Towards Universal Health Coverage:

California Policy Options for Improving Individual Market Affordability and Enrollment

Laurel Lucia
Ken Jacobs

University of California, Berkeley
Center for Labor Research and Education

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Executive Summary

California has made historic progress under the Affordable Care Act (ACA) by cutting the uninsurance rate by more than half, resulting in approximately 93% of Californians now having health insurance. Health coverage affordability has improved for many, especially for those who became newly eligible for Medi-Cal or subsidized coverage through Covered California. For those who purchase coverage individually, the ACA has not only provided financial assistance to help eligible low- and middle-income individuals afford premiums and out-of-pocket costs, but has also provided crucial protections to individual market enrollees of all income levels. These protections include requiring insurers to offer insurance to all without charging higher premiums for those with pre-existing conditions, setting a floor for the share of costs that insurers cover, and establishing a ceiling on enrollees' out-of-pocket costs.

However, many Californians continue to face difficulties in affording premium and out-of-pocket costs. Affordability challenges can deter enrollment in and retention of coverage, cause financial difficulties for those struggling to pay premiums or medical bills, and decrease access to care. In this report, we focus specifically on the affordability challenges for the 2.3 million Californians who purchase private insurance individually and for many of the 1.2 million Californians who are eligible to purchase insurance through Covered California but remain uninsured.

We also explore state policy options for improving affordability of individual market premiums and out-of-pocket costs, and consequently helping move the state closer to universal coverage. This set of policy options was developed based on analysis of the available evidence on affordability concerns in California's individual market, as well as on a review of policies used by other states and localities to improve affordability. The options include:

- Adding state premium subsidies to the federal ACA subsidies to further reduce enrollees' premium contributions;
- Providing financial assistance to further reduce deductibles, co-payments, and other cost sharing for some Californians already receiving ACA cost sharing subsidies, and making more Californians eligible for this assistance;
- Capping the percentage of income spent on premiums by Californians who earn too much for ACA premium assistance by providing state-funded premium subsidies;
- Establishing a state reinsurance program to lower premiums for unsubsidized individual market enrollees; and
- Extending eligibility for state-funded premium and cost sharing subsidies to children and spouses affected by the ACA "family glitch."

These policy options assume Covered California and its partners will continue the state's strong outreach and marketing efforts to increase awareness of the financial assistance available.

State policies to improve individual market affordability can help counteract the loss of insurance projected to occur beginning in 2019 as a result of the elimination of the ACA individual mandate penalty. Survey data indicates that subsidies are an even bigger driver of enrollment than penalties. Improved affordability would help to ensure strong enrollment by a broad population and help to minimize the growth in premiums that could occur if healthier people leave the market. Combining improve affordability with a state-level insurance requirement would further secure the stability of the insurance market.

These policy options could help Californians afford health coverage in the near-term in our existing health care system with its current cost structure. High and rapidly growing health care costs are a major driver of the affordability challenges facing Americans with all types of health coverage. Policies to reign in underlying medical costs, which are not the focus of this report, are also necessary.

* * *

The evidence on the extent and nature of Californians' affordability concerns underscores the need for state policy interventions. Based on our examination of survey data, analysis of Covered California enrollment data and premiums, and synthesis of the existing research on affordability, we found that:

Affordability concerns are a barrier to individual market enrollment and renewal of coverage

- Affordability is the top reason that those eligible for Covered California lack insurance, regardless of income level.
- Californians who were potentially eligible for ACA premium subsidies based on income were more likely to be uninsured and more likely to have paid the federal tax penalty for lacking insurance in 2015, compared to those with higher income.
- Many Californians enrolled in the individual market report difficulties affording premiums and out-of-pocket costs.

High out-of-pocket costs can be a barrier to care, cause financial problems, and potentially dissuade enrollment

- Even with ACA subsidies, combined premium and out-of-pocket spending in the individual market can exceed 10% of income for some Californians with median out-of-pocket spending, and can reach 20% to 30% of income for some with very high medical use.
- More than one-third of Covered California enrollees with incomes between $24,120 and $48,240 for a single individual are enrolled in Bronze plans with a $6,300 individual annual deductible.

- The vast majority of Americans eligible for ACA premium subsidies based on income do not have liquid assets sufficient to cover a $6,300 deductible.
- Research has shown that high out-of-pocket costs can be a barrier to care and cause financial problems. Out-of-pocket costs are a major consideration in individuals' enrollment decisions.

The high cost of living in California and broader financial insecurity may exacerbate health insurance affordability concerns for some individuals

- ACA premium subsidies are based on the Federal Poverty Level, but the higher cost of living in California may squeeze some families' ability to afford healthcare.
- The upper income limit for premium subsidies under the ACA—four times the Federal Poverty Level—is equivalent to five times that level in California and six times that level in San Francisco.
- In all California counties, some individuals face an affordability gap in that they earn too much to qualify for Medi-Cal with no premiums or cost sharing, but do not earn enough to afford Covered California insurance even with subsidies, based on a household budget analysis.

Some citizens and lawfully present immigrants lack access to coverage that meets ACA affordability standards

- Affordability can be a challenge for people who earn too much to be eligible for premium subsidies, especially for those age 50 or older and those who have family income between $48,240 and $72,360 for a single individual. In every region of California, premiums for some of these individuals exceed the standard of affordability under the ACA individual mandate.
- Some Californians have access to neither affordable employer-sponsored insurance nor affordable individual market coverage. Under the ACA "family glitch," they are ineligible for subsidies through Covered California because they have an offer of employer-sponsored coverage through a parent or spouse, but that employer-sponsored dependent coverage is unaffordable.

Concerns about affording health insurance and care are common among Americans with all types of health insurance, but affordability challenges are especially prevalent among those who rely on the individual insurance market. California's high cost of living makes affording health care even more challenging for some. California has substantially narrowed its coverage gaps as a result of the state's effective implementation of the ACA. Building on that momentum, California policymakers could take additional steps to make individual market insurance more affordable in the near-term, moving the state closer to universal and affordable coverage.

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Background

California has made substantial gains in individual market enrollment and affordability under ACA

The percentage of Californians with health insurance has grown dramatically under the Affordable Care Act (ACA), from 83% in 2013 to 93% in 2016, the largest increase in coverage of any state.[1] These coverage gains were due in part to substantial growth in the state's individual market, in which individuals without job-based coverage purchase private insurance either through the state's health insurance Marketplace, called Covered California, or directly from an insurer.

Enrollment in the individual market grew from 1.5 million in 2013 to 2.3 million in 2016[2] due to several provisions in the ACA as well as California's extensive and effective implementation of the law. Particularly important were:

- Federal premium subsidies and financial assistance to reduce deductibles, co-payments, and other cost sharing, depending on income;
- The requirement that insurers cannot deny coverage or charge higher premiums for applicants with pre-existing conditions;
- Improved ability of consumers to shop for coverage and compare plans owing to the creation of the state marketplace and the standardization of plan benefit designs;
- Strong state-level investment in outreach, advertising, and enrollment assistance to help individuals understand their options and apply for coverage; and
- The requirement that individuals have insurance or pay a penalty.

Improved affordability is likely one of the biggest factors explaining the net enrollment gain of 800,000 Californians in the individual market. A survey conducted for Covered California found that 70% of respondents receiving premium subsidies in 2015 said that the availability of subsidies was a very or extremely important factor in their decision to purchase a plan. In fact, subsidies were a bigger driver of enrollment than the ACA individual mandate penalty, which was cited by 44% of subsidized respondents as a very or extremely important motivator.[3]

In addition to providing financial assistance with premiums and out-of-pocket costs, the ACA also established new consumer protections that help to limit out-of-pocket liability for individuals of all income levels:

- The ACA set a floor for the share of medical costs that individual market plans must cover —60% of costs across an average population.[4] Before the ACA floor was implemented, half of Americans with individual market coverage were in plans that paid less than 60% of costs.[5] The higher share of costs paid by individual market insurers in California under the ACA[6] improves financial protection for families and reduces barriers to care due to cost.
- The ACA set a ceiling on out-of-pocket costs paid by households ($7,350 for individuals and $14,700 for families in 2018).[7] While many of the households that incur high

healthcare expenses likely struggle to pay out-of-pocket costs even with these maximum limits, no limits existed before passage of the ACA, and some families with individual market coverage spent as much as $27,000 on out-of-pocket costs in 2010.[8]

- The ACA banned insurers from limiting the amount of medical benefits covered for an enrollee over a lifetime or during any given year.

As a result of the financial assistance and consumer protections established by the ACA, enrollees reported improved affordability. A longitudinal study by the Kaiser Family Foundation followed a panel of Californians who were uninsured prior to the first ACA open enrollment period. Respondents who had gained private insurance or Medi-Cal by the time of the second ACA open enrollment period in 2015 were far less likely to report difficulty for their family in affording health insurance (49%) than they had been prior to the ACA (86%). These respondents were about half as likely report problems paying medical bills (23%) as they had been prior to the ACA (45%), and more than half (53%) reported that having health insurance made them feel more financially secure.[9]

Additionally, the share of Californians in the individual market who reported spending more than 10% of their family income on premiums and out-of-pocket costs fell from 43% in 2013 to 34% in 2015, according to analysis of Current Population Survey data by the State Health Access Data Assistance Center.[10]

Affordability is the main reason that those eligible for Covered California remain uninsured

However, there are at least 1.2 million Californians who remain uninsured despite being eligible to purchase insurance through Covered California, with or without subsidies (Exhibit 2, page 9). This is the second largest group of uninsured residents in the state, after undocumented residents who are excluded from the ACA and Medicaid under federal law.[11]

In 2014 through 2016, cost was identified as the top reason for lacking insurance among uninsured citizens in California, regardless of income level, according to the California Health Interview Survey. The vast majority of citizens who tried to purchase insurance through Covered California but ultimately remained uninsured said they found it difficult to find an affordable plan.[12]

Affordability is more of a challenge for those with individual market coverage than for most other insurance types

Among California citizens with individual market coverage, nearly half (45%) reported finding it very or somewhat difficult to find an affordable plan through Covered California in 2014 through 2016.[13]

Individuals with all types of health insurance can face difficulties affording insurance and care, but the challenges are greatest for those with individual market coverage, and, by some measures, Medicare. A national study by the State Health Access Data Assistance Center found that in 2015, 39% of those with individual market insurance spent in excess of 10% of family income on premiums and out-of-pocket costs, compared to 26% of those with Medicare, 20% of those with employer-sponsored insurance, and 16% of those with Medicaid.[14] National analysis by the

In discussing affordability concerns and potential state policy solutions, this report references various levels of income as they relate to the Federal Poverty Level (FPL). For reference, Exhibit 1 shows the FPL thresholds most frequently discussed in this report for the most common household sizes.

:

Annual Income as a Percentage of the Federal Poverty Level (FPL), 2017

FPL	Household size			
	1	2	3	4
139%	$ 16,760	$ 22,570	$ 28,380	$ 34,190
150%	$ 18,090	$ 24,360	$ 30,630	$ 36,900
200%	$ 24,120	$ 32,480	$ 40,840	$ 49,200
250%	$ 30,150	$ 40,600	$ 51,050	$ 61,500
267%	$ 32,200	$ 43,360	$ 54,520	$ 65,680
300%	$ 36,180	$ 48,720	$ 61,260	$ 73,800
400%	$ 48,240	$ 64,960	$ 81,680	$ 98,400
500%	$ 60,300	$ 81,200	$ 102,100	$ 123,000
600%	$ 72,360	$ 97,440	$ 122,520	$ 147,600

Notes: Under the ACA, 2017 FPLs are used to determine eligibility for premium and cost sharing subsidies in plan year 2018. Income amounts in this exhibit are rounded to the nearest $10.

Commonwealth Fund found that the rate of "underinsurance," the term for the situation in which insured individuals face out-of-pocket costs that are high relative to income, was higher for those with coverage in the individual market (44%) and for the non-elderly disabled enrolled in Medicare (47%) than for those with employer-sponsored insurance (24%) and Medicaid (26%) in 2016.[15]

Ensuring affordable individual market coverage is one potential state response to the elimination of the ACA individual mandate penalty

The enrollment and uninsurance estimates in this report reflect current policy, but trends could change starting in 2019, when the ACA penalty for lacking insurance will be eliminated. Under this federal policy change, the number of uninsured Americans is projected to grow and the number enrolled in individual market coverage, Medicaid, and employer-sponsored insurance is projected to decline. Individual market premiums are expected to increase as healthier people become less likely to purchase insurance, and the resulting premium increases would cause even more people to not purchase insurance.[16] The amount by which individual market enrollment will decline in California is uncertain. Some estimates indicate that several hundred thousand fewer Californians could enroll in the individual market in the initial year of the penalty elimination.[17] Most of the enrollment reduction is likely to occur among subsidized enrollees.[18] The coverage losses are expected to grow over the first few years without a penalty, then level off, according to Congressional Budget Office estimates.[19]

California could take steps to mitigate the coverage losses by enacting its own individual mandate, continuing and expanding its strong outreach efforts, and adopting policies that improve affordability, like those described in this report. Implementing all of these policies in combination

Defining "affordable"

Affordable health insurance is difficult to define using a one-size-fits-all standard. The amount that is "affordable" to an individual or family for the purchase and use health insurance depends on a constellation of factors including income, age, family size, medical use, cost of living, and the family's budget for other household expenses or outstanding debts. However, several different approaches have been developed and can be useful in evaluating health insurance affordability. Affordability can be evaluated using a household budget approach—at each level of income, are sufficient funds available to pay for healthcare after accounting for spending on other essentials like housing, food, transportation, and childcare? Another approach is to examine how much households currently spend on health care as an indicator of the level of spending that is feasible. Finally, benchmarks from public programs, such as Medicaid premium and cost sharing limits, could be used.

Each of these approaches to measuring affordability has advantages and limitations.[20] This report does not rely on a single standard of affordability, but instead presents evidence that reveals the concerns and challenges with affordability in the individual market in California, and outlines state-level policy options for improving affordability of coverage for those at all income levels without necessarily meeting one standard definition of affordability.

The ACA set various standards of affordability; these provide useful context for understanding the progress made under the law toward making affordable health coverage available, as well as the gaps that remain:

- Premium affordability standards are implied for individuals who are eligible for subsidies to purchase insurance through the Marketplaces. Enrollee premium contributions vary on a sliding scale from 3.38% of household income at 139% of the Federal Poverty Level to 9.56% of household income at 300% to 400% of the FPL.[21]
- Out-of-pocket affordability standards are implied by the level of cost sharing assistance for those under 250% FPL, which is based on a sliding scale. For low-income enrollees, insurers must cover between 73% and 94% of medical costs, on average, depending on the exact income level. When insurers pay a higher share of costs, families pay less in deductibles, copayments and other cost sharing.
- Individuals are exempt from the ACA individual mandate if they lack access to affordable coverage, defined as costing less than 8.16% of household income in 2018.
- Employer-sponsored insurance is considered affordable if a household's premium contributions to cover only the worker cost less than 9.56% of household income and if the insurer covers at least 60% of medical costs, on average. (See page 17 for further details.)

Affordability remains a concern for many Californians with access to individual market insurance that meets these ACA standards of affordability, but understanding these standards is important for understanding the affordability gaps discussed in this report.

would have the strongest impact in counteracting the loss of individual market coverage and increase in individual market premiums expected to occur without a federal mandate.

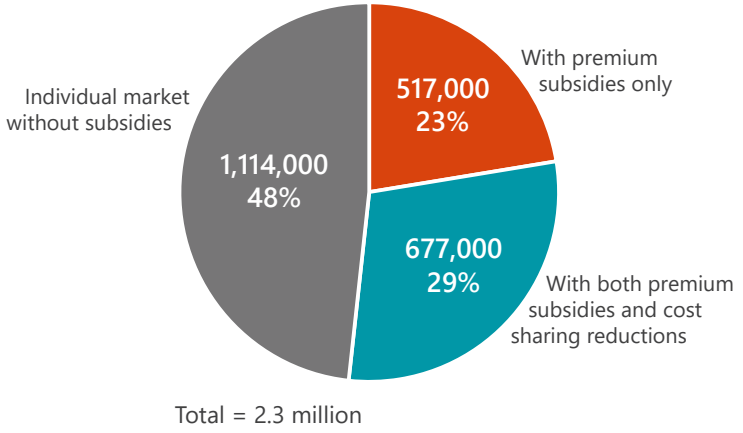
Affordability concerns among Californians eligible for or enrolled in the individual market

When premiums are affordable, individuals are more likely to enroll in and retain coverage over time. Younger individuals' and low-income individuals' decisions to enroll in Covered California are especially sensitive to the price of health insurance.[22] When health insurance is affordable, a broader population enrolls, supporting a balanced risk mix, a more stable market, and lower premiums.

This section summarizes the existing evidence on the extent and nature of affordability concerns among the 2.3 million Californians already enrolled in the individual market (Exhibit 2) and the approximately 1.2 million uninsured Californians who are likely eligible to enroll in Covered California (Exhibit 3).[23]

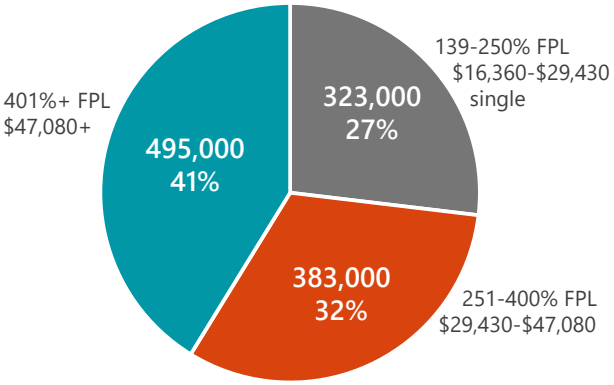
We consider first the affordability concerns of Californians with household incomes at or below 400% FPL, the upper eligibility threshold for premium subsidies under the ACA. Then, the affordability concerns of Californians not eligible for subsidies based on income are discussed. This section will last explore the health insurance affordability concerns of Californians caught in the ACA "family glitch," in which they are ineligible for subsidies through Covered California because they have an offer of employer-sponsored family coverage through a parent or spouse, but that employer-sponsored dependent coverage is unaffordable.

Exhibit 2:
Individual market enrollment, California, 2016



Source: Katherine Wilson, California Health Insurers Hold on to Previous ACA Gains, California Health Care Foundation Blog, July 13, 2017, https://www.chcf.org/blog/california-health-insurers-hold-on-to-previous-aca-gains/. Covered California, Active Member Profile, June 2016, http://hbex.coveredca.com/data-research/library/active-member-profiles/12-13-17/CC_Membership_Profile_2016_06.xlsx

Exhibit 3:
Uninsured citizens ages 0-64 with household income above Medi-Cal eligibility threshold, California, 2016



Note: Due to data limitations, this chart does not include lawfully present immigrants, though they are also eligible to enroll in Covered California and receive subsidies if eligible based on income.[24] This chart excludes uninsured citizen adults ages 19-64 in households with income below 139% FPL and uninsured citizen children ages 0-18 in households with income below 267% FPL because they are eligible for Medi-Cal.

Source: 2016 California Health Interview Survey

Affordability concerns for Californians currently eligible for subsidies

Approximately half of individual market enrollees in California, or nearly 1.2 million, receive ACA subsidies (Exhibit 2, page 9). Of those who are eligible for Covered California but remain uninsured,[25] six out of ten, or more than 700,000, may be eligible for subsidies based on income. Approximately half of this uninsured subsidy-eligible group may be eligible for premium subsidies and the other half may be eligible for both premium and cost sharing subsidies (Exhibit 3, page 9). Not every individual with income at or below 400% FPL is necessarily eligible for subsidies: they may have an offer of employer-sponsored insurance that disqualifies them from subsidies, or they may have an unsubsidized premium that falls below the maximum required premium contribution under
the ACA.

Premium affordability concerns remain in spite of ACA subsidies

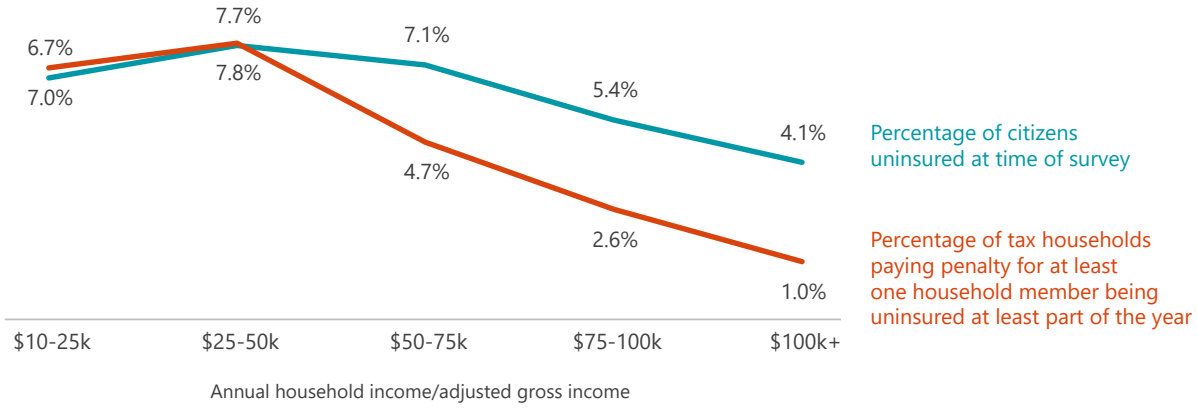
Under the ACA, citizens and lawfully present immigrants are eligible for premium subsidies if their household income is at or below 400% FPL, which is $48,240 annually for a single individual or $98,400 for a family of four. Premium subsidies are calculated on a sliding scale such that households pay between 2.01% and 9.56% of income (further details are shown in Appendix Exhibit A1). For individuals who receive premium subsidies, in 2017 the federal government paid on average 71% of premium costs, reducing average annual premium contributions per subsidized California household by over $6,000.[26] In 2018, monthly premium payments for Covered California enrollees receiving premium subsidies are between $47 and $384 for a single individual, depending on income, and up to $784 for a family of four.[27] By contrast, Californians with employer-sponsored insurance paid on average $85 per month for single coverage and $410 per month for family coverage in 2016.[28]

In 2015, Californians with incomes in the subsidy-eligible range were more likely to be uninsured and more likely to have paid the tax penalty for lacking insurance than those with higher income (Exhibit 4, page 11).[29] As a result, uninsured households in the subsidy-eligible income range comprised at least three-quarters of Californian households paying the tax penalty for not having insurance in 2015.[30] The higher rates at which Californians in this income range are uninsured and paying the tax penalty, coupled with survey data showing that affordability is the top reason for uninsurance among citizens at all income levels, indicates that significant affordability challenges remain for Californians with incomes in the subsidy-eligible range.

Non-elderly adults potentially eligible for Covered California subsidies are more likely to remain unenrolled than adults eligible for Medi-Cal. More than 1.1 million adults ages 19 to 64 with incomes at or below 400% FPL were enrolled in Covered California with subsidies in 2016,[31] compared to 671,000 uninsured working age citizens with incomes between 139% and 400% FPL,[32] some of whom may not have been eligible for subsidies due to an offer of employer-sponsored insurance.[33] By contrast, nearly 5.7 million adults ages 21 to 64 were enrolled in comprehensive Medi-Cal benefits,[34] compared to 379,000 uninsured working age citizens with incomes below 139% FPL in 2016.[35] Given that Medi-Cal has no premiums or cost sharing for adults, the higher level of enrollment in Medi-Cal is another indicator that affordability is a barrier to enrollment for some who lack insurance and are eligible for Covered California with subsidies.

Exhibit 4:

Uninsurance rate among citizens and percentage of households paying penalty for lacking insurance, by household income, California, 2015



Note: $50,000 in annual income is equivalent to approximately 410% FPL for a single individual and approximately 200% FPL for a family of four. $75,000 in annual income is equivalent to approximately 620% FPL for a single individual and approximately 300% FPL for a family of four. Graph excludes households with income below $10,000 because they are likely eligible for Medi-Cal, as well as often exempt from the individual mandate due to their income being below the tax filing threshold.

Sources: UC Berkeley analysis of American Community Survey (ACS) 2015 data; U.S. Internal Revenue Service (IRS), California Individual Income Tax Returns: Selected Income and Tax Items by State, County, and Size of Adjusted Gross Income, Tax Year 2015.

One survey found that affordability concerns are common even among Californians enrolled in the individual market. At least four out of ten surveyed non-elderly adults enrolled in the California individual market had some or a lot of difficulty paying their premiums in 2014, and a similar share had difficulty affording out-of-pocket costs. The prevalence of affordability concerns was relatively similar between individuals with incomes below 250% FPL and those with incomes between 250% and 400% FPL. The study found that premium affordability difficulties were worse for those who purchased insurance through the off-Exchange market where federal subsidies are not available.[36]

Premium affordability may be especially concerning to the lowest-income Covered California enrollees. Approximately 25,000 lawfully present immigrants enrolled in Covered California have incomes below 139% FPL.[37, 38] Additionally, some Medi-Cal enrollees experiencing an increase in income may face challenges transitioning from zero premiums in Medi-Cal to monthly premium contributions of at least $46 in Covered California, given the low income of those who earn a little too much to qualify for Medi-Cal (approximately $1,400 per month for a single individual or $2,850 for a family of four).

A number of studies have shown how premiums can hamper enrollment and retention of coverage for low-income individuals.[39] One recent study found that "near poor" non-elderly adults who were eligible for Marketplace coverage because they lived in a state that did not expand Medicaid were more likely to be uninsured than their counterparts in expansion states.[40] Medicaid generally requires no premiums while single Marketplace enrollees with incomes between 100% and 138% FPL pay between $20 and $46 on monthly premiums after subsidies. In many states, including California, Medicaid requires no cost sharing.

High out-of-pocket costs can hinder access to care, cause financial problems, and potentially deter enrollment

Research has also shown that high deductibles and other cost sharing can create barriers to care. Insured Americans with deductibles and out-of-pocket costs that meet the Commonwealth Fund's standard for "underinsurance" are more likely to: forgo seeing a doctor when they have a medical problem; leave a prescription unfilled, skip a medical test, and decline doctor-recommended treatment or follow-up; and forgo seeing a specialist despite a doctor's recommendation.[41] According to the California Health Interview Survey, in 2014 through 2016, two-thirds (67%) of non-elderly Californians in the individual market reported delaying care due to cost, a lower rate than among the uninsured (81%) but a higher rate than among those with employer-sponsored insurance (35%). For the subset of Californians with incomes at or below 400% FPL, the relative rates of delaying access to care due to cost by coverage type were similar.[42]

Underinsurance does not just impede access to care; it also increases the prevalence of difficulties paying medical bills and the likelihood of related financial problems such as taking on credit card debt or using up savings.[43]

Out-of-pocket costs that are high relative to income "will likely dissuade many individuals from enrolling or re-enrolling" in coverage, according to Linda Blumberg and John Holahan of the Urban Institute.[44] According to one national survey that asked uninsured individuals who tried to purchase insurance why they decided not to enroll, out-of-pocket costs were the second most important factor named after premiums. As a decision-making consideration, out-of-pocket costs ranked higher in importance than covered benefits, the individual mandate penalty, and the availability of doctors in the plan network.[45]

Under the ACA, eligible individuals with incomes at or below 250% FPL ($30,150 for a single individual or $61,500 for a family of four) are offered cost sharing reductions, which provide federal financial assistance to reduce deductibles, co-payments, and other costs, on top of premium subsidies. Cost sharing subsidies had an average value of nearly $1,500 annually per subsidized California household in 2016.[46] Eligible Californians continue to receive this financial assistance in spite of President Trump's decision in October 2017 to discontinue federal payments to insurers for cost sharing reductions[47] because insurers are still legally required to provide cost sharing reductions and California insurers have raised the premiums for certain Silver plans to reflect the reduction in federal payments.

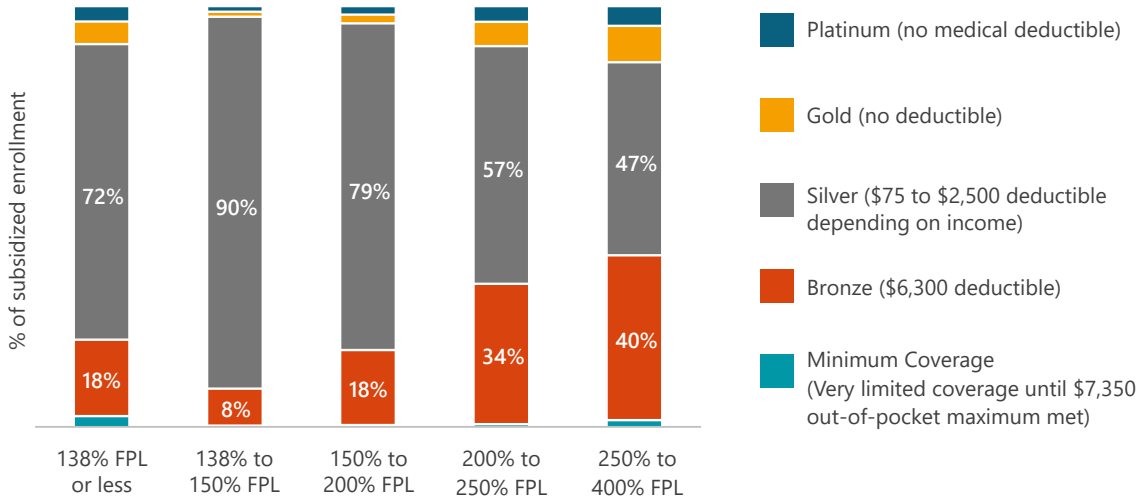
Cost sharing reductions have greatly improved out-of-pocket affordability for many Californians. Those in the individual market have also benefited from the state's decision to standardize benefit designs for plans offered through Covered California, and the subsequent efforts by Covered California, in partnership with stakeholders, to design benefits to maximize value and access to care. In Silver plans offered through Covered California, doctor visits, emergency room care, lab tests, x-rays, and imaging are not subject to medical deductibles. The annual medical deductible of $2,500 in the Silver plan only applies to hospital care. (See Appendix Exhibit A2 for further details on Covered California standardized benefit designs, including the deductibles, co-payments, and other cost sharing under each plan type.)

Nonetheless, one-quarter of Covered California enrollees with incomes at or below 400% FPL were enrolled in Bronze plans in 2017, which offer the least financial protection of the plans offered through Covered California. The rate of Bronze enrollment was even higher (37%) among Covered California enrollees with incomes between 200% and 400% FPL.[48] These rates of Bronze enrollment for low- and middle-income Covered California enrollees are significantly higher than those for Californians with employer-sponsored insurance: 11% of Californians with insurance through a small employer and only 1% of those with insurance through a large employer had coverage equivalent to or somewhat better than a Bronze plan in 2016.[49] Individuals who have difficulty affording premiums for Silver plans may opt to enroll in a Bronze plan because of the lower premiums. Covered California estimated that while 60% of subsidized enrollees could purchase a Silver plan for less than $100 per month in plan year 2018, nearly three-quarters (74%) could purchase a Bronze plan for less than $10 a month.[50]

While Bronze premiums are lower than Silver premiums, individuals who enroll in Bronze plans are at significant risk of out-of-pocket costs due to the plans' $7,000 out-of-pocket maximum and $6,300 individual medical deductible, which applies to all services except the first three doctor visits. Individuals eligible for cost sharing reductions only receive that financial assistance if they enroll in a Silver plan, and the level of financial assistance provided is most substantial for people with incomes below 200% FPL (Appendix Exhibit A2). This may be one explanation for lower Bronze enrollment among those in the lower income range compared to enrollment among those with incomes between 200% and 400% FPL (Exhibit 5).

Although some middle-income individuals who enroll in Bronze plans may feel confident that they can afford the deductible and out-of-pocket limit if they were to incur high health care

Exhibit 5:
Covered California enrollment distribution by metal tier and income level under 400% FPL, June 2017



Source: Covered California Active Member Profile, June 2017

costs, this sentiment is likely shared by only a minority of enrollees. Research by the Kaiser Family Foundation found that American non-elderly households with incomes between 150% and 400% FPL had median liquid assets of $1,902 for single-person households and $2,811 for multi-person households in 2016. These numbers reflect the potential for severe affordability challenges for those enrolled in Bronze plans, given their deductible of $6,300 for all care other than the first three doctor visits. Liquid assets sufficient to cover a Bronze deductible were found to be available to fewer than one out of three American households with incomes between 150% and 400% FPL. The affordability risk associated with the Bronze deductible was even higher for U.S. households with incomes at or below 150% FPL, which had median liquid assets of approximately $500 in 2016. Only approximately one in ten of these low-income households had liquid assets sufficient to cover a Bronze deductible.[51]

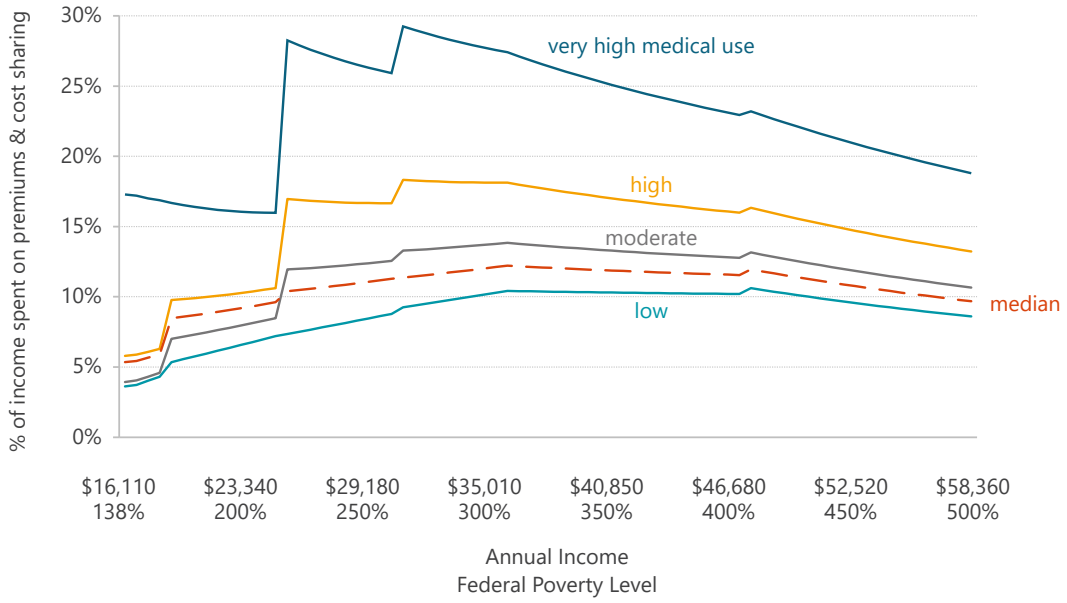
Combined premium and out-of-pocket spending can reach 10% to 30% of income for some Californians

The affordability problem is compounded when premium and out-of-pocket costs are considered in combination. As shown in Exhibit 6, a single 40-year old in San Francisco with median health care use and with an income level between approximately 200% and 485% FPL would have spent more than 10% of income on Silver plan premiums and out-of-pocket costs in 2015 after subsidies. San Franciscans with similar demographics but very high medical use would have spent more than 20% percent of annual income at income levels between approximately 200% and 470% FPL, with some individuals spending nearly 30% of their income on health insurance and care.[52]

Exhibit 6:

Total expected health spending for single 40-year old, San Francisco, 2015

Premium & out-of-pocket spending after subsidies for second lowest cost Silver plan through Covered California



Source: UC Berkeley analysis excerpted from Health Management Associates, Addressing Affordability of Health Insurance in San Francisco, Technical Report Presented to San Francisco Department of Public Health, June 2015, https://www.sfdph.org/dph/files/uhc/HMA-FinalReport-SFDPH-PublicBenefitProgram-June2015.pdf.

While the range of health spending is relatively similar across all regions in the state (more than 10% of income for some with median health use and as much as 20% to 30% of income for some with high medical use), the specific spending levels at each income level may vary slightly by region. This is especially the case for individuals who earn too much to receive premium subsidies and who therefore are not shielded from regional premium differences.[53]

High cost of living and general financial insecurity exacerbate affordability concerns

Concerns about health insurance affordability do not necessarily stem solely from premium and out-of-pocket costs. For many, these concerns may also reflect broader financial insecurity related to living expenses and other factors. The high cost of living in certain regions of California undoubtedly leave little room in some families' budgets for health insurance.

ACA premium subsidies are set on a sliding scale based on the Federal Poverty Level, but the cost of living in much of California is higher than in most other parts of the U.S., primarily due to high housing costs. Using the California Poverty Measure, an unofficial measure that accounts for cost of living and a range of family needs and resources, the 400% FPL upper limit for eligibility for ACA premium subsidies is equivalent to approximately 500% FPL statewide in California, and up to 600% FPL in a high-cost region like San Francisco.[54]

Previous analysis by the UC Berkeley Labor Center estimated the minimum household income needed to pay Covered California premiums for a Silver plan and out-of-pocket costs after federal subsidies, while also meeting other basic needs. The analysis found that in every California county there is an affordability gap for some residents who earn too much to qualify for zero-premium Medi-Cal, but not enough to be able to afford Covered California insurance and care while also covering their other basic needs.

The income level at which health care costs could be considered affordable varied by county based on cost of living. A typical family of four in the highest-cost region, Marin County, might be able to afford premiums and out-of-pocket costs with earnings of $110,300, or 455% FPL, in 2016. This is compared to a typical family of four in the California county with the lowest cost of living, Modoc, where $54,600 in annual income, or 225% FPL, might be sufficient for a family of four to afford healthcare costs through Covered California. These estimates were conservative in that they assumed low medical use by all household members and a minimal household budget for other expenses, based in part on the California Budget & Policy Center's "Making Ends Meet" household budget estimates by county. (An interactive map with estimates for all 58 California counties and further information about this analysis is available on the California Health Care Foundation website.[55])

More than one-third (36%) of California non-elderly adults newly insured through Covered California in 2014 reported feeling financially insecure in general, according to a survey conducted by the Kaiser Family Foundation. Four out of ten (41%) reported that it was somewhat or very difficult to pay for necessities, two-thirds (66%) reported that it was somewhat or very difficult to save money, and more than half (54%) reported that it was somewhat or very difficult to pay off debt.[56] A national survey of uninsured adults in 2015 found that more than half (58%) had $100 or less left over each month after paying bills, and more than half (56%) had less than $100 in

CASE STUDY:

High Housing Costs in Certain Regions Squeeze Household Budgets, Exacerbating Heath Insurance Affordability

A single 40-year old man with income of $3,015 per month (300% FPL) living in San Mateo, California, where the median rent for a studio apartment is over $2,000 a month[58] would have approximately $1,000 left each month after paying rent to cover food, transportation, utilities, taxes, other expenses, and health care. In 2018, he would face the following health coverage choices if he were not offered affordable insurance through his job.

- He could pay $280 per month in premiums, after subsidies, for the lowest cost Silver plan, leaving a little over $700 per month after housing for all other expenses including taxes. This might cause difficulty affording other basic needs.
- He could pay $95 per month, after subsidies, for the lowest cost Bronze plan, which may be more manageable than Silver premiums but would put him at greater risk of high out-of-pocket costs. He has $2,000 in savings, which would only partially cover the $6,300 deductible if he incurred high medical expenses. If he were to select this plan, he might forgo needed care due to cost.
- He could remain uninsured and pay approximately $58 per month in penalties for the 2018 tax year.[59] In 2019, he would not owe a penalty for lacking insurance unless the state enacts its own mandate.

The evidence shows that Californians in situations like this are making all three of these choices, depending on their individual circumstances.

savings.[57] This broader financial insecurity may make it difficult for some Californians to afford health insurance even with subsidies.

Affordability concerns for Californians not eligible for subsidies based on income

Affordability is also a challenge for people who earn too much to qualify for premium subsidies: more than $48,240 for a single individual or $98,400 for a family of four. Covered California estimates that nationally the median household income of off-Marketplace individual market enrollees was approximately $75,000 in 2016.[60] While the typical unsubsidized Marketplace enrollee is not poor, they are also generally not high-income individuals.

The ACA exempts uninsured individuals from paying a penalty if the lowest cost Bronze plan available to them costs more than 8.16% of income, but no financial assistance is available to individuals with incomes above 400% FPL to make insurance more affordable for them. Many of the approximately 1 million California individual market enrollees in households earning more than 400% FPL[61] face Bronze premiums that cost more than 8.16% of income. Some individuals face premiums for a Bronze plan that are equal to more than 20% of their income.[62]

Affordability challenges for those seeking unsubsidized coverage are most likely to affect those age 50 or older.[63] The ACA limited the allowable variation in premiums based on age so that older individuals pay no more than three times the amount younger individuals pay—but this still results in older people facing significantly higher premiums than younger people. Even so, Bronze plans can fail to meet the individual mandate affordability exemption standard (8.16% of income) for single individuals as young as age 36 in San Mateo County, the pricing region with the highest 2018 Bronze premium. In the lowest premium region of California, Los Angeles, only older single individuals—those at least 51 years old— may be subject to Bronze premiums that cost more than 8.16% of income (Appendix Exhibit A3).

All other things equal, premiums constitute a higher share of income for married couples than for single individuals of the same age; this is because unsubsidized premiums for a couple are double those for a single individual, while the Federal Poverty Level for a couple is only 35% higher than for a single individual. As shown in Appendix Exhibit A4, in some parts of Northern California, couples as young as age 18 would pay Bronze premiums that fail to meet the individual mandate affordability standard. As a percentage of income, unsubsidized Bronze premium spending for families with children (not shown) generally falls in between spending by single individuals and married couples without children.

Among unsubsidized enrollees, individuals with incomes between 400% and 600% FPL (between $48,240 and $72,360 for a single individual) are the most likely to pay a higher percentage of income on premiums,[64] but even higher-income individuals sometimes face premiums that fail to meet the individual mandate affordability standard. Bronze premiums exceed the individual mandate affordability exemption standard for single 64-year olds with incomes up to 652% FPL in Los Angeles (Region 15) and up to 982% FPL in San Mateo (Appendix Exhibit A3). The problem of high premium spending relative to income extends higher up the income scale for married 64-year old couples: 968% FPL in Los Angeles (Region 15) and 1,458% FPL in San Mateo (Appendix Exhibit A4).

Appendix Exhibits A3 and A4 show the results of our analysis on the full range of ages and income levels for which Bronze premiums may be unaffordable for individuals with incomes above 400% FPL. Our analysis found that while it is possible for some Californians as young as 18 or with incomes well above 1000% FPL to face unaffordable Bronze premiums, it is older and middle-income Californians who are the most likely to face these affordability challenges.

Californians lacking access to affordable employer-sponsored and individual market coverage due to the "family glitch"

In order to curb "crowd out," or the reduction of enrollment in employer-sponsored insurance as a result of the expansion of publicly-subsidized coverage options, the ACA requires large employers to offer coverage to full-time employees and their dependent children or pay a penalty. No penalty is owed for not offering coverage to spouses. Large employers that offer unaffordable coverage to full-time employees may owe a penalty, but the ACA imposes no penalty for offering unaffordable coverage to dependent children and spouses.[65]

To maintain the primary role of employer-sponsored insurance in the U.S. health coverage system, the ACA also prohibits individuals with an offer of affordable employer-sponsored insurance from receiving subsidies to purchase coverage through the Marketplaces. Because of this provision,

CASE STUDY:
Older Individuals Ineligible for Subsidies based on Income

A married couple, both age 55 and self-employed, living in San Mateo, California, and earning $73,080 annually (450% FPL) would pay $1,200 per month total for the lowest cost Bronze plan offered in that region. Premium spending would equal nearly 20% of the couple's income, before any out-of-pocket spending on health care costs under the plan's $6,300 deductible.

CASE STUDY:
"Family Glitch" Affected Households

A married California couple with two children earns $66,420 (270% FPL), a little too much for the children to be eligible for Medi-Cal. One spouse works full time and the other spouse is the primary caregiver for the family's young kids. The worker's employer offers health insurance requiring an employee premium contribution of $140 per month for worker-only coverage and $810 per month for coverage for the whole family. This family would pay 2.5% of income to enroll the worker and 14.7% of income to enroll the entire family in employer-sponsored insurance. The worker's spouse and children are not eligible for premium subsidies through Covered California because the worker-only premiums are affordable under the ACA definition for the purposes of determining premium subsidy eligibility. Some families in this scenario may struggle to pay the employer-sponsored premiums for the whole family, while other families may be unable to do so, leaving some family members uninsured.

In a second example, a married couple without children earns $24,360 (150% FPL). One spouse is offered employer-sponsored insurance requiring an employee premium contribution of $140 per month for worker-only coverage and $400 per month for the couple. This household would pay 6.9% of income to enroll the worker in employer-sponsored insurance and 19.7% of income to enroll the couple.

workers with an offer of insurance coverage that costs less than 9.56% of household income cannot receive subsidies through the Marketplaces. The ACA statute was unclear, however, on the affordability standard for coverage offered to dependents and spouses of a worker.[66] In 2013, the Internal Revenue Service (IRS) decided to define affordability using the cost of worker-only coverage, meaning dependent children and spouses of workers with affordable worker-only coverage would also be ineligible for subsidies, regardless of the cost of family coverage.[67]

The IRS's decision was significant because, in many cases, worker-only coverage through an employer may be affordable while family coverage is not. Premiums for employer-sponsored family coverage are much higher than premiums for worker-only coverage, and the share of premiums that employees are required to contribute for family coverage is often higher than for worker-only coverage.[68] Some employers that cover a significant portion of their employees' premiums allow the employees to include their dependent children and spouses on the plan but do not cover any of their premiums.

For "family glitch" affected households, purchasing individual market coverage without subsidies is an option under current policy. However, in those circumstances when a spouse requires coverage, this option may be particularly formidable since the cost of coverage for spouses, which varies by age, is higher than for children.

If children and spouses caught in the family glitch choose not to enroll in a health insurance plan, most are exempt from the individual mandate and do not face a penalty for not having coverage.[69] Despite the exemption from the individual mandate penalty, many individuals affected by the family glitch maintain unaffordable insurance.

State policy options to improve individual market affordability

States can play a role in further improving affordability of individual market coverage beyond the standards set by the ACA. Several states and localities have already enacted policies that reduce premium and/or out-of-pocket costs for some residents. Massachusetts provides additional premium and cost sharing subsidies to eligible individuals with incomes at or below 300% FPL who enroll in Commonwealth Care, a program that began under the state's health reform efforts enacted in 2006 and was modified under the ACA. The Vermont Premium Assistance program provides premium and cost sharing assistance to eligible individuals with incomes at or below 300% FPL. Under the San Francisco Health Care Security Ordinance, some San Franciscans with incomes at or below 500% FPL receive premium and cost sharing subsidies through the Covered San Francisco MRA program if they have an employer that fulfills the law's health care spending requirement by contributing to the City Option program.[70] Finally, three states—Alaska, Minnesota, and Oregon—have received federal approval for state reinsurance programs that will reduce premiums for unsubsidized enrollees, most of whom have incomes above 400% FPL.

These programs serve as examples for some of the five state policy options explored in this report:

1. Adding state premium subsidies for those who are already eligible for federal ACA subsidies;
2. Increasing the level of financial assistance to reduce deductibles, co-payments, and other cost sharing, and expanding eligibility for this assistance;
3. Limiting premium contributions for individuals not eligible for ACA premium subsidies based on income;
4. Establishing a state reinsurance program that would reduce premiums for unsubsidized individual market enrollees; and
5. Extending eligibility for state-funded premium and cost sharing subsidies to children and spouses affected by the ACA "family glitch."

These policy proposals are discussed as separate options, but implementing them in combination would likely produce effects that are greater than the sum of the effects of each policy in isolation. Implementing these policies in concert would increase enrollment in the individual market to an extent exceeding the pooled effect of each individual policy. Correspondingly, the state cost to implement these policies in combination could be higher than the sum of the cost of each policy on its own. The potential for these policies to result in lower premiums due to the enrollment of a healthier population would be greater if these policies were implemented in combination,[71] thereby further improving affordability for unsubsidized enrollees, further reducing federal spending on premium subsidies, and helping to limit some of the state cost associated with any new premium subsidies provided. Implementing a package of these policies in combination may also potentially "crowd out" enrollment in employer-sponsored insurance beyond the sum of the effects of each policy.[72]

Enhance premium subsidies for those already eligible

California could consider using state funds to increase premium subsidies for eligible individuals with incomes at or below 400% FPL in order to improve affordability and increase enrollment.

Policy design considerations:

The state could increase premium subsidies for Californians under 400% FPL in a variety of ways. Premium contributions could be reduced proportionally for all enrollees in this income range, or premium contributions could be reduced by differing amount at various income levels. For example, California could add state premium subsidies that result in households with incomes under 139% FPL paying zero premiums, households with incomes between 300% and 400% FPL paying no more than 8% of income on premiums, and improved affordability scaled to income for households in between. This could improve premium affordability both for those who currently receive subsidies through Covered California as well as for those eligible but not enrolled.

Programs in Massachusetts, Vermont, and San Francisco provide examples of various standards for premium affordability that California policymakers could consider. (See Appendix Exhibit A5 for details.)

One potential element of a policy to improve premium affordability for those already eligible would be to eliminate premium contributions for the 25,000 lawfully present immigrants in Covered California who have incomes below 139% FPL but are not eligible for Medi-Cal.[73] As described earlier in this report, these individuals, who earn less than $1,400 per month if single, face premiums of up to $46 per month for a single individual. Eliminating premiums for this population, as Massachusetts has done (for those with incomes at or below 150% FPL), would improve affordability and create parity with the other Californians in this income range who are eligible for Medi-Cal and pay no premiums.

Number of Californians affected:

If state premium subsidies were provided to all Californians currently eligible for ACA premium subsidies, affordability would improve for the 1.2 million Californians already enrolled in subsidized coverage (Exhibit 2, page 9). The projected increase in enrollment would depend on the size of the reductions in premium contributions. A 15% decrease in net premium contributions would be estimated to increase individual market enrollment by tens of thousands, and a 50% decrease in net premiums would result in an increase in enrollment that is in the low hundreds of thousands.[74] These estimates do not take into account the elimination of the ACA individual mandate penalty, which is expected to reduce enrollment. Providing state premium subsidies would help to counteract the reduction in individual market enrollment that would occur when the ACA individual mandate penalty is eliminated, but we have not quantified how many Californians would retain coverage if the state provides premium subsidies in the absence of a penalty for lacking insurance.

Impact on premiums:

Under this policy option, the new enrollees in the individual market would likely be somewhat healthier on average than existing enrollees, which could slightly reduce premiums across the whole market. This, in turn, would result in unsubsidized enrollees paying less than they otherwise

would have, and the federal government spending less on premium tax credits for subsidized enrollees. RAND estimated that reducing subsidized premium contributions by 15% under a federal policy would decrease Silver premiums by 0.2% in 2020.[75] A larger reduction in premium contributions for subsidized enrollees, or enhancing premium subsidies in combination with other policies to improve affordability, would likely yield higher premium reductions across the market.

Funding considerations:
California would likely need to rely solely on state funding to further improve premium subsidies beyond ACA standards. If this policy were pursued under a 1332 State Innovation Waiver, federal deficit neutrality calculations would be unlikely to result in federal pass-through savings to the state, though the exact impact would depend on the specifics of the proposal and projections of how much enrollment and premiums would change as a result. Although federal spending on premium subsidies per enrollee could be reduced by enrollment of a broader, healthier population, those federal savings might be offset by an increase in federal spending resulting from higher enrollment with improved affordability.[76]

Impact on employer-sponsored insurance:
In determining the level of state premium subsidies to provide, policymakers might consider the impact that improving the affordability of coverage offered to individuals without employer-sponsored insurance would have on the offer of and enrollment in employer-sponsored insurance. A national analysis by RAND indicated that 1,000 fewer people would be enrolled in employer-sponsored insurance for every 2,800 more people enrolled in individual market coverage, under a federal policy scenario in which net enrollee premium contributions would be 15% lower than under the ACA.[77]

Enhance cost sharing subsidies and expand eligibility

California policymakers could consider improving financial assistance for out-of-pocket costs (cost sharing reductions) to lower deductibles, co-payments, and other costs in order to improve access to care, reduce financial problems related to medical bills, and potentially increase enrollment.

Policy design approach:
Improving affordability of co-pays, deductibles, and other costs could involve providing additional financial assistance to those currently eligible for ACA out-of-pocket assistance as well as providing financial assistance to those with incomes above 250% FPL. Massachusetts and Vermont have reduced out-of-pocket costs for eligible individuals with incomes at or below 300% FPL and San Francisco provides financial assistance to reduce out-of-pocket costs to certain residents with incomes at or below 500% FPL in recognition of the city's high cost of living. Further details about these programs are provided in Appendix Exhibit A6.

Number of Californians affected:
This policy option would improve out-of-pocket affordability for some of the 680,000 Californians already receiving cost sharing reductions (Exhibit 2, page 9), depending on the income levels for which additional financial assistance is provided. If California used state funds to extend eligibility for cost sharing reductions to Covered California enrollees with incomes up to 400% FPL, as many

as 320,000 additional individuals could benefit from increased out-of-pocket affordability, based on the current number of Covered California enrollees in that income range.[78]

Under this policy option, all individuals receiving state-funded cost sharing subsidies would pay lower co-payments, which could improve access to care and reduce financial burdens. This policy would especially improve affordability for Californians with the highest health care use because it could reduce their deductibles and out-of-pocket maximums by hundreds or thousands of dollars annually, depending on the specific policy design. State spending on such a policy would be most concentrated on the Californians who need the most care.

Enhanced cost sharing could also potentially increase enrollment among the uninsured, for whom out-of-pocket costs are one of the most important considerations in their enrollment decisions. It is not known how many Californians would be likely to become newly insured if out-of-pocket costs were reduced. This policy option also could also potentially improve retention of coverage, which is particularly important in the context of the elimination of the ACA individual mandate penalty.

Impact on premiums:
The impact of state-funded enhanced on premiums would depend on the extent to which reducing out-of-pocket costs changes the amount and mix of health services used by enrollees, and whether the average risk mix in the market would change as a result of any new enrollment under this policy. No existing research was found that could be used to predict these impacts.

Funding considerations:
This policy would likely need to be completely funded using state funds.

Impact on employer-sponsored insurance:
In determining the level of state financial assistance to provide for enhanced cost sharing subsidies, policymakers might consider the impact that reducing out-of-pocket costs for individuals without employer-sponsored insurance would have on the offer of and enrollment in employer-sponsored insurance. For Californians who have insurance through a small employer, insurers paid 79% of medical costs, on average, and enrollees paid the other 21% in 2016. For Californians with insurance through a large employer, insurers paid between 86% and 90% of costs, on average, in 2016.[79] Marketplace Silver plans for individuals with incomes above 200% FPL pay a lower share of costs, on average, compared to the amount paid by employer-sponsored plans.

Cap premium contributions for individuals not currently eligible for subsidies

State policymakers could consider limiting premium contributions for all individuals eligible for Covered California to a certain percentage of income and providing a state tax credit for the amount by which premiums exceed this standard.

Policy approach:

Under the ACA, individuals are exempt from paying a penalty for lacking insurance if they have no offer of affordable coverage, defined as premiums costing no more than 8.16% of income, but premium subsidies are only provided to households with annual income equivalent to or below 400% FPL, or $48,240 for a single person. To make coverage more affordable to Californians with incomes above 400% FPL, premiums could be capped at 8.16% of income for the lowest cost Bronze plan. The ACA individual mandate affordability standard is just one example of a standard that policymakers could consider in making coverage more affordable for Californians in this income range. Policymakers could design the policy using a different affordability standard, tying the affordability standard to a different benchmark plan, or applying the policy to a more limited income range, such as 400% to 600% FPL or 400% to 800% FPL. Assistance could be provided through a refundable income tax credit or through another mechanism.

One consideration in developing a mechanism for financial assistance with premiums for those over 400% FPL is that some individuals in this income range may lack the liquid assets to pay premiums upfront and then receive a tax credit when they file their taxes. The ability to pay premiums upfront will also depend on how much financial assistance a particular individual needs to make coverage affordable. A Kaiser Family Foundation analysis indicated that in 2016, the vast majority (93%) of U.S. households with incomes between 400% and 800% FPL had liquid assets of at least $1,000, while more than two-thirds (68% to 73% depending on household size) had at least $5,000, and over half (53% to 54%) had at least $10,000.[80]

Number of Californians affected:

A policy capping premiums for Californians with incomes above 400% FPL at 8.16% of income for the lowest cost Bronze plan would improve affordability for those who are already enrolled in individual market coverage that exceeds this affordability standard. Out of the approximately 1 million California individual market enrollees with incomes at or above 400% FPL, the number currently enrolled in coverage that is unaffordable by this standard is estimated to be in the low hundreds of thousands.[81] This policy would be especially likely to improve affordability for Californians ages 50 and older who have incomes between 400% and 600% FPL, or $48,240 to $72,360 for a single individual.[82] Improved affordability for those already enrolled could lead to greater retention of coverage.

In addition, individual market enrollment could increase by tens of thousands as a result of such a policy, as some Californians would likely become newly insured as a result of the more affordable options that this policy would yield.[83] This estimate does not take into account the elimination of the ACA individual mandate penalty.

Impact on premiums:

RAND estimated that capping premium contributions at 9.95% of income based on the second-lowest cost Silver plan would be projected to reduce Silver premiums across the individual market by 2.5% for a 40-year old in 2020 as a result of enrollment by individuals who are healthier, on average, than existing enrollees.[84]

Funding considerations:
State policymakers could consider applying for a 1332 State Innovation Waiver in order to try to obtain federal pass-through funding to help offset a fraction of state costs for this proposal. This policy has the potential to reduce federal spending on premium tax credits as a result of new enrollment by healthier individuals who are not eligible for ACA subsidies, which would reduce premiums across the market. The policy is unlikely to substantially increase enrollment among those eligible for ACA premium subsidies and therefore would likely not result in increased federal spending on premium tax credits.

Impact on employer-sponsored insurance:
In evaluating the impacts of this policy, policymakers might consider how it could affect the role of employer-sponsored insurance. Under one federal policy scenario that would cap premium contributions for individuals with incomes above 400% FPL, RAND estimated that 1,000 fewer people would be enrolled in employer-sponsored insurance for every 4,000 more people enrolled in individual market coverage.[85]

Reduce premiums for unsubsidized enrollees via state reinsurance

Another approach to improving affordability for individuals not currently eligible for premium subsidies based on income would be to establish a state-level reinsurance program to help insurers pay for high-cost claims or high-cost enrollees. This would result in reduced premiums across the individual market and improved affordability for unsubsidized enrollees, most of whom have incomes above 400% FPL. Premium contributions paid by subsidized enrollees would generally remain constant because they are based on a percentage of income, but federal spending on premium tax credits for subsidized enrollees would be reduced. Reinsurance programs also help to maintain a stable market and increase insurer participation.

Policy approach:
The ACA established a temporary reinsurance program from 2014 through 2016. Under this program, insurance plans received payments when the costs for a particular enrollee exceeded a certain initial amount (the "attachment point") and payments continued until the costs for that enrollee exceeded a higher amount (the "cap"). Specifically, federal funding covered 100% of individual market insurers' costs between $45,000 and $250,000 in claims in the first year of the program, approximately half of claims between those claims amounts in the second year, and approximately half of insurers' costs between $90,000 and $250,000 in claims in the last year.[86] The ACA reinsurance program reduced premiums by an estimated to 10% to 14% in the first year.[87] The Medicare Part D program also has a reinsurance program.

In 2017, three states—Alaska, Minnesota, and Oregon—received federal approval for 1332 State Innovation Waivers for their reinsurance programs. The Minnesota and Oregon programs will provide payments to insurers to cover a percentage of costs for claims within a certain dollar range, while Alaska covers all claims costs for enrollees that have one of 33 designated health conditions.

Number of Californians affected:
This policy option has the potential to reduce premiums for the approximately 1.1 million Californians enrolled in the individual market without subsidies (Exhibit 2, page 9). It could also increase enrollment among the uninsured who are eligible for Covered California without subsidies. A 7% premium reduction (see discussion of premium impact below) would be estimated to result in an increase in unsubsidized enrollment that is in the low tens of thousands.[88] This estimate does not take into account the elimination of the ACA individual mandate penalty.

Impact on premiums:
For every $1 billion in gross reinsurance payments in California, individual market premiums would be reduced by approximately 7%, on average, in 2019.[89] Alaska and Minnesota each aim to reduce premiums by 20%, on average, while Oregon is targeting a premium reduction of approximately 7%.[90] Premium reductions may vary by issuer and region depending on the risk mix of each plan, but premium reductions would not vary based on how much financial assistance each enrollee needs to make premiums affordable. As a result, this policy option is less targeted to the unsubsidized Californians with the greatest affordability challenges than the policy option that would cap premium contributions as a percentage of income.

Funding considerations:
Ongoing state funding would be required for a state reinsurance program. The three states with 1332 Waiver approval will receive federal pass-through funding to offset a share of the state payments to insurers for reinsurance. The most dominant factor in the calculation of federal pass-through funding under a Waiver is the estimated reduction in federal spending on premium tax credits as a result of lower premiums. Federal funding will offset an estimated 80% of the gross reinsurance spending in Alaska, 51% in Minnesota, and 33% in Oregon. The states remain responsible for the remainder of the cost.

The share of state reinsurance payments that would be offset by federal funding in California would be dependent on actuarial analysis and the state's negotiations with the U.S. Department of Health and Human Services on the calculations of federal deficit neutrality. One key driver of the level of federal pass-through funding is the state's share of the individual market enrollment that is subsidized. A higher share of the market receiving premium subsidies yields greater opportunity for federal savings to offset the state's costs. In California, approximately 52% of individual market enrollees received premium subsidies in 2016 (Exhibit 2, page 9), compared to 23% in Minnesota,[91] 39% in Oregon,[92] and 66% in Alaska in 2016.[93]

Impact on employer-sponsored insurance:
In evaluating the impacts of this policy, policymakers might consider how it could affect the role of employer-sponsored insurance. Under two federal reinsurance scenarios with varying levels of funding, RAND estimated that 1,000 fewer people would be enrolled in employer-sponsored insurance for every 2,350 to 3,000 more people enrolled in individual market coverage.[94]

Extend ACA affordability standards to Californians with unaffordable employer-sponsored insurance for dependents

California policymakers could consider offering state-funded premium and cost sharing subsidies to Californians in households with incomes at or below 400% FPL who have an offer of unaffordable employer-sponsored insurance through a parent or spouse. These individuals are currently excluded from subsidy eligibility under the ACA "family glitch."

Policy approach:

Our analysis focuses on a policy option under which children and spouses caught in the family glitch would become eligible for subsidies through Covered California and workers with an affordable offer of employer-sponsored insurance would continue to be ineligible for subsidized coverage. An alternate option for fixing the family glitch, which would affect more Californians and would require greater state funding, would allow the workers to enroll in subsidized coverage through Covered California, along with their dependents, even if the worker has an offer of affordable worker-only coverage.

Number of Californians affected:

This proposal would improve affordability for an estimated 110,000 Californians who would be expected to switch from employer-sponsored insurance to more affordable subsidized insurance through Covered California, according to estimates by the UC Berkeley Labor Center and UCLA Center for Health Policy Research in 2011.[95] National estimates by the Urban Institute also suggest that, if the family glitch were fixed in this way, most new enrollees in subsidized coverage would have already been insured through unaffordable employer-sponsored insurance.[96] RAND estimates that most who would newly enroll in subsidized coverage under this policy would have had employer-sponsored insurance or unsubsidized individual market coverage.[97] Families purchasing unaffordable private or employer-sponsored insurance have less room in their budgets for other essentials, and some go into debt to pay their premiums.[98]

According to national analysis by the Urban Institute, employer-sponsored insurance costs for households that fall into the family glitch average 15.8% of household income. If these households became eligible for subsidized marketplace coverage, their average premiums could fall to a more affordable 9.3% of income in combined costs for subsidized marketplace coverage and employer-sponsored insurance.[99]

In addition, an estimated 30,000 Californians would become newly insured under this proposal, according to the 2011 UC Berkeley–UCLA estimates. Approximately half of the 140,000 Californians who would be projected to newly enroll in Covered California under this proposal are children and half are adult dependents, primarily spouses but also adult children.[100]

Impact on premiums:

The Californians who would be projected to enroll under this proposal would be younger and healthier than existing enrollees, which could slightly reduce average premiums across the market, with the potential to slightly improve affordability for unsubsidized enrollees.[101] RAND estimates that allowing dependents with unaffordable employer-sponsored insurance offers to be eligible

for ACA subsidies would result in Silver premiums for a 40-year old that are approximately 1% lower than they otherwise would be, due to the shift in enrollment of some relatively healthy workers from employer-sponsored coverage to Marketplace coverage.[102]

Funding considerations:
This policy option would rely completely on the use of state funds.

Impact on employer-sponsored insurance: Approximately 110,000 fewer Californians would be expected to have employer-sponsored insurance under this policy option because they would switch to subsidized insurance through Covered California, according to estimates by the UC Berkeley Labor Center and UCLA Center for Health Policy Research in 2011.[103]

Continue strong outreach and marketing efforts to improve awareness of financial assistance available

The policy options discussed above, individually and collectively, would reduce the amount that Californians struggling to afford coverage and care would spend, but perceived unaffordability can also be a barrier to enrollment in the individual market. A recent survey conducted for Covered California by Greenberg Strategy found that nearly three-quarters of uninsured Californians eligible for subsidized coverage either did not know they were eligible for subsidies or falsely believed they were ineligible. This finding is important because the same survey also found that uninsured people who expected to be eligible for subsidies were twice as likely to plan to enroll.[104] While California has been a leader among states in conducting strategic outreach campaigns and investing in marketing and enrollment assistance to help individuals understand their coverage options, more work is needed to ensure that people understand their eligibility and shop for coverage at the time that they are eligible. These efforts are not a focus of this report, but will always be needed as people churn in and out of needing individual market coverage as their income fluctuates, as their access to job-based coverage changes, or as they undergo other life transitions. Ensuring awareness of the financial assistance available would become even more important if California enacted policies to make coverage more affordable.

Conclusion

The ACA has significantly improved the affordability of and enrollment in coverage among Covered California-eligible individuals who lack access to employer-sponsored insurance or Medi-Cal. However, at least 1.2 million Californians eligible for Covered California, with or without subsidies, remain uninsured, with affordability concerns being the leading reason for lacking insurance. Many of the 2.3 million Californians enrolled in individual market coverage struggle to afford premiums, causing financial problems and putting retention of coverage at risk. Many Californians also face high out-of-pocket costs, which can cause financial hardship, result in delay or avoidance of necessary care, and potentially serve as a deterrent to enrollment. The evidence from California indicates that affordability is a concern for both those already eligible for ACA premium subsidies and those who earn too much to qualify.

Policies to improve affordability of individual market coverage are an important and necessary component to making health coverage more universal and affordable in this state. Affordability concerns are one of the biggest drivers of uninsurance in California, second only to the exclusion of undocumented immigrants from coverage options.

California policymakers could consider improving premium subsidies and cost sharing assistance for those already eligible under the ACA, and expanding cost sharing assistance to individuals who are not currently eligible based on income. Massachusetts, Vermont, and San Francisco have implemented policies that could serve as models. These policies have the potential, especially if implemented in combination, to improve affordability, enrollment, and access to care, while reducing premiums for unsubsidized enrollees if a broader and healthier population enrolls.

California could also limit premium spending as a share of income for individuals who earn too much to be eligible for ACA premium subsidies. A state reinsurance program would be another way to reduce premiums for unsubsidized enrollees. Both of these options would improve affordability for individuals who are ineligible for ACA premium subsidies based on income, though the affordability help provided under a cap on premium spending as a share of income would be more targeted to those with affordability concerns than would be the case under a reinsurance program. Both of these options also have the potential to increase enrollment, leading to a broader and healthier enrollment population that would consequently result in lower premiums.

Providing state-funded premium and cost sharing subsidies mirroring the ACA subsidies would benefit Californians caught in the ACA "family glitch"—in which children and spouses have an offer of family coverage through a parent's or spouse's job, rendering them ineligible for ACA subsidies, but whose family coverage offer is unaffordable. This policy option would reduce spending on health care by families caught up in this glitch by allowing them to switch from unaffordable employer-sponsored coverage to subsidized coverage through Covered California. It would also result in new enrollment in subsidized coverage among some who remain uninsured due to this eligibility gap in the ACA.

Consideration and adoption of policy options to increase health care affordability takes on greater importance with the elimination of the federal individual mandate penalty starting in 2019, which threatens to reduce individual market enrollment and increase individual market premiums. However, survey data indicate that affordability considerations are a bigger driver of the enrollment decision than concern over the penalty for not having insurance.

With these improvements to individual market affordability, California could continue to build upon the progress it has made under the ACA by bringing the state even closer to universal coverage. The state has already served as a national model for successful implementation of the ACA. Implementation of these policies could further expand the state's role as a model for how states can go beyond the ACA.

Appendix

Exhibit A1:
Premium contributions under ACA by income level, 2018

Income as a percent of the federal poverty level (FPL)	Maximum premium contributions for second-lowest cost silver plan		
	As percentage of income	Monthly $ (single)	Monthly $ (family of 4)
Less than 139% FPL	2.01% – 3.32%	$ 0 – 47	$ 0 – 96
At least 139% but less than 150%	3.38% – 4.03%	$ 47 – 61	$ 96 – 124
At least 150% but less than 200%	4.03% – 6.34%	$ 61 – 127	$ 124 – 260
At least 200% but less than 250%	6.34% – 8.10%	$ 127 – 204	$ 260 – 415
At least 250% but less than 300%	8.10% – 9.56%	$ 204 – 288	$ 415 – 588
At least 300% but less than 350%	9.56%	$ 288 – 336	$ 588 – 686
At least 350% but not more than 400%	9.56%	$ 336 – 384	$ 686 – 784

Exhibit A2:

Excerpts from Covered California Standardized Benefit Designs, 2018

Benefits in blue are not subject to a deductible

Coverage category	Bronze	Silver	Enhanced Silver 73 200–250% FPL	Enhanced Silver 87 150–200% FPL	Enhanced Silver 94 100–150% FPL	Gold	Platinum
Primary care visit	$75*	$35	$30	$10	$5	$25	$15
Specialist visit	$105*	$75	$75	$25	$8	$55	$30
Generic drugs	Full cost until drug deductible is met	$15 after drug deductible is met	$15 after drug deductible is met	$5 or less	$3 or less	$15 or less	$5 or less
Emergency room	Full cost until deductible is met	$350	$350	$100	$50	$325	$150
Hospital facility fee	100% coinsurance	20% coinsurance	20% coinsurance	15% coinsurance	10% coinsurance	$600 per day up to 5 days	$250 per day up to 5 days
Individual Medical deductible	$6,300	$2,500	$2,200	$650	$75	N/A	N/A
Individual Pharmacy deductible	$500	$130	$130	$50	N/A	N/A	N/A
Individual Out-of-pocket maximum	$7,000	$7,000	$5,850	$2,450	$1,000	$6,000	$3,350

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

For a fuller description of cost sharing by metal tier and service see Covered California's Standardized Benefit Design chart here https://www.coveredca.com/PDFs/2018-Health-Benefits-table.pdf. More details are available from Covered California at http://hbex.coveredca.com/stakeholders/plan-management/PDFs/2018-Covered-California-Patient-Centered-Benefit-Plan-Designs.pdf?v=2.0.

Exhibit A3:

Characteristics of **single individuals** in California with incomes above 400% FPL for whom lowest cost Bronze premium exceeds ACA individual mandate affordability standard, by Covered California pricing region, 2018

Covered California Pricing Region	Lowest cost Bronze premium exceeds ACA individual mandate affordability standard (8.16% of income), 2018	
	For this age range, depending on income	For this income range as a percentage of the Federal Poverty Level, depending on age
1 – Northern Counties	Age 43+	401% – 888% FPL
2 – North Bay Area	41+	401% – 935%
3 – Greater Sacramento	43+	401% – 888%
4 – San Francisco County	38+	401% – 969%
5 – Contra Costa County	43+	401% – 888%
6 – Alameda County	42+	401% – 912%
7 – Santa Clara County	47+	401% – 795%
8 – San Mateo County	36+	401% – 982%
9 – Santa Cruz, Benito, Monterey	42+	401% – 912%
10 – Central Valley	47+	401% – 795%
11 – Fresno, Kings, Madera Counties	48+	401% – 758%
12 – Central Coast	44+	401% – 874%
13 – Eastern Counties	46+	401% – 829%
14 – Kern County	47+	401% – 794%
15 – Los Angeles County (partial)	51+	401% – 652%
16 – Los Angeles County (partial)	48+	401% – 738%
17 – Inland Empire	49+	401% – 708%
18 – Orange County	49+	401% – 731%
19 – San Diego County	47+	401% – 788%

Source: Authors' analysis of Covered California rates, 2018.

Exhibit A4:

Characteristics of **married couples** in California with incomes above 400% FPL for whom lowest cost Bronze premium exceeds ACA individual mandate affordability standard, by Covered California pricing region, 2018

Note: Examples assume spouses are the same age for simplicity.

Covered California Pricing Region	Lowest cost Bronze premium exceeds ACA individual mandate affordability standard (8.16% of income), 2018	
	For this age range, depending on income	For this income range as a percentage of the Federal Poverty Level, depending on age
1 – Northern Counties	Age 18+	401% – 1320% FPL
2 – North Bay Area	18+	401% – 1389%
3 – Greater Sacramento	18+	401% – 1320%
4 – San Francisco County	18+	401% – 1439%
5 – Contra Costa County	18+	401% – 1320%
6 – Alameda County	18+	401% – 1354%
7 – Santa Clara County	26+	401% – 1181%
8 – San Mateo County	18+	401% – 1458%
9 – Santa Cruz, Benito, Monterey	18+	401% – 1354%
10 – Central Valley	26+	401% – 1181%
11 – Fresno, Kings, Madera Counties	28+	401% – 1125%
12 – Central Coast	19+	401% – 1298%
13 – Eastern Counties	21+	401% – 1232%
14 – Kern County	26+	401% – 1179%
15 – Los Angeles County (partial)	38+	401% – 968%
16 – Los Angeles County (partial)	29+	401% – 1096%
17 – Inland Empire	31+	401% – 1052%
18 – Orange County	29+	401% – 1085%
19 – San Diego County	27+	401% – 1171%

Source: Authors' analysis of Covered California rates, 2018.

Exhibit A5:
Premium Affordability Programs in Other States and Localities

Program	Eligibility	Premium Contributions for second-lowest cost Silver plan	Reduction in premiums compared to under ACA
Commonwealth Care (Massachusetts)	Eligible for ACA premium subsidies and income at or below 300% FPL	No premiums for those at or below 150% FPL, premium contributions of between 2.90% and 7.45% of income between 150% and 300% FPL, compared to between 4.03% and 9.56% of income under the ACA	100% reduction for those with incomes at or below 150% FPL Varies from 0% to 54% reduction for those with incomes 150-300% FPL
Vermont Premium Assistance	Eligible for ACA premium subsidies and income at or below 300% FPL	Reduces premiums by 1.5% of income on top of ACA subsidies (e.g., maximum required contribution under ACA is 4.03% at 150% FPL and in Vermont it is 2.53%)	Sliding scale from 75% reduction below 133% FPL to 16% reduction at 300% FPL
Covered San Francisco MRA	Adult residing in San Francisco with income at or below 500% FPL, enrolled in Covered California, not eligible for Medi-Cal or Medicare, employer meets City health spending requirement by contributing to City Option	For individuals with subsidized coverage, enrollee pays 40% of net premium after ACA subsidies For individuals with unsubsidized coverage, enrollee pays 40% of total premium	60% reduction

Sources: Massachusetts Health Connector, Final Affordability Schedule for Calendar Year 2018, Board of Directors Meeting, April 13, 2017, https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2017/04-13-2017/CY2018-Final-Affordability-Schedule-VOTE-041317.pdf. Correspondence with Department of Vermont Health Access, January 2018. Ken Jacobs (UC Berkeley Labor Center), Universal Access to Care: Lessons from San Francisco, Testimony to the California Assembly Select Committee on Health Care Delivery Systems and Universal Coverage, December 11, 2017, http://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/Ken%20Jacobs%20powerpoint%20presentation%20Lessons%20from%20San%20Francisco.pdf.

Exhibit A6:

Actuarial value of plans offered to eligible individuals by household income level under ACA and programs in states and localities that provide additional financial assistance with out-of-pocket costs

Note: Actuarial value is a measure of the percentage of claims an insurer pays, on average, across a population, with enrollees paying the remainder of costs. Deductibles and other cost sharing amounts can vary even among plans with the same actuarial value.

	Household income as a percentage of the Federal Poverty Level (FPL)					
Program	**At or below 100% FPL**	**100–150% FPL**	**150–200% FPL**	**200–250% FPL**	**250–300% FPL**	**300–500% FPL**
Affordable Care Act	94%	94%	87%	73%	70%	70% if enrolled in benchmark plan
Commonwealth Care (Massachusetts)	99%	97%	97%	95%	95%	
Vermont Premium Assistance	94%	94%	87%	77%	73%	
Covered San Francisco MRA	Financial assistance is not directly tied to actuarial value: cost sharing assistance is provided to keep deductible below 5% of income (after ACA cost sharing reductions when applicable)					

Sources: Suzanne Curry, Maintaining Affordable Health Coverage in Massachusetts, Presentation to Families USA Health Action 2015, January 2015, http://slideplayer.com/slide/4103559/. Correspondence with Department of Vermont Health Access, January 2018. Ken Jacobs (UC Berkeley Labor Center), Universal Access to Care: Lessons from San Francisco, Testimony to the California Assembly Select Committee on Health Care Delivery Systems and Universal Coverage, December 11, 2017, http://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/Ken%20Jacobs%20powerpoint%20presentation%20Lessons%20from%20San%20Francisco.pdf.

Endnotes

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[3] NORC at the University of Chicago. October 22, 2015. Covered California Overview of Findings from the Third California Affordable Care Act Consumer Tracking Survey. http://hbex.coveredca.com/data-research/library/2015CA-Affordable-Care-Act%20Consumer-Tracking-Survey.pdf.

[4] Individuals under age 30 also have the option of a "Minimum Coverage" that offers limited coverage before the deductible is reached. Approximately 12,000 Covered Californians were enrolled in these plans in June 2017. (Covered California. September 1, 2017. Active Member Profile June 2017. http://hbex.coveredca.com/data-research/library/active-member-profiles/12-13-17/CC_Membership_Profile_2017_06.xlsx.)

[5] Gabel JR, Lore R, McDevitt RD, et al. June 2012. More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges As Of 2014. *Health Affairs* 31(6): 1339-1348.

[6] In California prior to the ACA, many individual market plans covered less than 60% of costs and some plans paid as little as 32% of medical costs. (McDevitt R. October 2008. Actuarial Value: A Method for Comparing Health Plan Benefits. Prepared for California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2017/12/PDF-HealthPlanActuarialValue.pdf.) After the ACA, insurers paid 78% of medical costs for subsidized enrollees in Covered California, on average, and 71% for unsubsidized enrollees in 2016. (UC Berkeley analysis of data from: Covered California. March 14, 2017b. Bringing Financial Assistance Within Reach. http://hbex.coveredca.com/data-research/library/Bringing_Health_Care_Coverage_Within_Reach_Data_Sheet_2016.xlsx.) Data is not available for the individual market outside of Covered California.

[7] In Covered California, maximum out-of-pocket spending is limited to $7,000 for an individual and $14,000 for a family in 2018, with lower spending limits for individuals receiving financial assistance to reduce out-of-pocket costs and for those enrolled in Gold or Platinum plans. After this out-of-pocket limit is reached, insurers must pay for all covered care without any enrollee contributions. Most families do not use enough care to reach this out-of-pocket spending limit.

[8] Gabel et al. 2012.

[9] DiJulio B, Firth J, and Brodie M. July 2015. California's Previously Uninsured after the ACA's Second Enrollment Period, Kaiser Family Foundation. Kaiser Family Foundation. https://www.kff.org/health-reform/report/californias-previously-uninsured-after-the-acas-second-open-enrollment-period/.

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[12] California Health Interview Survey, pooled 2014-2016 data.

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[15] Collins SR, Gunja MZ, Doty MM. October 2017. How Well Does Insurance Coverage Protect Consumers from Health Care Costs? Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016. Commonwealth Fund. http://www.commonwealthfund.org/publications/issue-briefs/2017/oct/insurance-coverage-consumers-health-care-costs.

[16] Congressional Budget Office. November 8, 2017. Repealing the Individual Health Insurance Mandate: An Updated Estimate. https://www.cbo.gov/publication/53300.

[17] Approximately 378,000 fewer Californians would be estimated to enroll in the individual market without an individual mandate, based on a survey in which 18% of respondents enrolled in the California individual market reported that they would not have purchased insurance in 2017 if the penalty had not existed. (Hsu J, Fung V, Chernew ME, et al. March 1, 2018. Eliminating the Individual Mandate Penalty in California: Harmful but Non-Fatal Changes in Enrollment and Premiums. *Health Affairs Blog*. https://www.healthaffairs.org/do/10.1377/hblog20180223.551552/full/.) Using the Congressional Budget Office's national estimates of individual market coverage losses in 2019 (Congressional Budget Office 2017), and assuming that the coverage loss in California would be proportionate to California's share of the national individual market enrollment in 2016, we estimate that 440,000 fewer Californians would be enrolled in the individual market in 2019.

[18] Prior estimates by Covered California, with PricewaterhouseCoopers, projected that if the individual mandate was not enforced, 280,000 fewer Californians would be enrolled in subsidized individual market insurance and 60,000 fewer Californians would be enrolled in unsubsidized individual market coverage in 2018. (Bertko J and Hunt S. April 27, 2017. Analysis of Impact to California's Individual Market if Federal Policy Changes are Implemented. http://hbex.coveredca.com/data-research/library/CoveredCA_Impact_to_CA_ind_market_4-27-17%20(1).pdf.) This is consistent with the more recent estimate that of the approximately 378,000 fewer Californians expected to enroll in individual market coverage due to the elimination of the individual mandate penalty (Hsu et al. 2018), 250,000 are currently insured through Covered California. Given that the vast majority of Covered California enrollees are subsidized, most of the enrollment loss would also be likely to be among subsidized enrollees. These projections are also consistent with research by Evan Saltzman. He concluded from his analysis of data from Covered California that "individuals with income above 400 percent of FPL are not sensitive to the existence of the mandate, compared to those with income below 400 percent of FPL." (Saltzman E. 2017. Demand for Health Insurance, Evidence from the California and Washington ACA Marketplaces. Wharton Health Care Management. https://repository.upenn.edu/cgi/viewcontent.cgi?article=1140&context=hcmg_papers.)

[19] Congressional Budget Office 2017.

[20] Blumberg LJ, Holahan J, Hadley J, and Nordahl K. 2007. Setting a Standard of Affordability for Health Insurance Coverage. *Health Affairs* 26(4): w463-473.

[21] Individuals with incomes at or below 133% FPL pay 2.01% of income on premiums under the ACA. This applies to a subset of lawfully present immigrants who are not eligible for Medi-Cal.

[22] Saltzman 2017.

[23] Throughout this report, due to data limitations, data on uninsured citizens is referenced as a proxy for those eligible for Covered California but lawfully present immigrants are also eligible to enroll in Covered California and receive subsidies. Undocumented Californians are not eligible to purchase insurance through Covered California under federal law, but are eligible to purchase private insurance directly from insurers in the individual market.

[24] Non-citizens made up approximately 15% of enrollees with individual market coverage through Covered California in 2015 through 2016, according to the California Health Interview Survey. However, it is not known how many uninsured Californians with incomes at or above 139% FPL are lawfully present immigrants.

[25] Adults with household incomes below 139% FPL are covered by Medi-Cal, with zero premiums and zero cost sharing. Children are also eligible for Medi-Cal if they are in households with incomes below 267% FPL. Depending on income, some children have zero premiums and no cost sharing, while others have modest premiums and co-pays.

[26] Covered California, Active Member Profile June 2017.

[27] These are premium contributions for the benchmark plan, the second-lowest cost Silver plan. Premium contributions are lower for individuals purchasing the lowest cost Silver plan or a Bronze plan.

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[29] 2015 is the most recent tax data available for California at the time of this report's publication. The number of California households paying the penalty may have been lower in 2016 as uninsurance rates in the state continued to decline. Nationally, the number of households paying the penalty declined 26.8% between tax year 2015 and tax year 2016. (U.S. Treasury Inspector General for Tax Administration. January 31, 2018. Results of the 2017 Filing Season. https://www.treasury.gov/tigta/auditreports/2018reports/201840012fr.pdf.)

[30] 76% of Californians paying the tax penalty for not having insurance in 2015 had household income between $10,000 and $50,000, which in most cases would make them eligible for subsidies through Covered California. Another 14% of Californians paying the tax penalty had income between $50,000 and $75,000 and in some cases could have been eligible for subsidies based on income, depending on household size. (Internal Revenue Service (n.d.). Individual Income Tax Returns: Selected Income and Tax Items by State, County, and Size of Adjusted Gross Income, Tax Year 2015. https://www.irs.gov/pub/irs-soi/15incyca.xls.)

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[32] California Health Interview Survey 2016.

[33] In 2014, fewer than one in five (18%) of uninsured citizen adults in the subsidy-eligible income range had an offer of employer-sponsored insurance that they declined. It is not known to what extent these offers of employer-sponsored insurance met the ACA affordability standards for the purpose of determining subsidy eligibility. (California Health Interview Survey 2014.)

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[35] California Health Interview Survey 2016.

[36] Fung V, Liang CY, Donelan K, et al. January 2017. Nearly One-Third of Enrollees in California's Individual Market Missed Opportunities to Receive Financial Assistance. *Health Affairs* 36(1): 21-31.

[37] Covered California, Active Member Profile June 2017.

[38] Under federal law, only a subset of lawfully present immigrants are considered "qualified" immigrants eligible for Medi-Cal. Certain other immigrants are eligible for Medi-Cal using state funds, such as Lawful Permanent Residents who are subject to the federal "five-year bar." Lawfully present immigrants who are not eligible for Medi-Cal under federal or state law— such as those with Temporary Protective Status (TPS), individuals with work visas, student visas, or certain other visas, or individuals applying for certain statuses —are eligible for Marketplace coverage and subsidies (depending on income). (National Immigration Law Center, Center on Budget and Policy Priorities, and the Georgetown Center for Children and Families. September 19, 2014. Overview of Immigrant Eligibility Policies for Health Insurance Affordability Programs. https://www.nilc.org/wp-content/uploads/2015/12/CMS-Immigrant-Eligibilty-Presentation-2014-09-19.pdf.)

[39] Snyder L and Rudowitz R. February 2013. Premiums and Cost Sharing in Medicaid: A Review of the Research Findings. Kaiser Commission on Medicaid and the Uninsured. https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417-premiums-and-cost-sharing-in-medicaid.pdf.

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[43] Collins et al. 2017.

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https://www.hhs.gov/about/news/2017/10/12/trump-administration-takes-action-abide-law-constitution-discontinue-csr-payments.html.

[48] Covered California, Active Member Profile June 2017.

[49] These estimates include employer-sponsored insurance plans with an actuarial value of between 60% and 69%. The large group plans in this estimate include only those that are fully insured. Large group estimates based on analysis of California SB 546 filings. (California Labor Federation (n.d.). California's Fully Insured Large Group Market: Findings from the First Year of SB 546 Filings. http://calaborfed.org/californias-fully-insured-large-group-market-findings-from-the-first-year-of-sb-546-filings/.) Small group enrollment distribution by actuarial value is based on the PricewaterhouseCoopers (PWC) analysis for California Health Benefits Review Program (CHBRP) of the 2016 distribution of enrollees by benefit plan type obtained through PWC surveys of health plans, CHBRP's estimate of the 2018 population split by market and broad plan type, and the calculated weighted average actuarial values.

[50] Covered California. October 11, 2017. Press Release: Covered California Keeps Premiums Stable by Adding Cost-Sharing Reduction Surcharge Only to Silver Plans to Limit Consumer Impact.

[51] Liquid assets sufficient to cover a Bronze deductible are available for between 27% and 29% of American households with incomes between 150% and 400% FPL, and between 7% and 11% of households with incomes under 150% FPL, depending on household size. (Rae M, Claxton G, and Levitt L. November 2017. Do Health Plan Enrollees have Enough Money to Pay Cost Sharing? Kaiser Family Foundation Issue Brief. https://www.kff.org/report-section/do-health-plan-enrollees-have-enough-money-to-pay-cost-sharing-issue-brief/.)

[52] These estimates for San Francisco are consistent with a national analysis by the Urban Institute, which estimated that individual market enrollees with incomes between 200% and 500% FPL and median health use spent more than 10% of income on premiums and out-of-pocket costs, on average, in 2016. Combined premium and out-of-pocket spending exceeded 20% of income for individuals in the same income range with health spending at the 90th percentile. The Urban Institute concluded that under the ACA the burden of premium and out-of-pocket costs in the individual market is highest among individuals with incomes between 200% and 500% FPL. (Blumberg LJ, Holahan J, and Buettgens M. December 2015. How Much Do Marketplace and Other Nongroup Enrollees Spend on Health Care Relative to Their Income? Urban Institute. https://www.urban.org/sites/default/files/publication/76446/2000559-How-Much-Do-Marketplace-and-Other-Nongroup-Enrollees-Spend-on-Health-Care-Relative-to-Their-Incomes.pdf.)

[53] An individual living in Los Angeles with the same demographics as the individual in the Exhibit 6 example would have spent the same percentage of income as someone in San Francisco through approximately 285% FPL. Between 286% and 500% FPL, a single 40-year old in Los Angeles would have spent 6.9% to 11.9% of income on combined premium and out-of-pocket spending in 2015 with median health use, and 16.0% to 27.6% of income with very high health use. These ranges are slightly lower than in San Francisco, where combined health spending for an individual with these demographics would have been 9.7% to 12.0% of income with median health use and 18.8% to 27.7% with very high health use.

[54] Authors' analysis extrapolating from the California Poverty Measure (CPM), produced by Public Policy Institute of California and the Stanford Center on Poverty and Inequality, https://inequality.stanford.edu/publications/research-reports/california-poverty-measure. These estimates are based specifically on CPM data, which are averaged over 2013 to 2015 and show the resources required by

county for a family of four to live out of poverty assuming they do not own their home. (Public Policy Institute of California and Stanford Center on Poverty and Inequality (n.d.). California Poverty by County, 2013-2015. http://www.ppic.org/data-set/california-poverty-by-county-and-legislative-district/.)

[55] Lucia L. June 2016. How Affordable is Health Insurance through Covered California When Local Cost of Living is Taken into Account? California Health Care Foundation Publication. https://www.chcf.org/publication/balancing-the-books-how-affordable-is-health-insurance-through-covered-california-when-local-cost-of-living-is-taken-into-account/.

[56] Garfield R, Majerol M, and Young K. May 2015. Coverage expansions and the remaining uninsured: A look at California during year one of ACA implementation, Kaiser Family Foundation. https://www.kff.org/health-reform/report/coverage-expansions-and-the-remaining-uninsured-a-look-at-california-during-year-one-of-aca-implementation/.

[57] Robert Wood Johnson Foundation et al. 2015.

[58] U.S. Department of Housing and Urban Development. Fiscal Year 2018 Fair Market Rents. https://www.huduser.gov/portal/datasets/fmr.html.

[59] Kaiser Family Foundation. November 7, 2017. Individual Mandate Penalty Calculator. https://www.kff.org/interactive/penalty-calculator/.

[60] This is only somewhat higher than the overall U.S. median income of $66,000 for all Americans ages 19 through 64. (Covered California. January 18, 2018. The Roller Coaster Continues—The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies. http://board.coveredca.com/meetings/2018/01-18/CoveredCA-Roller_Coaster_Continues_1-18-18.pdf.)

[61] Over 1.0 million individual market enrollees were in households with incomes above 400% FPL in 2016, according to the California Health Interview Survey.

[62] UC Berkeley Labor Center analysis using Covered California 2018 rates by age.

[63] UC Berkeley Labor Center analysis using Covered California 2018 rates by age. These findings are consistent with national analysis by RAND. (Eibner C and Liu J. October 2017. Options to Expand Health Insurance Enrollment in the Individual Market. Commonwealth Fund. http://www.commonwealthfund.org/publications/fund-reports/2017/oct/expand-insurance-enrollment-individual-market.)

[64] Ibid.

[65] The ACA requires employers with an average of 50 or more full-time employees to offer these full-time employees affordable health insurance, with "affordability" defined as not costing the employee more than 9.56% of his or her income. The plan must also meet a minimum value standard under which it covers 60% of medical costs, on average. Coverage must also be offered to employees' children under age 26. If employers do not make such an offer, employers may owe a penalty to the IRS. See the IRS's website for more information about Employer Shared Responsibility Provisions, https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions.

[66] Interpretations of the text of the ACA varied on whether the cost of worker-only coverage or family coverage should be compared against household incomes to determine eligibility for subsidies. The Joint Committee on Taxation (JCT) interpreted the statute to define affordability using the cost of worker-only coverage, but some experts argued that there was a strong legal basis for interpreting

the statute to define affordability using the cost of family coverage for determining eligibility for dependents. (Internal Revenue Service. November 17, 2011. Public Hearing on Proposed Regulations 26 CFR Part 1. http://www.taxhistory.org/www/features.nsf/Articles/1C04199B199E24678525794C00541F-D8?OpenDocument.)

[67] IRS Code Title 26, Chapter 1, Subchapter A, Part 1 §1.36b-3.

[68] In 2016, the average monthly premium for worker-only coverage was $597 in California while the average premium for a family of four was $1,634. Employers in California contributed 86% of premiums for worker-only coverage, on average, and 75% for family coverage. (Whitmore and Gabel 2017.)

[69] These dependents are exempt from the individual mandate if the cost of purchasing overage for all family members would exceed 8.13% of household income.

[70] For more information about San Francisco's City Option program see: http://sfcityoption.org/whatiscityoption/.

[71] For example, a national analysis by RAND estimated that a particular federal policy option to improve premium subsidies for those with incomes at or below 400% FPL would decrease Silver premiums for a 40-year old by 0.2%, another policy option to extend premium subsidies to those with incomes above 400% FPL would decrease premiums by 2.5%, but in combination the policies would decrease premiums by 4.8%. (Eibner and Liu, October 2017.)

[72] The term "crowd-out" describes when enrollment in private coverage decreases because of the expansion of publicly-subsidized coverage options. This can occur in a variety of ways, including employers no longer offering coverage or workers and/or their dependents no longer enrolling in employer-sponsored insurance in response to the availability of publicly subsidized programs.

[73] Covered California, Active Member Profile June 2017.

[74] These are order-of-magnitude estimates by the authors based on a working paper by Evan Saltzman of the University of Pennsylvania Wharton School estimating changes in demand for health insurance based on changes in price, using Covered California data from 2014–2015. The price elasticities of demand are applied to estimates of uninsured Californians not offered or eligible for employer-sponsored insurance, by income level, using 2016 California Health Interview Survey. All estimates assume that take-up rates will not exceed 90% under any scenario. (Saltzman 2017.)

[75] Eibner and Liu, October 2017.

[76] Manatt Health. February 2018. Understanding the Rules: Federal Legal Considerations for State-Based Approaches to Expand Coverage in California. California Health Care Foundation Publication. https://www.chcf.org/wp-content/uploads/2018/02/UnderstandingTheRules-FederalLegalConsiderations.pdf.

[77] Eibner and Liu, October 2017.

[78] Covered California, Active Member Profile June 2017.

[79] The large group plans in this estimate include only those that are fully insured. Large group estimates based on analysis of California SB 546 filings. (California Labor Federation (n.d.).) Small group enrollment distribution by actuarial value is based on the PricewaterhouseCoopers (PWC) analysis for the California Health Benefits Review Program (CHBRP) of the 2016 distribution of enrollees by benefit

plan type obtained through PWC surveys of health plans, CHBRP's estimate of the 2018 population split by market and broad plan type, and the calculated weighted average actuarial values.

[80] Correspondence with Matthew Rae, Kaiser Family Foundation, October 2017.

[81] UC Berkeley analysis of Covered California 2018 rates by age and region, compared to analysis of individual market enrollment by age, income, and region using data from the California Health Interview Survey, 2016.

[82] RAND also estimated that people age 50 and over and people with incomes between 400% and 600% FPL would disproportionately benefit from a similar policy option at the federal level. (Eibner C and Liu J. July 2017. Extending Marketplace Tax Credits Would Make Coverage More Affordable for Middle-Income Adults. Commonwealth Fund. http://www.commonwealthfund.org/publications/issue-briefs/2017/jul/marketplace-tax-credit-extension.)

[83] These are order-of-magnitude estimates by the authors in part based on a working paper by Evan Saltzman, The Wharton School, estimating changes in demand for health insurance based on changes in price, using Covered California data from 2014–2015. The price elasticities of demand are applied to estimates of uninsured Californians with demographics that would make them potentially eligible for this state policy option, using 2016 California Health Interview Survey. All estimates assume that take-up rates will not exceed 90% under any scenario. (Saltzman 2017.) RAND projected that a potential federal policy that would cap premiums for individuals with incomes at or above 400% FPL at 9.95% of income based on the second-lowest cost Silver plan (a more affordable standard than 8.16% of income based on lower-cost Bronze) in 2020 would result in 1.6 million additional individual market enrollees. (Eibner and Liu, October 2017.)

[84] Eibner and Liu, October 2017.

[85] The federal policy scenario would cap premium contributions for the second-lowest cost Silver plan at 9.95% of income in 2020. (Eibner and Liu, October 2017)

[86] Harrington SE. September 11, 2017. Stabilizing Individual Health Insurance Markets with Subsidized Reinsurance. University of Pennsylvania Leonard Davis Institute of Health Economics Issue Brief. https://ldi.upenn.edu/brief/stabilizing-individual-health-insurance-markets-subsidized-reinsurance.

[87] Volk J. September 2017. The ABCs of State Reinsurance Programs. Presentation for Community Catalyst Learning Community Webinar.

[88] These are order-of-magnitude estimates by the authors based on a working paper by Evan Saltzman, The Wharton School, estimating changes in demand for health insurance based on changes in price, using Covered California data from 2014–2015. The price elasticities of demand are applied to estimates of uninsured Californians not offered or eligible for employer-sponsored insurance, by income level, using 2016 California Health Interview Survey. All estimates assume that take-up rates will not exceed 90% under any scenario. (Saltzman 2017.)

[89] Gross reinsurance spending of $1 billion in 2019 would be approximately 7% of estimated aggregate individual market premiums in that year, using 2015 actual aggregate premiums from Milliman adjusted up by 7% annually to estimate premium growth. (Milliman. April 2017. Individual Health Insurance Market Profile: State of California, 2015. http://www.milliman.com/uploadedFiles/insight/2017/state-profiles/CA-summary-april-17.pdf.)

[90] State Health Value Strategies. January 4, 2018. State Options for Responding to Changes in the Individual Market. https://www.shvs.org/wp-content/uploads/2018/01/Consolidated-Tax-Bill-Slide-Deck_20180104.pdf.

[91] Minnesota Department of Commerce, Division of Insurance. May 20, 2017. Minnesota Section 1332 Waiver Application. http://mn.gov/commerce-stat/pdfs/mn-1332-actuarial-analysis.pdf.

[92] Oregon Department of Consumer and Business Services. August 31, 2017. Oregon 1332 Draft Waiver Application. http://healthcare.oregon.gov/DocResources/1332-application.pdf.

[93] Tomczyk T, Mueller R, and Kaczmarek P (n.d.). Alaska 1332 Waiver Application: Oliver Wyman Actuarial Analyses and Certification. https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=105951.

[94] Both federal policy options analyzed would pay a share of claims up to $250,000. Under one of the options, reinsurance would pay 100% of claims starting at an attachment point of $45,000, while under the other option reinsurance would pay 50% of claims starting at $90,000. (Eibner and Liu, October 2017.)

[95] Jacobs K, Graham-Squire D, Roby DH, et al. December 2011. Proposed Regulations Could Limit Access to Affordable Health Coverage for Workers' Children and Family Members. UC Berkeley Center for Labor Research and Education, and UCLA Center for Health Policy Research. http://laborcenter.berkeley.edu/pdf/2011/Proposed_Regulations11.pdf.

[96] Buettgens M, Dubay L, and Kenney GM. 2016. Marketplace Subsidies: Changing The 'Family Glitch' Reduces Family Health, Spending But Increases Government Costs. *Health Affairs* 35(7): 1167-1175.

[97] Nowak SA, Saltzman E, and Cordova A. 2015. Alternatives to the ACA's Affordability Firewall. RAND Corporation. https://www.rand.org/content/dam/rand/pubs/research_reports/RR1200/RR1296/RAND_RR1296.pdf.

[98] Pollitz K, Cox C, Lucia K, and Keith K. January 7, 2014. Medical Debt Among People with Health Insurance. Kaiser Family Foundation. https://www.kff.org/private-insurance/report/medical-debt-among-people-with-health-insurance/.

[99] Buettgens et al. 2016.

[100] Jacobs et al. 2011.

[101] Jacobs et al. 2011.

[102] Nowak et al. 2016.

[103] Jacobs et al. 2011.

[104] Greenberg Strategy. October 5, 2017. Covered California Sentiment Research, Wave 2: A Quantitative Study on Current Attitudes of Uninsured and Select Insured Californians Toward Health Insurance Coverage. https://www.coveredca.com/PDFs/October_2017_Covered_California_Sentiment_Survey_FINAL.pdf.

Institute for Research on Labor and Employment
University of California, Berkeley
2521 Channing Way
Berkeley, CA 94720-5555
(510) 642-0323
laborcenter.berkeley.edu

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About the authors

Laurel Lucia is director of the health care program at the UC Berkeley Center for Labor Research and Education. **Ken Jacobs** is Chair of the UC Berkeley Center for Labor Research and Education.

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