

Covered California and Individual Health Insurance

MARCH 2019

Exploring the basics of health policy in California

Signed into law in March 2010, the federal Patient Protection and Affordable Care Act (ACA) imposes sweeping changes in the rules governing private health insurance and expands eligibility for Medicaid (Medi-Cal) among other provisions. For individuals who do not have employer coverage, and are not eligible for public coverage programs, the individual market is often the last available option to secure health coverage.

California became the first state to create a state-based ACA exchange,¹ and Covered California is now the largest state-based exchange in the nation.

Since 2014, enrollment in Covered California (and the expansion of Medi-Cal) reduced the rate of uninsured Californians under age 65 to 8.5 percent in 2017.²

This issue of **ESSENTIALS** reviews the basics of California's state-based exchange and the market for individual coverage.

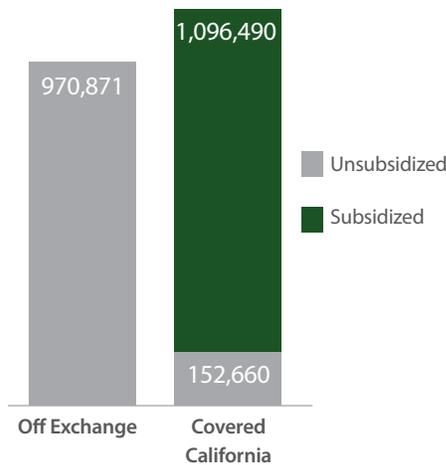
Overview

The ACA establishes a federal floor that ensures individuals in every state have basic protections in common with respect to the availability, affordability, comparability and transparency of health coverage. A central theme of the ACA is to organize markets and products in ways that both protect consumers and make it easier for them to compare and choose among their coverage options.

A cornerstone of the ACA is the establishment of state-level health insurance exchanges that serve as marketplaces to support individuals and small employers in comparing coverage options. Exchanges also administer federal financial assistance that helps low-income individuals and families purchase coverage.

Individual coverage is for most people a last resort. Absent financial assistance, they must pay the full premium and cost sharing for their coverage, unlike job-based coverage where employers contribute to the payment of premiums. For this reason, affordability and strategies to encourage individuals to sign-up are especially critical in the individual market.

Figure 1. PROFILE OF CALIFORNIA'S INDIVIDUAL MARKET, 2017



Source: Katherine Wilson, "State Releases Data on California 2017 Health Insurance Enrollment" California Health Care Foundation, August 2018, companion Excel file.

FAST FACTS

2.2 Million

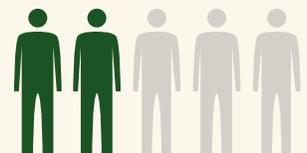
Californians purchase private individual coverage

1.3 Million

Californians on average are enrolled in Covered California

90%

of Covered California consumers receive federal subsidies



2 in 5

Covered California enrollees report difficulty paying monthly premiums³

DEFINITIONS

ACA Premium Tax Credit is a federal, refundable tax credit that reduces exchange monthly premiums for eligible individuals and families at or below 400 percent of the Federal Poverty Level (FPL) (\$48,560 in annual household income for one person) who are not eligible for Medi-Cal.

Actuarial Value (AV) is the average percent of benefit costs covered by a health plan product compared to the out-of-pocket costs paid by the covered person. A 70% AV plan covers 70% of benefit costs and the enrollee pays 30%. The ACA assigns metal labels to specific AVs: bronze (60%), silver (70%), gold (80%) and platinum (90%).

Cost Sharing Reductions (CSRs) are federal payments to qualified health plans that reduce out-of-pocket costs for individuals between 138 and 250 percent FPL (between \$16,753 and \$30,350 in annual household income for one person) purchasing a silver level plan in the exchange. In 2017, the federal government eliminated the CSR payments to health plans. Regardless of the federal contribution, plans are still required to reduce cost sharing for low-income enrollees under the ACA. See the California Story for how the state responded to the federal action.

Essential Health Benefits (EHBs) are ten categories of health services that must be covered in individual and small employer health plans under the ACA.

Out-of-Pocket Costs are the amounts an enrollee pays for covered services at the point of care, also known as cost-sharing. Out-of-pocket costs typically come in the form of coinsurance, copayments, and deductibles.

Qualified Health Plan (QHP) is a health plan that meets state and federal ACA marketplace requirements and is certified by Covered California to offer health coverage through the exchange.

Pre-ACA Individual Market

Prior to the ACA, individual coverage was expensive, often with very limited benefits and high out-of-pocket costs. Health plans selling individual policies routinely denied coverage or hiked premiums based on an applicant's health status or medical history or imposed coverage exclusions for pre-existing health conditions.

Health plans in California and most other states had total discretion to collect and use medical and health information to evaluate individual applicants (known as medical underwriting); no two health plans had identical criteria for making coverage and rating decisions. Common conditions triggering a denial of coverage included cancer, diabetes and mental health disorders, but also less obvious conditions such as asthma, acne, and obesity.

Coverage in the individual market often included annual and lifetime dollar limits on benefits, fixed limits on coverage (e.g., maximum 60 days of hospital coverage) and no upper limit on consumer out-of-pocket costs. Some policies excluded coverage for basic primary and preventive care and focused primarily on high-cost services like hospitalization.

ACA Individual Market

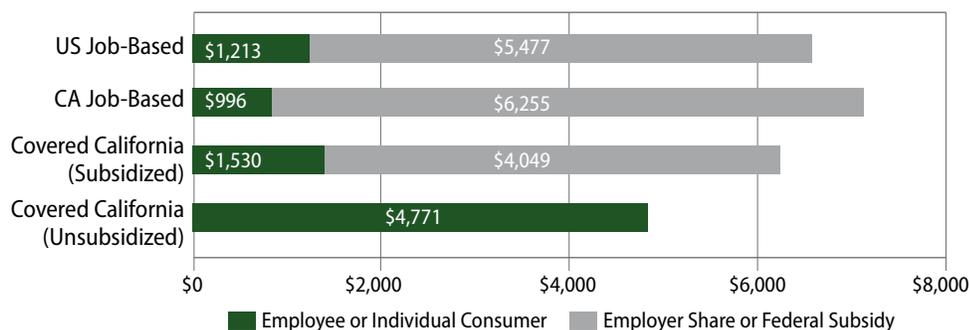
Before ACA, states assumed the primary role in setting market rules and regulating most aspects of private health insurance. Under the ACA, states continue to have the lead in oversight but now also enforce ACA federal standards affecting virtually all aspects of health insurance—including eligibility for coverage, benefits, premium rates, market conduct, quality, and transparency—with the

most sweeping changes affecting coverage in the individual and small group markets.

The ACA changed the individual market by removing barriers to coverage, setting minimum standards for coverage and funding federal premium and CSR subsidies. New ACA market rules include:

- ▶ Insurers can no longer deny coverage based on health status, medical history, or pre-existing conditions and must offer and renew coverage to all eligible applicants (known as guaranteed issue and renewal),
- ▶ No coverage or benefit limits can be imposed because of pre-existing health conditions,
- ▶ No annual or lifetime dollar limits on benefits,
- ▶ Children can stay on a parent's health insurance plan as dependents until age 26,
- ▶ Premiums must be based solely on age and geography (using state developed regions),
- ▶ Premiums cannot vary by more than a three-to-one ratio from the youngest enrollee to the oldest,
- ▶ Health plans must cover all ten essential health benefits, including mental health and substance use treatment,
- ▶ Health plans must meet federally defined minimum values and disclose the actuarial value of products, and
- ▶ Consumer cost sharing is limited to a maximum out-of-pocket amount set annually by federal formula.⁴

Figure 2. COMPARISON OF CONSUMER SHARE OF PREMIUMS, EMPLOYER-SPONSORED AND INDIVIDUAL COVERAGE



Source: California Health Care Foundation, California Employer Health Benefits: Workers Shoulder More Costs, June 26, 2018. Covered California, June 2017 Membership Profile. Chart prepared by Insure the Uninsured Project.

Federal Framework

Guaranteed Issue and Coverage Requirement

The ACA requires health plans (referred to as “issuers” in federal law) that offer individual coverage to guarantee issue (accept for coverage) all eligible applicants regardless of health status or claims history, gender, age or other specified factors, subject to annual open enrollment periods and special enrollment periods.⁶

Open enrollment periods are set time periods when individuals can apply for and secure coverage, typically on an annual basis. The current federal open enrollment period for individual coverage is November 1 to December 15 for coverage effective January 1. Special enrollment periods apply when individuals have a life changing, “triggering” event affecting their health coverage, such as loss of job-based coverage, divorce or marriage. Individuals eligible for special enrollment can obtain coverage outside of the open enrollment period.

In addition, the ACA requires individuals to maintain minimum health coverage, or pay a tax penalty equal to \$695 or 2.5 percent of the individual’s income, whichever is greater, unless they are eligible for an exemption. ACA exemptions can be based on a number of circumstances, including certain hardships, some life events, health coverage or financial status. Individuals can meet the “individual mandate” with coverage offered through their job, public programs such as Medicare and Medicaid, or privately purchased individual coverage.

Individual Mandate Penalty. Although Congress failed to repeal the ACA in 2017 and 2018, despite repeated efforts, the 2018 federal Tax Cuts and Job Act eliminated the ACA financial penalty (reduced it to zero) for individuals who do not maintain coverage starting in the 2019 coverage year.

Grandfathered Plans. Under the ACA, individual and small group health plans that existed on March 23, 2010 – the day the ACA was enacted – known as grandfathered plans, are subject to only certain provisions of the law. For example, grandfathered health plans are limited to those enrolled prior to the ACA but can charge more based on pre-existing conditions. Grandfathered plans are not required to meet all of the ACA’s essential benefits requirements. Grandfathered health plans can lose this status if certain significant changes are made to the coverage that reduce benefits or increase consumer costs.

State-Based Marketplaces

The ACA requires states to establish health insurance exchanges, also referred to as marketplaces, for individuals and small employers. States choosing to develop a state-based exchange must do so through a governmental or nonprofit entity.⁷ A state-based exchange can establish separate markets for individuals and small businesses or combine these markets. Federal funding to establish a state marketplace was available from 2011 through 2015, at which time exchanges were expected to be self-sustaining.⁸

Although the ACA requires states to establish exchanges, as implementation unfolded, many states could not or did not establish exchanges. As a result, the federal government established a federal health insurance marketplace (healthcare.gov). See Figure 3 for more information about exchange models by state.

The ACA requires state-based exchanges to perform the following functions: (1) certify qualified health plans to be offered in the exchange consistent with federal ACA guidelines; (2) operate a toll-free telephone assistance hotline; (3) assign a rating to each health plan based on relative quality and price; (4) establish a Navigator program to award grants to organizations for public education and enrollment; and (5) meet other federal requirements, including consulting stakeholders on exchange activities.⁹

Health Insurance Oversight in California

For more than 50 years, two state agencies have shared responsibility for regulating health insurance in California.

Currently, the Department of Managed Health Care (DMHC) regulates Health Maintenance Organizations (HMOs) and some Preferred Provider Organization (PPOs) under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene).

The California Department of Insurance (CDI), led by the elected Insurance Commissioner, regulates some PPOs and traditional indemnity coverage (fee-for-service plans that generally have no limits on eligible providers), subject to provisions of the California Insurance Code.

Prior to the ACA, the two departments enforced different standards for health plans and approached oversight very differently. For example, Knox-Keene plans had to offer specific basic health benefits, while CDI-regulated plans did not have similar minimum coverage requirements. For more information on health insurance oversight in California, see [Ready for Reform: Health Insurance Regulation in California Under the ACA](#).⁵

With implementation of the ACA, new federal rules apply to all individual coverage reducing the differences between DMHC and CDI requirements. Non-grandfathered health plans offering individual (and small group) coverage are generally subject to the same federal and state standards regardless of the regulator that oversees the coverage.

Although similar rules and standards now apply, legacy differences remain and parallel statutes have not always resulted in parallel regulations or enforcement.

Figure 3. ACA INDIVIDUAL EXCHANGE MODELS BY STATE

Exchange	Brief Description	States Using the Model
Federally-facilitated Exchange (FFE)	The federal exchange offers coverage and federal subsidies in states that choose that option. Consumers as well as small employers and their employees in states using the FFE apply for and enroll in coverage through <i>healthcare.gov</i> . In many states with FFEs, the exchange is wholly operated and administered by HHS, while some states partner with HHS to perform additional functions, such as plan management or consumer assistance.	Alabama, Alaska, Arizona, Florida, Georgia, Hawaii, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, Wyoming Partnerships: Delaware, Illinois, Iowa, Michigan, New Hampshire, West Virginia
State-based Exchange (SBE)	States running a SBE for performing all exchange functions for both the individual and small business markets. Consumers as well as small employers and their employees in these states apply for and enroll in coverage through exchange websites established and maintained by the states.	California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington
State-based Exchange – Federal Platform	State administered exchanges that rely on the FFE information technology platform for enrollment functions.	Arkansas, Kentucky, Nevada, New Mexico, Oregon

Source: Vanessa C. Forsberg, “[Overview of Health Insurance Exchanges](#),” Congressional Research Service, June 20, 2018.

ACA Federal Financial Assistance

The ACA establishes federal subsidies to help low- and moderate-income individuals afford exchange coverage as premium tax credits for individuals with incomes at or below 400 percent FPL. In 2018, nearly 90 percent of Covered California enrollees receive premium assistance.¹⁰

ACA also establishes cost sharing reduction subsidies to reduce out-of-pocket costs for consumers with incomes at or below 250 percent FPL. ACA requires the federal government makes CSR payments to health plans who then reduce consumer cost sharing. In 2017, the President eliminated CSR payments; however plans are still required to reduce consumer cost sharing under the ACA. See the California Story for information about California’s response.

Coverage under the ACA

The ACA defines four “metal tiers” of coverage based on a product’s actuarial value (AV), as shown below.¹¹ The AV is the average portion of the total health care costs covered by the health plan versus the portion paid by consumers out-of-pocket at the point of service.

- ▶ **Bronze Tier** (60% AV)
- ▶ **Silver Tier** (70% AV)

- ▶ **Gold Tier** (80% AV)
- ▶ **Platinum Tier** (90% AV)

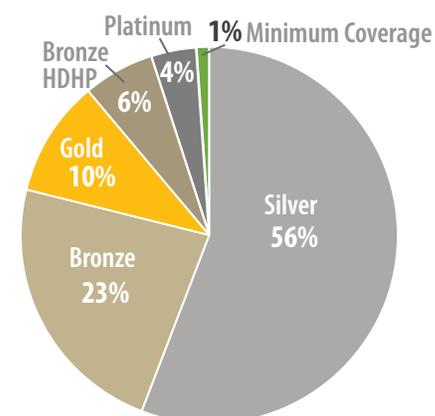
In addition, the ACA establishes a minimum coverage plan, or Catastrophic Plan, with lower monthly premiums and a high deductible (\$7,900 in 2019).¹² To purchase a Catastrophic Plan, an individual must be under age 30 or qualify for a hardship or affordability exemption. The “minimum coverage” plan includes three doctor or urgent care visits with no out-of-pocket costs and offers free preventive benefits.¹³

State Framework

California enacted legislation to conform with the ACA and in many instances enacted policies that exceed ACA requirements. Examples of California provisions that exceed federal requirements:

- ▶ Requires Covered California to choose health plans through a competitive process (selectively contract) to “provide health care choices that offer the optimal combination of choice, value, quality and service.”
- ▶ Federal law requires exchange health plans to offer at least one silver and one gold option.¹⁴ California requires exchange health plans to offer coverage at all five levels, including the minimum coverage option.¹⁵

- ▶ Limits health plans only selling individual coverage outside the exchange (off-exchange) to only offer products in the four metal tiers and prohibits them from offering catastrophic coverage. Requires off-exchange plans to offer coverage in all four metal tiers.

Figure 4. COVERED CALIFORNIA ENROLLMENT BY COVERAGE LEVEL, 2018

Source: Covered California, [Health Insurance Companies and Plan Rates for 2019](#). Data reflects individuals who signed up and paid premiums to complete (effectuate) the enrollment. Totals may not add due to rounding.

Active Purchaser

Covered California is required to select participating health plans through a competitive process. For each coverage year, Covered California actively negotiates with potential plans on premiums, networks, geographic coverage and quality performance. In addition, Covered California health plan contracts impose contract requirements adopted by the independent Covered California Board related to quality, performance and public reporting.

Geographic Regions

Consistent with federal law, California divides the state into 19 pricing or rating regions. (See Figure 7.) Insurers wanting to participate in the exchange propose regions and partial regions they wish to serve and region-specific rates, which are then negotiated with Covered California. Premium rates are also subject to rate review by DMHC and CDI. The regulators determine the reasonableness of the rates but cannot approve or disapprove the final rates.

Covered California rating regions differ in premium costs and the number and type of health plan options available. For example, comparing regions like San Francisco and Los Angeles, premiums can be as much as 24 percent higher in San Francisco.¹⁶ In some of the rating regions, and in some zip codes, consumers have only one or two health plan choices in the exchange, often contributing to much higher premiums than areas of the state with greater competition among health plans.

Standardized Benefit Designs

As permitted in federal law and authorized in California law, Covered California requires contracted health plans to offer standard benefits at each coverage level, based on specified benefits and consumer cost sharing. Standardized benefit designs support

consumer decision making by simplifying the choice between health plans, allowing for an “apples to apples” comparison of health plan premium prices and other features.

Covered California worked with stakeholders to develop what it refers to as “Patient-Centered Designs” that encourage access to primary and preventive care services before the consumer has to meet any annual deductible. For example, in silver-tier coverage, higher outpatient services are not subject to a deductible, while in bronze coverage three outpatient visits are covered before the deductible applies. The standard designs also have separate medical and pharmacy deductibles. (See Appendix A.)

Financing

From 2011 through 2015, California received over \$1 billion in federal grants to develop and operate the state exchange. Exchanges were required to be self-sustaining in 2015.

To become self-sustaining, state-based exchanges are authorized to charge participation fees. The current participation fee for California individual market health plans is equal to four percent of the gross premium attributable to each enrollee each month.¹⁹ In Covered California for Small Business, the QHP participation fee is 5.2 percent of the premium due by each enrollee.²⁰

Federal premium tax credits make Covered California coverage more affordable for many. The majority of Covered California enrollees (90 percent) receive subsidies.

THE DATA

Figure 5. INDIVIDUAL MARKET ENROLLMENT BY REGULATOR, 2017

Department of Managed Health Care (DMHC)	1,961,899
California Department of Insurance (CDI)	33,493
DMHC Grandfathered Plan Enrollment	92,225
CDI Grandfathered Plan Enrollment	132,414

Sources: DMHC, Enrollment Summary Report – 2017 and CDI, Individual Health Plan Totals by Company, December 31, 2017. Chart prepared by Insure the Uninsured Project.

Essential Health Benefits

The ACA requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHBs) in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

Under the ACA and subsequent federal rules, states must select a “benchmark plan” that establishes the required benefits and coverage from among several options specified in federal rules. New federal rules for 2019 provide states with greater flexibility in selecting a benchmark plan, if they choose to make a change, or they can continue to require the existing benchmark plan.¹⁷

California selected as its benchmark plan the Kaiser Foundation Small Group HMO, which at the time was the largest plan by enrollment in California’s small employer market. The state enacted detailed standards on the services and items health plans subject to the ACA EHB requirement must meet, including preserving existing state benefit requirements as permitted in federal law. Federal law generally requires states that mandate additional benefits beyond the selected benchmark plan with EHBs to defray the costs of the additional benefit(s).¹⁸

Figure 6. PRELIMINARY COVERED CALIFORNIA ENROLLMENT, 2019

Category	2018	2019	Change
Renewals	1,133,180	1,217,903	+7.5%
New Sign-Ups	388,344	295,980	-23.7%
Total	1,521,524	1,513,883	-0.5%

Source: Covered California, “Covered California 2019 Open Enrollment Early Observations and Analysis,” January 30, 2019. Note: Numbers in this chart reflect individuals who initially selected a health plan but will be adjusted to reflect the number that pay premiums and complete the process.

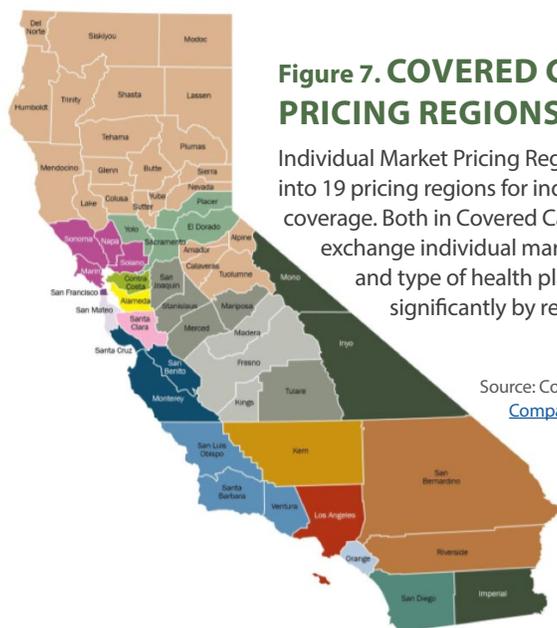


Figure 7. COVERED CALIFORNIA PRICING REGIONS

Individual Market Pricing Regions. California divides the state into 19 pricing regions for individual and small employer coverage. Both in Covered California, and in the non-exchange individual market, premiums and the number and type of health plan options available can differ significantly by region.

Source: Covered California, [Health Insurance Companies and Plan Rates for 2019](#).

The California Story

California's pre-ACA individual market offered limited, and often expensive coverage that also completely excluded many individuals who could not pass the strict medical underwriting rules in place at the time.

On passage of the ACA, California fully embraced the market reforms and established the first ACA state exchange in the country. California also enacted state policies that exceed federal ACA requirements with the goal of ensuring a stable and competitive marketplace.

In 2014, the first year of implementation, enrollment in individual market coverage increased by 47 percent.²¹ Half the Californians with individual market coverage in 2014 purchased their coverage from the newly created marketplace, Covered California.²²

California also responded aggressively to federal policy changes over the last two years that could undermine the state's success. For example, in 2017 and 2018 when the federal government significantly reduced spending on outreach and enrollment, Covered California

maintained a robust outreach and marketing campaign which included efforts to encourage younger and healthier individuals to sign up. Bringing them into coverage results in a healthier risk mix and lowers premiums for everyone.

When the federal government stopped the CSR payments, Covered California worked to ensure the premium impacts were added only to silver tier plans, a practice known as "silver loading," so that the extra costs would be covered by increased federal subsidies rather than increasing premiums for consumers.

Despite these efforts, Covered California did experience a 23.7 percent decrease in new enrollment for 2019 as shown in Figure 6.

Covered California is still reviewing the enrollment data but it seems likely that at least some portion of the decline is because of the elimination of the individual mandate penalty. Policymakers are considering state action in this area, including imposition of a state mandate penalty.²³

Key Take Aways

► Individual Market as Only Option.

Individual health insurance is often the last resort for individuals who do not have job-based coverage or eligibility for public coverage programs such as Medi-Cal. Because individuals must pay the full premium and cost sharing for their coverage, unlike job-based coverage where employers contribute to the premiums, financial assistance, affordability and the need for outreach that encourages individuals to sign-up are especially important in the individual market.

► **Covered California Success.** California has successfully implemented a strong and resilient SBE. Resources dedicated to outreach, marketing, and application assistance, and state-level policies that exceed ACA requirements, have helped maintain steady enrollment in the nation's largest state-based marketplace.

► **Individual Market for Lower-Income Californians.** Federal ACA subsidies are critical to the success of Covered California and maintaining California's relatively low uninsured rate. Cost is the primary reason Californians report for remaining uninsured.²⁴ In 2018, 90 percent of Covered California enrollees were eligible for and received federal subsidies.²⁵

► **Covered California Resilience being tested.** Starting in 2019, individuals no longer face a federal tax penalty for failure to maintain health coverage. New enrollments in Covered California dropped by 23.7 percent for 2019, signaling the need for careful monitoring and state action to strengthen the individual market so as to preserve the gains California has made to date.

Notes

1. [Assembly Bill \(AB\) 1602](#) (Perez) Chapter 655, Statutes of 2010 and [Senate Bill \(SB\) 900](#) (Alquist) Chapter 659, Statutes of 2010.
2. UCLA Center for Health Policy Research, [2017 California Health Interview Survey](#), Public Use File, October 2018.
3. Covered California, "[Options to Improve Affordability in California's Individual Health Insurance Market](#)," February 1, 2019.
4. 42 United States Code (USC) § 300(gg-gg 19b) and § 18022.
5. Kelch Associates, "[Ready for Reform? Health Insurance Regulation in California Under the ACA](#)," California Health Care Foundation, June 23, 2011.
6. 42 United States Code (USC) § 300(gg-1); Code of Federal Regulations (CFR) Title 45 Subtitle A Subchapter B Part §147.104.
7. 42 United States Code (USC) § 13031(d); CFR Title 45 Subtitle A Subchapter B Part §147 et seq.
8. Center for Consumer Information and Insurance Oversight, "[Initial Guidance to States on Exchanges](#)," accessed online February 2019.
9. ACA, 42 USC § 13031(d)(4).
10. Covered California, [Covered California's Health Insurance Companies and Plan Rates for 2019](#), August 2018.
11. Healthcare.gov, [The 'metal' categories: Bronze, Silver, Gold & Platinum](#), accessed February 2019.
12. Healthcare.gov, [Catastrophic Health Plans](#), accessed February 2019.
13. Healthcare.gov, [Catastrophic Health Plans](#).
14. ACA, 42 USC § 18021(a)(1).
15. HSC § 1366.6 and CIC § 10112.3.
16. Covered California, [Covered California's Health Insurance Companies and Plan Rates for 2019](#), August 2018.
17. Centers for Medicare and Medicaid Services, [Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019](#), Federal Register, Vol. 83, No. 74, Tuesday, April 17, 2018.
18. 45 CFR § 155.170.
19. Covered California, [Qualified Health Plan Issuer Contract Through 2017-2019 for the Individual Market](#).
20. Covered California, [Qualified Health Plan Issuer Contract for 2017-2019 for Covered California for Small Business](#).
21. Katherine Wilson, "[Enrollment in Individual Health Plans Up 47% in 2014](#)," California Health Care Foundation, May 20, 2015.
22. Wilson, "Enrollment Individual Health Plans Up 47% in 2014."
23. See [Assembly Bill 414](#) (Bonta) and [Senate Bill 175](#) (Pan).
24. UCLA Center for Health Policy Research, [2017 California Health Interview Survey](#), Public Use File, October 2018.
25. Covered California, [Covered California's Health Insurance Companies and Plan Rates for 2019](#), August 2018.

Resources

The federal Center for Consumer Information and Insurance Oversight
www.cms.gov/ccio/

Covered California
www.coveredca.com

Covered California Board
www.hbex.coveredca.com

Department of Managed Health Care
www.dmhc.ca.gov

California Department of Insurance
www.insurance.ca.gov

About ITUP

Insure the Uninsured Project (ITUP) is a Sacramento-based nonprofit health policy institute that for more than two decades has provided expert analysis and facilitated convenings for California policymakers and decisionmakers focused on health reform.

The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad-based stakeholder engagement.

ITUP is generously supported by the following funders:

- ▶ Blue Shield of California Foundation
- ▶ California Community Foundation
- ▶ California Health Care Foundation
- ▶ Kaiser Permanente
- ▶ The California Endowment
- ▶ The California Wellness Foundation



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Appendix A. Covered California 2019 Patient-Centered Benefit Designs and Medical Cost Shares

As authorized under state law, Covered California established the attached standard benefit designs for each of the metal tiers to facilitate consumer comparison and emphasize access to primary and preventive care. Below are key terms used in the attached overview of the benefit designs.

Key Terms

Deductible is the amount a consumer pays for covered health care services before coverage begins. For example, with a \$2,500 deductible, the consumer pays the first \$2,500 of covered services.

Premium is the monthly amount the purchaser pays for health coverage. Premiums do not include cost sharing at the point of care (out-of-pocket costs) such as deductibles, copayments, and coinsurance.

Enhanced Silver Plans have silver plan coverage and premiums but lower out-of-pocket costs. Eligibility is based on income. The Enhanced Silver plan pays 94 percent, 87 percent, or 73 percent of expenses (in total) for covered benefits, depending on the plan an individual is eligible to purchase, with enrollees responsible for the remaining percentage.

Annual Out-of-Pocket Maximum refers to the highest amount a consumer is required to pay for covered services per year. After individuals reach the maximum, the health plan pays 100% of the costs without any additional cost sharing. The out-of-pocket maximum does not include monthly premiums or the cost of benefits the plan does not cover. The ACA establishes the dollar limits which are annually adjusted by formula.

Actuarial Value (AV) is the average percent of benefit costs covered by a health plan product compared to the out-of-pocket costs paid by the covered person. The ACA assigns metal labels to specific actuarial values: bronze (60%), silver (70%), gold (80%) and platinum (90%).

Copayment is a fixed amount the consumer pays for a covered health care service.

Covered California defined Prescription Drug Tiers:

Tier 1: Most generic* drugs or low-cost preferred** brand drugs (referred to as Generic Drugs)

Tier 2: Preferred Brand drugs or non-preferred generic drugs (referred to as Preferred Drugs)

Tier 3: Non-preferred Brand Drugs or non-preferred generic drugs (referred to as Non-preferred Drugs)

Tier 4: Prescription drugs or net drug cost per prescription over \$600 (referred to as Specialty Drugs).

**Generic* generally refers to prescription drugs that are approved by the Food and Drug Administration to be safe, effective and equivalent to the brand-name counterparts.

***Preferred* commonly refers to prescription drugs that do not have a generic equivalent but have been in the market for a time and are widely accepted. These drugs are usually listed on health plan formularies (a list of covered prescription drugs developed by individual health plans).



2019 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers 0% until out-of-pocket maximum is met	Covers 60% average annual cost	Covers 70% average annual cost	Covers 73% average annual cost	Covers 87% average annual cost	Covers 94% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	\$24,281 to \$30,350 (>200% to ≤250% FPL)	\$18,211 to \$24,280 (>150% to ≤200% FPL)	up to \$18,210 (100% to ≤150% FPL)	N/A	N/A
Annual Wellness Exam	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Primary Care Visit	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	\$75*	\$40	\$35	\$15	\$5	\$30	\$15
Urgent Care		\$75*	\$40	\$35	\$15	\$5	\$30	\$15
Specialist Visit		\$105*	\$80	\$75	\$25	\$8	\$55	\$30
Emergency Room Facility	Full cost per service until out-of-pocket maximum is met	Full cost until deductible is met	\$350	\$350	\$100	\$50	\$325	\$150
Laboratory Tests		\$40	\$35	\$35	\$15	\$8	\$35	\$15
X-Rays and Diagnostics		Full cost until deductible is met	\$75	\$75	\$30	\$8	\$55	\$30
Imaging		Full cost until deductible is met	\$300	\$300	\$100	\$50	\$275 copay or 20% coinsurance***	\$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)			\$15**	\$15**	\$5 or less	\$3 or less	\$15 or less	\$5 or less
Tier 2 (Preferred Drugs)	Full cost per script until out-of-pocket maximum is met	Full cost up to \$500 after drug deductible is met	\$55**	\$50**	\$20**	\$10 or less	\$55 or less	\$15 or less
Tier 3 (Non-preferred Drugs)			\$80**	\$75**	\$35**	\$15 or less	\$75 or less	\$25 or less
Tier 4 (Specialty Drugs)			20% up to \$250** per script	20% up to \$250** per script	15% up to \$150** per script	10% up to \$150 per script	20% up to \$250 per script	10% up to \$250 per script
Medical Deductible	N/A	Individual: \$6,300 Family: \$12,600	Individual: \$2,500 Family: \$5,000	Individual: \$2,200 Family: \$4,400	Individual: \$650 Family: \$1,300	Individual: \$75 Family: \$150	N/A	N/A
Pharmacy Deductible	N/A	Individual: \$500 Family: \$1,000	Individual: \$200 Family: \$400	Individual: \$175 Family: \$350	Individual: \$50 Family: \$100	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	\$7,900 individual only	\$7,550 individual \$15,100 family	\$7,550 individual \$15,100 family	\$6,300 individual \$12,600 family	\$2,600 individual \$5,200 family	\$1,000 individual \$2,000 family	\$7,200 individual \$14,400 family	\$3,350 individual \$6,700 family

Drug prices are for a 30 day supply.

* Copay is for any combination of services (primary care, specialist, urgent care). After three visits, future visits will be at full cost until the medical deductible is met.

** Price is after pharmacy deductible amount is met.

*** See plan Evidence of Coverage for imaging cost share.