ITUP Insure the Uninsured Project

Issue Brief

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Exploring Public Options in California

Key Issues and Considerations

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This report explores public plan choice, often referred to as the "public option," through a California lens. This report highlights for policymakers and stakeholders the issues and options related to public plan choice given California's unique history, delivery system, health insurance landscape and health reform experience. To help frame the policy conversation, this report identifies how a public option might be developed in California and, through scenario-based analysis, identifies key issues and questions that will need to be addressed.

Introduction

California remains focused on protecting existing health care programs on the one hand, while continuing to advance state-based reforms on the other. California policymakers are considering state-level proposals to improve health care and coverage, from incremental coverage expansions for the remaining uninsured to large-scale system change, such as enactment of a state single payer program.

As part of the current health reform debate, California policymakers and stakeholders are exploring whether the state can (or should) adopt a form of public option, similar to proposals Congress rejected in the lead up to the ACA. While there is energy and enthusiasm for the public option among many California stakeholders, there are also very different views as to what it would look like or accomplish. This report underscores the unique character and structure of public and private health care in California and how it will impact the advisability and feasibility of a state public option. Section 5 offers principles for policymakers to consider as they evaluate public options for California, including setting clear goals and expectations for the policy changes.

Fundamentally, there are two threshold issues in considering implementation of public plan choice in California: (1) what is the problem that policymakers are trying to solve and (2) in what ways is expanded public plan choice a workable and effective solution to the problem?

I. PUBLIC PLAN CHOICE AT THE FEDERAL LEVEL (Pre-ACA)

As Congress was considering legislative proposals leading to passage of the ACA, debate in the final days centered on the issue of "public plan choice" – whether Americans younger than 65 who lack employment-based coverage should have the choice of enrolling in a new public health insurance plan modeled after Medicare.[1] Although present in several interim bills and November 2009 legislation passed by the U.S. House of Representatives, Congress omitted the public option from the ACA bill package finally passed by both houses and signed by President Obama in March 2010.

From the beginning of the 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.[2] 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.[3] In addition, observers recognized the public option was a highly visible symbol of the deep divide on the proper role of government in achieving universal coverage, which characterized the broader health reform debate, as well as prior national health reform debates over many decades.[4]

Advocates for public plan choice, also known as the public option, promote it as *a publicly insured plan in direct competition with other options for private health insurance coverage*, with the hope that the features of a publicly sponsored option, and the competition it would bring to markets, will drive down both premiums and underlying health care costs.[5]

Proponents believe 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 sufficient enrollment to achieve volume discounts with providers.[6] Another stated intent of the public option is to replace "unhealthy" market competition, in which health plans compete to attract the healthiest individuals, with "healthy" competition based on a broader set of plan features.[7] This view holds that healthy competition, with meaningfully different choices, would spur lower costs and improve quality. In addition, many proponents of public plan choice promote the policy specifically because of the benefits they see in *publicly operated* coverage. These benefits include, in their view, public governance, greater transparency and accountability, and the absence of shareholders or a profit motive.

During the national debate, supporters 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 security.[8]

For background and illustration, the section below highlights features of two competing versions of the public option considered by Congress in 2009.

Congressional Public Option Proposals (2009)

On November 7, 2009, the U.S. House of Representatives approved the H.R. 3962, the Affordable Health Care for America Act (House version) and on November 21, 2009 the majority leader of the Senate, Senator Harry Reid, introduced S.Amdt. 2786 to H.R. 3590 (Senate amendment). Both bills included language for a public option.[9]

The two bills would give the Secretary of Health and Human Services start-up funding and authority to enter into contracts for the establishment and administration of a public option. The Secretary would establish geographically adjusted premiums to cover medical claims, administration, a contingency margin (reserves for anticipated claims), and repayment of start-up funds.

The Senate amendment would allow states to opt out of offering the public option on the state exchange. The House version did not allow states to opt out. Both bills would require the public option to, at a minimum, offer the same benefits as in the exchange, as specifically defined in each bill, and the Senate amendment allowed states with the public option in the state exchange to require coverage of additional benefits in the public plan.

Other key provisions include:

- ***Eligibility.*** Individuals eligible for the exchange, including those eligible for exchange subsidies, could choose the public option in both versions.
- ***Contract administrator.*** The Senate amendment set criteria for the contract administrator, including that it must be competitively bid and a nonprofit entity. If the administrator was a for-profit entity, the administrator would be required to repay any start-up funds and would be permanently prohibited from offering a qualified health plan (QHP) on the exchange. There was no similar provision in the House version.
- ***Provider network.*** In the House version, the provider network for the public option would be established through deeming Medicare providers to be in the public plan, unless they opted out, and providers could participate as both preferred or non-preferred providers. The Senate amendment specified that providers would voluntarily participate in the public option with no comparable provision relating to preferred providers.
- ***Provider payment rates.*** The Secretary would negotiate provider payment rates in both bills. In the House bill, rates could not be lower than Medicare rates or higher than average rates paid by qualified health plans (QHPs) in the exchange. Under the Senate amendment, rates could be no higher than average QHP rates.
- ***Consumer protections.*** Under the House version, enrollees would have access to the federal courts for the enforcement of rights as in Medicare, while under the Senate amendment the consumer protection laws of each state would apply to the public option. The amendment required states that did not opt out to establish a State Advisory Council to advise the Secretary on the operation of the public option.

- ***Federal funding.*** The House version prohibited the public option from receiving federal funds if it became insolvent. The Senate amendment required the public option to meet state solvency standards, as well as new federal solvency standards to be established by the Secretary. In the event of the plan's insolvency, the Senate amendment required the President to submit federal legislation that would remedy the insolvency and Congress would have to consider the proposal.

A preliminary Congressional Budget Office (CBO) analysis of the public option included in the House version in 2009 (H.R. 3962) underscores the multiple complex factors that determine whether a public option will succeed in offering a less costly coverage choice. CBO concluded:

> *… a public plan paying negotiated rates would attract a broad network of providers but typically have premiums somewhat higher than the average premiums for the private plans in the exchanges. The rates the public plan pays to providers would, on average, probably be comparable to the rates paid by private insurers participating in the exchanges. The public plan would have lower administrative costs but would probably engage in less management of utilization by its enrollees and attract a less healthy pool of enrollees …*[10]

II. THE CALIFORNIA CONTEXT FOR PUBLIC PLAN CHOICE

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 is nearly universal in public and private health care coverage. For example, 60 percent of Californians are enrolled in HMOs, compared to an average of 32 percent nationally.[11]

California's successful implementation of the ACA included formation of a dynamic state exchange marketplace, companion market rules for individual and small employer coverage that exceed federal requirements, along with dramatic expansion of Medi-Cal enrollment and growth in the state's health care safety net. Because of this, 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. It is also generally true that policy options that may be 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.

Finally, federal policy and federal funding play a significant role in how states like California can organize, deliver and pay for health care, making it challenging to contemplate major health system changes absent a constructive and collaborative relationship with federal health officials. The current Administration in Washington has different priorities and focuses on different strategies, including efforts to rollback existing health care programs and reforms. The new federal context will limit what

California can do to expand public health plan choice in the near term, likely necessitating significant state investment to move forward, with little additional federal support or flexibility.

California Characteristics Relevant for Designing Public Options

This section highlights California-specific factors that will influence options the state has to expand public plan choice and identifies key policy questions. Unique California characteristics include:

- ***Active purchaser exchange.*** Unlike most other state exchanges, Covered California is authorized to select participating health plans through a competitive process. State law specifically requires the exchange to contract with health plans that "offer the optimal combination of choice, value, quality, and service." The exchange enabling statute also requires Covered California to offer a choice of qualified health plans (QHPs) at each of the five coverage levels in each region of the state. For each coverage year, Covered California selectively contracts with health plans that meet state and federal QHP requirements, and actively negotiates with potential plans on premiums, networks and geographic coverage. In addition, Covered California health plan contracts impose contract requirements adopted by the independent Covered California Board related to quality, performance and public reporting. As authorized in California law, Covered California also requires health plans to offer standard benefit designs to help consumers more easily compare available QHPs on price, networks, and quality.

  Question: Will additional public plan choices in the exchange offer lower premiums and introduce additional competition to drive down overall premiums beyond what Covered California has accomplished as an active purchaser?

- ***Existing network of local public health plans.*** California developed a network of local public health plans to serve Medi-Cal recipients starting in the early 1980s. Local health plans are authorized in state law and established at the county level through local ordinances and/or joint powers agreements. California's local public plans contract with the state to provide services to Medi-Cal beneficiaries and operate in 35 California counties in two models – Local Initiative Health Plans (LIs) and County Organized Health Systems (COHS). In COHS counties, one county-wide health plan serves as the single public plan for all Medi-Cal beneficiaries and in LI counties a local public plan competes with a commercial health plan. Local public plans in California are publicly governed with governing bodies that typically include a mix of local elected officials and consumer and provider representatives, depending on the specific local plan authority and model. As public entities they are more transparent than private plans subject to California's open meeting laws, including public meetings, disclosure of financial performance and public review of community investments. In many respects, the Med-Cal managed care (MCMC) program, especially in Two-Plan model counties, already embodies a form of public plan choice.

Question: Do California's local public plans have the capacity to expand beyond Medi-Cal, or to serve additional geographic regions, and with what impacts on access and quality in the Medi-Cal program?

- ***Strong California standards and consumer protections.*** California has some of the strongest consumer protection laws and health plan regulations in the country, including individual and small group market rules that exceed federal ACA requirements. Under the Knox-Keene Health Care Service Plan Act (Knox-Keene), the Department of Managed Health Care (DMHC) licenses health plans and enforces standards related to minimum and essential benefits, financial solvency and capacity, network adequacy, consumer disclosure, grievances and appeals, and review of quality and utilization management systems. The California Department of Insurance (CDI) enforces the same market rules in the individual and small employer markets, including essential health benefits, and regulates insurer solvency, network adequacy, claims payment and appeals, and market conduct. To participate as a qualified health plan in Covered California health plans must be licensed by DMHC or certificated by CDI. In the Medi-Cal program, LIs must be licensed under Knox-Keene but COHS plans are exempt from licensure unless they choose to voluntarily apply.

  Question: If California expands public plan choice to compete with private health plans, should publicly sponsored plans meet the same standards and follow the same rules as private health plans operating in those markets?

- ***California communities with severe provider shortages and lack of competition.*** In many underserved areas of California, particularly remote and rural areas, consumers have only one or two health plan choices in the exchange, and also may have limited choice in employer and other private coverage, often leading to premiums much higher than other regions of the state. For 2018, Covered California has approximately 213 zip codes and partial zip codes (or approximately 8 percent of zip codes in California) with only one health plan. Five percent of Covered California enrollees (66,000 individuals) have one health plan choice.[12] Covered California consumers experiencing a premium increase can often select another health plan in the same region to reduce costs. However, in areas with limited health plan choice, such as the rural North, consumers can still face significant premium increases even if they switch to another plan in the region. Geographic inaccessibility, provider shortages and provider concentration within markets can make it challenging for health plans to develop an adequate network and/or lead to high provider prices, increasing premiums and potentially motivating health plans to leave the area.

  Question: Will publicly sponsored plans effectively overcome the barriers in underserved areas that currently lead to limited health plan choice and higher premiums?

- ***State safety net linked to public health plans.*** California developed local public health plans in the Medi-Cal program in part to embrace the potential benefits of managed care, while preserving the state's health care safety net, including public health systems and community clinics and health centers. From the beginning in the 1980s, COHS plans included all willing and qualified Medi-Cal providers in the counties served, including safety-net hospitals and clinics. In the early 1990's, with state policymakers committed to expanding MCMC beyond COHS counties, the Department of Health Services (DHS at the time) proposed the "Two-Plan managed care model in counties with public hospitals and county-operated ambulatory care clinic networks. The Local Initiative developed in Two-Plan counties was specifically designed to incorporate public and private providers to maintain the vibrancy of the safety net.[13] This strong partnership between safety-net providers and local public plans continues. For example, the Department of Health Care Services (DHCS) 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 MCMC plans.[14]

  Question: As California explores public plan choice, what are the potential benefits or risks in terms of funding and viability of the state's safety net?

Local Public Plans in California

California's local health plans serve a majority of Medi-Cal beneficiaries enrolled in MCMC. COHS plans enroll all MCMC enrollees in the counties served. As of December 2017, 2.2 million Medi-Cal enrollees are enrolled in six COHS plans in 22 counties (17 percent of Medi-Cal beneficiaries). LIs participate in the "Two-Plan model" of MCMC, where they serve as the public plan choice in a county alongside a commercial, non-governmental health plan. There are more than five million Medi-Cal enrollees in nine LIs in 13 counties (37 percent of Medi-Cal beneficiaries). Statewide, 75 percent of MCMC enrollees in Two-Plan counties are enrolled in the LI.[15]

While local plans primarily serve Medi-Cal enrollees, they may also have other lines of business such as Medicare Advantage and health coverage for county employees. Local plans that administer the Cal-MediConnect program, a three-year demonstration project to improve care coordination for individuals with both Medi-Cal and Medicare coverage who enroll voluntarily, compete for enrollment with other Medicare options available to potential enrollees, including Medicare Advantage. Table 1 profiles California's existing local health plans including the lines of business each plan offers and MCMC enrollment.

Table 1

Profile of Local Health Plans in California

State Licensure and Enrollment, by Plan and Model Type, 2017

Local Initiative (LI) Health Plans (9 plans, 13 counties)	Lines of Business[16 17] **(as of January 2017)**	Enrollment[18] **(December 2017)**	Penetration[19]
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	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** **5,083,549**	Statewide, 75% 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
Alameda Alliance for Health	Medi-Cal, In-Home Supportive Services (IHSS)	264,480	80%
Contra Costa Health Plan	Medi-Cal, IHSS, Medicare Advantage, County Employees	182,985	87%
CalViva Health	Medi-Cal	Fresno – 299,170	73%
		Kings – 27,661	58%
		Madera – 36,532	66%
Kern Family Health	Medi-Cal	248,244	77%
LA Care	Medi-Cal, Cal MediConnect/ Medicare Advantage, IHSS, Covered California	2,057,191	67%
Inland Empire Health Plan	Medi-Cal, Cal MediConnect/ Medicare Advantage	Riverside – 601,361	87%
		San Bernardino – 623,542	89%
San Francisco Health Plan	Medi-Cal, IHSS, Healthy Kids	133,936	87%
Health Plan of San Joaquin	Medi-Cal, Medi-Cal Access Program (AIM)	San Joaquin – 219,589	91%
		Stanislaus – 129,418	64%
Santa Clara Family Plan	Medi-Cal, Cal MediConnect/ Medicare Advantage, Healthy Kids	259,440	78%

Table 1
Profile of Local Health Plans in California
State Licensure and Enrollment, by Plan and Model Type, 2017

County Organized Health System (COHS) (6 plans 22 Counties)	Lines of Business[20 21] **(as of January 2017)**	Enrollment[22] **(December 2017)**	Penetration[23]
One county-wide health plan authorized in federal and state law serves as the single public plan for all Medi-Cal beneficiaries	State law exempts COHS plans from licensure for Medi-Cal but no other lines of business	**Total Statewide COHS Enrollment 2,177,868**	COHS plans enroll all Medi-Cal managed care enrollees in the counties served with a few exceptions
CalOptima	Medicare Advantage, Cal MediConnect, Program of All Inclusive Care for the Elderly	767,433	"
CenCal	AIM	San Luis Obispo – 54,202	"
		Santa Barbara – 125,435	"
Central California Alliance for Health	IHSS and AIM	Merced – 126,304	"
		Monterey – 155,564	"
		Santa Cruz – 68,410	"
Gold Coast Health Plan		202,817	"
Health Plan of San Mateo	Medi-Cal (voluntarily), IHSS, Healthy Kids, Medicare Advantage, County Coverage Program	109,842	"
Partnership HealthPlan	Previously licensed for Healthy Kids programs which are no longer active	Del Norte – 11,430	
		Humboldt – 52,273	"
		Lake – 30,928	"
		Lassen – 7,423	"
		Marin – 39,266	"
		Mendocino – 38,452	"
		Modoc – 3,121	"
		Napa – 28,526	"
		Shasta – 59,282	"
		Siskiyou – 17,435	"
		Solano – 110,513	"
		Sonoma – 111,399	"
		Trinity – 4,321	"
		Yolo – 53,492	"

Source: Insure the Uninsured Project; California Department of Health Care Services; California Department of Managed Health Care; Local Health Plans of California. See source details in end notes.

III. CONSIDERING PUBLIC OPTIONS FOR CALIFORNIA: THREE SCENARIOS

As a framework through which to identify issues and options, ITUP developed three scenarios of how a public plan choice might be organized in California. The scenarios acknowledge California's extensive network of local public health plans and the heavy concentration of managed care in the existing Medi-Cal program.

Key Concepts and Definitions

As background, the following key concepts highlight potential "public" roles in the provision of health care coverage.

- ***Public Program.*** A program *administered and funded* by government (typically federal, state and/or local) generally with established rules of eligibility, benefits and payment rates. A public program may contract with governmental (public) and/or non-governmental (private) health plans and providers to organize and deliver the services. In California, both Medi-Cal and Medicare contract with public and private plans.
- ***Publicly financed.*** Coverage funded in whole, or in part, by the federal, state and/or local governments.
- ***Publicly operated.*** Coverage *developed, administered and managed* by a public, governmental entity.

In developing the scenarios, ITUP used the following definitions:

- ***Public Option*** means a publicly operated health plan choice that directly competes with private health plans in specified target markets. A public option does **not** include public programs such as Medicare, Medi-Cal or CHIP, but may be modeled after, or offered as an adjunct to, public programs.
- ***Exchange Public Option*** means a public plan(s) choice that competes with private health plans in the state Affordable Care Act (ACA) exchange, Covered California. (Scenarios 1 and 2.)
- ***Medi-Cal Buy-in Public Option*** means a public plan choice for individuals not eligible for Medi-Cal who purchase coverage through the Medi-Cal program infrastructure rather than through a private health plan. A Medi-Cal buy-in might have different benefits and providers than Medi-Cal and could also include public financing, using state funds to lower premiums or out-of-pocket costs for some or all the individuals purchasing coverage. (Scenario 3.)
- ***Medi-Cal expansion*** means modifying the eligibility rules for Medi-Cal, a public program, which may include changes in age, income, immigration status or other eligibility factors, to increase the number of Californians eligible for the program. A Medi-Cal expansion is publicly financed either by federal/state funds, or if the population or program does not qualify for federal matching funds, with state-only/local funds.

Three Scenarios

The scenarios that follow are meant to provide a concrete framework by which to identify the issues, questions and legal constraints related to public options in California. In this first round of analysis, the

scenarios speculate on foundational issues for each approach, including potential structure, policy objectives, relevant state and federal laws, and financing.

If policymakers consider a public option within the state's current health care system, the public option model will need to be designed taking into account how California insurance markets operate, including Covered California, and the potential limitations of federal program rules, including federal Medicaid requirements. As the scenarios in this report suggest, public plan choice in California would most likely be accomplished through either additional public plan choices in the state exchange, or a public plan choice developed through the Medi-Cal infrastructure.

Scenario 1 – Exchange Public Option: Local Health Plans

Scenario 1 considers how the state might increase the participation of local public health plans in the exchange. In 2018, there is one LI, L.A. Care Health Plan, and one non Medi-Cal county-operated health plan, Valley Health Plan successfully participating in Covered California. This scenario raises numerous administrative, operational and legal challenges to expanding local plan participation in Covered California (discussed in more detail in Section V). State, federal and contractual requirements that apply to any health plan seeking certification as a QHP can be costly and are significantly different than the requirements for MCMC plans. California explored some of these issues when it considered developing a Bridge Plan prior to ACA implementation. See Appendix A for more on the Bridge Plan in California.

Scenario 2 – Exchange Public Option: New State Health Plan

Scenario 2 contemplates an alternative approach to increasing public plan choice in the exchange in the event local health plans are unable or unwilling to expand or for regions where there is no local health plan. A state health plan option raises many of the same challenges as for local public plans but additionally presents the challenge of how a new state plan might be structured, administered and funded. In addition to the start-up costs and challenges, there are complex issues surrounding regulation and oversight of a state-operated health plan. A baseline question is whether the state plan would be licensed and regulated according to state and federal requirements for individual or small group coverage and, if not, what oversight there might be. Finally, depending on the configuration of the state plan, it might be practical to organize the plan using a for-profit administrator or health plan(s), possibly making it less desirable to those promoting the public option as an alternative to private plans.

Scenario 3 – Medi-Cal Buy-in Public Option

Scenario 3 explores development of a competing coverage choice through the existing Medi-Cal infrastructure. This scenario is distinct from expanding eligibility for Medi-Cal using state funds through a state-only Medi-Cal expansion. Scenario 3 contemplates allowing individuals not eligible for Medi-Cal to buy coverage through the Medi-Cal infrastructure. By competing with private health plans to cover individuals not enrolled in Medi-Cal, the buy-in of Scenario 3 is consistent with the pre-ACA vision of a national public option. While Scenario 3 relies on the existing statewide Medi-Cal infrastructure, a buy-in program would likely need significant adjustments to serve as a viable public plan choice competing

against private health plans. Depending on whether the buy-in competes in the individual market and is subject to market rules, and state health insurance regulation, the state otherwise has unlimited flexibility to set benefits, premiums and provider networks in a state-only buy-in program. However, this scenario could require federal waivers or approvals if the state wanted to allow exchange eligible individuals to buy-in and continue to receive federal ACA subsidies. California explored some of these issues when it considered developing a Basic Health Plan prior to ACA implementation. See Appendix B for issues surrounging a possible Basic Health Plan in California.

Table 2

Scenarios for Public Options in California

(For Analysis Purposes Only)

	Scenario 1 Exchange Public Option (Existing Local health plans)*	Scenario 2 Exchange Public Option (New state health plan)	Scenario 3 Medi-Cal Buy-in Public Option
Description	Increased participation of local public health plans in the state exchange, as the public plan choice in Covered California and individual market	A state-operated public health plan choice offered through the state exchange and outside individual market	Public coverage choice offered for private purchase through the Medi-Cal program infrastructure
Potential Policy Objective(s)	Offer publicly operated alternative to compete with private health plans Improve affordability through choice and competition that lowers premiums and health care costs Increase choice in underserved areas with only one plan on the exchange Improve continuity for individuals whose eligibility fluctuates between exchange and Medi-Cal Make it easier for families to choose the same health plan if some family members are in Medi-Cal and some in the exchange Strengthen the state safety net	Offer publicly operated alternative to compete with private health plans Improve affordability through choice and competition that lowers premiums and health care costs Increase choice in underserved areas with only one plan on the exchange Offer a public plan choice in areas without local health plans available or willing to participate	Offer publicly operated alternative to compete with private health plans Improve affordability through choice and competition that lowers premiums and health care costs Increase coverage choices in areas with only one or two health plan choices Strengthen the state safety net

Table 2
Scenarios for Public Options in California
(For Analysis Purposes Only)

	Scenario 1 Exchange Public Option (Existing Local health plans)*	Scenario 2 Exchange Public Option (New state health plan)	Scenario 3 Medi-Cal Buy-in Public Option
Target population: Eligibility	1) Individuals not eligible for Medi-Cal who are eligible to enroll in the exchange or are seeking to purchase non-group, individual coverage outside of the exchange 2) Could also include small employers through Covered California for Small Business	1) Individuals eligible to buy coverage through the exchange or seeking non-group, individual coverage outside of the exchange 2) Could also include small employers through Covered California for small business	Individuals not eligible for Medi-Cal who are either: 1) Not eligible for exchange subsidies because of income or immigration status, and/or 2) Eligible for subsidies in the exchange **(with federal ACA Section 1332 waiver or approved Basic Health Plan)** 3) Could include small employers
Program Structure	1) Individual local health plans <u>or</u> 2) Consortium of existing local health plans sharing common infrastructure and operational resources to facilitate greater participation in the exchange or 3) Combined health plan choice through one lead local health plan that subcontracts with some or all existing local plans, collectively offered as one health plan option	State would design and implement a state health plan choice that could include: 1) Direct operation of the health plan by the state (provider contracting, claims payment, quality and utilization management, customer service, etc.) <u>or</u> 2) Subcontract(s) with external administrator to organize the network and manage some or all operational elements	Existing Medi-Cal infrastructure State contracts with local health plans and private health plans in MCMC Benefits need to be adjusted beyond what MCMC plans currently cover because of MCMC "carve-outs," such as mental health and substance use disorder services
Administering agency	Covered California	State agency (other than Covered California) with expertise in contracting for health coverage (e.g., CalPERS, County Medical Services Program, DHCS) <u>or</u> New state agency with independent board; governance structure like Covered California	Department of Health Care Services (DHCS) Depending on the program design, DHCS may not have existing capacity to organize and operate a public health plan choice to compete with private insurers DHCS would also have to ensure separate tracking and accounting of federal Medicaid funds

Table 2
Scenarios for Public Options in California
(For Analysis Purposes Only)

	Scenario 1 Exchange Public Option (Existing Local health plans)*	Scenario 2 Exchange Public Option (New state health plan)	Scenario 3 Medi-Cal Buy-in Public Option
Federal authority	Affordable Care Act, including requirements for exchange QHPs, unless federally exempted or waived	Affordable Care Act, including requirements for exchange QHPs, unless federally exempted or waived	No federal restrictions on program design for a state-administered and funded program; states can determine eligibility, benefits, cost sharing, delivery system, etc. Federal approval/waiver required to use federal exchange subsidies Federal requirements for health insurance issuers would potentially apply if the buy-in offers coverage to individuals and small employers
State authority	State ACA implementing laws, state licensure to meet QHP requirements (Knox-Keene license or California Department of Insurance certificate) In California, Local Initiatives must be licensed for Medi-Cal. Most County-Organized Health Systems are exempt and not licensed for Medi-Cal. If one lead local health plan contracts with other local health plans for assignment of lives and risk, contracted plans may require a Knox-Keene full service or restricted license depending on the risk arrangement May require changes to state enabling statutes for local plans and/or to local ordinance authority for each plan	State legislation would be required to establish the program Enabling legislation would need to address, in addition to issues above: ▪ Extent to which the state health plan must meet federal and state requirements for QHPs, including state licensure and regulatory oversight ▪ Terms of negotiation between the state plan and the exchange, including whether Covered California would be required to include the state health plan as a choice in regions where available	State legislation would be required to establish and define the program Enabling legislation would need to address, in addition to issues above: ▪ Whether health plans participating in the buy-in would meet the same requirements as MCMC plans or ▪ All buy-in plans must be state licensed, and ▪ State funding level and timeline, including whether the buy-in would have to be financially self-sustaining

Table 2

Scenarios for Public Options in California

(For Analysis Purposes Only)

	Scenario 1 Exchange Public Option (Existing Local health plans)*	Scenario 2 Exchange Public Option (New state health plan)	Scenario 3 Medi-Cal Buy-in Public Option
Financing	Possible significant start-up and product development costs, which could be repaid over time through premiums Once operational, existing ACA revenues: ▪ Individual premiums ▪ Federal premium tax credits for eligible individuals ▪ Federal cost-sharing reduction (CSR) payments (not currently available pursuant to federal administrative action)	Significant state funding for the start-up costs of a new state program and for development of a new competitive health plan choice, including funds for initial financial reserves Once operational, existing ACA revenues: ▪ Individual premiums ▪ Federal premium tax credits and CSR payments ▪ Ongoing state costs, unless the new plan is financially viable and self-sustaining	Significant state funding for the start-up costs, development and ongoing operation of the buy-in plan, including funds for initial financial reserves Once operational: ▪ Private premium payments ▪ Ongoing state costs, unless the buy-in program is financially viable and self-sustaining ▪ Potential for ongoing state funds to subsidize premiums and/or cost-sharing

Source: Insure the Uninsured Project, February 2018.
**Current federal and state law requires eligible individuals between 138-400 percent of the Federal Poverty Level (FPL) seeking coverage to enroll in the exchange to receive premium and cost sharing subsidies. Moving exchange subsidy eligible individuals to a Medi-Cal buy-in program requires a federal Section 1332 ACA waiver, or establishment of a basic health plan under federal rules, to maintain federal premium and cost sharing subsidies. See Appendix B on the Basic Health Plan.*

Covered California Underserved Areas and Local Health Plans

As noted in Table 2, one policy objective for a public option would be to offer a public plan choice in regions where exchange enrollees do not have adequate health plan choice. In 2018, Covered California enrollees are limited to one health plan in Inyo, Mono, Monterey, San Benito, San Luis Obispo, and Santa Barbara counties, and over half of Kings county. El Dorado, Fresno, Madera and Placer counties have only one Covered California health plan operating in many of the zip codes and partial zip codes in these counties - between 14 and 33 percent of the zip codes in these counties.

Developing a viable local plan option in underserved counties could prove problematic, given the low number of individuals a public plan could enroll and the costs associated with developing a competitive QHP that complies with exchange standards. Table 3 lists the counties (or partial counties) with just one health plan offering in Covered California and shows whether there is a local health plan in the county. The enrollment data for Covered California highlights the relatively low overall exchange enrollment available in those regions, potentially complicating the viability of offering a public plan to address the current lack of health plan choice.

Table 3
Counties with One Plan Choice in Covered California

County	Local Health Plan	Zip Codes in the County with One Plan Choice	Covered California Enrollment (September 2017)
El Dorado	No LHP	33%	420
Fresno	CalViva Health	14%	23,680
Inyo	No LHP	All Zip Codes	670
Kings	CalViva Health	58%	2,320
Madera	CalViva Health	16%	4,180
Mono	No LHP	All	930
Monterey	Central CA Alliance for Health	All	13,110
Placer	No LHP	27%	14,540
San Benito	No LHP	All	1,590
San Luis Obispo	CenCal	All	12,470
Santa Barbara	CenCal	All	16,040

Source: Insure the Uninsured Project; Covered California 2018 Products by Zip Code, March 2018; Covered California 2017 September Active Member Profiles.

IV. OPERATIONAL CONSIDERATIONS FOR PUBLIC PLANS IN THE EXCHANGE

Any public plan option to be offered on the exchange, existing or new, local or state-administered, could experience challenges and costs related to QHP operational and certification requirements, including state licensure for the state health plan and for COHS plans not already licensed under Knox-Keene.

In evaluating the potential for an exchange public option in California, policymakers will need to consider the costs and effects of public plans complying with exchange standards. There may be compelling reasons to adjust the standards for public plan offerings while still ensuring quality and consumer protections are maintained.

Local public plans in particular may encounter operational challenges related to exchange requirements that differ significantly from Medi-Cal requirements, including: (1) Specific member support for billing issues, including subsidy determination, (2) Billing and collecting monthly premiums from enrollees, and (3) Paying the health plan assessment at 4 percent of premium. In addition, plans sold on the exchange must be National Committee on Quality Assurance (NCQA)-certified and offer the same products inside and outside the exchange. The list below highlights major areas of difference between Medi-Cal managed care and Covered California.

- ***Agent/Broker Support and Engagement.*** Agents/brokers have been responsible for over 40 percent of enrollment in Covered California for the past three years. Consumers have the option to enroll directly with the exchange, enroll through Community Based Organizations (known as Certified Enrollment Entities), or utilize a California licensed agent/broker. Covered California

does not compensate licensed agents for enrolling new members; therefore, participating plans are required to register, pay and support licensed agents who enroll members into their plan.

- ***Customer Service Capacity and Technology*.** Covered California currently has 1.3 million members enrolled in 11 health plans. Participating plans are required to support enrollees with billing and enrollment issues. Health plans in Covered California experience increased call volumes during open enrollment periods. To accommodate increased volumes during peak periods, most plans utilize value-added technology, telephony, and website services. Medi-Cal enrollment occurs throughout the year, rather than during a limited open enrollment period, and therefore does not generate the same type of high volume peak periods.
- ***Marketing.*** Covered California health plans must compete for market share in each region where they offer coverage. Covered California spends approximately $100 million each year on marketing and encourages participating plans to allocate significant funding for their own marketing purposes. Medi-Cal does not allow MCMC plans to market directly to enrollees.[24]
- ***Premium Collection.*** The exchange does not provide premium collection and aggregation services for participating health plans. Covered California plans are responsible for collecting monthly premiums from members, based on advance premium tax credit eligibility, and tracking member out-of-pocket expenditures. Medi-Cal does not collect premiums and MCMC plans do not have to track enrollee out-of-pocket costs.
- ***Fees.*** The exchange requires participating plans to pay a monthly assessment of 4 percent of total exchange premiums to support operation of the exchange. Medi-Cal does not impose a similar administrative fee.
- ***Market and Off Market.*** Plans participating in Covered California must offer the same products to individuals and small employers outside of the exchange and guarantee availability to all applicants. The commercial market is unfamiliar to most local health plans; competition with commercial health plans could be an expensive challenge and could lead to the public plans taking on a more high-risk population.
- ***Quality Reporting.*** Both the exchange and Medi-Cal require plans to participate in state and federal quality programs. However, the Exchange has unique quality measurement and reporting requirements that differ from other state and federal coverage programs.
- ***Qualified Health Plan Requirements.*** The ACA and state law require all health plans participating in the exchange to meet specific requirements related to state licensure, product offerings and rating rules, guaranteed availability and renewability, pooling of risks and regulatory review of premiums. California law requires Covered California to set minimum requirements for participating carriers as well as the standards and criteria for selecting qualified health plans and to apply the standards equally to all health plans in the exchange.[25]
- ***Reporting***. Both Covered California and Medi-Cal have quarterly and annual reporting requirements. The exchange has additional and unique data requirements applicable to participating plans that exceed Medi-Cal requirements.[26]

Local health plans participating in the Cal MediConnect program may be best prepared to meet exchange requirements due to similarities in operations between Cal-MediConnect and the exchange. Operational similarities between Cal MediConnect and the Exchange include: (1) The use of licensed insurance agents as a distribution channel, (2) Plans must submit proposals/bids and set rates, and (3) Core benefits are determined by the federal program rules for the exchange and for Cal MediConnect. Local plans that participate in Cal MediConnect include CalOptima, Health Plan of San Mateo, Inland Empire Health Plan, L.A. Care Health Plan, and Santa Clara Family Health Plan.[27]

Table 4 below highlights some of the operational and QHP certification requirements for participation in Covered California.

Addressing operational challenges for public plans

California law authorizes Covered California to take on various administrative processes such as premium collection, customer service and agent support.[28] In collaboration with public plans, Covered California could support key administrative functions that might reduce costs and complexity and facilitate greater participation by public plans.

California explored ways to reduce the administrative requirements of public plan participation in the exchange when it attempted to develop a "bridge plan" option in the lead up to ACA implementation. Under California's proposal at the time, Covered California would contract with MCMC plans to offer QHP products for specific populations under 250 percent of the federal poverty level. (See Appendix A for more on the Bridge Plan program considered in California.) The Bridge Plan approach focused on continuity of coverage, reducing disruptions in care as individuals change plans between the exchange and Medi-Cal and creating access to more affordable coverage.[29]

As part of the state's proposal for federal approval, Covered California proposed, along with other features, streamlining the QHP certification process for MCMC plans that only offer coverage in the non-commercial market:

- Allow Medi-Cal Managed Care plans to defer those elements of the solicitation that have not been applicable to a non-commercial health plan (e.g., waive quality data collection and tracking in 2014).
- Accept state Medi-Cal quality and performance requirements as satisfying exchange quality requirements during 2014.
- Coordinate with Department of Managed Health Care to streamline regulatory approval that may be required.
- Develop a separate timeline for certifying Bridge qualified health plans for 2014 and later years.
- Waive the state requirement that QHPs offer all coverage levels and catastrophic coverage, as well as the requirement to sell the same plans outside of Covered California, and limit public plan offerings to silver and gold coverage levels as required in federal law.

Table 4

Exchange Public Option

Operational Challenges for Public Health Plans in the Exchange

	Capacities Needed for Exchange Participation
Agents/Brokers	▪ Internal support to assist agents/brokers in addressing calls, payments, certification/enrollment ▪ System for tracking agent activity/sales ▪ Compliance process for agent activity
Customer Service	▪ Online tools for determining eligibility and tracking coverage and payments ▪ Provide access to web-based education materials and/or real-time assistance via chat or phone ▪ Capacity planning and management of high-volume periods (e.g., open enrollment) ▪ Back-office functions, e.g., eligibility verification documentation ▪ Staff to handle complex calls related to network, open enrollment, special enrollment, eligibility and calculation of subsidies, premiums, and out-of-pocket requirements
Fees/Funding	▪ Plans pay 4% of each premium received to Exchange
Marketing	▪ Expansion of marketing resources to reach additional territory ▪ Development of robust website, digital marketing, and collateral
Premium Collection	▪ Need for additional financial personnel ▪ System for collecting and tracking payments ▪ System for reporting subsidy payments to federal government
Quality Programs	▪ NCQA certification required ▪ Enrollees must be assigned to a primary care provider ▪ Ability to aggregate data across health plans ▪ Monthly submission of data elements to Truven Health Analytics
Rate Review Process	▪ Hiring of additional personnel to conduct product development, rate determination/actuarial service
Reporting	▪ Monthly submission of data elements to Truven Health Analytics ▪ Annual submission of quality performance data via EValue8 ▪ System for reporting subsidy payments to Federal government
Risk Sharing Program	▪ Financial ability to participate in Federal risk sharing program
Selling On/Off Exchange	▪ Online tools for determining eligibility and tracking coverage and payments ▪ Provide access to web-based education materials and/or real-time assistance via chat or phone

Source: Insure the Uninsured Project, 2018

V. PRINCIPLES FOR POLICYMAKERS

As policymakers and stakeholders consider the costs and benefits of expanded public plan choice in California, ITUP recommends the following guiding principles:

- ***Identify the problem and consider whether public plan choice will effectively address the problem.*** There are two threshold issues in considering public plan choice: (1) what is the problem that policymakers are trying to solve and (2) is public plan choice the most effective and efficient way to solve the problem? For example, while there may be potential for public options to address lack of health plan competition and choice in some underserved areas, it is less likely that public options, on their own, could address the problem of the remaining uninsured, given that 81 percent have incomes below 400 percent FPL.[30] It is unlikely that offering more public plan choices, without state funding for financial assistance, will help low-income uninsured individuals get coverage. Even if premiums for public plans are lower, the difference will likely not be enough for those who have to pay the full cost of the premium.
- ***Preserve consumer protections in law and regulation.*** California has strong consumer protections that apply to health plans in the state, ranging from financial solvency review to extensive consumer rights and disclosures. The decision on whether to maintain key consumer protections and regulatory oversight, and whether the goal in establishing public options is to ensure a level playing field between public and private health plans, is a central question for consideration. In large measure, state licensure and regulatory oversight of health plans originated in the early, scandal filled days of MCMC, which included fraud and financial insolvency. If current standards are not necessary, meaningful or effective, and need only apply to some types of health plans, the question remains whether the rules themselves need to be revisited.
- ***Evaluate the feasibility and cost benefit of public plan choice to achieve specific policy goals.*** While public plan choice may address specific policy goals, in theory, it will be important to consider state costs and relative public benefits from any proposal. Depending on the approach, the costs or potential unintended consequences might outweigh the benefits. As proposals emerge, each should be evaluated for feasibility, costs, benefits and legal constraints that will determine advisability of the proposal. For example, while adding local public plans in the exchange might be desirable, the relatively small number of enrollees any one plan, or even a consortium of plans, would likely secure might be insufficient to ensure viability, or to justify the allocation of capitol and human resources needed to comply with relevant standards and develop additional capacity.
- ***Maximize federal funding.*** As the scenarios highlight, many approaches to expand public plan choice would be most effective with federal collaboration and could require federal approval and/or waivers. Federal cooperation under the current Administration and political climate may be less likely than at other times. While states have flexibility in state funded programs, there may be features the state needs to include, or avoid, to preserve and maximize federal funds available to the state.

- ***Prioritize approaches that benefit consumers.*** Prioritize approaches likely to accomplish tangible and measurable improvements in consumer choice, affordability, access and continuity of care. It will also be critically important to consider potential positive and negative impacts on the ability of existing programs, including Covered California and Medi-Cal, or local health plans and the state safety net, to effectively serve the interests of consumers.

VI. CONCLUSION

This report initiates a series of issue briefs to inform the California discussion about expanding public plan choice in the state. The premise of the series is that California has a unique history and current infrastructure of exiting public plans, a successful state exchange and a Medi-Cal delivery system that is more than 80 percent managed care. These California-specific conditions need to be the starting point for exploring public options and will directly impact the advisability and the feasibility of specific policies.

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Insure the Uninsured Project (ITUP) is a nonprofit, 501(c)(3) organization, founded in 1996 to focus attention on California's significant number of uninsured. Based in Sacramento, California, ITUP's mission is to advance creative and workable policy solutions that expand health care access and improve the health of Californians. ITUP conducts policy-focused research and brings together broad-based stakeholders through an annual statewide conference in Sacramento, and regional and statewide workgroups, on health reform topics affecting health and health care in the state.

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