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Sources of Success in California's Individual Marketplace under the Affordable Care Act

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Abstract When passed in 2010, the Affordable Care Act (ACA) became the greatest piece of health care reform in the United States since the creation of Medicare and Medicaid. In the 9 years since its passage, the law has ushered in a drastic decrease in the number of uninsured Americans and has encouraged delivery system innovation. However, the ACA has not been uniformly embraced, and states differ in their implementation of the law and in their individual health insurance marketplace's successfulness. Furthermore, under the Trump administration the law's future and the stability of the individual market have been uncertain. Throughout, however, California has been a leader. Today, the state's marketplace, known as Covered California, offers comprehensive, standardized health plans to over 1.3 million consumers. California's success with the ACA is largely attributable to its historical receptiveness to health reform; its early adoption of the law; its decision to have Covered California operate as an active purchaser, help shape the plans sold through the marketplace, and design a consumer-friendly enrollment experience; its engagement with stakeholders and community partners to encourage enrollment; and Covered California's commitment to continually innovate, improve, and anticipate the needs of the individual market as the law moves forward.

Keywords Affordable Care Act, health reform, health insurance marketplace, state policy making, Covered California

Within 6 months of President Obama signing the Affordable Care Act (ACA) into law, California became the first state to pass legislation establishing a health insurance exchange or marketplace. California's law, known as the 2010 California Patient Protection and Affordable Care Act, was signed by

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Governor Schwarzenegger on September 30, 2010, and created the California Health Benefit Exchange, now known as Covered California.

Over the years, California had made significant progress laying the foundation for adopting the market-based reforms that were an integral feature of the ACA. These efforts included (a) the Knox-Keene Act of 1975, which established standards for managed care organizations; (b) the 1982 selective contracting law, which set the stage for health plans to compete and employ narrow networks; (c) a health insurance market with four large insurers having relatively equal market shares, allowing for competition in most areas of the state; (d) active purchaser organizations, including CalPERS and the Pacific Business Group on Health; and (e) the Health Insurance Act of 2003 (SB 2), which established an employer mandate to provide insurance or pay a tax (i.e., pay or play), but was repealed the following year when it failed as a proposition referendum. Finally, in 2007, then Governor Schwarzenegger proposed legislation to adopt a Massachusetts-like reform in California. All of these previous health reform efforts, even those that were unsuccessful, contributed to an environment receptive to market-oriented reforms that allowed California to act quickly to implement the ACA after it was enacted in 2010.

California under the ACA

While the ACA has been undeniably successful at reducing the uninsured rate in the United States, there has been variability among states in how smoothly the law has been implemented. California, the most populous state in the country, has been one of the law's greatest success stories. Since the passage of the ACA in 2010, the uninsured rate has been dropping in California. Although the main coverage provisions of the law did not go into effect until 2014, the state began implementation early and quickly began seeing coverage gains. The uninsured rate among 18- to 64-year-olds in the state has dropped from a high of 25.8% in 2010 to 9.7% in 2017 (fig. 1), with most of this reduction occurring since 2013 (from 23.7% to 9.7%) (Cohen and Martinez 2006, 2007, 2009, 2012, 2013, 2014, 2015; Cohen, Martinez, and Free 2008; Cohen, Martinez, and Ward 2010; Cohen, Ward, and Schiller 2011; Cohen, Zammitti, and Martinez 2016, 2017; Cohen, Zammitti, and Martinez 2018).

A significant portion of the ACA's success in California can be attributed to the Medicaid expansion. The ACA expanded eligibility for Medicaid for all legal residents up to 138% of poverty. Although the 2012 U.S. Supreme Court decision made the Medicaid expansion voluntary for states,

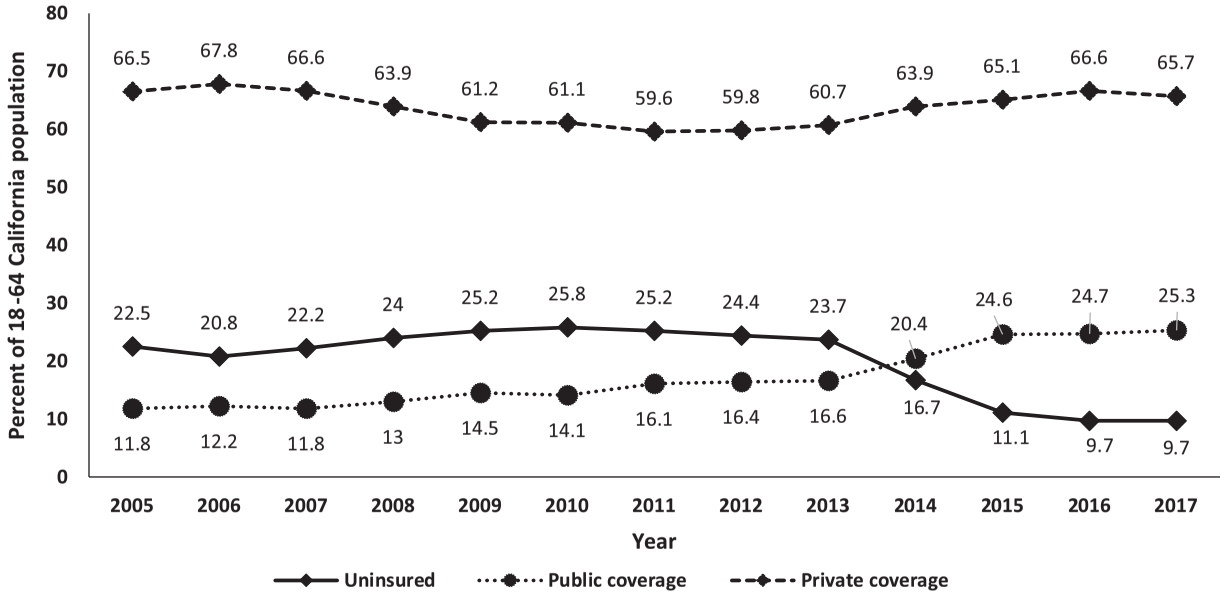

Figure 1 Coverage Trends in California Among Residents 18–64 Years of Age, 2005–17.

Sources: Cohen and Martinez 2006, 2007, 2009, 2012, 2013, 2014, 2015; Cohen, Martinez, and Free 2008; Cohen, Martinez, and Ward 2010; Cohen, Ward, and Schiller 2011; Cohen, Zammitti, and Martinez 2016, 2017; Cohen, Zammitti, and Martinez 2018.

Notes: The annual figures may sum to more than 100 as some individuals have both private and public coverage.

California was one of the 36 states that chose to expand the program. Medicaid, known as Medi-Cal in the state, has seen substantial enrollment gains, from an average enrollment of about 7.8 million individuals in January 2013 to over 13 million in August 2018 (California Department of Health Care Services 2016, 2018a).[1] California's growth in Medi-Cal enrollment of more than 60% is higher than the national average (about 30%) (CMS 2017a). Nearly 4 million of Medi-Cal's enrollees, about 28%, are from the expansion population, including about 656,000 individuals who were previously enrolled in the state's 1115 waiver Low Income Health Program (LIHP) and who transitioned directly into Medi-Cal on January 1, 2014, without having to submit an application (California Department of Health Care Services 2017).

California has also been successful at creating a stable and strong individual market. While the state largely avoided the problems associated with the flawed rollout of the HealthCare.gov website, there have been some bumps in the road. During the first open enrollment period, the Spanish-language version of the online application wasn't ready until the very end of 2013—more than 3 months into the open enrollment period—despite the fact that Latinos made up an estimated 46% of Californians eligible in 2013 for financial assistance through the state's health insurance marketplace, known as Covered California (Covered California 2013). After the first enrollment period there was also an issue with more than 148,000 enrollees needing to provide additional documentation to prove their citizenship or immigration status. These individuals were sent notices in September, and nearly all (except a little over 10,000 people) were cleared by mid-October (Covered California 2014a).

Another goal of the ACA's insurance marketplaces is to make sure there is no wrong door for individuals seeking coverage, requiring marketplaces to have a seamless eligibility determination process for premium tax credits and Medicaid. Covered California has embraced this goal to serve as a "one-stop shopping" experience for individuals. However, in the early days of the ACA rollout the state faced challenges in achieving the goal. By March 2014, the backlog in unprocessed Medi-Cal applications reached an estimated total of 900,000, largely because of difficulties with the Covered California online application system and its coordination with the state's Medi-Cal eligibility software (Kaiser Commission on Medicaid and the Uninsured 2015). This backlog in applications was not completely resolved until early 2015 and ultimately led

1. These state enrollment numbers vary somewhat from federal enrollment data. According to the CMS (2017b), 7.7 million Californians were enrolled in Medi-Cal in July–September 2013, and this has increased to 12.2 million as of April 2017.

consumer advocates to file suit against the California Department of Health Care Services to comply with their requirements for timely processing of Medi-Cal applications (Gorn 2015).

Despite these challenges, 1.4 million Californians shopped and selected a health plan in the first open enrollment period for coverage through Covered California. In June 2014, the effectuated enrollment in plans sold through Covered California was nearly 1.2 million (table 1). This number has remained steady with some slight increases each year, rising to more than 1.4 million in 2018 (Covered California 2018a). About 1 million additional individuals purchase coverage off-exchange, with total individual market enrollment reaching about 2.2 million Californians in 2017 (California Department of Insurance 2018; California Department of Managed Health Care 2017; Wilson 2018).

Premiums for coverage through Covered California have also remained relatively steady over the 5 years of the program. According to Covered California, the statewide weighted average premium for all plans sold through Covered California increased between 2014 and 2015 by 4.2% and by 4% between 2015 and 2016, increases that were similar to or better than the national averages of 0% and 6%, respectively (table1) (Gabel et al. 2016; Covered California 2016a). Looking only at the benchmark plan's premium, Covered California had a 4% increase after the first year, a 0% increase after the second year, a 9.3% increase after the third year, and a 26.1% increase after the fourth year (table 2) (Kaiser Family Foundation 2014–18a).[2] These increases are comparable to or better than those seen in states with a federally facilitated marketplace (FFM). Analysis of plan offerings and enrollment decisions in 2014 through 2016 also found that the average premium of plans weighted by enrollment was between 11.6% and 15.2% lower than the average unweighted premium of plans offered through Covered California, indicating enrollees were more likely to choose plans with lower premiums (Gabel et al. 2017).

About 90% of Covered California enrollees receive subsidies from the federal government to help pay for their coverage, and those subsidies cover on average about 70% of the premium cost. Still, as much as 31% of individual market enrollees in California may be missing out on opportunities for financial assistance, either by purchasing plans through the off-exchange market or not purchasing a Silver plan that would afford them access to cost-sharing reductions (Fung et al. 2017). For those with subsidized coverage,

2. This large increase between 2017 and 2018 is due to a surcharge that Covered California required insurance companies to place on Silver plans in order to compensate for the ending of federal payments for cost-sharing reductions. This is discussed in greater detail later in the article.

Table 1 Characteristics of Individual Market in Covered California

Characteristic	2014	2015	2016	2017	2018
Effectuated enrollment	1,173,280	1,318,960	1,384,460	1,386,280	1,418,070
Number of Californians enrolled in subsidized coverage	1,068,550	1,193,270	1,234,030	1,210,390	1,252,490
Subsidized coverage	91%	90%	89%	87%	88%
Average gross monthly premium	$576	$594	$611	$672	$559
Average net monthly premium	$147	$157	$172	$186	$115
Average monthly advanced premium tax credit	$429	$436	$440	$499	$444
Unsubsidized coverage	9%	10%	11%	13%	12%
Average gross monthly premium	$484	$510	$535	$577	$446
Weighted average premium rate increase[a]	—	4.2%	4.0%	13.2%	12.5%
Average premium change if consumer switched to lowest-cost plan in same metal tier during open enrollment[a]	—	N/A	–4.5%	–1.2%	+3.3%
Number of health insurance companies offering coverage in Covered California	11	10	12	11	11
Demographic profile of enrollees					
Age (years)					
0–18	4.3%	4.8%	5.4%	6.2%	7%
19–29	13.7%	15.1%	16.6%	17.8%	17.9%
30–44	23.8%	23.6%	23.1%	23.1%	23.3%
45–64	50.1%	50.1%	50.8%	51.6%	51.1%
65+	8.1%	6.5%	4.2%	1.3%	0.7%

Table 1 (*continued*)

Characteristic	2014	2015	2016	2017	2018
Income					
<138% FPL	2.8%	2.4%	1.8%	2.7%	2.7%
138–250% FPL	45.0%	66.2%	65.2%	62.9%	60.7%
250–400% FPL	13.9%	23.5%	23.7%	24.0%	25.3%
400% FPL+	1.5%	3.0%	3.5%	4.1%	4.3%
FPL unavailable or unsubsidized application	36.8%	4.9%	5.7%	6.3%	7%
Race/ethnicity					
White	38.3%	39.4%	39.7%	39.0%	37.5%
Black	2.5%	2.4%	2.3%	2.2%	2.2%
Latino	27.8%	28.2%	27.9%	27.8%	28%
Asian	23.7%	22.3%	22.6%	23.3%	23.5%
Other	7.6%	7.6%	7.5%	7.6%	8.6%

Sources: Unless otherwise noted, Covered California Active Member Profile, June 2014, March 2015, March 2016, March 2017, and March 2018, all available at hbex.coveredca.com/data-research/.

Notes: FPL, federal poverty level; N/A, information not available, not applicable. Distribution of race/ethnicity only includes those enrollees who reported their race/ethnicity.

[a]Covered California 2017d.

Table 2 Characteristics of Individual Market Under the ACA: Federally Facilitated Marketplace (FFMs) and Covered California

Characteristic	FFMs	Covered California
Health care costs in marketplace[a]		
Benchmark premium, 2014	$183–426	$300
Benchmark premium, 2015	$196–488	$312
Average increase to benchmark premium, 2014–15	2%[b]	4%
Benchmark premium, 2016	$212–719	$312
Average increase to benchmark premium, 2015–16	7.2%[b]	0%
Benchmark premium, 2017	$273–926	$341
Average increase to benchmark premium, 2016–17	25%[b]	9.3%
Benchmark premium, 2018	$339–865	$430
Average increase to benchmark premium, 2017–18	37%[b]	26.1%
Benchmark premium, 2019	$339–865	$435
Average increase to benchmark premium, 2018–19	–2%	1.2%
Take-up rates among eligible consumers[c]		
2014	33%	58%
2015	49%	64%
2016	64%	79%
Insurer participation		
Average number of insurance companies participating in market, across first 5 years of the ACA[a]	4.89	11
Customers with a choice between at least two insurers, 2018	71%[b]	95%[d]
Customers with a choice between at least three insurers, 2018	45%[b]	82%[d]
Mean risk score of marketplace enrollees[e]		
2016	1.69	1.11
2017	1.69	1.09

Sources: [a] Kaiser Family Foundation 2014–18a, 2014–18b. Premiums were analyzed using the second-lowest-cost silver (benchmark) premium for a 40-year-old in each county and weighted by county plan selections. Average increase to benchmark plans was calculated from raw data. While the increases given for California are unweighted, those for FFMs are weighted by enrollment.

[b] Assistant Secretary of Planning and Evaluation 2014, 2015, 2016, 2017.

[c] Lee et al. 2017.

[d] Covered California 2017d.

[e] Centers for Medicare and Medicaid Services 2017c.

Notes: Numbers for FFMs include those for SBMs that use the federal platform for eligibility determinations and enrollment (AL, AK, AZ, AR, DE, FL, GA, HI, IL, IN, IA, KS, KY, LA, ME, MI, MS, MO, MT, NE, NV, NJ, NM, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, WV, WI, WY).

the average net monthly premium was less than $200 each of the 5 years. The monthly premiums for the unsubsidized portion of the market was less than $600 (Covered California 2018a, 2017h, 2016b, 2015c, 2014f). Much like in the rest of the country, however, in 2017 premiums increased more than they had in previous years (13.2%). Analyses largely attributed this increase to the end of the federal reinsurance program (Cox and Levitt 2017). For 2018, Covered California premiums rose by a weighted average of 12.5%, with an additional 8–27% increase for Silver plans sold on the exchange in order to cover the cost of the defunding of cost-sharing reductions at the federal level. A large portion of the 12.5% increase (about 7%) was attributable to increased medical spending, according to Covered California.

There are 19 rating regions in the state under the ACA. Covered California decided to have more rating regions that represent smaller areas to reduce the amount of cross-subsidization between different regions within the state. Premiums in these regions vary substantially, with northern counties having, on average, higher premiums than southern counties. In 2018, the average premium for a 40-year-old living in Northern California was $496 a month compared to $379 for a 40-year-old in Southern California (Covered California 2017d).

Competition in the individual market has been robust during the 5-year period. Between 10 and 12 insurance companies have sold coverage through Covered California each year for an average of 11 issuers between 2014 and 2018. This is higher than the average number of insurers participating in FFMs, which during the first 5 years of the ACA averaged 4.89 insurers (table 2) (Kaiser Family Foundation 2014–18b).[3] In all years except 2015, consumers in every county in the state had at least two issuers to choose from when selecting coverage (Covered California 2015e, 2014d, 2017b, 2014g). Returning customers also saw decreases in their premiums. In 2016, consumers could reduce their premiums by an average of 4.5% if they switched to a lower-cost plan within the same metal tier and by an average of 12% in 2017 (table 1) (Covered California 2015e, 2016a). In the open enrollment period for 2015, the first-time individuals could decide to renew their coverage or change plans, and approximately 40% of customers visited the online application to explore the options available to them and see if they wanted to change their health plan. About 6% of consumers selected a different plan from the one they were enrolled in for 2014 (Covered California 2015d).

3. The number of participating insurers in FFMs ranged from 1 to 11 in 2018, 1 to 13 in 2014, 1 to 15 in 2017, and 1 to 16 in 2015 and 2016.

Eleven insurance companies returned to the Covered California market to offer plans for 2018. Although not every Californian had a choice between carriers for 2018, 95% of consumers could choose between at least two insurers, 82% could choose from three or more, and no counties were bare. At the national level among states with FFMs, 19% of consumers could choose between at least two insurers in 2018, and 45% could choose between three. Both of these numbers are down from 2017, when 79% of FFM customers had a choice between at least two insurers, and 56% had a choice between at least three (table 2) (Assistant Secretary of Planning and Evaluation 2017). Leading up to the 2018 open enrollment period, there was great uncertainty around whether or not there would be any bare counties in the country. However, by the time open enrollment began, all counties had at least one insurance company offering coverage to customers through the marketplace.

Covered California enrollees are also a healthy mix of individuals. A recent analysis of data on Covered California customers found that, statewide, they had a mean risk score of 1.09 in 2017, down from 1.11 in 2016 (Covered California 2017b). The risk score of California enrollees is lower than those in FFMs (risk score = 1.69) or other state-based marketplaces (SBMs; risk score = 1.53) (table 2; data for other SBMs not shown) (CMS 2017c). The age distribution of Covered California consumers has gotten somewhat younger over the first 5 years of implementation. In 2014, about 58% of consumers were 45 years and older, compared to about 52% in 2018 (table 1). In 2016, of the 3.05 million remaining uninsured, an estimated 322,000 were eligible for Medi-Cal and another 401,000 for subsidies, while 1.79 million were ineligible due to immigration status and 550,000 had incomes too high to qualify for subsidies (Dietz et al. 2016).

The Individual Market in California before the ACA

Before the passage of the ACA, the individual market in California covered about 1.5 million people (fig. 2). Enrollment in the individual market had been decreasing in California after reaching a high of about 3 million in 2006 (Wilson 2011). Although the California Department of Insurance and Department of Managed Health Care tracked enrollment numbers in the individual and small group markets, it was much more difficult prior to the ACA to get information on plan costs. There was no standardization in plan rates as health insurers could risk rate each individual customer. Premiums also varied by age, with older adults paying as much as five times that of younger Californians. In 2011, for example, a sampling of

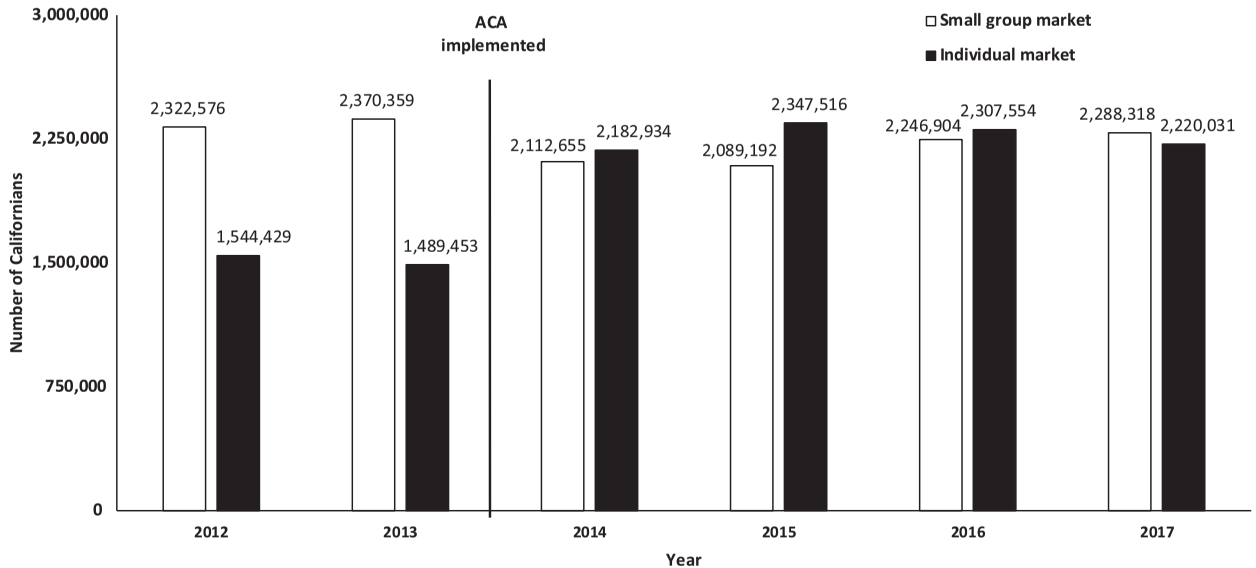

Figure 2 Enrollment in California's Individual and Small Group Markets, 2012–17.

Sources: California Department of Insurance 2015, 2016, 2017, 2018; California Department of Managed Health Care 2014, 2015, 2016, 2017; Wilson 2015, 2018.

Table 3 Characteristics of California's Individual Market Before the ACA

Characteristic	Value
Health care costs on the individual market	
Average premium increase 2009–10[a]	15.7%
Average actuarial value, 2009[b]	55%
Expected out-of-pocket costs, 2009[b]	$2,180
Enrollees in high deductible health plan, 2011[b]	69%
Access to care	
Delayed or went without needed care because of cost, 2012[c]	11%
Demographic profile of enrollees, 2013[c]	
Age (years)	
0–17	17.2%
18–24	18.1%
25–39	25.3%
40–64	39.1%
65+	0.2%
Income	
<100% FPL	8.3%
100–199% FPL	16.0%
200–299% FPL	17.5%
300% FPL+	58.2%
Race/ethnicity	
White	58.7%
Black	2.2%
Latino	19.2%
Asian	14.9%
Other	4.9%

Sources: [a] Gruber 2014.
[b] Wilson 2011.
[c] California Health Interview Survey 2012, 2013; UCLA Center for Health Policy Research 2012, 2013.
Note: FPL, federal poverty level.

available health insurance plans found that monthly premiums ranged from $113 to $205 for a 26-year-old, from $116 to $238 for a 32-year-old, from $199 to $222 for a 42-year-old, from $311 to $376 for a 52-year-old, and from $410 to $777 for a 64-year-old. These premiums were also very changeable from year to year; one analysis estimated that in 2010 the average premium rate in California for plans in the individual market increased 15.7% over 2009 rates (table 3) (Gruber 2014).

Out-of-pocket costs in the individual market prior to the ACA were also quite high in California. An estimated 69% of individual market enrollees

were enrolled in plans with high deductibles in 2011, while only about 35% of those in the small group market and 1% of those in the large group market were enrolled in high deductible health plans that year.[4] Similarly, the actuarial value of individual market plans in California was much lower than that of plans in the group market (55% vs. 85%, respectively). This lower actuarial value and high enrollment in high-deductible health plans translated into higher out-of-pocket costs. In 2009, expected out-of-pocket expenses were about $2,180 on the individual market, compared to only $748 in the group market (Wilson 2011). These high out-of-pocket costs played a role in customers delaying or foregoing needed medical care because of costs. According to the 2011–12 California Health Interview Survey, 16.1% of Californians with coverage through a high-deductible plan in the individual market delayed needed medical care because of the cost (table 3) (Charles et al. 2014).

Furthermore, prior to the ACA, people with chronic illnesses, older adults, and lower-income individuals were often priced out of the individual market. Nearly 60% of enrollees had incomes 300% of the federal poverty level or higher, were white, and were below the age of 40 (table 3).

California's ACA Implementation

As a diverse state, both demographically and geographically, California faced challenges in successfully implementing the ACA. State legislators recognized this early on and embraced reform. California submitted and was approved to begin an early expansion of Medicaid under an 1115 waiver from the Centers for Medicare and Medicaid Services (CMS). The approved waiver built on a previous 1115 waiver demonstration project in 10 counties known as the Health Care Coverage Initiative, which provided federal matching funds for counties to expand services under their indigent care programs and to enroll uninsured adults not eligible for Medi-Cal. The new waiver program, part of the state's "Bridge to Reform" proposal to CMS, allowed all California counties to provide health care coverage to low-income individuals through the LIHP, with the federal government paying for 50% of the cost of care for beneficiaries (Thomason and Long 2014). The income eligibility for coverage ranged from 25% to 200% of the federal poverty level and was based on citizenship status, age, income, county of residence, and not being pregnant. LIHP launched in 2011, and

4. High-deductible health plans are those that have a minimum annual deductible of $1,200 for an individual ($2,400 for families) and a maximum out-of-pocket and deductible amount of $5,950 for an individual ($11,900 for families) for in-network services.

by 2013, the last year of the program, 53 of 58 counties in the state had established LIHPs and covered more than 650,000 Californians (Kominski et al. 2013; UCLA Center for Health Policy Research 2013). Although LIHP was not a true Medicaid expansion, it provided a head start for enrollees to gain coverage prior to their actual enrollment in Medi-Cal in January 2014, when more than 650,000 Californians were seamlessly transferred into Medi-Cal under the ACA's Medicaid expansion (California Department of Health Care Services 2017). Those LIHP enrollees with incomes above the eligibility threshold for Medi-Cal were referred to Covered California, where about half of them were eligible to purchase coverage (Thomason and Long 2014).

On the private insurance side of reform, within 6 months of the signing of the ACA into federal law, California became the first state to pass legislation establishing a health insurance marketplace. One of the defining aspects of Covered California is that it is an "active purchaser": the exchange negotiates premiums with insurance companies and reviews applications from health insurers before approving them to sell plans in the marketplace (Covered California 2014d; Scheffler et al. 2016). California law requires that Covered California selectively contract with insurers that provide "health care coverage choices that offer the optimal combination of choice, value, quality, and service" (Weinberg and Haase 2011: 8). This competitive bidding process ensures that there are an adequate but not overwhelming number of plans for consumers to choose from, all of which offer enrollees a comprehensive set of services and access to a robust provider network. Allowing only those plans that meet the standards set by the purchasing agent (in this case, Covered California) to be sold to customers on the market is a key aspect of Alain Enthoven's (1978, 1993) model of managed competition, an idea that strongly influenced the ACA's architects. In the first year of operation, 33 insurers submitted bids to participate in Covered California, resulting in 13 insurers being selected to offer plans through the exchange.[5] Most states have opted to take a more passive role in certifying qualified health plans to sell coverage through the marketplace, and only three other states (Massachusetts, Rhode Island, and Vermont) specified in the legislation creating their state marketplace that the exchange should act as an active purchaser (Dash et al. 2013).

The state law establishing Covered California also included a number of provisions aimed at easing the process of enrolling in coverage and creating

5. One plan in 2014 was later removed from the exchange, as it was not approved by the state to sell health insurance in the commercial market.

an even playing field between Covered California and the off-exchange individual market. To facilitate comparison shopping, Covered California requires all insurers to offer a standardized benefit design within each metal tier (i.e., Bronze, Silver, Gold, and Platinum). Standardizing policies to promote comparisons of similar products by price is another key component of Enthoven's (1978) managed competition. Covered California's plan standardization allows consumers to only look at the premium levels, quality ratings, and provider networks of plans in the same metal tier when deciding which one to enroll in. The standard benefit design is reviewed and adjusted each year to make sure it is best serving patients. For example, in 2017, copays for customers in Silver, Gold, and Platinum plans were reduced for primary and urgent care visits.

Silver plans sold through Covered California also must provide access to outpatient services without making them subject to a deductible, a requirement that no other SBM has yet made for plans sold through the individual market. The number of services that fit into this category increased over the first 4 years of the program and for 2017 included an annual wellness exam; primary care, urgent care, specialist, and emergency room visits; laboratory tests; X-rays and diagnostics; imaging; and generic drugs (Covered California 2017e).[6] Gold and Platinum plans do not have deductibles, and Bronze plans also offer some out-of-pocket cost protections by allowing customers to have three deductible-free visits to a primary care physician or specialists each year, along with an annual wellness exam and laboratory tests. Premiums can vary among people based on age, family status (individual or family plan), and geography, as allowed under the ACA. The state decided to not allow plans to vary premiums by smoking status, although federal law permits this.

Health insurers selected to offer qualified health plans through Covered California are required by state law to offer a plan in each of the four metal tier coverage levels, both inside and outside of the exchange. Even those insurers who do not participate in Covered California must offer the full range of metal tiers plans if they sell coverage in the off-exchange individual market. For those insurers who participate in the exchange, all plans that are offered in the off-exchange market must also be sold through Covered California at the same price, in compliance with federal law, to prevent "cream skimming" into the off-exchange market.

To encourage early participation from health insurers in Covered California, the exchange participated in multiyear contracting in its first 2 years

6. Enhanced Silver 94, Gold, and Platinum plans also provide deductible-free access to nongeneric drugs.

of operation. Insurers that did not receive a contract in the first year were not eligible to sell plans in 2015 either.[7] Product changes were also not allowed in 2015. Carriers that participate in Covered California are the only ones that are allowed to offer catastrophic coverage (meaning that the enrollee pays for the cost of all of their care until the out-of-pocket maximum has been reached).

California also decided against allowing grandmothered plans to stay in the market. Grandmothered plans are plans that began between policy years March 2010 and October 2013 and do not comply with the ACA's coverage requirements. While not originally included in the ACA's legislative language, the Obama administration issued regulations giving states the opportunity to allow grandmothered plans to remain in effect through 2018. This decision came after the negative response from people in these plans when they learned their coverage would be cancelled starting in 2014, even after President Obama had promised that "if you like your health care plan, you can keep your health care plan" throughout the promotional rollout of the law (Jost 2017a). Most people who would stay in the risk-rated and less generous grandmothered plans are likely to be healthier. Therefore, in states that allowed grandmothered plans to stay in the market, this transitional policy may have contributed to rising premiums and insurer losses in 2014 (American Academy of Actuaries 2014; Huth and Karcher 2016).

The ACA has fundamentally changed the type of insurance products purchased in the individual market. Between 2013 and 2015, the percentage of enrollees who purchased policies regulated by the Department of Managed Health Care rose from 30% to 86%, while actual HMO enrollment increased from 32% to 39% (Wilson 2017). The Department of Managed Health Care regulates all HMOs and two large PPOs, and enrollment in these two PPOs grew by more than 800,000 members during this period.

Covered California has also been proactive in designing and implementing tools to facilitate plan selection. In January 2014, during the last few months of the first open enrollment period, a star quality rating system was put into place (Covered California 2014b).[8] The ratings were originally based on a 4-star system and used data from the Consumer Assessment of Healthcare Providers and Systems survey (Covered California 2014b) to provide potential customers with an easy-to-interpret

7. Exceptions to this rule were made for new entrants to the market and for Medi-Cal plans.

8. The federal marketplace, by comparison, began piloting the use of health plan quality ratings only during the 2018 open enrollment period, and these star ratings were used only in Virginia and Wisconsin (healthcare.gov n.d.). Seven other SBMs (Colorado, Connecticut, Maryland, Minnesota, New York, Rhode Island, and Washington) use quality ratings in their plan comparisons on their online platforms, some of which have been doing so since 2015 (Greene, Hibbard, and Sacks 2016).

evaluation of how the plan's perceived quality by other customers compares to other plans available in the western region of the United States. For 2018 coverage, the quality ratings were improved to compare members' experience and medical care to national standards. The ratings use three composite measures (getting the right care, members' care experience, and members' plan service experience) to create an overall summary measure that is displayed alongside the plan information to consumers while they shop (Covered California n.d.) In 2015, Covered California added a series of questions to assist individuals in selecting a plan based on their expected level of utilization during the upcoming year. These consumer-friendly policies led *Consumer Reports* to put Covered California on its "Nice" list for 2015, and each year the marketplace continues to improve and innovate (Covered California 2015a). For the open enrollment period for 2017 coverage, Covered California also started ordering plans by estimated yearly cost and added an out-of-pocket cost calculator to make it easier for customers to determine how much they could expect to pay overall rather than just on premiums (Rao, Hewitt, and White 2017).

The exchange also prioritized outreach programs to educate potential enrollees about the availability of affordable health care coverage. For the 2014 open enrollment period, the state spent $45 million on advertising. Through 2014, Covered California also provided $40 million in grants to community-based organizations that were best equipped to provide targeted outreach to eligible populations (Community Health Councils 2013). The exchange also supported a robust program for enrollment assisters to help consumers enroll in coverage. Certified enrollment counselors are paid $58 for each individual they initially enroll in a Covered California health plan or Medicaid and $25 for renewals (Covered California 2014e). Learning from the first open enrollment period, Covered California expanded the number of enrollment assisters it used even more and began the 2015 open enrollment period with more than 12,000 certified insurance agents, 10,000 county eligibility workers, and 6,400 certified enrollment counselors (Covered California 2014c).

Overall, in 2015 and 2016, Covered California spent $265 million on marketing and outreach investments, and consumers have benefited from this heavy investment, with 60% of Covered California customers receiving some level of assistance during the enrollment process for coverage in 2017 (Lee et al. 2017). A recent survey by Covered California provides evidence for continued support for marketing and outreach. The survey found that nearly 75% of subsidy-eligible uninsured Californians did not think they were eligible for financial help or were not sure (Covered

California 2017f). Accessing this population will require continued marketing efforts as well as partnered outreach with community partners. Reflecting this, budgeting for 2018 marketing and outreach in California was increased by $5 million over 2017, to $111 million (Covered California 2017c). Meanwhile, at the national level, massive changes were made. While the federal government originally dedicated significant resources for marketing and outreach in states with FFMs ($118.2 million in 2016 and $163 million in 2017 after an initial investment of $217 million in 2014), under the Trump administration the budget was cut considerably (Hill, Wilkinson, and Courtot 2014). The 2018 proposed budget for all 39 states with FFMs dropped 71% from 2017 levels to $46.8 million. An analysis from Covered California estimates that if the federal government were to provide the same amount of resources for marketing and outreach as California does, as a percentage of premium, it would need to have spent $480 million in 2018. With this increase to the marketing and outreach budget, the analysis estimates that an additional 1.3 million Americans would sign up for subsidized coverage through FFMs (Lee et al. 2017).

The flexibility that Covered California has shown during the first years of implementation has allowed more Californians to enroll in coverage, including extending enrollment deadlines to help manage the surge of shoppers toward the end of open enrollment periods. Covered California also worked with state revenue agencies and tax preparers in 2015 to allow for a special enrollment period during tax season for Californians who were unaware of the tax penalty for not having health insurance until they went to file their taxes for the year (Covered California 2015b).

Finally, there has recently been a significant amount of uncertainty about the ACA at the national level. The Republican led Congress spent the first 9 months of 2017 working on bills to repeal the ACA through budget reconciliation. While these bills ultimately failed and the ACA remains the law of the land, the Trump administration has taken a number of steps to undermine the law. In October 2017, President Trump announced that the federal government would stop making payments to health insurance companies for the cost-sharing reductions (CSRs) they provide as required by the ACA (Liptak, Luhby, and Mattingly 2017). Prior to this announcement, the Department of Health and Human Services under President Trump had been making these payments on a monthly basis without a promise of future payments, causing great financial uncertainty for insurers. Even before the final announcement that the federal government would stop making the CSR payments, Covered California took steps to stabilize the individual market and added a surcharge to all Silver plans sold through the exchange for 2018 (Covered California

2017d). This surcharge covers the amount of money needed for insurers to provide the CSR subsidy program in the absence of federal payments. Subsidized consumers enrolled in these plans did not see an increase to their net premium, however, as their federal premium subsidy also increased. Unsubsidized customers are able to buy the same plan without the surcharge in the off-exchange individual market, and all customers who purchase Bronze, Gold, and Platinum plans are not negatively affected by the CSR payment cancellation. After the state's announcement, the US Department of Health and Human Services released guidelines for other states that decide to go a similar route to deal with CSR payment uncertainty and extended the deadline for 2018 rate filings to allow more states to consider implementing a similar strategy (Jost 2017b).

The reductions in federal marketing and outreach have been another way that the Trump administration has used its power to disrupt the ACA. As an SBM, however, California was not affected by these actions and instead took a proactive stance, increasing its funding to continue to find and enroll harder-to-reach populations. Similarly, the Trump administration greatly reduced the open enrollment time period for consumers in states using HealthCare.gov from November 1–January 31 to November 1–December 15, cutting 45 days off the time frame for enrollment (Shafer and Dusetzina 2017). Again, Covered California decided to ignore the federal standard and instead allowed individuals to sign up for coverage through January 31, as in previous years.

Finally, the GOP tax bill passed at the end of December 2017 zeroed out the ACA's individual mandate tax penalty, effective in 2019. While the individual mandate technically remains in the law, this move via the tax bill removed the mandate's financial incentive and has been likened to repeal of the individual mandate. The Congressional Budget Office (2017) estimated that repealing the individual mandate will increase the number of uninsured individuals by 4 million in 2019 and 13 million in 2027 and reduce the federal deficit by $338 billion over the 2018–27 period. The Congressional Budget Office also estimates that premiums in the individual market would increase by 10% under a repeal of the individual mandate. In their 2019 rate booklet, Covered California reported insurers added between 2.5% and 6% to their premium rates in the first year following the zeroing out of the individual mandate penalty as a result of concerns about the health risk of the individual market pool (Covered California 2018c). Using the California Simulation of Insurance Markets (CalSIM) microsimulation model, researchers at UCLA and UC Berkeley estimate that between 150,000 and 450,000 more Californians will be uninsured in 2020, increasing to between 490,000 and 790,000 more uninsured Californians

by 2023 as a result of the zeroing out of the individual mandate penalty (Dietz et al. 2018). Covered California's executive director, Peter Lee, has been an outspoken critic of the changes the Trump administration has made, including the repeal of the tax penalty associated with individual mandate (Covered California 2017g). Although no action has yet been taken by California, the state may pass legislation to create its own individual mandate penalty, something that has been discussed by state policy makers and supported by Mr. Lee (Kliff 2017).

Throughout this time of federal uncertainty, Mr. Lee has also encouraged his staff to undertake proactive research on the potential effects of various federal efforts to repeal or reduce the effectiveness of the ACA. Grantees and staff researchers for Covered California have released a number of reports detailing the negative impacts of GOP proposals to repeal the ACA, as well as early estimates on the effects of stopping CSR payments. This forward-thinking approach has led to minimal disruption in the individual market, as evidenced by stable insurer participation and good enrollment numbers, even during a period of such great uncertainty. Data from the 2018 open enrollment period show that enrollment was up 3% over 2017, and even though there were significant increases to premium costs in 2018 compared to 2017, Californians receiving financial assistance for coverage through Covered California will pay less for health coverage in 2018 than in 2017 (Covered California 2018b). For those not eligible for financial assistance, the average increase in monthly premium was $55 (Covered California 2018b).

When the ACA first passed, California quickly embraced the law and took steps to fully implement its provisions. Today, the state continues to lead the way in innovative approaches to improve the individual market for all stakeholders and stabilize the market in the face of uncertainty. How the state moves forward to protect consumers and its individual market will be closely watched in the next several years.

Conclusion

In its first 5 years of business, Covered California has been successful at keeping costs low, attracting customers, and encouraging insurer participation. For 2018, in the face of great uncertainty for the future of the ACA, the agency continued to take preemptive steps to protect consumers and insurers. California's successful implementation of the ACA comes after years of foundational work by the state and stakeholder groups to create competitive markets, identify populations in need, and promote consumer-focused policies. By the time the ACA was passed, the state was

ready to embrace reform and moved to immediately implement the law, quickly bringing the ACA's benefits to millions of residents. Whether the state will be able to maintain these significant accomplishments will depend in part on the outcome of "repeal and replace" efforts that continue to be discussed in Congress. But, in keeping with California's tradition of continually looking to build on previous efforts to move toward universal access, stakeholders met during 2017 in Sacramento and in large counties around the state, such as Los Angeles, to explore contingency plans for preserving the progress made by the state and Covered California in establishing a competitive marketplace for 2.3 million Californians in the individual market and expanding Medi-Cal to 3.8 million adults. In 2016, California expanded Medi-Cal using state funds to all low-income children 18 and younger regardless of immigration status. And in his first budget proposal since taking office in 2019, Governor Newsome proposed expanding Medi-Cal to low-income adults age 19–25 regardless of immigration status, instituting a state individual mandate penalty, and increasing premium and cost-sharing subsidies for coverage purchased through Covered California. While parts of the country would prefer to return to a pre-ACA world and only do the bare minimum in terms of implementing the health reform law, California continues its long arc of progress toward universal access to health care.

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