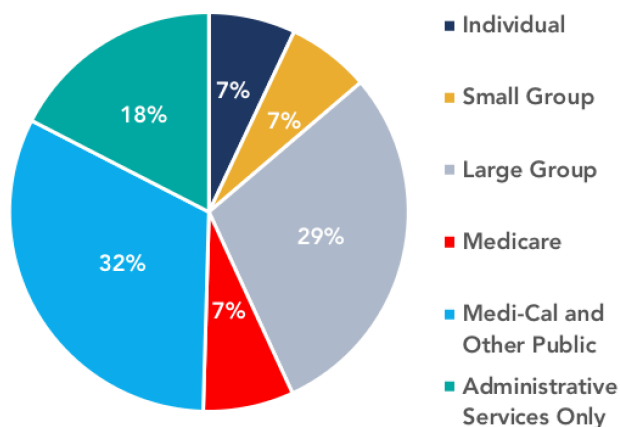
three hospitals in a given region, below the average of ten.²⁷

In response to these problems, Covered California has added an online search tool for providers in the “Shop and Compare” section of the Covered California website.²⁸ Building on this, the Oakland-based Integrated Healthcare Association’s Provider Directory Utility Initiative aims to become the single place for updating network data for commercial plans, as well as Medicare and Medi-Cal plans, so that the plans can provide more accurate data to their consumers. This is a first-in-the-country project, undertaken by the state Department of Managed Health Care, medical groups, stakeholders, and a consortium of insurers led by Blue Shield of California.

Coordinating with Medi-Cal: “No Wrong Door”

The ACA, for the first time, converted Medicaid into a program that insures all poor Americans rather than only those with low incomes plus other eligibility criteria, such as gender or disability. Thirty-one states, including California, elected to expand Medicaid, or Medi-Cal as it is known in California, under the new coverage rules. This decision led to the growth of an already large program and required a massive administrative lift commensurate with this task.

California Insurance Enrollment by Market, 2016



Source: California Health Care Foundation, California Health Insurance Enrollment, 2016”

Starting in June 2012, California began constructing an eligibility and enrollment system known as CalHEERS to process the enrollment and to link data between the exchange, the Department of Healthcare Services (DHCS), which administers Medi-Cal, and several state welfare agencies.²⁹ It aimed to create a “no wrong door” approach through which any applicant would be readily steered to the right program or insurance choices based on her income, location, or family structure.

A primary goal was making the Covered California portal one principal entry point (along with county social services offices and mail-in requests, as before) for those seeking coverage through Medi-Cal and other government programs. Though this take-up process was not glitch-free, in retrospect California’s new enrollment engine has performed well. It brought down an initial backlog of over 1 million potentially eligible Medi-Cal enrollees at the beginning of 2014 to fewer than 350,000 by year’s end, and eliminated it early the following year.³⁰

This expansion was greatly facilitated by a Section 1115 federal Medicaid waiver, which funded California’s Low-Income Health Program and was known as the “bridge to reform.”³¹ As a result of having prior coverage, 630,000 of these beneficiaries were auto-enrolled into Medi-Cal at the beginning of 2014, streamlining a large part of a huge enrollment process.

As of late 2017, total enrollment in Medi-Cal was 13,325,171. Almost 4 million beneficiaries were part of the ACA expansion, and the bulk of these individuals, around 11 million, were enrolled in managed care plans.³² To grasp the scale of the program, the number of those covered by Medi-Cal exceeds the total number of residents in all but three American states: Texas, New York, and Florida.³³ Medicaid managed care plans that serve these enrollees often also offer plans in the exchange marketplace.

Where California and the Nation Go From Here

After months of equivocation, the federal administration ceased making cost-sharing reduction payments (CSRs) to insurers in September 2017, just at the moment when health insurers had to lock in rates for the coming year. Insurers and regulators across the country scrambled to react. California had anticipated this and prepared a response, the first of its kind, to work with insurers to add additional premiums exclusively to the silver tier of coverage for exchange products while preserving the level of cost-sharing subsidy the consumers were receiving based on their incomes. Silver-level products purchased outside of the exchange were not affected.

The effect of this was to protect those consumers who received tax credits, since the amount they pay in premiums is capped at a percentage of their income. The only consumers who were forced to make changes as a result of this policy were those who did not receive tax credits but were purchasing silver-level coverage through Covered California. Covered California noted that it had been encouraging many unsubsidized applicants who wanted to buy silver tier coverage to compare off-exchange coverage that would have been less expensive for many individuals.

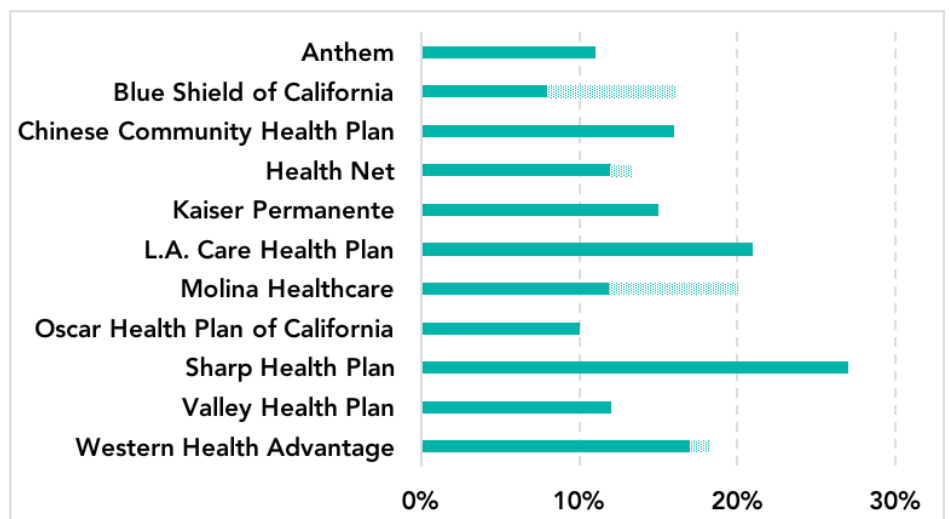
This work-around or “Silver Switcheroo,” as some have termed it, contributed in part to a slight decline in enrollment for an enrollment period that otherwise went very smoothly.³⁴ The marketplace enrolled 1,520,000 individuals, down just 2 percent from the previous year. Over 420,000 customers enrolled for the first time. While the federal government cut the shopping period in half and reduced federal spending on outreach by 90 percent, California exercised its prerogative to keep it open until January 31, 2018, with good effect. Both the risk mix and the

percentage of younger people enrolling seem to have been in line with previous years, and in contrast to the less favorable risk mix in the federal ACA marketplace.

The ACA Looks Surprisingly Robust but Uncertainty Lies Ahead

In California and nationally, especially for states that operate their own marketplaces, the ACA appears surprisingly robust. This belies the expectations of many observers in mid-summer 2017, when numerous counties looked as if they would fail to attract a single insurer.³⁵ Before the suspension of CSR payments, though, a number of surveys had suggested that the individual marketplace for subsidized health insurance across the nation was in the process of stabilizing, and the ACA market appeared increasingly profitable for insurers. Some insurers – Centene in particular, which recently purchased HealthNet, one of California’s major players in the individual market – have been making money on the ACA and have scaled up their business nationwide.³⁶ Despite the much shorter enrollment period in Healthcare.gov, the federally-run marketplace, enrollments were down only five percent.

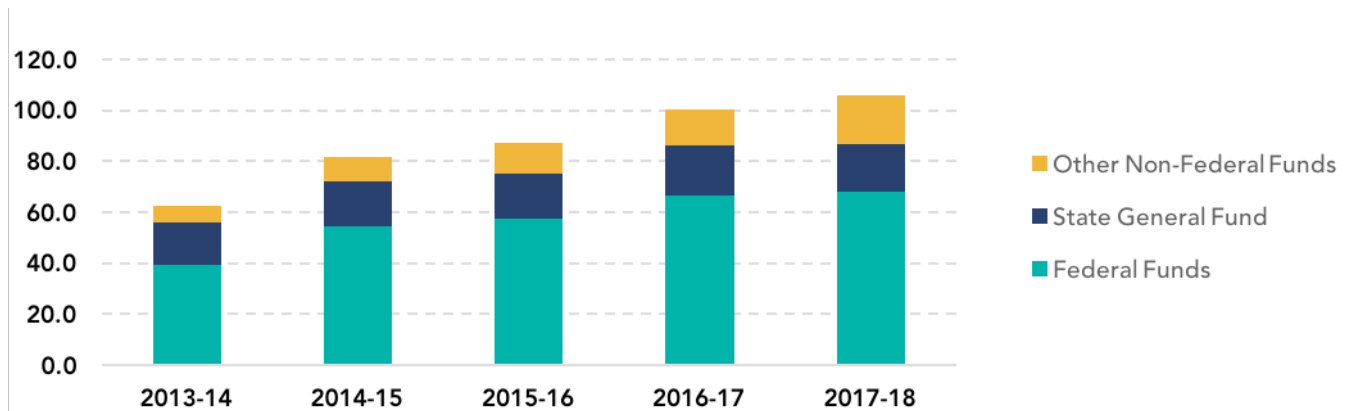
Increase in 2018 Premiums as a Result of Loss of CSR Payments



Note: Bars with dotted fill are ranges

Source: Kaiser Family Foundation, “How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums”

Total Medi-Cal Spending (in Billions of Dollars)



Source: Shannon McConville, Paul Warren, and Caroline Danielson, "Funding the Medi-Cal Program," Public Policy Institute of California, March 2017; California Department of Health Care Services, Medi-Cal Local Assistance Estimates

In California, the Affordable Care Act has increasingly become part of the landscape. Ads for Covered California are as ubiquitous as those for other health insurance offerings. Nevertheless, California's healthcare leadership and a number of independent analysts paint a potentially dire picture for 2019, with negative trends that could buffet the federal exchange and spill over into California's marketplace and other state-run exchanges. These changes include the recent elimination of the individual mandate penalty, further reduction of marketing and outreach for the federally-facilitated marketplaces (FFM), the creation of association and short-term health insurance plans, and an uptick in the cost of medical care.³⁷ Many insurers that stayed the course for 2018 are suggesting they are planning an exit in 2019 absent federal activity aimed at stabilizing the markets. This would increase the number of counties without choice of insurer and again raise the possibility of having some counties with no coverage altogether.³⁸

Repeal and Replace: The Sequel

Republicans in Congress are divided over whether to continue to push to repeal Obamacare or to pass legislation that will effectively keep most of the ACA in place while stabilizing state individual and small-group marketplaces. Senators Lindsay Graham, the co-sponsor of 2019's Graham-Cassidy bill, and Ted Cruz have been vocal in pushing for the continuation of repeal efforts. As Senator Graham remarked in January 2018,

"The Republican Party cannot avoid the obligation to replace...I think it would be crazy if you don't [try]. How can you repeal the individual mandate and say we're done? The thing's going to crumble. We better find a replacement that works."³⁹

A version of the "Graham-Cassidy" legislation the Senator advanced last year would dramatically make over the ACA, and in fact the broader health care financing system, by replacing the current system of Medicaid funding and tax credits with a block grant of health funding to states. This reform would greatly disadvantage states like California that chose to expand Medicaid under the ACA. Similarly, an earlier repeal-and-replace effort, the American Health Care Act (AHCA), would have resulted in a projected \$18 billion reduction in federal spending for Medi-Cal expansion enrollees. California currently spends 27 percent of its state budget on Medi-Cal, much higher than the national average of 17 percent.

Despite this, Medi-Cal is in many respects a lean program. Its per capita cost is one of the lowest in the country, driven by its relatively very low payments to providers. Its main drawback is that its low payments are insufficient to attract enough doctors, despite an uptick in participating providers after the passage of the ACA. This has resulted in problems of access and timely care for some beneficiaries.⁴⁰ Two successful ballot initiatives in recent years have increased and stabilized funding for Medi-Cal.⁴¹ There are a number of ways the program could operate more efficiently, such

as rewarding managed care plans that perform better, promoting access to better palliative care and long-term care, encouraging provider competition, and removing restrictions on scope of practice. However, there is no chance that the existing program could absorb the funding cuts in recently-proposed federal legislation without reducing benefits, cutting the number of beneficiaries, or raising taxes—and probably all three of these.⁴² It would be a devastating blow to the state budget and would indefinitely postpone any aspirations of achieving universal statewide insurance coverage.⁴³

A State-Level Individual Mandate or Its Equivalent

The Tax Cuts and Jobs Act of December 2017 eliminated the penalty for failing to carry insurance coverage, known as the individual mandate, starting in 2019. Nationally, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimated that after one year eliminating the penalty would result in four million individuals becoming uninsured and would cause a 10 percent rise in premiums. Many analysts feel that these estimates are too high, especially for a state with California's profile. This is largely because so high a percentage of current enrollees are subsidized, it is uncertain how healthy those who eschew coverage will be compared to those who remain, factors other than the mandate penalty drive the demand for marketplace coverage, and inertia with respect to retaining coverage often prevails. Taking these factors into account, along with California's relatively stable individual markets and strong outreach, others estimate that ending the penalty in California would raise premiums by 7 percent per enrollee, a significant but not crippling increase.⁴⁴

Nevertheless, should subsidies be reduced or the risk pool become unhealthier—or, more pertinently, if insurers set their rates in anticipation of this—there may need to be a state-level provision for either a mandate or a requirement of continuous coverage. Alternatively, insurers could be reimbursed retroactively for covering a sicker group of enrollees than they had anticipated. At present, only Massachusetts has a state-level mandate on the books, which was put in place before the passage of the ACA.⁴⁵ The District of Columbia has approved a resolution recommending an individual

mandate for the district. State lawmakers in California and several other states are exploring the possibility of enacting a mandate. Such state-level mandates may include innovative features that could distinguish them from the federal mandate, such as Maryland's proposal to hold individuals' penalties in escrow for later use as a down payment on future premiums.⁴⁶ The challenge here is as much political as administrative or policy-driven. The mandate—the single feature of the ACA that was consistently unpopular in isolation—would be very hard to enact on its own, especially if it is viewed as a burdensome tax rather than as a civic obligation.⁴⁷ Second, studies have shown that individuals who purchase unsubsidized coverage and who are most directly affected by the mandate precisely fit the profile of those who are most politically active.⁴⁸ The positive benefits of the mandate are large but diffuse, while its burden falls on a small number of people, always a challenge in policy design.

Association Health Plans and Short-Term Plans

President Trump has proposed the expansion of "association health plans" that would be offered across state lines and appeal to sole proprietors and others, some of whom currently purchase ACA-compliant coverage either on or off-exchange. Moreover, in mid-February 2018, HHS announced a proposed rule that would allow short-term insurance plans to offer products that are not ACA-compliant for a full year, up from a current limit of three months, though state insurance commissioners have some discretion over whether these will be offered in California and in other states.⁴⁹

Over time, such options would segment the existing risk pool if healthier individuals dropped ACA-compliant coverage in favor of these cheaper plans with much skimpier coverage. (This pool is calculated together on both those who buy through Covered California and who purchase products outside it, from the same health plans.) The regulatory process to allow this expansion, however, is complicated both at the federal and the state level, so such plans are unlikely to make much of a dent in the market until 2019 at the earliest, even if this process is expedited.⁵⁰ Presumably such plans would be most attractive to unsubsidized individuals who would no longer incur a penalty for violating the terms of the

individual mandate. Covered California actuaries have estimated that the short-term impact of such plans would be around a one percent premium rise in the individual market.⁵¹ Legislation has been introduced in California (SB 910—Hernandez) that would ban altogether the sale of short-term insurance in the state.

1332 Waivers

These waivers, named for the section of the ACA in which they appear, are aimed to allow states a degree of flexibility in designing their coverage and benefits to match the population of their state, or to respond to other problems with insurance markets. Several states, including Alaska and Iowa, have received waivers from the federal government to implement a state reinsurance program—with the intent of keeping insurers from abandoning the ACA or raising premiums as a result of a handful of high-cost enrollees.⁵²

The waivers are supposed to result in coverage that is no less affordable or comprehensive than the original program, though these terms are not defined precisely and in practice are at the discretion of the federal DHHS. A number of states are seeking to use the request for waivers aggressively to seek to overturn the ACA's essential benefits provisions and to allow coverage that is skimpier and cheaper than that currently allowed. Idaho has taken a further step and has invited the marketing of plans that are explicitly not ACA-compliant and likely against the law. The DHHS has stated that that Idaho must change or modify its recent advice to health plans and health advocacy groups are also poised to challenge such non-ACA-compliant products in the courts.

California's legislative leadership and the executive staff of Covered California have contemplated using the 1332 waiver to make changes to the ACA. In particular, they were on the cusp of submitting a request to cover undocumented adults through the marketplace, though this is now on hold.⁵³ Most of the more substantial changes that the state might consider are probably beyond the purview of this option since it is limited to the use of the funds and regulations that apply directly to the ACA marketplaces.

Improving Affordability in the Individual Marketplace

The precise impact on California of the ongoing federal changes is uncertain. However, in the absence of state action to mitigate them, they will surely drive up premiums and make buying health coverage in individual markets less affordable, in particular for unsubsidized purchasers, many of whom are already priced out or close to being so. For instance, taking an even more pessimistic view than federal analysts, the Urban Institute projects that California's ACA premiums will rise by 17.8 percent in 2019 as a result of the repeal of the individual mandate penalty and the expansion of short-term coverage options alone.⁵⁴

To counter these trends, California could turn to a variety of policy options. Strictly limiting short-term coverage options, and in particular by demanding that they abide by the consumer protections included in the ACA, such as the end of annual or lifetime caps on coverage, would be one such possibility.⁵⁵ Another option would be to raise the subsidy level for ACA enrollees by adding state-funded premium subsidies to the existing federal subsidies, thereby shifting a larger portion of the costs of premiums away from beneficiaries.

Implementing a state-level reinsurance program could improve affordability for those who don't receive individual market subsidies by helping insurers pay for high-cost enrollees or high-cost claims. This would reduce the extent to which insurers have to pass those high costs onto consumers in the form of higher premiums. Estimates suggest that for each \$1 billion spent in gross reinsurance payments, Covered California premiums would decrease by an average of 7% in 2019.⁵⁶

Statewide Single-Payer Plan

One alternative to fighting to preserve particular elements of the Affordable Care Act would be to engage in more holistic statewide health reform. One major proposal to do so would create a statewide "single payer" system for California, similar in many of its details to the Canadian system. According to this plan, the state government would amass all public

funding for healthcare services and use it to create a uniform, publicly-run program that would finance access to healthcare for all residents regardless of documentation status. All current health coverages would be eliminated and private payment for any covered benefit would be rendered illegal.

Creating a state single-payer system has been an actively promoted policy proposal in California for decades. SB 840, sponsored by Senator Sheila Kuehl of Santa Monica, passed the legislature in 2008 but was vetoed by Governor Schwarzenegger. More recently, SB 562, a less well-specified proposal, succeeded in passing the Senate but was shelved by Speaker Anthony Rendon for its lack of a financing mechanism.

There are many policy, political, and operational hurdles to enacting such a law, and the process of implementing a single-payer system would be arduous if not prohibitively difficult for a single state. According to estimates, a single-payer plan would cost California between \$106 and \$250 billion in new taxes.⁵⁷ Total spending on the plan therefore would likely be greater than the state's entire current budget.

Single-payer initiatives have stumbled in other states, such as Colorado and Vermont, in which the concept had strong appeal in principle. Moving in the direction of single payer would require substantial changes to federal Medicare and Medicaid law as well as far-reaching state policy changes to completely rework the relationships and responsibilities among the state, counties and cities. The political and policy barriers to implementing the law, therefore, go far beyond the current strained relationship that exists between California and the federal administration, and would necessitate more than the creative application of existing waiver programs. Eliminating private insurance would also radically alter if not make impossible the operation of integrated delivery systems, in which a private insurance company is aligned with a particular set of providers.

In addition to the challenges that would confront any state striving to create a single-payer system, California also faces several other state-specific hurdles. It would probably require the elimination or reversal of an existing constitutional limit on state spending, the Gann

Limit, and more than likely would have to be approved by the state's voters through a ballot initiative.⁵⁸

Conclusion

The implementation of the Affordable Care Act has proceeded on a very different trajectory in California than in many other states. But while in some respects the state remains the "great exception"—as the journalist Carey McWilliams dubbed California generations ago—with respect to the ACA and other policies California must continue to rely, in part, on federal cooperation. The state probably needs the maintenance of federal health care funding to retain the gains in insurance coverage and delivery reform it has carried out as a result of the ACA, let alone to contemplate more ambitious goals.

However, this dependence may be mutual. Should Congress want to keep some version of the ACA up and running, emulating the innovations that California has pioneered—from outreach strategies to plan designs to delivery reform—will be critical to enabling the ACA to survive and flourish.⁵⁹

Notes

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