Open Enrollment Preview: Checking the Vitals of the Marketplaces

Alliance for Health Reform
Peter V. Lee
September 26, 2016
Covered California’s Promise

**Vision:**
To improve the health of all Californians by assuring their access to affordable, high-quality care.

**Mission:**
To increase the number of insured Californians, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

Better Care • Healthier People • Lower Cost
## How Covered California Makes the Promise Real

<table>
<thead>
<tr>
<th>Creating Competitive Markets</th>
<th>Offering Affordable Products</th>
<th>Effectively Reaching and Enrolling Consumers</th>
<th>Encouraging the Right Care at the Right Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Plan competition for enrollment (seek at least three plans)</td>
<td>• High enrollment of subsidy eligible to assure good risk mix</td>
<td>• Robust and ongoing marketing</td>
<td>• Benefit design promoting appropriate access</td>
</tr>
<tr>
<td>• Provider-level competition and distinction between plans</td>
<td>• Long term affordability through delivery system changes</td>
<td>• Cost effective enrollment support</td>
<td>• Requirements for plans to promote effective delivery of coordinated care</td>
</tr>
<tr>
<td>• Benefit designs foster informed consumers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Affordable Care Act Is Being Woven Into the Fabric of Health Care in California and the Nation

The Affordable Care Act has dramatically changed the health insurance landscape in California with the expansion of Medicaid, Covered California and new protections for all Californians – 2013 to 2015 – Census Bureau reports cutting rate of uninsured in half – to 8.6%.

Data shown in above graph is from: California Health Benefits Review Program (http://bit.ly/1TV9076); Center for Medicare and Medicaid Services, The Commonwealth Fund (http://bit.ly/1TV98n7); California Healthcare Foundation (http://bit.ly/1LFbXGm); Covered California 2015 Active Member Profiles (http://bit.ly/21KMUZM), and ABx1 Quarterly Report (http://bit.ly/1oVUgYs)

Note: Medicare recipients and other publicly funded insured are not included in the graph.
Covered California Health Plan Offerings for 2017: Broad Choice and Multiple Local Options

For full details on plans and rates, see Health Insurance Companies and Plan Rates for 2017: http://bit.ly/2c6AS9U
Covered California Enrollees Able to Choose Both Low Premium and Low Out-of-Pocket Designs

More than 69 percent of Covered California subsidy-eligible enrollees selected a Silver Plan — which have NO deductibles for any out-patient services and 58 percent of all subsidy eligible enrollees qualified for an “Enhanced Silver”, which means even lower out-of-pocket costs when accessing services.

2015 Subsidized Enrollment by Metal Tier

- Bronze 24% 280,000
- Silver 11% 128,000
- ENHANCED Silver73 11% 128,000
- ENHANCED Silver94 17% 199,000
- ENHANCED Silver87 30% 357,000
- Platinum 3% 40,000
- Gold 4% 52,000

Source: Covered California enrollment data as of April 2015, including only subsidized enrollees who have paid for coverage.

A few notes on monthly premium costs:

- 77 percent pay less than $150 per month per individual.
- More than 120,000 enrollees pay less than $10 per month per individual.
- 25 percent of enrollees in an Enhanced Silver plan pay less than $25 per month per individual, while more than half pay less than $50.
  In addition, these individuals pay only $3 for doctor visits.

Covered California’s Patient-Centered Benefit Design:

- Bronze — three office visits and lab work, not subject to deductible.
- Silver, Gold, Platinum — no deductibles on any outpatient services.

More than 69 percent of Covered California subsidy-eligible enrollees selected a Silver Plan — which have NO deductibles for any out-patient services and 58 percent of all subsidy eligible enrollees qualified for an “Enhanced Silver”, which means even lower out-of-pocket costs when accessing services.
Covered California 2017 Patient-Centered Benefit Designs

In California, standard benefit designs allow apples-to-apples plan comparisons and seek to encourage utilization of the right care at the right time with many services that are not subject to a deductible. Benefits below shown in blue are not subject to a deductible.

### Covered California 2017 Patient-Centered Benefit Designs by Metal Tier

<table>
<thead>
<tr>
<th>Coverage Category</th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Wellness Exam</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Primary Care Visit</td>
<td>$75</td>
<td>$35</td>
<td>$30</td>
<td>$15</td>
</tr>
<tr>
<td>Specialty Care Visit</td>
<td>$105</td>
<td>$70</td>
<td>$55</td>
<td>$40</td>
</tr>
<tr>
<td>Urgent Care Visit</td>
<td>$75</td>
<td>$35</td>
<td>$30</td>
<td>$15</td>
</tr>
<tr>
<td>Emergency Room Facility</td>
<td>Full cost until out-of-pocket maximum is met</td>
<td>$250</td>
<td>$250</td>
<td>$150</td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>$40</td>
<td>$35</td>
<td>$35</td>
<td>$20</td>
</tr>
<tr>
<td>X-Ray and Diagnosis</td>
<td>$70</td>
<td>$55</td>
<td>$55</td>
<td>$40</td>
</tr>
</tbody>
</table>

**Deductible**

- Individual: $6,300 medical and $12,600 drug
- Family: $12,600 medical and $25,200 drug

**Annual Out-of-Pocket Maximum**

- Individual: $8,800 individual and $13,600 family
- Family: $8,796 individual and $13,600 family
- Individual: $4,000 individual and $6,000 family

### Covered California 2017 Patient-Centered Benefit Designs by Income

<table>
<thead>
<tr>
<th>Coverage Category</th>
<th>Enhanced Silver 84</th>
<th>Enhanced Silver 87</th>
<th>Enhanced Silver 73</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Based on Income and Premium Assistance</td>
<td>Covers 84% average annual cost</td>
<td>Covers 87% average annual cost</td>
<td>Covers 73% average annual cost</td>
</tr>
<tr>
<td>Single Income Ranges</td>
<td>up to $27,800 (100% FPL)</td>
<td>$27,800 to $32,900 (150% FPL)</td>
<td>$32,900 to $39,102 (200% to 400% FPL)</td>
</tr>
</tbody>
</table>

**Annual Wellness Exam**

- $0

**Primary Care Visit**

- $10

**Specialty Care Visit**

- $5

**Laboratory Tests**

- $5

**X-Ray and Diagnosis**

- $5

**Imaging**

- $10

**Deductible**

- Individual: $75 medical and $159 medical
- Family: $1,300 medical and $4,100 drug

**Annual Out-of-Pocket Maximum**

- Individual: $2,380 individual and $4,700 family
- Family: $2,380 individual and $4,700 family

Benefits shown in blue are not subject to any deductible.

### Drug Cost Shares - 30 Day Supply

<table>
<thead>
<tr>
<th>Generic Drugs (Tier 1)</th>
<th>Full cost up to $500, after deductible is met</th>
<th>$15 or less</th>
<th>$15 or less</th>
<th>$5 or less</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Drugs (Tier 2)</td>
<td>Full cost up to $200, after deductible is met</td>
<td>$15 or less</td>
<td>$15 or less</td>
<td>$10 or less</td>
</tr>
<tr>
<td>Non-preferred Drugs (Tier 3)</td>
<td>Full cost up to $500, after deductibles is met</td>
<td>$25 or less</td>
<td>$25 or less</td>
<td>$25 or less</td>
</tr>
<tr>
<td>Specialty Drugs (Tier 4)</td>
<td>Full cost up to $500, after deductible is met</td>
<td>20% up to $200 after drug deductible</td>
<td>20% up to $200 after drug deductible</td>
<td>10% up to $250</td>
</tr>
</tbody>
</table>
## 2017: Transition Year for Premiums

<table>
<thead>
<tr>
<th>Covered California Rate Change</th>
<th>2014-2015</th>
<th>2015-2016</th>
<th>2016-2017</th>
<th>3-Year Compounded Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighted average increase</td>
<td>4.2%</td>
<td>4%</td>
<td>13.2%</td>
<td>7%</td>
</tr>
<tr>
<td>Lowest-price Bronze plan (unweighted)</td>
<td>4.4%</td>
<td>3.3%</td>
<td>3.9%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Lowest-price Silver plan (unweighted)</td>
<td>4.8%</td>
<td>1.5%</td>
<td>8.1%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Second -lowest-price Silver plan (unweighted)</td>
<td>2.6%</td>
<td>1.8%</td>
<td>8.1%</td>
<td>4.1%</td>
</tr>
<tr>
<td>If a consumer shops and switches to the lowest-cost plan available in the same metal tier</td>
<td>—</td>
<td>-4.5%</td>
<td>-1.2%</td>
<td>—</td>
</tr>
</tbody>
</table>

### California:
- Initial rates in 2014 lower than anticipated and plans designed networks and delivery to meet marketplace demands from outset; in 2014 California carriers paid IN to the Risk Corridor Program
- For 2017, 80% of consumers can lower premiums or have increase of less than 5% by shopping for lowest plan at same tier

### Changes in 2017:
- Transition Year ALL States: end of reinsurance valued at 4-7%
- Transition Year Many States (NOT California): final years of uncertain pricing due to conversion to single individual market risk pool
- Transition Year Some Plans: correcting for incorrect pricing and Special Enrollment
In California Individual Market Acquisition Costs Have Dropped Significantly as a Percent of Total Premiums — Helping Lower Overall Premiums While Driving More Enrollment

Pre ACA Member Acquisition (National View)
7.6% of Total Premiums Spent on Member Acquisition

Post ACA Member Acquisition (California View)
5.8% of Total Premiums Spent on Member Acquisition

Pre ACA Assumptions / Estimates
- Broker assisted enrollment: 90% of members
- Broker Commissions: 7% of total premiums
- Direct enrollment: 10% of members
- Direct sales costs: 7.5% of premiums
- Payor Sales and Marketing Costs: 0.5% of premiums
- Note: costs reflect pre Exchange but after implementation of the ACA’s Medical Loss Ratio regulation
- Source: PwC National and Blues payor experience

Post ACA Assumptions / Estimates
- Covered California enrollment: 50% of overall market (per DMCH, CDI and CC)
- Covered California exchange fee: 4% of total premiums
- Broker assisted enrollment for ON exchange: 50% of members ON the exchange (per CC)
- Broker assisted enrollment for OFF exchange: 90% of members (PwC payor experience)
- Broker Commissions: 4% of premiums (per CC)
- Direct channel enrollment: 10% of OFF exchange members (PwC payor experience)
- Direct sales costs: 7.5% of premiums (PwC payor experience; ~$350 telesales spend per enrollee)
- Payor Sales and Marketing Cost: 0.5% - 0.7% of premiums, mid-point shown (per CC)

Sources: Kaiser Family Foundation, Covered California, PwC client average across national and Blues plans
Note: It is difficult to make an "apples to apples" comparison regarding overall impact on profitability for payors from pre to post ACA. Where there have been reductions to cost of acquisition, there were some likely increases (e.g., risk adjustment and new data transfer), increase in marketing to capture members on exchanges and through off exchange channels.
Effective Marketing and Outreach

Continued Investments of nearly $100 million planned for in fiscal year 2016-17.

Service Channel Preferences in Third Open Enrollment (2016)

- 45% Certified Insurance Agent
- 28% Unassisted
- 15% Service Center Representative
- 6% Navigator/Certified Enrollment Counselor
- 1% Certified Plan-based Enroller
- 1% County Eligibility Workers
Covered California is Big and Having Big Impacts

It is now one of the largest purchasers of health insurance in California and the nation.

- **1.4 MILLION** consumers have active health insurance as of March 2016.
- **$6.4 BILLION** estimate of funds collected from premiums in 2015.
- **2.5 MILLION** consumers served since Covered California began offering coverage on Jan. 1, 2014 (as of March 2016).
- **9 out of 10** consumers enrolled in coverage receive financial help to pay their premiums.

Covered California is now the second largest purchaser of health insurance in the state for those under age 65.

Covered California's size gives it the clout to shape the health insurance market.

More than 1.1 million Californians have benefitted from coverage through Covered California. Many of them now have either employer-based coverage or Medi-Cal.
More Than Two and a Half Million Consumers Served

The majority of those served have continuous coverage and of those who have left Covered California, the vast majority (85 percent) continue to have health insurance.

- Prior to 2014, Covered California forecasted that about one-third of enrollees would leave coverage on an annual basis.
- In the period from January 2014 through September 2015, more than two million Californians have had coverage for some period of time with approximately 700,000 of those no longer active in June 2015.
- As of June 2015, the actual rate of disenrollment is about 33 percent.
- Based on a recently completed Covered California survey of members who left ("disenrolled"), the vast majority (85 percent) left for employer-based, Medi-Cal, Medicare, or other coverage.

Estimated from Covered California enrollment data and 2015 member survey (n=3,373)
Affective Outreach, Partnerships, and Policies Creating a Healthy Risk Mix that Benefits the Entire Individual Market

Good Risk in California

- In 2015 California had the healthiest risk mix in the nation, about 19% lower than the national average. This is the second year in a row that California had the best risk mix.

- In 2014 Health insurance companies had consistently strong financial performance, contributing more than half of all risk corridor “excess” profits ($182 million).

The Percent of Enrollment of 18 to 34 Year Olds Continues To Grow

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>29%</td>
</tr>
<tr>
<td>2015</td>
<td>34%</td>
</tr>
<tr>
<td>2016</td>
<td>38%</td>
</tr>
</tbody>
</table>

Through our innovative data analysis, we were able to prove to our health insurance companies that the risk scores were decreasing over time, allowing Covered California to negotiate better prices.

Sources: Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year, and Health Services Research. “Sorting Out the Health Risk in California’s State-Based Marketplace.” Andrew B. Bindman, Dennis Hulett, Todd P. Gilmer, and John Bertko.
Covered California is Promoting Improvements in the Delivery of Care

Covered California contract requirements to promote the triple aim of improving health, delivering better care and lowering costs for all Californians include:

- **Promoting innovative ways for patients to receive coordinated care, as well as have immediate access to primary care clinicians**
  - All Covered California enrollees (HMO and PPO) must have a primary care clinician.
  - Plans must promote enrollment in patient-centered medical homes and in integrated healthcare models/Accountable Care Organizations.

- **Reducing health disparities and promoting health equity**
  - Plans must “track, trend and improve” care across racial/ethnic populations and gender with a specific focus on diabetes, asthma, hypertension and depression.

- **Changing payment to move from volume to value**
  - Plans must adopt and expand payment strategies that make a business case for physicians and hospitals.

- **Assuring high-quality contracted networks**
  - Covered California requires plans to select networks on cost and quality and in future years, will require exclusion of “high cost” and “low quality” outliers — allowing health insurance companies to keep outlier providers, but detailing plans for improvement.

Note: for detailed information about improvements in the delivery of care, Covered California requires health insurance companies to abide by Attachment 7 of the model contract. To view Attachment 7, go to [http://hbex.coveredca.com/stakeholders/plan-management/PDFs/2017_QHP_Issuer_Contract_Attachment_7_3-4-2016_CLEAN.pdf](http://hbex.coveredca.com/stakeholders/plan-management/PDFs/2017_QHP_Issuer_Contract_Attachment_7_3-4-2016_CLEAN.pdf)

Lessons Learned and Policy Options Building on Experience

- **Subsidies Matter:** revision the level and nature of subsidies to help more Americans have access to affordable care
- **Assuring Competition and Choice:** effective markets and good enrollment will promote plan options, gaps need to be addressed with real options
- **Benefit Designs:** build on lessons from “Simple Choice” and other patient-centered benefit designs to promote access to care and retention
- **Marketing and Outreach Investments:** ongoing and substantial marketing commitments are essential – beware the idea that this is a “public benefit” versus in the absence of a mandate, insurance must be sold and good risk is by-product of product, price AND marketing
- **Delivery System Costs Must Be Focus:** marketplaces should play a role with other public and private purchases to promote improvements in care delivery
Information for consumers

CoveredCA.com

Information on exchange-related activities

hbex.CoveredCA.com