

# Public Option in California

MARCH 2020

## Exploring the basics of health policy in California

In the final days of Congressional consideration of the Affordable Care Act (ACA), the debate centered on “public plan choice” – whether Americans under 65 who lack employment-based coverage should have the choice of enrolling in a new public health insurance plan modeled after Medicare.<sup>1</sup>

Although not included in the ACA, multiple states are currently considering or have adopted “public option” proposals. Several Presidential candidates also include a version of public option in their health care plans.

In his 2020-21 proposed budget Governor Gavin Newsom called for policy options to “strengthen enrollment, affordability, and choice in Covered CA,” (referred to in the budget as the state’s public option), as well as efforts “to leverage the statewide network of existing public Medi-Cal Managed Care Plans (MCPs).”

This issue of **ESSENTIALS** reviews, through a California lens, state-level public option concepts for coverage in the individual market.

## Overview

A public option is typically defined as a **publicly insured health plan in direct competition with other options for private health insurance coverage**. Public option proponents maintain that government-administered public plans offered in ACA exchanges (or potentially in some other form) will increase competition, resulting in both lower premiums overall and reduced underlying health care costs, as well as expanding transparency and choice of health plans for individuals purchasing exchange coverage.

While states explore the public option idea, most state-level proposals differ in scope and structure from this definition and the public option model contemplated during ACA deliberations.

States are considering (e.g., Colorado) or developing (e.g., Washington) **hybrid public-private partnership public options**, where state government takes a lead role in selecting, negotiating, and

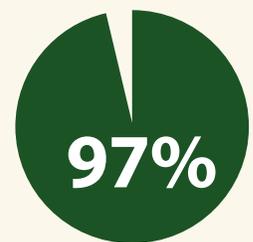
dictating the participation terms, beyond minimum ACA requirements, for some (or all) of the health plans competing in state ACA exchanges. States essentially characterize these hybrid programs as “public options” because of the substantive increase in state control over health plan participation and the competitive environment in the state exchange.

Importantly, California law already builds into Covered CA most of the features that other states include in their hybrid public options. Covered CA is an “active purchaser” exchange that selectively contracts with health plans meeting minimum standards and actively negotiates with potential plans on premiums, networks, and geographic coverage. In addition, Covered CA imposes additional contract requirements related to quality, performance, and public reporting.

## FAST FACTS

**1.5 million**  
Californian’s enrolled in  
**11**  
Covered CA health plans

**7.3 million**  
Medi-Cal enrollees in  
**15**  
local public plans



of local public plan enrollment is Medi-Cal

Sources: Covered CA, Department of Health Care Services and Department of Managed Health Care enrollment data

## DEFINITIONS

### Public Health Care Plan

Coverage option established, administered, and managed by a public, governmental entity.

### Public Option

A public health care plan offered in direct competition with other options for private health insurance coverage.

### Hybrid Public-Private Partnership

A public option model where the state government takes a lead role in selecting, negotiating, and dictating the participation terms, beyond minimum ACA requirements, for some (or all) of the public and private health plans competing in state ACA exchanges.

### Public Coverage Program

Coverage administered and funded by federal, state, or local government with established rules of eligibility, benefits, and provider payment rates. Public programs may contract with governmental (public) and/or non-governmental (private) health care plans to organize and deliver the services. In California, both Medi-Cal and Medicare contract with public and private health plans.

### Medi-Cal Managed Care Public Plans

Public health care plans that offer and manage coverage for eligible Medi-Cal beneficiaries. There are two types of local public plans in Medi-Cal: nine Local Initiative (LI) health plans in 13 counties and six County Organized Health Systems (COHS) serving 22 counties. For more on the models and profile of Medi-Cal public plans see Appendix A.

### Qualified Health Plan (QHP)

A health plan that meets federal and state requirements for participation in ACA exchanges.

## Federal Framework

Prior to the ACA, individual health insurance in most states, including California, were dominated by large statewide carriers that competed primarily on how well they were able to screen and select people based on their risk of incurring medical claims.

One of the primary goals of the ACA was to shift the focus in individual coverage away from risk selection to competition based on factors related to consumer value and quality. ACA provisions specifically aimed at changing the competitive dynamic in the individual health insurance market include:

- ▶ Requiring health plans to accept all applicants regardless of health status or expected costs;
- ▶ Prohibiting rate differentials based on health-related factors; and
- ▶ Requiring states to establish common geographic rating regions for all health plans.

In addition, the ACA further defined the terms of competition among health plans by establishing a consistent set of minimum “essential health benefits” and requiring products to be identified using predetermined actuarial values, referred to as coverage levels or “metal” tiers.<sup>2</sup>

Under the ACA, the federal government and many states, including California, established ACA marketplaces (exchanges) for individual (and small employer) coverage to offer competing health plans consistent with ACA policy goals. ACA exchanges serve as online marketplaces where individuals can purchase coverage, and receive federal subsidies if eligible, through public and private contracted health plans.

### Public Option and the ACA

During the national debate on the ACA, supporters of the public option envisioned a new public plan exemplifying the basic principles of Medicare – inclusive, affordable, transparent coverage with a broad choice of providers – that could both spur Medicare toward improved care delivery and cost containment and

ultimately light the way toward universal health care.

While there were multiple public option proposals at the time, key features included eligibility for individuals without other coverage to purchase the public option and federal responsibility to engage a contract administrator (for-profit or nonprofit depending on the proposal) to organize the provider network and negotiate provider rates. Some proposals set provider rate standards; for example, requiring that rates be no less than Medicare or no more than rates paid by other qualified health plans. Some proposals also deemed all Medicare providers as public option providers unless they opted out, while others made Medicare provider participation voluntary.

Proponents of the public option generally argue that a public option will improve health care coverage in two primary areas:

- ▶ **Lower costs.** This argument is that the public option will have inherent advantages that make it a lower-cost choice, including not having to pay profits, low overhead costs (e.g., no need for marketing), and enough enrollment to achieve volume discounts with providers. This view holds that healthy competition, with meaningfully different choices, will spur lower costs and improve quality in all health plans. Some public option proposals set provider rate standards in furtherance of this goal.
- ▶ **Public transparency and accountability.** This argument promotes the policy specifically because of the potential benefits of *publicly operated coverage*. These potential benefits include public governance, greater transparency and accountability, and the absence of shareholders or a profit motive. For some proponents of the public option, a primary benefit is the fact that the coverage is government-run, because in their view it will stand in stark contrast to privately administered health plans, giving consumers the opportunity to experience the benefits of public coverage.

From the beginning of the federal public option debate there was confusion not only about what a public option needed to look like but also what it would mean for the American health care system. Observers at the time acknowledged that one reason for the confusion, and resulting controversy, was that general outlines of how the public option would work were sometimes unclear, allowing both supporters and opponents to project their greatest fears and hopes onto the idea.

## State Framework

From the start, California's implementation of the ACA included significant changes to state law that exceed federal ACA requirements. Unlike the federal ACA exchange and most other state exchanges, Covered CA selects participating health plans through a competitive process. Selective contracting means that some health plans get contracts, while some do not.

California law specifically requires the exchange to choose health plans that "offer the optimal combination of choice, value, quality, and service."<sup>3</sup>

To accomplish this mandate, Covered CA negotiates with health plans on premium pricing, geographic coverage, and provider networks, along with additional quality and reporting requirements that provide consumers with information to compare health plans and provide Covered CA with leverage in contract negotiations.

For 2020 coverage, Covered CA selected 11 health plans representing a mix of major insurers and smaller companies, regional and statewide doctor and hospital networks, and for-profit and nonprofit plans.

California law also requires Covered CA to offer a choice of qualified health plans (QHPs) at each of the five ACA coverage tiers, and requires participating health plans to offer all five coverage tiers in each region they serve. California law imposes additional rules on product offerings for individual coverage outside the exchange.

Covered CA requires health plans to offer standard benefit designs to help consumers more easily compare coverage choices. Standard benefits eliminate cost-sharing as a feature of competition. With standard designs, health plans compete primarily based on price, provider networks, and quality.<sup>4</sup>

### California's Local Public Plans

California developed a network of local public health care plans to serve Medi-Cal recipients starting in the early 1980s. Local public plans are authorized in state law and established at the county level through local ordinance and/or joint powers agreements.

California's 15 local public plans contract with the state to provide services to Medi-Cal beneficiaries and operate in 35 California counties using two models – Local Initiative Health Plans (LIs) and County Organized Health Systems (COHS). In COHS counties, one countywide health plan serves as the single public plan for all Medi-Cal beneficiaries and in LI counties the local public plan competes with a commercial health plan. (See Appendix A for more on the state's local public health plans.)

Local public plans in California are publicly governed by bodies that typically include a mix of local elected officials and consumer and provider representatives, depending on the specific local plan authority and model. While local plans primarily serve Medi-Cal enrollees, they may also offer other lines of business, such as Medicare Advantage or health coverage for county employees.

As public entities, local public plans are more transparent than private plans because they are subject to California's open meeting laws, including public meetings, disclosure of financial performance, and public review of community investments. California developed local public plans in the Medi-Cal program both to embrace the potential benefits of managed care, but also to preserve the state's health care safety net, including public health systems and community clinics and health centers, as it expanded the reach of Medi-Cal managed care.

## THE CALIFORNIA STORY

Pre-ACA, the size and scale of California, including the geographic and health delivery system diversity that characterizes its numerous health care markets and regions, heavily influenced the development of public and private health plans in the state.

California has one of the highest managed care "penetration rates" (percent of the population enrolled in managed care) in the country, and some form of managed care (HMO, PPO, etc.) is nearly universal in public and private health care coverage. By way of illustration, 60 percent of Californians are enrolled in HMOs, compared to an average of 32 percent nationally.

The dominance of managed care in California extends to both Medicare and Medi-Cal and resulted in the state investing in an extensive network of local public plans to serve the Medi-Cal population.

California's successful implementation of the ACA built on its managed care history through formation of a dynamic state exchange marketplace, companion market rules for individual and small employer coverage that exceed federal requirements, and dramatic expansion of Medi-Cal enrollment and growth in the state's health care safety net.

California conducted extensive assessment and analysis of individual market conditions to develop the criteria and standards for its state exchange. Policymakers emphasized reducing premiums and promoting the ACA goal of shifting health plan competition away from risk and cost avoidance to competition-based on the features that matter most to consumers: price, provider network, and quality.

## Public Option Models

As stated above, states are currently exploring the public option primarily using a hybrid public-private partnership model. Figure 1 compares the two public option models on key features.

Figure 1. Comparison of Public Option Models		
Key Features		
	PUBLIC OPTION PLAN	PUBLIC-PRIVATE PARTNERSHIP
<b>Description</b>	Federal, state or local government organizes <i>and administers</i> an individual coverage option, contracting with providers directly or through an administrator, which then directly competes with private health plans in the market or exchange	Federal or state government selectively contracts with public and private health plans that meet additional state standards and goals beyond ACA requirements.
<b>Example</b>	No example nationally or in other states	<ul style="list-style-type: none"> <li>▪ Covered CA</li> <li>▪ Washington State Cascade Care (<i>implementation in process</i>)</li> </ul>
<b>Health Plan Premiums</b>	Set by the government agency administering the health plan	State entity or exchange negotiates premium rates with health plans by product and region, subject to state regulatory review.
<b>Participating Provider rates</b>	Provider rates may be set through contract negotiations and/or a fee schedule as in Medicare/Medicaid FFS.	<p><b>Covered CA</b> negotiates premium prices and health plans set provider rates through contracts.</p> <p><b>Cascade Care</b> will negotiate premiums and enforce minimum and maximum provider rates set by statute.</p>
<b>Benefits</b>	Minimum benefits set in law and regulation. Health plans may have to meet additional benefit standards.	<ul style="list-style-type: none"> <li>▪ Minimum benefits</li> <li>▪ Exchange sets benefit and cost sharing (standard benefit designs)</li> </ul>

## Public Option and Covered California

The California context for considering public plan choice is different than before the ACA and different than the 2009 debate surrounding a national public option.

In the 2018 [issue brief](#) on the public option, ITUP identified unique characteristics of California's health care system that need to be considered in thinking about how public plan choice might be expanded in the state:

- ▶ **Covered CA as active purchaser.** As described above, Covered CA already selectively contracts with health plans and actively negotiates with potential health plans on premiums, networks, geographic coverage, and quality. In addition, two local public plans offer coverage in Covered CA.<sup>5</sup>
- ▶ **Strong consumer protections.** California has some of the strongest consumer protection laws and health

plan regulations in the country. QHPs in Covered CA and Medi-Cal managed care plans (other than COHS plans) must meet extensive state licensing requirements affecting benefits, financial solvency and capacity, network adequacy, consumer disclosure, consumer appeals, and review of quality and utilization management systems.

- ▶ **Provider shortages and lack of competition.** In many underserved areas of California, particularly remote and rural areas, there are severe provider shortages and often fewer health plan choices than other regions. Geographic inaccessibility, provider shortages, and provider concentration within markets can make it challenging for health plans, public or private, to develop an adequate network. Lack of competition can lead to higher provider prices, increasing premiums.

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*Other states implementing a "public option" approach are focused on accomplishing many of the goals California has already prioritized in the structure and practices of Covered CA.*

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- ▶ **Network of local public plans.** California's extensive network of local public plans is unique and potentially offers existing models and lessons to inform discussion of broader public plan choice.

► **State safety net linked to local public plans.** In implementing Medi-Cal managed care, the state specifically ensured that local public plans include public and private safety net providers.<sup>6</sup> This strong partnership continues. For example, the Department of Health Care Services reported that between September 2013 and April 2015 60 percent of Medi-Cal enrollment growth in local public plans was attributed to safety-net clinics, compared to 42.2 percent in commercial plans participating in Medi-Cal.<sup>7</sup>

**Covered CA and the Hybrid Public-Private Partnership Option**

States now exploring the public option are moving toward the type of public-private partnership model that has characterized Covered CA from its inception.

Appendix B compares Covered CA to Washington state Cascade Care on key features. The comparison reveals the following:

► Covered CA has similar features to Cascade Care except that it does not have the authority to set or enforce provider rate standards, which will be a feature of Cascade Care. Covered CA health plan premium negotiation is the mechanism Covered CA uses to impact premiums and the underlying provider rates.

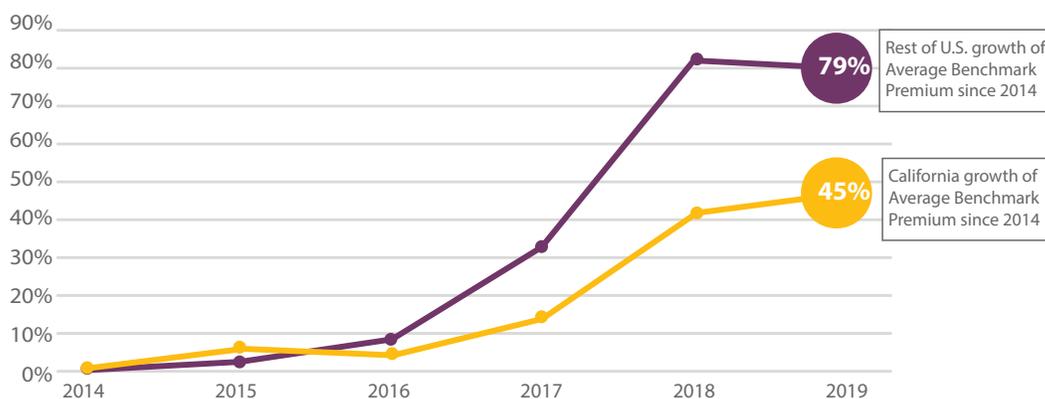
- Cascade Care is a program administered separate from the state exchange, Washington State Health Benefits Exchange (WAHBE), and will only contract with a subset of QHPs in the exchange to qualify as “public option plans.” Covered CA selectively contracts with and imposes its standards and requirements on all participating QHPs.
- California law is more prescriptive than Washington state in the levels of coverage health plans must offer inside and outside of the exchange.
- Covered CA limits product offerings to its standardized benefit designs, while public option QHPs in Washington State and other health plans in WAHBE will still be able to offer other non-standard products until 2025, contingent on further state legislation.
- In 2020, California implemented state-supported financial assistance for individuals up to 600 percent of the federal poverty level (FPL), (\$154,500 for a family of four) while Washington State will report to the legislature in November 2020 on a plan to implement state assistance up to 500 percent FPL.
- Covered CA has extensive quality and reporting standards enshrined in Attachment 7 to the QHP contract. A preliminary review of proposed Cascade Care standards suggests

Washington state standards are likely to be less rigorous than Covered CA in the first year.

**Premiums and Provider rates.** Cascade Care requires public option QHPs to pay providers in the aggregate no more than 165 percent of what Medicare would have paid for the same services, to pay primary care providers no less than 135 percent of Medicare, and to pay rural hospitals no less than 110 percent of costs. Washington estimates that implementation of Cascade Care will save 5-10 percent on premiums, attributed primarily to the cap on provider rates.

While California law does not cap or otherwise establish provider rates, as an active purchaser, Covered CA has negotiated lower premiums than the average experience nationwide as shown in Figure 2. Covered CA has also constrained premium rate increases by prioritizing healthy and stable enrollment through extensive marketing and outreach, including requiring participating QHPs to individually invest in marketing and outreach.

**Figure 2. Covered California Average Benchmark Rate v. National Average**



Source: Covered CA analysis of Center for Medicare and Medicaid Services (CMS) Data. Retrieved from <https://www.cms.gov/>

## Policy Questions

This section highlights several policy questions as California considers next steps to strengthen the state's public-private partnership public option, Covered CA.

### ► **Unclear Goal of Public Option**

**Strategy.** Fundamentally, there are two threshold issues in considering further efforts on public plan choice in California: (1) what are the problems that policymakers are trying to solve and (2) in what ways is expanded public plan choice a workable and effective solution to the problems? Activities of other states exploring the public option reveal that most are implementing a “public option” approach to accomplish many of the goals California has already included in the structure and practices of Covered CA. To most effectively implement additional public plan features or programs, it will be important to identify the goals for doing so and tailor state policies to accomplish those specific goals.

### ► **Unknown Impact of Provider Rate Setting.** The major difference between Covered CA and Cascade Care is the Washington provision capping provider rates benchmarked to

Medicare. As of this writing, no state level data exists to determine how Covered CA health plan provider rates compare to Medicare, or what impact provider rate standards might have on premiums, networks, or access. A 2019 review of insurer payments to hospitals found that California hospitals averaged more than double Medicare payments in 2015 and 2016. However, there was a wide range, with some hospitals being paid at 300 percent of Medicare while others, primarily public hospitals, were paid less than Medicare rates.<sup>8</sup> The available data was also not specific to Covered CA.

As a starting point, policymakers may want to get additional information on existing provider rates paid by Covered CA health plans. This could be accomplished by Covered CA health plans reporting to an independent outside consultant which publicly provides the data in the aggregate.

### ► **Role of Local Medi-Cal Plans.** The ITUP 2018 public option [issue brief](#) includes an extensive analysis of the potential reasons why only two of the state's local health plans currently participate in Covered CA. Policymakers might

want to revisit the business decisions local health plans are making and consider what would be needed to encourage greater participation in Covered CA. If analysis determines that local health plans would be able to offer lower rates to justify the effort, state policymakers or private foundations might consider providing one-time start-up funds to support them coming into compliance with the requirements of Covered CA.

However, the state is actively engaged in efforts to transform Medi-Cal through CalAIM. What are the trade-offs related to diverting local health plan time, attention, and resources to entering the individual market?

At the same time, Medi-Cal reform could present opportunities to coordinate standards and reporting between Medi-Cal and Covered CA, in ways that would facilitate future participation by local public plans in the exchange, without relaxing the landmark quality improvement efforts of Covered CA.

Do California's local public plans have the capacity to expand beyond Medi-Cal? What would be the impacts on Medi-Cal access and quality?

## Conclusion

The origin of the public option model dates to the federal debate on the ACA. However, policy options that seem feasible and desirable on a national scale may require significant modification to be workable at the state level or may not be viable for states to successfully implement.

Other states that are exploring public options are increasingly considering hybrid public-private partnerships that mirror many of the existing statutory and program elements Covered CA is already implementing.

This means that the starting point for consideration of public plan choice in California is different than any other state. Policymakers will need to evaluate which options for California can most effectively build on the successes of Covered CA.

For more in-depth analysis on the public option in California, including issues surrounding expansion of Medi-Cal local public plans into the individual market, see the March 2018 [issue brief, \*Exploring Public Options in California\*](#).

## Acknowledgements

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## Notes

1. Helen A. Halpin and Peter Harbage, "[The Origins and Demise of the Public Option](#)," Health Affairs 29, No. 6 (2010): 117-1124.
2. ACA coverage levels are based on actuarial value (the percent of covered benefits paid for by the health plan versus costs borne by the consumer) as follows: Platinum (90%), Gold (80%), Silver (70%) and Bronze (60%). The fifth level, the catastrophic plan, has significantly higher cost sharing and is limited to specific qualifying individuals.
3. California Government Code Section 100503 (c).
4. Swartz, Katherine, Mark Hall and Timothy Jost, [How Insurers Competed in the Affordable Care Act's First Year, Prepared for the Commonwealth Fund](#), June 24, 2015.
5. LA Care (LA Care Covered), a Medi-Cal LI, and Santa Clara Valley Health Plan (Valley Health Plan) operated by Santa Clara County, participate in Covered CA. Contra Costa Health Plan, a Medi-Cal LI, participated in Covered California in 2014 enrolling just over 1,000 individuals. Contra Costa withdrew in 2015 stating that it would be too costly for them to offer the same individual coverage product inside and outside the exchange as required in federal rules.
6. Tim Reilly, Bobbie Wunsch, and Steven Krivit, "[California's Local Community Health Plans: A Story of Cost Savings, Quality Improvement, and Community Leadership](#)," January 2010.
7. California Department of Managed Health Care (DMHC), "[Financial Summary of Medi-Cal Managed Care Health Plans – Quarter Ending June 30, 2017](#)."
8. Richard Kronick and Sara Hoda Neyaz, [Private Insurance Payments to California Hospitals Average More than Double Medicare Payments](#), West

Health Policy Center, May 20, 2019.

## Resources

Insure the Uninsured Project (ITUP), [Exploring Public Options in California](#), March 2018.

Covered California, [Covered California's First Five Years: Improving Access, Affordability, and Accountability](#), December 2019.

Covered California, [Plan Management and Delivery Systems Reform Stakeholder Advisory Group](#), online resources.

Kaiser Family Foundation, [10 Key Questions on Public Option Proposals](#), December 2019.

Washington State Health Care Authority, [Cascade Care](#), online resources.

## 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.*

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- California Community Foundation
- California Health Care Foundation
- Kaiser Permanente
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**Appendix A. Profile of Local Health Plans in California**  
**State Licensure and Medi-Cal Enrollment, by Plan and Model Type, 2019**

<b>LOCAL INITIATIVE (LI) HEALTH PLANS</b> (9 PLANS, 13 COUNTIES)	<b>LICENSED LINES OF BUSINESS</b>	<b>MEDI-CAL ENROLLMENT</b> (NOVEMBER 2019)	<b>MEDI-CAL PENETRATION</b>
<b>Authorized in state law and established by county ordinance and/or joint powers agreement, LIs participate in the “Two-Plan model” of MCMC, serving as the public plan choice alongside a commercial, non-governmental health plan</b>	LIs must be state-licensed under the Knox-Keene Act for Medi-Cal, and any other lines of business they offer, under the jurisdiction of the Department of Managed Health Care (DMHC)	Total Statewide LI Enrollment  5,048,912	Statewide, <b>75%</b> of Medi-Cal Managed Care enrollees in Two-Plan counties are enrolled in the LI. Most but not all Medi-Cal recipients must enroll in one of the two plans
<b>Alameda Alliance for Health</b>	Medi-Cal In-Home Supportive Services (IHSS)	Alameda 244,385	81%
<b>Contra Costa Health Plan</b>	Medi-Cal IHSS Medicare Advantage, County Employees	Contra Costa 172,122	87%
<b>CalViva Health</b>	Medi-Cal	Fresno 285,402	73%
		Kings 29,448	61%
		Madera 37,266	66%
<b>Kern Family Health</b>	Medi-Cal	Kern 259,069	80%
<b>LA Care</b>	Medi-Cal Cal MediConnect/ Medicare Advantage IHSS Covered California	Los Angeles 2,011,138	68%
<b>Inland Empire Health Plan</b>	Medi-Cal Cal MediConnect/Medicare Advantage	Riverside 606,956	91%
		San Bernardino 613,482	68%
<b>San Francisco Health Plan</b>	Medi-Cal IHSS Healthy Kids	San Francisco 125,966	88%
<b>Health Plan of San Joaquin</b>	Medi-Cal Medi-Cal Access Program (AIM)	San Joaquin 207,466	91%
		Stanislaus 127,378	68%
<b>Santa Clara Family Plan</b>	Medi-Cal Cal MediConnect/ Medicare Advantage Healthy Kids	Santa Clara 236,966	79%

**Appendix A. Profile of Local Health Plans in California**  
**State Licensure and Medi-Cal Enrollment, by Plan and Model Type, 2019**

<b>COUNTY ORGANIZED HEALTH SYSTEM (COHS)</b> (6 PLANS, 22 COUNTIES)	<b>LICENSED LINES OF BUSINESS</b>	<b>MEDI-CAL ENROLLMENT</b> (NOVEMBER 2019)	<b>MEDI-CAL PENETRATION</b>
<b>One countywide public health plan authorized in federal and state law serves as the single health plan for all Medi-Cal beneficiaries in the counties they serve</b>	State law exempts COHS plans from licensure for Medi-Cal. This column generally shows their non Medi-Cal lines of business licensed by DMHC.	<b>Total Statewide COHS Enrollment</b>  5,048,912	COHS plans enroll all Medi-Cal managed care enrollees in the counties served with a few exceptions
<b>CalOptima</b>	Medicare Advantage Cal MediConnect Program of All-Inclusive Care for the Elderly	Orange – 715,592	“
<b>CenCal</b> (Santa Barbara Health Authority)	AIM	San Luis Obispo – 50,827	“
		Santa Barbara – 122,985	“
<b>Central California Alliance for Health</b> (Santa Cruz, Monterey, Merced Mgd Care Commission)	IHSS and AIM	Merced – 120,125	“
		Monterey – 148,602	“
		Santa Cruz – 64,312	“
<b>Gold Coast Health Plan</b> (Ventura County Health Plan)	Large and small group commercial	Ventura – 192,824	“
<b>Health Plan of San Mateo</b>	Medi-Cal (licensed voluntarily) IHSS Healthy Kids Medicare Advantage County Coverage Program	San Mateo – 100,483	“
<b>Partnership HealthPlan</b>	Previously licensed for Healthy Kids programs which are no longer active	Del Norte – 11,073	“
		Humboldt – 51,820	“
		Lake – 29,484	“
		Lassen – 7,086	“
		Marin – 36,703	“
		Mendocino – 35,279	“
		Modoc – 31,98	“
		Napa – 27,655	“
		Shasta – 58,308	“
		Siskiyou – 16,859	“
		Solano – 104,395	“
		Sonoma – 102,174	“
		Trinity – 4,096	“
Yolo – 49,922	“		

Sources: California Department of Health Care Services; California Department of Managed Health Care; Local Health Plans of California. Chart Prepared by ITUP.

### Appendix B. Comparison of Covered California and Washington Cascade Care, Selected Features

PROGRAM	WASHINGTON (WA) STATE CASCADE CARE (SENATE BILL 5526, CHAPTER 364 OF 2019)	CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CA)
<b>Contracting Entity</b>	Starting in 2021, the WA Health Care Authority (HCA) will establish Cascade Care as a “public option” to compete with other individual health plan offerings in the Washington Health Benefit Exchange (WAHBE) (ACA marketplace).	California established Covered California as the state’s ACA exchange for individual and small group coverage. Covered CA began offering coverage for the 2014 coverage year.
<b>Agency Role in State Government</b>	HCA serves as the state Medicaid agency and is also the agency responsible for offering health benefits to public employees and teachers.  The WAHBE is established in state law as a public-private partnership “separate and distinct from state government” governed by an 11-member bipartisan board.	Covered California administers the state’s ACA exchange but no other state programs.  Exchange created in state government as “an independent public entity not affiliated with an agency or department,” governed by a five-member board appointed by the legislature and the governor. [CA Government Code §100500]
<b>Contracting Authority</b>	HCA, in consultation with the state exchange, must contract with one or more “health carriers,” to be offered as public option qualified health plans (QHPs) in WAHBE, in addition to other QHP offerings. Goal is to have a choice of QHPs in every county.	Requires exchange to “selectively contract” with carriers (health plans and insurers) providing health care coverage choices that offer “the optimal combination of choice, value, quality and service.” [CA Government Code (GOV) §100503]
<b>Minimum Requirements for Health Plans</b>	Cascade Care carriers must meet federal standards for QHPs, certification requirements set by WAHBE and additional requirements for Cascade Care set forth in SB 5526.  <i>Public option</i> QHPs in Cascade Care are defined as QHPs that have a standard benefit design and meet the additional quality and value requirements.	Covered CA health plans must meet federal QHP standards, Covered CA certification standards and be in good standing with respective licensing agency, Department of Managed Health Care or the California Department of Insurance [GOV §100507].
<b>Benefit Design</b>	Effective January 1, 2021, WAHBE will create <a href="#">standardized benefit designs</a> at the “bronze,” “gold” and “silver” coverage levels, as defined in federal law.	Covered CA is authorized but not required to adopt standardized benefit designs. Since its inception, Covered CA has required all participating QHPs to offer only its approved <a href="#">standardized benefit designs</a> .
<b>Product Offerings</b>	<b>Public option QHPs</b> must offer at least one coverage plan in each of the three standardized coverage levels.  QHPs not contracted as public option plans ( <b>standard QHPs</b> ) must offer at least one standard gold and silver plan, and if the carrier offers bronze, one standardized bronze plan, but may also offer other non-standard products in any coverage level.	Covered CA health plans must offer at least one product in each of the five federally defined ACA coverage levels (four metal tiers plus catastrophic). [GOV §100507].  In the outside individual market, non-exchange carriers must only offer the four coverage levels, must offer at least one standardized design in each of the four metal tiers, and may not offer catastrophic coverage.

Appendix B. Comparison of Covered California and Washington Cascade Care, Selected Features		
PROGRAM	WASHINGTON (WA) STATE CASCADE CARE (SENATE BILL 5526, CHAPTER 364 OF 2019)	CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CA)
<b>Provider Rates</b>	<p>Caps aggregate provider reimbursements (excluding pharmacy) paid by public option QHPs at no more than 160% of what Medicare would have paid providers for the same services. Sets minimum rates for primary care services (no less than 135% of Medicare) and rural hospitals (no less than 101% of costs).</p> <p>HCA has authority to waive these requirements if it determines a carrier is “unable to form a provider network that meets state network access standards.” HCA will also address pharmacy costs in standards for public option QHPs.</p>	<p>No similar provision. State law does not set minimum or maximum provider payment levels for coverage inside or outside of the exchange.</p> <p>There is currently no state-level data available on provider rates paid by Covered CA health plans to support a meaningful comparison with Medicare reimbursement rates.</p> <p>As an active purchaser, Covered California premium negotiations may put downward pressure on health plan costs, including provider reimbursement, for all participating health plans.</p>
<b>Health Plan Accountability</b>	<p>Public option QHPs must adhere to additional quality and value requirements beyond basic WHBE conditions of participation in addition to the standardized benefit designs.</p> <p>Requires public option QHPs to meet “additional participation requirements to reduce barriers to maintaining and improving health and align to state agency value-based purchasing.”</p> <p>Public option QHP standards are outlined in the <a href="#">Request for Applications</a> released by HCA.</p>	<p>Covered CA has broad authority to set minimum participation, criteria and contract standards “in the best interests of individuals and employers.”</p> <p>Covered CA imposes extensive reporting and quality standards in QHP contracts. <a href="#">Attachment 7, Quality, Network Management, Delivery System Standards and Improvement Strategy</a>, adds nine detailed articles, including among other elements, standards for value-based networks, quality improvement, network management and delivery system reform. Covered CA is currently working with stakeholders on a refresh of Attachment 7.</p>
<b>State Financial Assistance</b>	<p>Enabling statute requires WAHBE to submit a plan by November 1, 2020 to implement state premium subsidies for individuals up to 500 percent of the federal poverty level (FPL), with the goal of limiting premiums to no more than 10 percent of an individual’s adjusted income.</p>	<p>In 2019, California established new state premium subsidies for individuals with incomes up to 600 percent FPL. For 2020, consumer premiums are capped at 6-10 percent of income for individuals with incomes 200-400 percent FPL, and 10-18 percent for individuals with incomes 400-600 percent FPL.</p>
<b>Projected Savings</b>	<p>The state estimates that public option QHPs will save 5-10% in premiums compared to non-public option QHPs, largely due to capping provider reimbursement.</p>	<p>In its <a href="#">five-year report</a>, Covered CA estimated that it likely saved enrollees and the U.S. Treasury an estimated \$12.5 billion over the past five years.</p>

Sources: WA state [Senate Bill 5526, Chapter 364 of 2019](#), CA GOV §100500-100725. Chart prepared by ITUP.