

Golden Choice: California's Public Option

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Abstract

California's challenge and opportunity is to provide accessible, affordable, equitable, and continuously improving quality of care to its entire population. Governor Newsom has expanded Medi-Cal to cover undocumented adult immigrants, which when combined with the Biden administration's premium subsidy increases, will result in near universal coverage for all in California. Nonetheless, the affordability of such coverage remains a major challenge for the state. A recent CHCF / NORC survey of Californians reported that just over half (52%) of respondents said they skipped or postponed care due to costs. Additionally, more than 1 in 3 (36%) reported having medical debt, with 1 in 5 (19%) of those with medical debt owing \$5,000 or more. Just over half (52%) of people with lower incomes surveyed reported having medical debt, compared to 30% for those with higher incomes. Furthermore, Latino/x (52%) and Black (48%) Californians were more likely to have medical debt than White (28%) and Asian (27%) Californians. Between 2008 and 2018, Californians' health care spending experienced a 68% increase, compared to only a 16% increase in median household income. The growth in health insurance premiums has far exceeded that of wages over the last two decades.

Building on the success of Covered California (the state's innovative health insurance exchange) and the presence of organized/integrated medical groups and independent practice associations (IPAs) with experience in providing care under risk-adjusted per member per month payments, the state has the potential to develop a public option that increases competition in the health insurance market, which would lower price and can improve quality. A public option plan (POP) is a state plan to offer health insurance for the purpose of increasing competition, consumer choice, and affordability of coverage. Improvements in affordability would be particularly important for low-income and minority populations, as their wages are lower. We test the viability of our POP on Covered California and CalPERS. Furthermore, we show how the L.A. Care county-based plan was successful in attaining enrollment while lowering premium growth for all plans in the LA Regions of Covered California. At this time, we are not recommending that a POP be offered on Covered California or by CalPERS. This decision will need to be made by them, legislators, or the governor. Nonetheless, our analysis shows that our POP would have lower premiums than many of the plans currently on the Covered California.

Among our specific findings of particular importance are the following:

1. Based on our analysis, our proof of concept prototype plan would be the lowest plan in 14 of the 19 Covered California regions when compared to Gold and Silver plans.
2. This would result in an estimated \$243 million in premium savings based on the choice of the POP.
3. More competition within Covered California would result in reduced premiums for other plans. We estimate that if there had been at least 5 insurers participating in each of Covered California's 19 regions in 2020, \$57 million in 2021 premiums would have been saved. If all the markets had 5 or more insurers from 2016 to 2020, we estimate \$228 million in premium reductions.

4. Our analysis of CalPERS data suggests that the prototype public option would have the lowest premium among the 11 plans with whom they contract, with the exception of Health Salud y Mas, which is only available in Southern California and has providers in Mexico as part of its network. The average premium of the 11 CalPERS HMO plans is \$9,800, compared with \$7,767 for the public option plan.
5. L.A. Care becoming the lowest price plan in the LA Regions of Covered California led premiums to be \$225 lower than they otherwise would have been. L.A. Care produced an estimated \$345 million in savings due to a reduction in the rate of premium growth from 2019 to 2022.
6. Golden Choice does not regulate prices or interfere in the market as other state public options do, which is a key distinction of this Golden Choice approach. Finally, we encourage the state to apply for the 1332 waiver to capture savings from the public option plan.

To explore the feasibility of implementing a public option plan, we conducted interviews with seven leaders of health plans and medical groups with restricted Knox-Keene plans that have the ability to assume risk for care provided. Each said that under such a plan, they could provide care that would cost 5 to 10 percent lower in premiums than what is currently the case. They also emphasized the importance of having enrollees select a primary care provider (PCP). Additionally, we shared the plan at a meeting of 30 medical group/administrative leaders of America's Physician Groups (APG) — many of whom are in California — who independently confirmed what had been expressed in our interviews.

A number of questions, of course, remain to be discussed. These include who should administer the POP; what role the 17 existing county health plans might play; and how to best address the coverage and care needs in rural areas of the state where primary care provider to population ratios are low. The report concludes that a public option choice would serve the state well in making health insurance coverage more affordable now and over time.

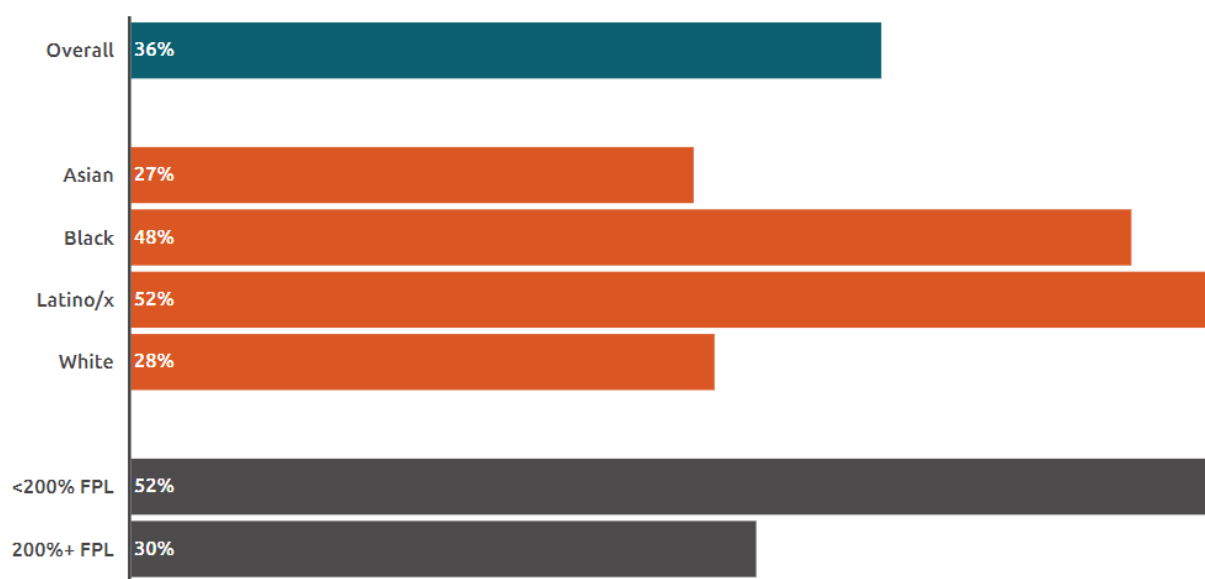
1. Introduction

A. What Problems Are We Trying to Solve?

California's challenge and opportunity is to provide accessible, affordable, and equitable quality of care to all its residents. Governor Newsom has expanded Medi-Cal to cover undocumented adult immigrants, and with the Biden administration's premium subsidy increases, California will achieve near universal health care coverage for all of its residents. Nonetheless, the affordability of such coverage remains a major challenge for the state. In 2022, a CHCF / NORC [survey](#) of Californians reported that just over half (52%) of respondents said they skipped or postponed care due to costs. Additionally, more than 1 in 3 (36%) reported having medical debt, with 1 in 5 (19%) of those with medical debt owing \$5,000 or more (Figure 1). Just over half (52%) of people with lower incomes surveyed reported having medical debt, compared to 30% for those with higher incomes. Furthermore, Latino/x (52%) and Black (48%) Californians were more likely to have medical debt than White (28%) and Asian (27%) Californians. From 2008 to 2018, Californians' health care spending experienced a 68% increase, compared to only a 16% increase in median household income. Medical prices have [grown](#) faster than nonmedical prices in major metropolitan areas in California. This increase is exacerbated by private insurer price increases, which are now [222% higher than Medicare prices](#). Figure 2 makes the problem particularly clear — premium growth has far exceeded wage growth in California over the last two decades. The gap between premiums and wages is even larger for women and minorities due to wage disparities.¹ In 2020, [64% of employees](#) making over \$128,000 at large California employers were men. Moreover, more than half (51%) of those who made over \$128,000 were White, compared to 3% and 9% being Black and Hispanic, respectively.

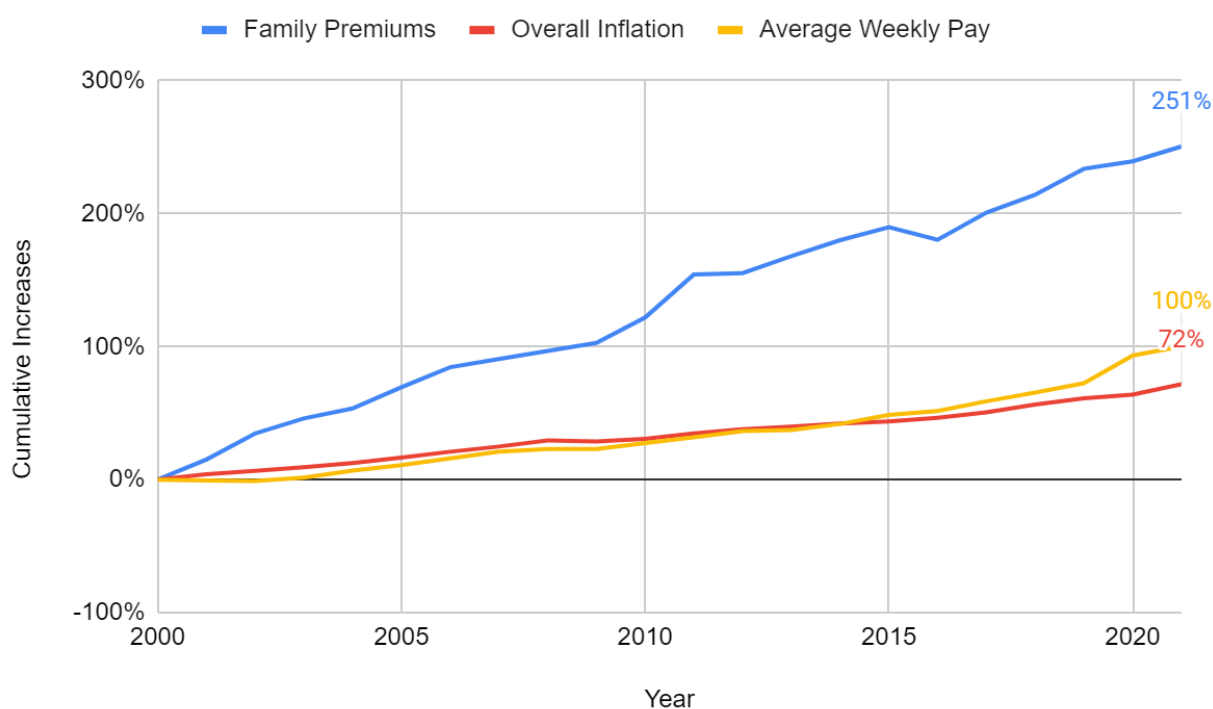
¹ The premium shown in the figure is the total family premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance. This premium includes different plan types (e.g., PPO and HMO) and does not include Covered California premiums. According to the [California Employer Health Benefits Survey](#), average annual family premium growth for PPOs and HMOs was similar (3.4% vs. 3.3%) from 2012 to 2017, but the latest data ([2020](#)) shows the level of HMO family premiums to be 26% lower than PPO family premiums (\$18,010 vs. \$24,311). The gross annual premium for Covered California members increased by 46% over 2014 to 2021 while wages increased by 41% over the same time period.

Figure 1: Percentage of Californians Who Say They Have Any Type of Medical Debt, 2022



Source: CHCF/NORC California Health Policy Survey (September 30-November 1, 2022)
<https://www.chcf.org/publication/2023-chcf-california-health-policy-survey/>

Figure 2: Premiums, Inflation, and Weekly Pay in California, 2000-2021



Notes: Petris Center analysis of data from MEPS-IC (family premiums) <https://datatools.ahrq.gov/meps-ic>, the California Department of Finance (inflation) <https://dof.ca.gov/forecasting/economics/economic-indicators/inflation/>, and the California Employment Development Department (average weekly pay) <https://www.labormarketinfo.edd.ca.gov/qcew/qcew-select.asp>.

Addressing affordability in coverage requires addressing California's highly concentrated insurance markets. Concentrated health insurance markets have consistently shown to lead to higher premiums (see e.g., Dafny et al. 2012). Table 1 shows the health insurer Herfindahl-Hirschman Indices (HHIs) and top two insurers by market share for each of California's 26 Metropolitan Statistical Areas (MSAs) in 2021. HHIs are calculated as the sum of squared market shares of the firms competing in the market.² The U.S. Department of Justice and Federal Trade Commission's [Horizontal Merger Guidelines](#) consider markets with HHIs above 2,500 to be highly concentrated and markets with HHIs between 1,500 and 2,500 to be moderately concentrated. The average health insurer HHI in California in 2021 was 3,255 — well above the threshold for a highly concentrated market. Among California's 26 MSAs, 20 were highly concentrated and 6 were moderately concentrated. The average market share of the largest insurer across the 26 MSAs was 48% (range: 30%-72%) and the average market share of the second largest insurer was 22% (range: 9%-34%). Anthem or Kaiser was the largest insurer in 25 of 26 MSAs.

Table 1: Health Insurer HHI by MSA, 2021

MSA	HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Bakersfield	2,688	Anthem	36	Kaiser	28
Chico	4,381	Anthem	58	BS of CA	31
El Centro	2,374	BS of CA	32	Anthem	30
Fresno	2,569	Anthem	36	Kaiser	25
Hanford-Corcoran	2,770	Anthem	42	BS of CA	28
Los Angeles-Long Beach-Anaheim	2,066	Kaiser	33	Anthem	25
Madera	2,592	Anthem	37	Kaiser	27
Merced	3,879	Anthem	58	BS of CA	19
Modesto	3,290	Kaiser	50	Anthem	26
Napa	4,338	Kaiser	63	Anthem	15
Oxnard-Thousand Oaks-Ventura	2,368	Anthem	35	Kaiser	25
Redding	4,945	Anthem	66	BS of CA	24
Riverside-San Bernardino-Ontario	2,785	Kaiser	46	Anthem	19
Sacramento-Roseville-Folsom	3,170	Kaiser	52	Anthem	14
Salinas	3,239	Anthem	46	BS of CA	32
San Diego-Chula Vista-Carlsbad	1,618	Kaiser	30	Anthem	16
San Francisco-Oakland-Berkeley	2,932	Kaiser	50	Anthem	14
San Jose-Sunnyvale-Santa Clara	2,365	Kaiser	41	Anthem	19
San Luis Obispo-Paso Robles	3,909	Anthem	55	BS of CA	27

² For instance, the HHI in a two-firm market where each firm had 50% market share would be 5,000 ($=50^2 + 50^2$).

Santa Cruz-Watsonville	2,160	Anthem	32	Kaiser	25
Santa Maria-Santa Barbara	3,326	Anthem	46	BS of CA	34
Santa Rosa-Petaluma	4,448	Kaiser	65	Anthem	12
Stockton	3,870	Kaiser	58	Anthem	20
Vallejo	5,370	Kaiser	72	Anthem	9
Visalia	4,252	Anthem	61	BS of CA	21
Yuba City	2,929	Anthem	47	Kaiser	18
Average	3,255		48		22

Source: Guardado J, Kane CK. 2022. Competition in Health Insurance: A comprehensive study of U.S. markets. American Medical Association. Pgs. 15-16. Available at <https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf>

Notes: HHI=Herfindahl-Hirschman Index. BS of CA=Blue Shield of California. Market shares are calculated using commercial PPO, HMO, POS, and Exchange enrollment.

Building on the success of Covered California (the state’s innovative health insurance exchange) and the presence of organized/integrated medical groups with experience in providing care under risk-adjusted per member per month (also called capitation) payments, the state has the potential for developing a public option that meets the goals of quality care at a more affordable price. Additionally, the state can use its [17 county-based health plans](#) (which by definition are already public options) to make coverage more affordable for commercial enrollees.

A public option plan (POP) is a state plan to offer health insurance to increase competition and affordability of coverage over time. It may take different forms, including 1) direct administration by a state agency, 2) a public-private partnership model in which the state sets requirements for private health plans to offer coverage, or 3) a county-administered plan. The main goal with the public option is to increase market competition in the insurance market.³

In this white paper, we begin by reviewing what other states have done or are considering, and discuss the lessons learned and their implications for California. We then describe and discuss the strengths of California’s health care delivery system to provide higher quality, lower cost care under a public option model operating under risk-adjusted per member per month payment rates. This is followed by an analysis showing how our proof of concept “prototype” POP would improve competition if it were made available by Covered California and CalPERS. We then analyze L.A. Care as a California county-based health plan, which has been listed on Covered California since 2014, and its impact on premium growth in the LA region. This is followed by an analysis of implementation issues based, in part, on interviews with a number of key stakeholders and key informants. We conclude by summarizing the advantages of offering a public option in the state and how to move ahead.

³ See Taylor, J. & Waldrop, T. [States Must Prioritize Health Equity as They Expand Coverage through Public Options](#) (September 8, 2022) for a discussion of how state public options can improve health equity by closing disparities in coverage rates.

2. What States Have Done or Attempted To Do

[Nearly 70% of voters across the country are supportive](#) of a public health insurance option.

Washington state was the first to implement a public option, in which private insurers offered a POP that met state-determined administrative, legislative, and regulatory requirements. Nevada and Colorado have also passed legislation related to a public option, while Minnesota recently advanced a bill to create a public option. Each of these states has its own [approach](#) that fits the characteristics of both their healthcare market and political landscape. Below, we provide further detail on each state's public option initiatives.

A. Details By State

Washington, Nevada, and Colorado have each passed a form of public option legislation. None of the plans are state government public options, but instead are all public-private partnerships. [Section 1332 waivers](#) under the ACA offer states the opportunity to provide innovative health coverage and affordability solutions that decrease costs to the federal government without diminishing coverage. [Premium tax credits](#) from the federal government are based on the second-lowest silver plan premium, income, and family size. The public option is designed to decrease premium costs in the state exchange, impacting premium tax credits. All of the plans are to be sold on the ACA exchange and target the individual and small group markets passed through a funding amendment.

Washington state enacted Cascade Care—the first state public option—in 2019. Cascade Care allowed individuals to purchase a state-sponsored plan on Washington's Health Benefit Exchange. The Washington Health Care Authority contracted with five health insurance carriers to provide different plans in the state exchange. Premiums and deductibles are kept low based on a reimbursement [rate cap](#) of 160% Medicare rates. Cascade 2.0 was recently established under [E2SSB 5377](#), effective July 2021. It created a state premium assistance program and cost-sharing reduction program with federal funds. This bill also established that if a public option is not available by 2022, Medicaid-funded hospitals and public or school-based employee benefits programs must contract with at least one public option; otherwise, the Office of the Insurance Commissioner and the Health Care Authority can take steps to ensure compliance. This clause was added in response to providers initially refusing to join the public option networks, affecting enrollment and thus the ability to provide [lower costs](#) and premiums.

In 2017, Nevada created a “state version of Medicare for All” called “Sprinklecare,” championed by former Assembly Member Mike Sprinkle in [AB374](#). Vetoed by the governor at the time, the state has since announced [Senate Bill 420](#) to create a public option to be available by 2026 for those who purchase health insurance as individuals or from the small group market, as well as for businesses with 50 or fewer employees, effectively targeting 7% of the population who are eligible. The goal is to add a low-cost public option to [spur competition](#), drive down costs, and reduce average premiums by 15% within the first four years. It would require providers who serve public employees under the state plan and Medicaid recipients to participate in the public option as well. Medicaid reimbursement rates would be [used as price floors](#). There would be

both a silver level (70% of costs) and a gold level (80%). The option would be sold on the exchange for 5% less than private plans, and the reimbursement rate for the public option would be [lower than that of the private insurers](#). The state estimates the potential for \$341 million to \$464 million in premium reductions in the first 5 years, with much of this going to the state under a 1332 waiver. Total savings in the first 10 years are estimated to be nearly \$1 billion. The local government would oversee the program but contract with private insurers. SB420 was signed into law on June 9, 2021, despite opposition largely by health care providers. It must be offered in both the small group and individual markets and cover essential benefits.

In Colorado, [HB21-1232](#) established a standardized health plan in small group and individual markets that insurers must offer. The [Colorado Option](#) standardized plan will cover essential health benefits. This bill was [amended](#) in favor of having standardized, regulated plans as opposed to a public health insurance option. Colorado submitted an [ACA Section 1332 State Innovation Waiver](#) in accordance with HB21-1232 that seeks to produce a [15%](#) premium reduction over three years, changed from 20% over two years. After the initial decrease, carriers must limit premium increases to that of medical inflation. Providers would no longer be required to accept these standardized plans if network adequacy is met and certain benefits and deductibles are regulated by a governor-appointed insurance commissioner. The reimbursement floor would be no lower than 165% of Medicare's rates for hospitals and no lower than 135% of Medicare's rate for providers, with added protections of reimbursement rates for critical access, independent, and rural hospitals. Signed by the governor on June 16, 2022, premiums are estimated to fall by [1.3% on average, while enrollment is estimated to rise by 0.8% in 2023](#). While the impact appears to be minor in the early stages of implementation, Colorado expects a reduction in premiums by nearly [14%, along with an 11% increase](#) in enrollment—covering approximately 10,000 people—by 2025. Additionally, premium reductions of up to [\\$367.6 million](#) at the federal level are anticipated by 2027, the end of the waiver period, due to Colorado's new waiver.

In February 2023, Minnesota House lawmakers [advanced a bill](#) to expand the state's public health insurance program, MinnesotaCare, by allowing all Minnesotans to buy in to the program. MinnesotaCare is currently only available to U.S. citizens who live at or below 200% of the federal poverty level. The new bill proposes premiums on a sliding scale for people above the 200% cap.

Several states have introduced or passed legislation to explore the public option or a Medicaid buy-in in the past, including [Delaware](#), [New Mexico](#), [Massachusetts](#), [New Jersey](#), [Iowa](#), and [Wyoming](#). More recently, [Illinois](#), [Wisconsin](#), and [Oregon](#), in addition to California, have expressed renewed interest in the public option. [Missouri](#), [Maryland](#), [New Hampshire](#), and [Maine](#) have also introduced legislation to research a public option or Medicaid buy-in.

Based on a Manatt 2020 report, Oregon is developing a Health Care for All Oregon Plan through Senate Bill 770. The report detailed a coordinated care organization (CCO)-led model, a carrier-led model, and a state-led model with a third-party administrator. Since then, [House Bill 2010](#) has been written to create a public option, such that individuals and small businesses

can buy state plans through the insurance exchange. The bill has been amended so that the Oregon Health Authority and Department of Consumer and Business Services are required to provide a [report](#) detailing design and implementation. Key features of the report include demonstrating cost growth at or below the statewide cost growth target of 3.4% and having a goal of 94-98% actuarial value to increase affordability without sacrificing coverage. The report also suggested expanding upon an existing 1332 waiver to implement the public option.

In California, [AB 2472](#) was put forth by Assemblymember Jim Wood in 2018 to use feasibility analysis to explore a public health insurance plan option, with the analysis to be submitted by October 2021. It was approved by the governor and filed with the Secretary of State after passing the Assembly Floor and Senate. It was not implemented due to a lack of funding source. Since then, [AB 1400](#), or the California Guaranteed Healthcare for All Act, was designed to create a single-payer healthcare system for all Californians. However, this bill was [withdrawn](#) in April 2021 so that lawmakers could address how to fund the bill. In June 2021, the “California Health Care Quality and Affordability Act,” [AB 1130](#), passed the Assembly and was moved to the state Senate where it was amended in February 2022. The governor’s budget included identical language to AB 1130 in a trailer bill. The bill creates the [Office of Health Care Affordability](#), which will analyze cost trends and spending drivers in the healthcare system to create policies for lowering costs. Governor Newsom signed [AB 133](#), which expanded Medi-Cal coverage to include undocumented individuals 50 years and older (a group that is often uninsured). This expansion could work in tandem with a public option to decrease the uninsured population in California. In a May 2021 letter to President Biden, Governor Newsom expressed interest in expanding federal waivers which would allow states to “assure competition by making public plan(s) options available.”

On a federal level, [President Biden has proposed a public option for the non-Medicaid expansion states](#). His budget included making ACA subsidies permanent (\$163 billion over 10 years), which would lower health insurance costs for those who purchase their own insurance. The public option at a federal level faces several [hurdles](#), including the Democrats’ slim House and Senate majorities.

B. Main Lessons

The Public Option on the state level has several overarching trends. First, the public option is offered in predominantly Democratic states. While several bills began with a state government public option, all current initiatives are public-private partnerships, defined as hybrid approaches. For instance, many have become locally overseen but involve privately-run partnerships due to lack of state funding needed for a state government public option. However, some are Medicaid buy-ins or buy-ins into existing low-income healthcare programs. Three states have fully passed a form of public option—Colorado, Nevada, and Washington—each with some form of cost control policy in place. In Colorado, the standardized health benefit premiums are set to be increasingly lower than the premiums of other health benefit plans offered; in Nevada, premiums are to be set 5% lower than the private benchmark plans on the

exchange with an eventual goal of a 15% reduction; and Washington has multiple [caps](#) on payments and costs based on Medicare rates.

State legislation has also demonstrated the importance of doing extensive research prior to adopting and implementing a public option. The payment rates involved are often in comparison to Medicare rates, with the goal of decreasing overall rates over time. Many of the options are geared towards small businesses and their employees, and have faced substantial opposition and lobbying despite the states being largely democratic. For example, in Colorado, insurers agreed to an 18% decrease in premiums over three years rather than facing a public option. In addition, state public options have now become a bellwether for federal healthcare policy, adding pressure for current public options to perform well. A key question is whether provider organizations (hospitals/health systems) and provider networks (physicians/medical groups/IPAs) in the public option states can deliver quality care at lower cost under the various arrangements.

A key distinction between our public option proposal and those in other states is that ours does not regulate prices and set other restrictions for providers to [participate](#). Finally, Golden Choice, by transferring the financial risk, does not require state financing.

3. Special Characteristics of the California Healthcare Delivery System

A. California's Delegated Model Integrated Delivery System

[California](#) is [well-prepared](#) to provide high quality, lower cost care under a public option approach. This is due to the fact that about 50% of physicians in the state practice as part of a medical group or IPA. About half of these physicians are part of a medical group or IPA that has over 200 physicians. Thirty four percent (34%) of the medical groups/IPAs themselves have more than 50 physicians. These organized groups/IPAs have extensive experience operating under a delegated model. A delegated model is where insurers transfer some or all of the financial risk for providing care to the medical groups or IPAs. Using these large physician groups and IPAs that have experience bearing risk to provide primary and specialty care give California a unique opportunity to provide care under a public option. Using a capitated risk-adjusted per member per month (pm/pm) payment for each enrollee provides the organization with a predictable revenue stream and incentives to keep people well, innovate, and continuously [improve care](#).

Provider organizations can accept full risk for the total cost of care for both hospital and physician/outpatient care or accept only partial risk for only the physician and outpatient component. Evidence from the 2019 Integrated Health Association (IHA) Atlas Data is shown in

Table 2.⁴ Here, we see that risk-based plans are lower cost and higher quality. It is worth noting that in the 1980s and 1990s, there was a large transition to managed care organizations (MCOs) in California that resulted in [backlash](#) due to diminished choice of providers, utilization controls, and the inability of many physician groups to assume risk. Between 1996 and 1999, [115 physician groups](#) went out of business, impacting millions of patients. To ameliorate this problem, the Department of Managed Health Care (DMHC) was created to enforce the Knox-Keene Act of 1975. Among its responsibilities, DMHC licenses plans and conducts financial reviews. Prior to 2000, managed care plans were monitored by the Department of Insurance (DOI) and Department of Corporations (DOC); with the passing of [AB 78](#), the DMHC was created to specifically monitor and enforce regulations for MCOs.

Table 2: Risk sharing associated with better clinical quality and lower cost

Risk Type	FFS (No Risk)	Professional Risk Only	Full Risk
Statewide Average Adjusted Total Cost 2019	\$5,452	\$4,849	\$4,908
Clinical Quality 2018	60.1	65.7	67.8
Clinical Quality Z-score Metric 2019	-1.11	-0.61	-0.39

Notes: The above data are based on 7,499,524 non Kaiser Permanente commercial members with 18% being full risk, 23% being professional risk only, and 58% being FFS no risk. Also included are 815,145 non Kaiser Medicare Advantage members with 79% being full risk, 20% being professional risk only, and 2% being FFS no risk. Total cost is the geographically and clinically risk-adjusted average payment for those on commercial plans. Lower total cost is better. Clinical quality 2018 scores are a combination of 10 clinical quality measures; data for the 2019 composite clinical quality scores are not yet available. Clinical quality Z-score metric 2019 is a Z-score comparing the commercial clinical quality associated with each risk type with the state average for commercial plans; the clinical quality metric is a composite of all clinical quality metrics available for 2019 ([IHA About the Data](#), p. 3). A higher Z-score indicates a higher clinical quality score, meaning full risk has the best clinical quality score as its Z-score is the highest, closest to 0. Kaiser Permanente is not included in any of these metrics. No risk is fee-for-service (FFS). Full risk includes both professional and facility risk. All data is from the [IHA Atlas](#).

The full risk provider organizations have significantly lower total cost of care and higher quality scores than the FFS provider organizations. They also have higher quality scores than the professional risk only organizations. In turn, the professional risk only provider organizations perform better on both cost and quality than those operating under fee-for-service. While not all physicians in the state are organized to currently take on such risk, a number of technical assistance initiatives have been [launched](#) to provide them with the infrastructure and capabilities to do so.

B. HMO Plans

Full risk health maintenance organizations (HMOs) on average saw enrollment growth from 2014 to 2020 in California. Total HMO enrollment increased by 27% and commercial HMO enrollment by 11% from 2014 to 2017 (Table 3). From 2017 to 2020, commercial HMO enrollment continued to grow on average by 6%, and 45 counties had an average yearly increase in enrollment. Commercial enrollment recorded at the end of 2020 varied across both

⁴ We used 2019 to avoid the impact of Covid-19 on total cost of care. Total cost of care is generally lower in 2020 because of Covid, but the same patterns apparent in Table 1 hold in 2020. See <https://atlas.ih.org/> for the 2020 total cost of care numbers.

rural and urban counties, likely due to the impacts of COVID-19 on employment and health insurance status, resulting in some counties seeing modest gains in commercial HMO enrollment while others saw losses (DMHC PRA Request and analysis by Petris Center). Due to the highly variable nature of the COVID-19 pandemic, changes in commercial enrollment will likely revert back to commercial HMO enrollment growing in the years following the pandemic. Significant increases in HMO enrollment occurred from 2013 to 2014, likely due to the implementation of the Affordable Care Act (ACA) creating the Covered California health insurance exchange and state's Medicaid and Medi-Cal expansion. Commercial HMO enrollment tended to increase in more populous regions compared to rural regions, likely due to changes in employer sponsored health insurance drastically affecting rural areas' commercial HMO enrollment. Overall enrollment increased in HMOs in both rural and urban areas from 2014 to 2017.

Table 3: HMO enrollment growth in California from 2014-2017

HMO Type	Averaged annual growth 2014-2017	Total growth 2014-2017	Number of enrollees 2017
Total	9%	27%	23,195,644
Commercial	3%	11%	10,351,481
Medi-Cal	16%	53%	10,723,623
Medicare	4%	14%	2,120,540

Notes: County level HMO enrollment data for 2013 to 2017 recorded in Quarter 1 is from [Cattaneo and Stroud](#). Data from 2013 was not included in growth analyses due to the implementation of the ACA. The average annual growth is the average of yearly percentage growth rates. Total is the sum of commercial, Medi-Cal, and Medicare HMO enrollees in California.

From 2014 to 2017, all HMO types saw enrollment growth. Medi-Cal HMO enrollment increased the most with a total growth of 53% and over 10.7 million enrollees (Table 3). This large enrollment increase in Medi-Cal is due to California moving more Medi-Cal enrollees out of fee-for-service (FFS) models and into managed care organizations (MCOs) to reduce [costs](#). Medicare HMO enrollment accounted for the smallest component of total enrollment, with 2.1 million enrollees and a growth of 14% from 2014 to 2017. Commercial HMO enrollment from 2014 to 2017 increased by 11% with an enrollment of 10.3 million. From 2014 to 2017, only Sierra County saw a decline in total HMO enrollment and Alpine county had no change in total HMO enrollment. All other counties saw enrollment increases, with Plumas, San Benito, and Mono counties seeing more than 100% total enrollment growth. On average, commercial HMO enrollment increased from 2014 to 2017, but many rural counties saw declines in commercial HMO enrollment. Commercial HMO enrollment tended to increase in larger population areas such as San Diego county, which saw 21% growth in HMO enrollment from 2014 to 2017.

C. Knox Keene and Partial Risk

HMOs are regulated in California by the [Department of Managed Health Care](#) (DMHC) in accordance with the laws set forth in the Knox-Keene Health Care Service Plan Act of 1975.

The [Knox-Keene Act](#) requires plans to receive licenses from the DMHC; these licenses fall into two categories: full service and specialized service. These licenses can be restricted; organizations with a restricted Knox-Keene (RKK) license must contract with a full-service Knox-Keene health plan provider and cannot directly enroll or sell plans to employers or individuals ([Knox-Keene Act](#), p. 606, 2021). RKK plans are [physician groups](#) that can take global capitation payments that include financial risk for all hospital charges. RKK plans assume both professional and institutional risk by covering professional and institutional costs and receiving periodic payments from providers who directly contract with employers or individuals ([Knox-Keene Act](#), p. 606-607, 2021). Partial risk plans are those with capitation for only professional risk or institutional risk, as opposed to a full or global risk plan where capitated payments are made for both types of risk ([Knox-Keene Act](#), p. 606, 2021 and [IHA Atlas](#), 2017). Partial risk plans with professional risk assume the cost of professional services, including “physician, ancillary, or pharmacy services” and are paid through periodic payments such as capitated payments by an HMO ([Knox-Keene Act](#), p. 606, 2021). Partial risk plans with institutional risk assume the cost of hospital services including inpatient, outpatient, and ancillary services, and are paid through periodic payments ([Knox-Keene Act](#), p. 606, 2021).

On average, RKK plans have seen enrollment increases between 2017 and 2020. The average enrollment increase from 2017 to 2020 was 5% across the RKK plans, shown in Table 4. As depicted in Appendix 9, plans with more enrollment generally have more net income per enrollee.

Table 4: Selected RKK plan enrollment changes

Restricted Knox-Keene Plan	2017	2018	2019	2020	Enrollment change 2017-2020
Bay Area Accountable Care Network, Inc. (Canopy)	14,647	25,246	45,373	43,432	197%
Brown & Toland Health Services, Inc.	9,722	10,045	13,287	18,609	91%
Sequoia Health Plan	7,544	8,387	9,422	10,912	45%
PRIMECARE Medical Network, Inc.	193,501	209,488	217,384	228,381	18%
Prospect Health Plan, Inc.	51,354	51,394	49,803	55,265	8%
Choice Physicians Network, Inc.	13,147	15,460	14,942	13,942	6%
EPIC Health Plan	64,382	71,951	71,434	68,015	6%
Dignity Health Provider Resources, Inc.	30,183	32,117	31,259	31,480	4%
Heritage Provider Network, Inc.	658,949	697,088	704,744	672,430	2%
Monarch Health Plan	154,349	143,297	141,868	151,446	-2%
Optum Health Plan of California	481,689	477,134	472,647	469,442	-3%
Inter Valley Health Plan	24,549	21,836	19,547	18,026	-27%
Total	1,704,016	1,763,443	1,791,710	1,781,380	5%

Notes: Restricted Knox-Keene (RKK) plans must contract with a full-service Knox-Keene health plan provider and cannot directly enroll or sell plans to employers or individuals. RKK plans are physician groups that can take global capitation payments that include financial risk for all hospital charges because they have a partial Knox-Keene health plan license (restricted license). Total enrollment change was calculated from 2017 to 2020. All enrollment data is from the [DMHC database](#) using annual data from Quarter 4. Sequoia Health Plan first reported enrollees to DMHC in 2017. Bay Area Accountable Care Network, Inc. (Canopy) and Dignity Health Provider Resources, Inc. first reported enrollees to DMHC in 2016 and Prospect Health Plan, Inc. first reported enrollees in 2015; all other plans began reporting enrollees in 2014 or earlier. See appendix for enrollment information from 2014 to 2016 for all plans.

4. Impact of Golden Choice on Covered California and CalPERS

The purpose of this section is to show the potential premium reductions from offering a POP to Covered California and CalPERS enrollees using California's integrated delivery system. Though we are testing our POP on Covered California and CalPERS, the results are only meant to show the viability of a POP. We are not recommending that a POP be offered on Covered California or by CalPERS. This decision will need to be made by them, legislators, and the governor.

Covered California is California's state-based ACA exchange (hereafter, the Exchange) where Californians can purchase health insurance. The Exchange provides coverage for Californians who do not qualify for Medicaid or Medicare and cannot obtain health insurance through their employers. As of February 2022, just under [2 million Californians](#) obtain health insurance through Covered California.

For the Exchange, our proposed solution is two-pronged. First, we propose a proof of concept prototype plan made up of non-Kaiser Permanente integrated medical providers accepting risk-based capitation payments. Kaiser Permanente is already 25% of the state's heavily concentrated health insurance market and on the ACA Exchange, so we utilize the remainder of the state's integrated delivery system to develop our proof of concept prototype plan. To demonstrate the viability of this approach, we develop a premium for our prototype integrated care public option using IHA's total cost of care data for Exchange HMO enrollees.

Next, we discuss a public option approach based on a county-based plan that offers Exchange coverage. L.A. Care — a county-based health plan serving Los Angeles County — has had considerable success gaining enrollment on the Exchange. We explain what they did and highlight the impact it had on enrollment and premium growth.

In the final part of the Exchange section, we show how introducing another plan onto the Exchange would reduce premiums. These analyses are meant to show the competitive effect potential of adding a public option to the Exchange. Under the current system, any reductions in premiums generated by the public option on the Exchange would mainly accrue to the federal government in the form of lower subsidy payments. We recommend that California, as several other states have done, apply for a 1332 waiver to allow the cost savings of reduction in premium growth from a public option on the Exchange to be captured by the state. The state could reinvest the savings to provide more generous coverage or subsidies.

In Section B, we show the impact of offering our prototype public option on CalPERS. The California Public Employees' Retirement System (CalPERS) is the nation's largest pension fund and California's largest public employer purchaser of health benefits. In addition to its retirement system, CalPERS provides health coverage for over [1.5 million](#) public employees, retirees, and families of the State of California and contracting agencies. Public employee pensions are

funded by CalPERS' investments, as well as employer and employee contributions. Total health premiums amounted to [\\$10.16 billion](#) in 2021, with employers and employees contributing \$3.93 billion for active members and \$1.84 billion for retirees. Annual health plan availability, covered benefits, health premiums, and co-payments are determined by the CalPERS Board of Administration. Enrollees of the CalPERS Health Program can choose between a basic Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and for members in certain California counties, Exclusive Provider Organization (EPO). Enrollees aged 65 and above who are eligible for Medicare Part A and Part B are required to enroll in both before [transferring into a CalPERS Medicare health plan](#) to continue coverage. CalPERS offers three types of Medicare health plans: Medicare Advantage HMO, Medicare Advantage PPO, and a PPO Supplement plan. Our analysis, discussed below, indicates that offering a low-cost, high quality public option to Exchange and CalPERS enrollees would reduce premiums and save money for both consumers and the state.

A. The Exchange

I. Prototype Integrated Care Public Option — Proof of Concept

For our Exchange analysis, we assess whether our proposed integrated care public option would be competitive in terms of premiums compared to the plans currently available on the Exchange. To do this, we compared the Gold and Silver premiums of the Exchange plans with the average total cost of care per member of Exchange HMO plan enrollees in the Integrated Healthcare Association (IHA) database. We did this for all 19 of the ACA regions in California. The Exchange data do not include co-pays or deductibles, while the IHA total cost of care figures do, but various adjustments were needed. In 2019, the ACA Gold enrollees in IHA's data had a member cost sharing of 10%. Thus, we add this amount to the Exchange premiums. While the Exchange premiums do include the profits and administrative expenses of the plans, the IHA average total cost of care does not. To adjust for this, we add 4% of premium to the IHA numbers.⁵ While the benefits between Gold plans on the Exchange and those reporting total cost care data to IHA are essentially similar, the Exchange plan data includes mental health services, while the IHA data does not, largely due to carve-outs for mental health services. Given that mental health services are about 4.1% of all health care costs, we add these to the IHA average risk adjusted total cost of care figure.⁶ Finally, we add 3.75% of premium to the IHA numbers to account for the listing fee to offer products on the Exchange.⁷ These adjustments provide a close comparison between the Exchange plan data on premiums and the IHA average risk adjusted total cost of care data. The IHA plans are more comparable in terms of benefits to a Gold plan than a Silver plan. Thus, to compare our prototype's regional premiums to Silver premiums, we first subtract the difference between average Gold premiums

⁵ Both [Medi-Cal Managed Care](#) plans and [CalPERS](#) plans report administrative expenses below 5%.

⁶ Given the state's focus on mental health this could be made higher for an actual public option offering. We show in Appendix 12 of the report that the prototype we discuss here would also rank favorably on Covered California if we assumed its premiums were 5% or 10% higher.

⁷ This fee is currently 3.25%, but was [3.75% in 2019](#).

and average Silver premiums in each region from our prototype's estimated premium in each region.

Table 5 presents the results of our analysis. The average age in the IHA data was 36 years old, so we compare the IHA total cost of care data to the 36-year-old Exchange premium in what follows. Column (2) shows the average Gold annual premium plus 10% for out-of-pocket spending in each of the 19 regions in 2019. Column (3) is the same as column (2) but for Silver premiums. Column (4) shows where a plan that was priced equal to the IHA total cost of care per member (after adding in listing fee, administrative expenses, and mental health) in the region would rank against the Gold plans in each market in 2019 (1 = lowest cost in the market). Column (5) repeats the ranking exercise but for Silver plans versus the IHA total cost of care in the region. Our analysis finds that plans priced at the IHA total cost of care in each region would be the first to third least expensive in 18 of the 19 regions when compared to both Gold and Silver plans. As a sensitivity analysis, we increased our estimated prototype premium by 5% and 10% and recalculated the ranks by region. The prototype still compares favorably in the 5% and 10% higher scenarios (see Appendix 12). Overall, IHA total cost of care (averaged over the 19 regions) was 14% lower than the average silver premiums across the 19 regions and 21% lower than the average gold premiums across the 19 regions. The lower rankings in San Francisco and Los Angeles could potentially be due to both markets already having health plans that are effectively public options: Healthy San Francisco, a health access program launched in 2007 by former Mayor Gavin Newsom to subsidize health care for uninsured residents of San Francisco, and L.A. Care, a county-run health plan that offers low-cost coverage in Los Angeles and competes on the Exchange.

Table 5: Exchange Premiums vs. Total Cost of Care of Full Risk Commercial Plans, 2019

(1) Covered California Regions	(2) Average Gold**	(3) Average Silver*	(4) IHA rank vs. Gold (1=lowest)	(5) IHA*** rank vs. Silver (1=lowest)
1 - Northern Counties	\$8,456	\$7,843	1	1
2 - North Bay Counties	\$8,826	\$8,271	1	1
3 - Greater Sacramento	\$7,954	\$7,333	1	1
4 - San Francisco County	\$8,837	\$8,165	3	3
5 - Contra Costa County	\$8,555	\$7,995	1	1
6 - Alameda County	\$7,701	\$7,033	1	1
7 - Santa Clara County	\$7,825	\$7,019	2	2
8 - San Mateo County	\$9,237	\$8,612	1	1

9 - Central Coast - North	\$8,412	\$7,800	1	1
10 - Central Valley - North	\$8,038	\$7,497	1	1
11 - Greater Fresno Area	\$5,701	\$5,124	1	1
12 - Central Coast - South	\$6,751	\$6,017	1	1
13 - Eastern Region	\$6,866	\$6,389	3	2
14 - Kern County	\$6,217	\$5,557	1	1
15 - Los Angeles - East	\$5,483	\$4,916	4	4
16 - Los Angeles - West	\$6,184	\$5,574	3	2
17 - Inland Empire	\$5,865	\$5,197	1	1
18 - Orange County	\$6,418	\$5,718	1	1
19 - San Diego County	\$6,411	\$5,852	1	1
AVERAGE	\$7,354	\$6,732	1 - 14 regions 2 - 1 region 3 - 3 regions 4 or lower - 1 region	1 - 14 regions 2 - 3 regions 3 - 1 regions 4 or lower - 1 region

Source: Authors' analysis of data from [Covered California](#), [HIX Compare](#), and [IHA](#).

Notes: IHA = Integrated Healthcare Association. The annual gold premiums shown here are for a 36-year-old individual to align with the fact that the average age of enrollees in the IHA plans in 2019 was 36. IHA's risk adjustment was done using Johns Hopkins ACG System. See IHA's [data methodology](#) for details.

*Average Silver = Average Annual Silver Premium + 10% for out-of-pocket expenses

**Average Gold = Average Annual Gold Premium + 10% for out-of-pocket expenses

***IHA = The average risk adjusted total cost of care per member of full risk commercial plan enrollees in the region + 4% administrative expenses + 4.1% mental health + 3.75% listing fees.

While Table 5 demonstrates the prototype plan is cost effective, it says nothing about the size of the non-Kaiser Permanente provider network underlying the IHA data. Figure 2 shows the number of IHA commercial physician organizations in each of California's 58 counties. While there are physician organizations in each of the 19 regions, suggesting adequate network coverage, it's clear from Figure 2 that some regions have greater network coverage than others. For instance, only 2 of the 20 counties that make up Covered California Region 1 have physician organizations that are part of the IHA data. This makes it unlikely that the prototype plan as presently constructed (i.e., with the network underlying the IHA data) could provide adequate access to any Californian residing in Region 1.

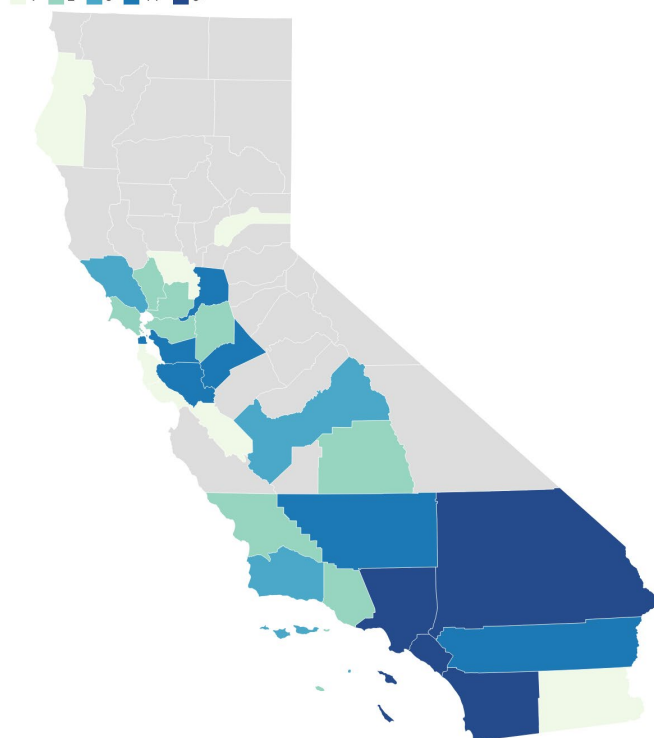
The right side of Figure 3 shows the number of primary care doctors and specialists per 10,000 people. As a rule of thumb, it is usually suggested that a county have [1 primary care doctor per 2,000-2,500 population](#) (or 4 to 5 primary care doctors per 10,000 people). The 29 counties with

IHA commercial physician organizations in Figure 2 (i.e., the non-grayed out counties) had 6.5 primary care physicians per 10,000 people on average. However, there are some counties on the list that don't meet the recommended 4-5 primary care doctors per 10,000 population (e.g., Imperial).

Figure 3: Count of IHA Commercial Physician Organizations by County, 2019

IHA Physician Organizations by County

1 2 3 4-7 8+



Created with Datawrapper

County	# of Commercial Phys. Orgs.	Primary Care Docs per 10k people	Specialists per 10k People
Alameda	5	8.2	34.5
Contra Costa	2	5.2	8.4
Fresno	3	4.2	10.9
Humboldt	1	6.1	6.8
Imperial	1	1.2	3.9
Kern	5	4.8	12.4
Los Angeles	64	17.0	51.6
Marin	2	11.2	26.5
Napa	2	17.8	28.8
Nevada	1	12.4	41.0
Orange	22	14.5	40.0
Riverside	7	2.6	4.9
Sacramento	7	9.0	21.5
San Benito	1	3.8	12.9
San Bernardino	18	7.0	16.5
San Diego	14	6.4	23.0
San Francisco	5	11.0	27.8
San Joaquin	2	3.3	8.1
San Luis Obispo	2	4.1	20.3
San Mateo	1	2.3	6.8
Santa Barbara	3	2.4	8.2
Santa Clara	6	8.5	15.4
Santa Cruz	1	2.2	7.2
Solano	2	1.3	4.8
Sonoma	3	5.0	9.4
Stanislaus	4	11.6	21.0
Tulare	2	3.6	5.5
Ventura	2	1.8	7.1
Yolo	1	1.5	2.5
AVERAGE	6.5	6.5	16.8

Notes: Petris Center analysis of data from MEPS-IC (family premiums) <https://datatools.ahrq.gov/meps-ic>, the California Department of Finance (inflation) <https://dof.ca.gov/forecasting/economics/economic-indicators/inflation/>, and the California Employment Development Department (average weekly pay) <https://www.labormarketinfo.edd.ca.gov/qcew/qcew-select.asp>.

Table 6 estimates the enrollment at the level of IHA's total cost of care per member that each region would have attained had it entered the market in 2019. To calculate the estimated enrollment for each region, we assigned the number of open enrollment enrollees of the plan currently ranked in the position where the prototype would enter (among silver plans) to the prototype. For instance, the prototype would be the lowest cost silver plan in Region 2 (North Bay Counties). In 2019, the Kaiser Permanente HMO was the lowest cost silver plan in Region 2 and had 36,820 enrollees, 28,170 renewals and 8,650 new enrollees. Among the 28,170 renewals, we assume 15% would go to our prototype plan. Our 15% assumption is based on a paper that found the switching rate on Covered California to be in the range of 10-20%. In sum, our estimated enrollment for our prototype plan in Region 2 is 12,876 (=8,650 + 0.15 x 28,170). Repeating this exercise for the rest of the 18 ACA regions in California leads to a total predicted enrollment of 175,497 for our prototype plan.

These enrollment predictions make a number of assumptions. First, we are only using enrollment from the plan that the prototype would replace in the premium rankings. Some of the enrollment gains would be from other plans further down the ranking as well. Additionally, the 15% switching rate assumption could be adjusted up or down depending on whether the plan being replaced is an HMO or PPO. Enrollees in PPO value a broad network and probably would not switch as often to our prototype plan compared to HMO enrollees. Ultimately, the estimates we present in Table 6 should be treated as “ballpark” for the prototype’s first year of participation. We’d expect the prototype enrollment to increase the longer it is offered on the Exchange. This is due to low premium plans attracting new enrollees. They do less well with re-enrollees, who show inertia in their plan choices and don’t often switch plans. The more new enrollee cycles the prototype experiences, the larger we would predict its enrollment to be. As is, we estimate \$243 million in premium reductions if the enrollees in Table 6 moved from their current plans into our prototype public option.⁸

Table 6: Estimated Enrollment by Regions for an IHA priced plan, 2019

(1) Covered California Regions	(2) Estimated Enrollment
1 - Northern Counties	344
2 - North Bay Counties	12,876
3 - Greater Sacramento	8,476
4 - San Francisco County	2,377
5 - Contra Costa County	12,531
6 - Alameda County	17,814
7 - Santa Clara County	9,039
8 - San Mateo County	6,423
9 - Central Coast - North	2,365
10 - Central Valley - North	13,854
11 - Greater Fresno Area	8,582
12 - Central Coast - South	17,458
13 - Eastern Region	12

⁸ To estimate savings from adding a public option on the exchange, we multiply the estimated enrollment for our prototype for each region by the difference in the gold premiums and our prototype premium. We sum the estimated savings for each region to arrive at total savings from the prototype.

14 - Kern County	4,225
15 - Los Angeles - East	18,385
16 - Los Angeles - West	2,501
17 - Inland Empire	16,120
18 - Orange County	13,928
19 - San Diego County	8,192
TOTAL	175,497

Source: Authors' analysis of data from [Covered California](#), [HIX Compare](#), and [IHA](#).

II. L.A. Care's Public Option

Another public option is the county-based plans. There are [17 county-based health plans](#) that provide access to healthcare services for low-income populations enrolled in Medi-Cal. With over 7 million enrollees, the plans serve approximately 70% of the 10 million beneficiaries enrolled in Medi-Cal managed care. These plans are all already [Knox-Keene plans](#). We focus on, which is a full risk capitated plan.

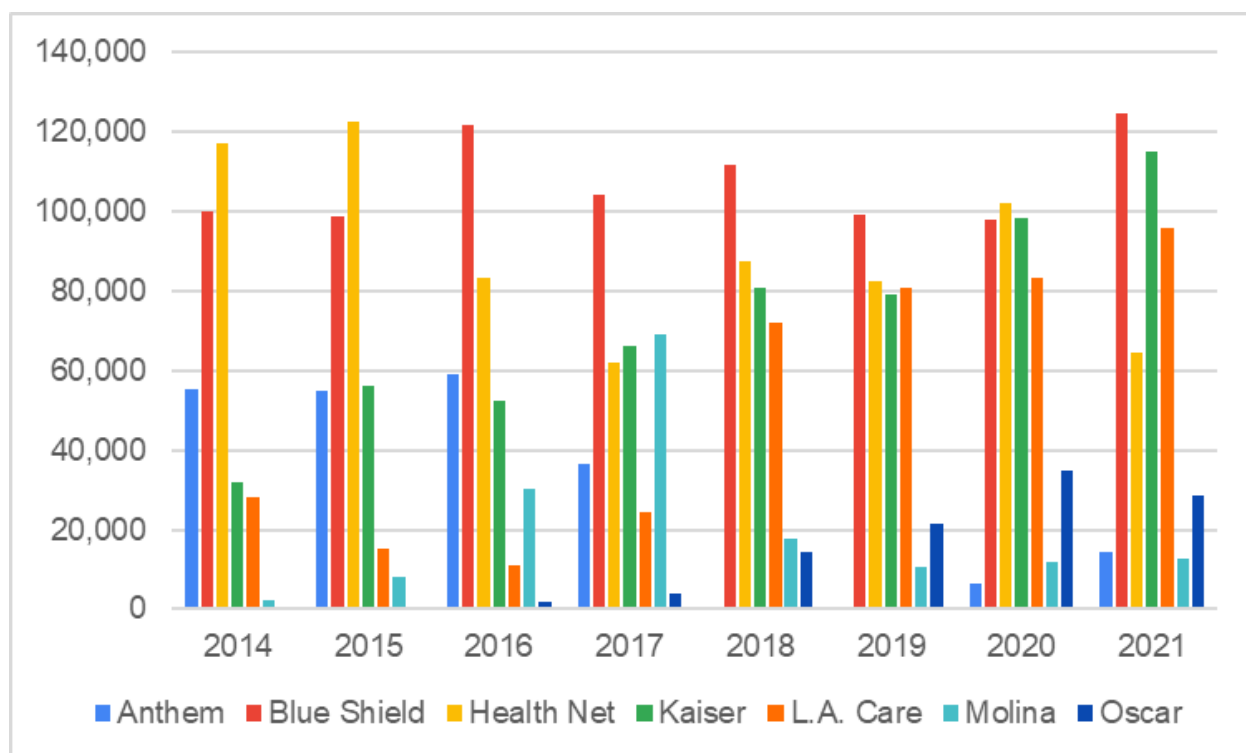
L.A. Care already offers coverage on the Exchange in regions 15 and 16 (East and West Los Angeles County). L.A. Care's enrollment success story on the Exchange can serve as a blueprint for any of the other 16 local, not-for-profit, publicly governed health care plans that may be interested in offering coverage on the Exchange and becoming a viable public option. Another one of these plans — CalOptima — has recently sought [to launch a Covered California plan](#).

Figure 4 shows enrollment across the plans offering coverage in regions 15 and 16 from 2014 to 2021. From the figure, it is clear that L.A. Care's enrollment success on the Exchange is a more recent phenomenon — it didn't happen immediately. From 2014 to 2017, L.A. Care had roughly 25,000 enrollees per year or fewer. Since 2017, though, L.A. Care has had over 70,000 enrollees every year and reached 95,000 enrollees in 2021. How did L.A. Care gain so much enrollment between 2017 and 2018? Figure 5 suggests that L.A. Care's lower premiums may be a major reason. While L.A. Care has always offered some of the lower premiums in regions 15 and 16, 2018 was the first time it had the lowest premium in both regions (rank = 1).⁹ A large increase in enrollment followed. The lesson for the other local, not-for-profit, publicly governed health care plans in California is that smaller, regional plans gain considerable enrollment as

⁹ L.A. Care being able to offer the lowest premium was not due to it narrowing its provider network. The provider network for its exchange product has increased over time. For example, UCLA, Adventist Health Care Network, Inc., and Serendib Healthways, Inc. were added to the network in 2019, 2020, and 2020, respectively. Additionally, these large additions to the network occurred after L.A. Care's large increase in enrollment in 2018, so we attribute its increase in enrollment in 2018 mainly to it becoming the lowest cost plan. After 2018, L.A. Care's enrollment increase is likely due to both a competitive price and an expanding provider network.

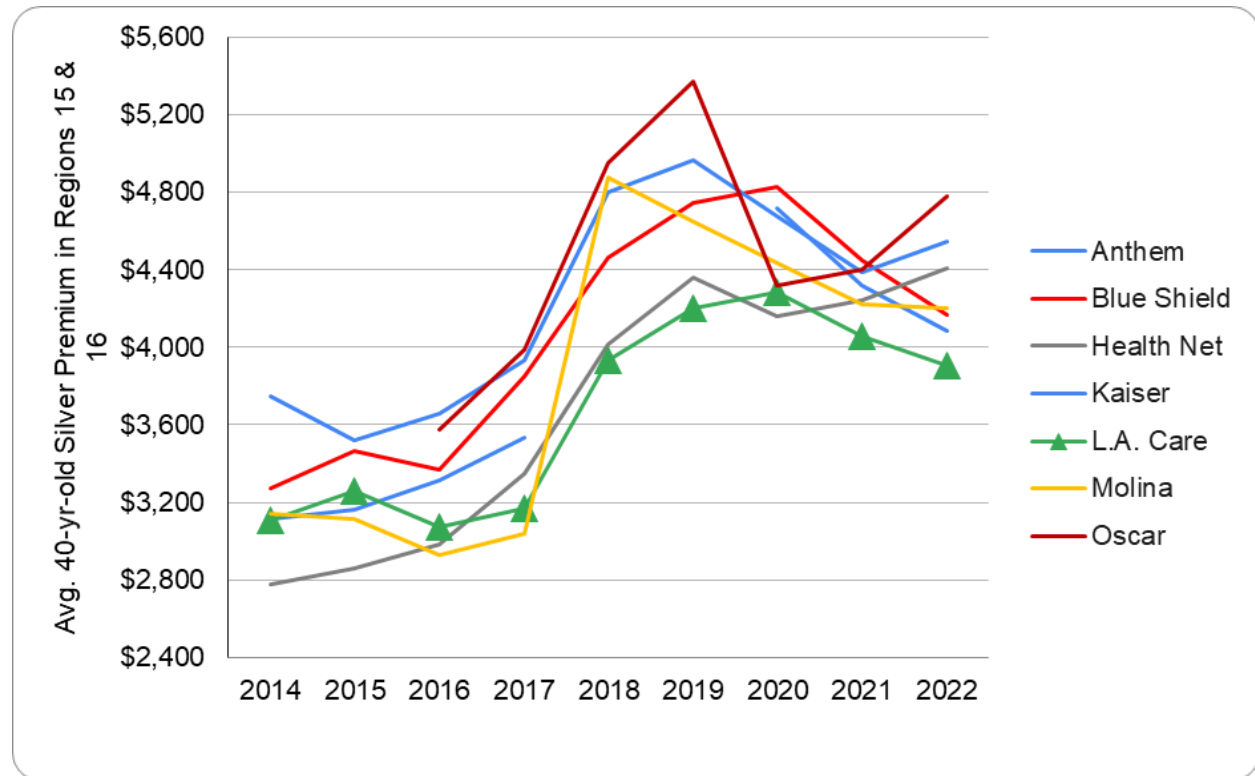
long as they are able to offer lower premiums than the insurers currently operating in the region and have adequate providers in their networks.

Figure 4: Exchange Enrollment in Regions 15 (Los Angeles County East) & 16 (Los Angeles County West), 2014-2021



Source: Authors' analysis of data from [Covered California](#) and [HIX Compare](#).

Figure 5: Average Silver Premiums Across Regions 15 (Los Angeles County East) & 16 (Los Angeles County West) by Insurer, 2014-2022



Source: Authors' analysis of data from [Covered California](#) and [HIX Compare](#).

III. Competitive Impact of the Public Option on the Exchange

We now turn to analyzing the impact that adding a public option would have on Covered California premiums. That is, how would Exchange plans currently offering coverage respond to a low-priced public option entering their market?

Some notable studies have already analyzed the impact of the number of insurers on Exchange premiums. Harvard economist Leemore Dafny and colleagues estimated that the benchmark premium (i.e., the second lowest silver premiums) would have been [5.4% lower on average](#) in the first year of the Exchanges had UnitedHealthcare decided to participate in the Exchanges. Jean Marie Abraham and colleagues found each additional entrant to the Exchanges to be associated with [an approximate 4% decrease in premiums](#). Stanford economist Maria Polyakova and coauthors found an increase from the 10th to 90th percentile in the number of insurers to be associated with [a 9% decrease in annual benchmark premiums](#). Recent work by researchers at the Urban Institute shows Exchange premiums in markets with one insurer to be [\\$189.50 per month higher](#), on average, than premiums in markets with five or more insurers.

We extend these papers by focusing on the impact of the number of insurers on California Exchange silver premium growth. Economic theory predicts premiums to be lower in markets with more insurers, all else equal. It also predicts that market concentration on the provider side of the market could impact premium growth reductions. Our plan-level premium of interest is the silver premium. We focus on the silver premium because silver plans account for the majority of enrollment on the Exchanges both nationally and in California (57% of enrollment on the California Exchange in 2021 was in silver plans).

Appendix 13 shows the coefficient estimates from our regression model. It shows that premium growth was 1.6% lower in markets with 5 or more insurers. In 2021, 12 of the 19 Covered California regions had fewer than 5 insurers. Our analysis suggests that if there had been at least 5 insurers in all 19 regions in 2020, \$57 million in 2021 premiums would have been saved. If there had been at least 5 insurers in all 19 regions from 2016 to 2020, we estimate \$228 million in premium savings. These premium reductions mainly went to the federal government in the form of lower subsidy payments. If California had applied for a 1332 waiver, these savings could have gone to the state. The overall takeaway is that more competition restrains premium growth. Adding a public option to all markets will spur competition, but it will be particularly powerful in the Covered California regions with the fewest insurers.

Next, we look at the competitive impact of a low-priced public option that already exists in the LA region after L.A. Care became the lowest priced plan in 2018¹⁰. Our data consist of plan-level yearly premiums for the 19 Covered California regions from 2014 to 2022. We use a difference-in-differences (DID) model for our analysis. Our main dependent variable is log (Annual Premium¹¹ (\$)). Our main independent variable (treatment) is a dummy variable equal to 1 for LA (Markets 15 and 16) for the years 2019 and later. We use 2019 as the year of treatment since any competitor response to the lower L.A. Care premium in 2018 would be observed in the following year. The control group contains 17 other California markets for the entire period. We include market, insurer, and year fixed effects in the model. The inclusion of “year fixed effects” captures average changes in premium growth across years, “market fixed effects” captures differences in average growth rates across markets, and “insurer fixed effects” captures differences in average growth rates across insurers. We test for parallel trends using formal and graphical tests. The parallel trends assumption implies that there are no significant differences in premium growth trends between LA and non-LA groups prior to 2019. The graphical test indicates that parallel trends are satisfied. The linear trends model also suggests that parallel trends are satisfied.

Appendix 14 shows the results from the regression analysis. It shows that, relative to the rest of CA, there was a 4.8% decline in premium growth in the LA region since 2019 (after L.A. Care became the cheapest plan). The effect is statistically significant at 5 percent level. This implies that had L.A. Care not become the lowest price plan in 2018, average individual premiums in

¹⁰ The complete economic evaluation of L.A. Care can be found in Arjun Teotia, Daniel R. Arnold, and Richard M. Scheffler, “Association Between a Capitated, Low-Cost, County-Based Public Health Insurance Option and Affordable Care Act Premium Growth in California,” *JAMA Health Forum* 4, no. 4 (Apr. 21, 2023): e230488.

¹¹ Premium adjusted for inflation using CPI-U (Consumer Price Index for All Urban Consumers (www.bls.gov))

the LA region would have been higher by \$225. Given that the average yearly enrollment in the LA region in 2019 was 342,840, the low-cost of L.A. Care led to approximately \$77 million in yearly savings in 2019. Similarly, savings from lower premiums in LA amounted to \$85 million in 2020, \$88 million in 2021, and \$95 million in 2022, totaling \$345 million over 2019 to 2022.¹² Our results strongly suggest that having a low-priced public option can reduce premiums using county plans.

B. CalPERS and a Public Option

CalPERS' [1.5 million enrollees in 2022](#) are split between basic (1.2 million) and Medicare (0.3 million) plans. Our focus is on lowering the cost of CalPERS members in basic plans. CalPERS members looking for basic plan coverage have several health carriers and plan types to choose from.

- HMOs:
 - Anthem Blue Cross, Blue Shield of California, Health Net, Kaiser Permanente, Sharp, United Healthcare
- EPOs:
 - Anthem Blue Cross, Blue Shield of California
- Self-funded PPO administered by Anthem Blue Cross:
 - PERS Gold, PERS Platinum
- Association plans:
 - California Association of Highway Patrolmen (CAHP) Health Benefits Trust, California Correctional Peace Officers Association (CCPOA), Peace Officers Research Association of California (PORAC)

Just under 70% of the 1.2 million CalPERS basic plan enrollees are enrolled in one of the available HMO plans. For the remainder of this subsection, we focus on how our proposed integrated care public option plan would compete on premiums against the HMOs currently offered through CalPERS. This analysis complements recent work by Ben Handel and coauthors that analyzed the impact new potential PPO plan additions and found varying results depending on the amount of risk adjustment and inertia (Handel et al. 2020).

CalPERS has two sets of in-state premiums — a statewide set of premiums for state and California State University (CSU) employees and a regional set of premiums for its public agency and school members, which vary across three regions (Northern California, greater Los Angeles area, rest of Southern California). We compare our prototype integrated care public option to the statewide rates in what follows to illustrate our point, but a similar analysis could be done for each of the three regions used for setting public agency and school premiums.

¹² We calculate savings from L.A. Care using the average year enrollment in L.A. Care since 2019 and the estimated reduction in premiums due to L.A. Care. To estimate the reduction in premiums, we used our estimate of the average treatment effect and multiplied it with the average premium in the LA region for years 2019 to 2022.

As we proceed, it is important to keep in mind that the HMO plans listed above are not available in every California county. A snapshot of the availability of CalPERS plans by county is shown in Table 7 below.¹³ On average, there are 3.6 HMOs available to CalPERS members across California's 58 counties. Los Angeles County has the most, with 9 HMO options, while several rural counties have none.

Table 7: CalPERS plan availability for selected counties, 2022

County	Anthem Blue Cross EPO	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditional HMO	Blue Shield Access+ HMO	Blue Shield Access+ EPO	Blue Shield Trio HMO	CAHP	CCPOA	Health Net Salud y Más	Health Net SmartCare	Kaiser Permanente	PERS Gold & PERS Platinum	PORAC	Sharp Performance Plus	UnitedHealthcare Signature Value Alliance	UnitedHealthcare Signature Value Harmony	Western Health Advantage HMO
Alameda		•	•	•			•	•		•	•	•	•		■		
Alpine							•					•	•				
Amador							•				•	•	•				
Butte			•	•			•	•				•	•				
Calaveras							•					•	•				
Colusa					•		•					•	•				•
Contra Costa		•	•	•			•	•		•	•	•	•		■		
Del Norte	•						•					•	•				
El Dorado		•	•	•		•	•	•			•	•	•				•
Fresno		•	•	•			•	•		•	•	•	•		•		
Glenn			•	•			•					•	•				
Humboldt			•	•			•					•	•				•
Imperial		•	•	•			•	•				•	•				
Inyo							•					•	•				
Kern		•	•	•			•	•	•	•	•	•	•		•		
Kings			•	•			•	•		•	•	•	•		•		
Lake							•					•	•				
Lassen					•		•					•	•				
Los Angeles		•	•	•		•	•	•	•	•	•	•	•		•	•	

Source: <https://www.calpers.ca.gov/docs/forms-publications/2022-health-benefit-summary.pdf> pgs. 6 & 7

The annual one subscriber premiums for the 11 HMOs currently available to CalPERS members are shown in Table 8. The average annual premium across the 11 HMOs is \$9,800, and the premiums range from \$5,838 (Health Net Salud y Mas) to \$14,377 (Anthem Blue Cross Traditional HMO).

¹³ See <https://www.calpers.ca.gov/docs/forms-publications/2022-health-benefit-summary.pdf> pgs. 6 and 7 for the full availability by county.

Table 8: CalPERS HMO annual premiums for one subscriber, 2022 (sorted lowest to highest)

HMO Plan	Annual Premium for One Subscriber (\$)
Health Net Salud y Mas	\$5,838
Sharp Performance Plus	\$8,390
UnitedHealthcare SignatureValue Harmony	\$8,848
Western Advantage HMO	\$8,895
Blue Shield Trio HMO	\$8,912
Kaiser Permanente	\$9,656
UnitedHealthcare SignatureValue Alliance	\$9,816
Anthem Blue Cross Select HMO	\$10,177
Blue Shield Access+ HMO	\$10,803
Health Net SmartCare	\$12,086
Anthem Blue Cross Traditional HMO	\$14,377
AVERAGE	\$9,800

Source: <https://www.calpers.ca.gov/docs/health-rates-in-state-2022.pdf>

We calculated the statewide premium for our CalPERS integrated care public option similarly to how we calculated premiums for each of the 19 Covered California regions.

1. Start with [\\$5,277](#) — IHA's reported statewide average 2019 total cost of care for enrollees in commercial HMO plans.
2. Add 4.1% of premium for mental health.
3. Multiply the resulting number by 17% due to the average age in IHA's data being 36 while the average age of CalPERS members is 45. The 17% comes from [the age difference in premiums](#) allowed by the ACA.
4. Multiply the resulting number by 0.99/0.95 to account for the fact that the actuarial value of CalPERS' HMO plans is close to 99% as opposed to 95% for IHA's commercial HMO plans.¹⁴
5. Multiply the resulting number by 1.05³ to convert 2019 premiums to 2022 premiums under the assumption that premiums grow 5% per year. 5% is roughly

¹⁴ IHA doesn't report an actuarial value figure, but we estimate the actuarial value to be about 95% based on the fact that member cost-sharing is around 5% for IHA's commercial HMO enrollees.

in line with KFF's [Employer Health Benefits](#) survey, which showed family premiums grew by 4% per year on average over the last 5 years.

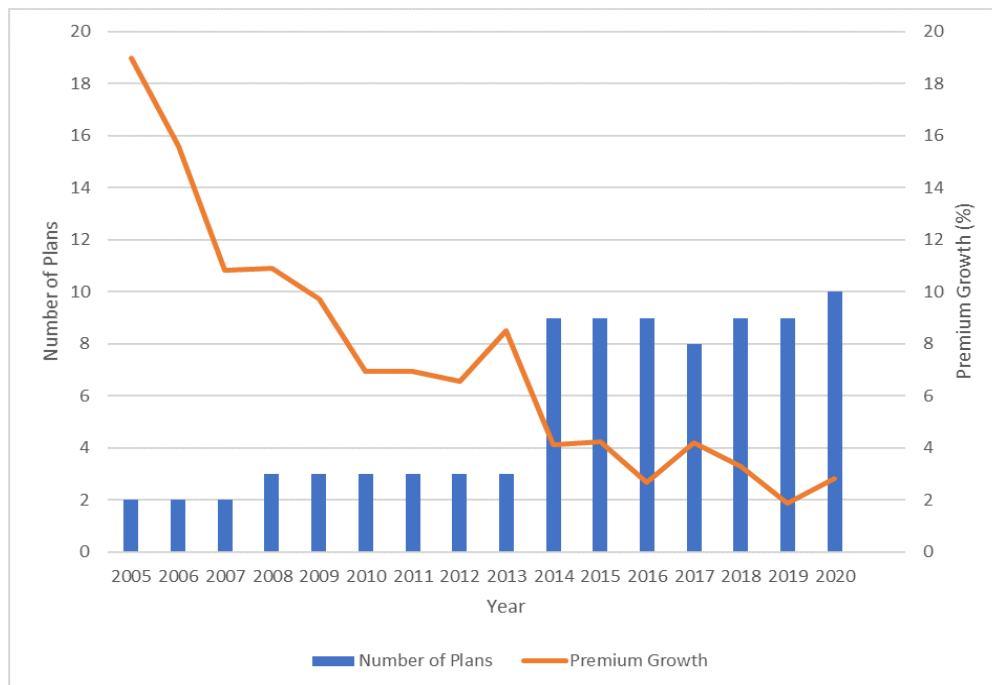
Following these steps leads to an estimate of \$7,767 for our CalPERS integrated care public option. Our CalPERS integrated care public option would be the second least expensive HMO option for CalPERS, behind only Health Salud y Mas,¹⁵ which is only available in Kern, Los Angeles, Orange County, Riverside, San Bernardino, and San Diego. This means if our CalPERS integrated care public option were able to be offered statewide, it would be the lowest cost HMO option in 52 of California's 58 counties. To provide a sense of the potential savings to enrollees in our prototype public option, we found that there would be \$57 million in premium savings if Blue Shield Trio's nearly 50,000 enrollees moved into our prototype public option.

This was, of course, an illustrative example. A good test case in the years to come for the viability of our prototype CalPERS integrated care public option will be the [UnitedHealthcare SignatureValue Harmony](#) (HMO) plan. The Harmony plan was recently made available to CalPERS members in Southern California and is a lower-cost alternative to UnitedHealthcare's Alliance plan. The Harmony plan contracts with a number of the integrated physician organizations (e.g., Monarch, HealthCare Partners) that we envision being contracted with our prototype CalPERS integrated care public option.

We now examine the competitive impact of the number of plans in CalPERS on premium growth. This provides evidence on how our CalPERS integrated care public option would affect premium growth. Figure 6 shows the number of plans in CalPERS and the three-year moving average of annual premium growth since 2005. The number of plans in CalPERS tripled from 3 in 2013 to 9 in 2014. The increase in the number of plans was accompanied by a sharp decline in premium growth from 8.5% in 2013 to 4.5% in 2014. The growth in premiums declined to 3.2% in 2020, when the number of plans increased to 10. This suggests that a well-priced public option would have the competitive impact of further reducing premium growth.

¹⁵ Health Salud y Mas is marketed to the Hispanic population in Southern California and includes providers in Mexico.

Figure 6: CalPERS Premium Growth (3-year Moving Average) and Number of Plans (2005-2020)



Source: Authors' analysis of data from CalPERS.

5. Testing the Feasibility of Implementation — Interviews with Leaders

To help assess the feasibility of implementing a public option plan (POP) for the state, we conducted separate one-hour interviews with seven leaders of health plans and medical groups associated with restricted Knox-Keene plans that have the ability to assume risk for care provided. (A list of those associated with a restricted Knox-Keene license with a total of 1,781,380 enrollees is provided in Appendix 8.) Enrollment in the plans of those we interviewed ranged from 43,432 at Canopy Health to 672,430 at Heritage Provider Network. We asked them to comment on the design features of the POP; their ability to provide care under the POP; and their concerns, challenges, and recommendations.

There was unanimous agreement that a POP would serve the state well as a means for expanding health insurance coverage to the currently uninsured, as well as potentially being offered to the small group market and for self-insured employers to offer it as an option for their employees. Interviewees acknowledged California's ability to provide a high quality, lower cost POP due to its experience in providing care under risk-based capitation agreements.

The leaders who were interviewed felt that they had the capabilities to do well under either a full risk global risk-adjusted budget or a partial risk capitated per member per month payment. Most had various mixed models of payment to their individual primary care and specialty care physicians. A number of them paid their primary care physicians a capitation rate for each enrollee, plus an additional 10-20% or so for achieving quality and service metrics. Some of those treated the 10-20% as a penalty as opposed to an incentive — physicians' base rates would be lower than their market rate so that quality performance would bring them up to standard pay. Others also capitated specialists, while some negotiated various contractual payment relationships.

Those interviewed mentioned that one challenge would be to adjust the capitation rate to account for the social determinants of health (housing, food insecurity, etc.), especially considering that the ability to do this is in early development. Concerns were raised about the technicalities of data collection and how best to utilize the information beyond demographic reporting. A few suggested that predicting the social determinants of health would be enhanced by using advances in artificial intelligence (AI). In the meantime, it is possible to use direct adjustment of the rates by using median income or a related measure contained in area deprivation indices at the census tract level of each enrollee.

Many of the interviewees emphasized the importance of having the enrollee select a primary care provider (PCP) as a usual source of care upon enrollment, rather than the attribution methods that have been used in ACO assignment of enrollees. Upfront designation of a PCP enables the provider organization to proactively manage the enrollees' care needs and to establish an ongoing relationship. Expanded investment in the state's primary care capacity will be needed to promote and sustain cost/effective quality of care over time. Those interviewed also believed that if the cap rate was for professional risk only, then achieving hospital "buy in" would be important for purposes of constraining the rate of growth in overall costs.

On the topic of quality measurement reporting, all agreed on the importance of achieving a standard set of quality measures to be used by all payers. The POP measures should align with the ongoing work of the Integrated Healthcare Association (IHA), as reviewed earlier, to achieve such standardization.

There was also considerable discussion of how the POP might be administered. The main options are either direct contracting by the state with provider organizations or having the state establish the benefit package and overall guidelines but using commercial carriers to handle the billing, data collection, performance reporting, and related functions, as is the case with the Medicare program. Most of those interviewed favored the direct contracting approach. Under the direct contracting model, the state would still have to make an investment in the infrastructure cost to administer the plan. The alternative would be to negotiate a reduced rate to have one or more of the commercial carriers do it. In either case, for a "franchise fee" that was recently reduced from 3.75% to 3.25%, the POP would be listed on the Covered California exchange subject to its qualifying and reporting requirements.

When asked directly whether they could provide care in such a way that the POP would have 5-10% less premium cost to the enrollee than plans currently on the exchange, every person interviewed said “yes.” The two keys were 1) the importance of upfront prepaid risk-adjusted and social determinants of health-adjusted per member per month capitated payment to provide a predictable source of revenue and incentive for innovation and continuously improving care and 2) an administrative structure for the POP that would reduce the cost associated with those structures that currently exist among the commercial plans. In addition, it was recognized that there may need to be special arrangements for providing care in the rural areas of the state where provider coverage is now minimal.

6. Summary and Conclusion

Our analysis of our two-pronged approach supports the views of plan and provider group leaders in the state that a viable public option (with mandated ACA similar benefits) can be offered at lower cost than plans currently offered on the Covered California Exchange. We tested one approach with data provided by IHA on 9.8 million commercial HMO enrollees to estimate premiums of our POP. After making adjustments to the risk adjusted total cost of care in each of the 19 Exchange ratings areas to make them comparable to the Exchange’s current offerings, we found that the POP based on these commercial HMOs would be the lowest silver plan in 14 of 19 regions. For gold plans, this was the case in 14 regions as well.

The potential competitive impact of adding a plan to the Exchange is substantial. We estimate that if there had been at least 5 insurers participating in each of Covered California’s 19 regions in 2020, \$57 million in 2021 premiums would have been saved. If all the markets had 5 or more insurers from 2016 to 2020, we estimate \$228 million in premiums reductions. As things currently stand, these savings mainly would have gone to the federal government in the form of lower subsidy payments. Any potential future savings generated by adding competition to Covered California could instead be captured by the state if it applies for and receives a 1332 waiver.

While our analysis displays significant competitive influence if a plan were to be added to the Exchange, this is likely to underestimate the impact of introducing a POP because the POP’s premiums would be at the low end on the Exchange. Furthermore, we found that the competitive impact was highest in rating regions in northern California that are known to be the most concentrated. In short, our analysis strongly supports the value of offering a POP-based on integrated delivery system that uses risk-based payments in commercial HMOs. The competitive impact analysis using CalPERS data also shows that offering a POP could reduce premium growth.

Our CalPERS analysis showed significant savings in health insurance premiums and lowering of the rate of premium growth. The estimated one-year savings of our prototype plan for CalPERS was \$57 million but the potential savings from its competitive impact on the commercial health insurance market is far greater. As stated previously, we tested our POP on

the Exchange and CalPERS, but the results are only meant to show the viability of a POP. We are not recommending that a POP be offered on the exchange or by CalPERS.

We then analyzed a POP that has already been successful: L.A. Care, a county-run plan that has 100,000 Exchange enrollees and the lowest silver premiums in the Exchange's LA regions. We calculated the one-year savings generated by L.A. Care's presence on the Exchange to be \$77 million and the competitive impact of L.A. Care over four years (2019 to 2022) to be \$345 million. This is very promising as other county plans have the potential to offer a plan on Covered California. There are 17 such local not-for-profit county plans that provide 70% of the enrollment for the more than 10 million low-income enrollees in Medi-Cal. One of these plans — CalOptima — has recently sought to launch a Covered California plan. While many of the other not-for-profit county-run plans are small, L.A. Care has indicated an interest in potentially providing such plans with the necessary administrative infrastructure support to succeed. We also show that the low cost of L.A. Care led to, on average, a 4.8% reduction in premium growth among all providers in the LA region.

We have tested the proposed POP on the Exchange, but it could also be offered to commercially insured individuals in group markets, including those employers that are self-insurers. With its lower premiums for the same benefit package, we believe the option would be attractive.

There are a number of questions, of course, that still need to be addressed. For example, how would the state treat the POP plan off the exchange? Would it be offered as a state-run POP, or state-guided but with delegation to existing insurers to provide the administrative functions? As noted, are there county plans like LA Care that could be offered, either on or off the exchange? How to best address the needs of rural areas warrants further attention. The state can address these and related questions with the confidence that California's integrated delivery system, with medical groups and IPA's experience in delivering care under risk-based capitation arrangements, are fully capable of achieving high quality, lower cost care under a public option approach. Finally, the key distinction between our public option proposal and those in other states is that ours does not regulate prices or force providers to participate. Any financial risk from the state's POP would be borne by the risk-based capitated medical groups. We suggest the state apply for a 1332 waiver as part of the implementation of the POP to capture a significant amount of savings due to the implementation of Golden Choice.

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Appendices

APPENDIX 1:

Several states have pursued research into the public option in the past. Delaware completed an initial [report](#) in 2019, but the state ended up pursuing a 1332 waiver for state reinsurance. New Mexico has [looked into Medicaid buy-in](#) for those who do not qualify for ACA subsidies, but ultimately did not take any further action. Massachusetts has completed [studies](#) evaluating a Medicaid buy-in in 2018. Since then, [Bill S.697](#) was created to establish a public health option, but as of January 2021, no further action was taken. New Jersey has explored the public option for the last few years. In 2017, Senator Nia Gills put forth NJ [S3138](#), the New Jersey Public Option Healthcare Act, which set up a public option to compete in the exchange with private insurers. This bill, however, died in committee. It was subsequently carried over in [Senate Bill 561](#) in 2018, and recently as [Assembly Bill 5029](#) in 2020. It has been introduced and referred to the Assembly Financial Institutions and Insurance Committee. New York has also explored a single payer system (not a public option, [S5474](#)). Iowa and Wyoming both introduced legislation in 2018 related to a public option or Medicaid buy-in. In [Iowa](#), the legislation “Health Iowans for a Public Option” was introduced but did not advance beyond the state Senate. [Wyoming](#) introduced legislation with the intention of creating a Medicaid buy-in without success.

More recently, Illinois, Wisconsin, Minnesota, Oregon, and California have renewed interest in the public option. Illinois’s Bill [HB5442](#) in January 2021 would have created the Health Care Affordability Act, which would have required the Department of Healthcare and Family Services to conduct a study to explore a Basic Health program, public option, Medicaid buy-in, and state subsidies. In February 2021, Wisconsin Governor Tony Evers’s budget included the creation of a state-based health insurance exchange and a public option (in addition to a Medicaid expansion). Those under the public option [could buy into BadgerCare](#), a healthcare coverage program currently aimed towards low-income Wisconsin citizens. The public option would be available in 2025, or 2022 if the ACA no longer exists. The [budget](#) also included a recommendation for the Office of the Commissioner of Insurance to conduct an actuarial analysis of the public option. As of January 2021, the [Minnesota Legislature](#) is exploring the Minnesota Care Public Option. This public option would allow more people to participate in MinnesotaCare beyond the current income requirements using a sliding income-based scale. MinnesotaCare has already existed since 1992 as a bipartisan plan to provide insurance for low-income Minnesotans, not as a public option. It would allow for undocumented immigrants to enroll and also address the “[family glitch](#),” where under the ACA, individual worker and their family cannot get help from ACA if they can enroll in affordable ESI. Small employers would be able to offer MinnesotaCare to employees as well. This was predicated by a MinnesotaCare buy-in bill in 2018. In 2019, the state of Oregon pursued healthcare [reform](#) through a Manatt report (released in late 2020) detailing the outcomes of a Medicaid buy-in and a public option; this stemmed from [Senate Bill 770](#), which created a task force designated with designing a Healthcare for All Oregon Plan. The report detailed a CCO plan (coordinated care organization-led model), a carrier-led model, and a state-led model with a third-party administrator. Since then, [House Bill 2010](#) had been written to create a public option, such that individuals and small

businesses can buy state plans through the insurance exchange. [Missouri](#), [Maryland](#), [New Hampshire](#), and [Maine](#) also passed legislation to research a public option or Medicaid buy-in.

APPENDIX 2:

Selected populous counties commercial HMO enrollment growth 2017-2020:

County	Averaged annual growth 2017-2020	Total growth 2017-2020	Number of enrollees 2020
Riverside	3%	8%	657,678
Sacramento	2%	7%	585,020
Alameda	2%	6%	613,757
San Diego	2%	5%	960,670
Santa Clara	2%	5%	595,939
Orange	2%	4%	809,111
Los Angeles	1%	4%	2,549,181
San Francisco	-2%	-5%	242,179

Enrollment growth on average from 2017 to 2020 was positive for most populous counties, though the average annual growth rate and total growth rates were lower than in 2014 to 2017. San Francisco county saw declines in total and averaged annual growth as growth rate declined by 8% in 2020, likely due to the pandemic. The data records commercial HMO enrollment of DMHC regulated plans on December 31 of the listed year. The data was obtained through a public records act request.

APPENDIX 3:

Medi-Cal HMO Enrollment 2014-2017:

County	Averaged annual growth	Total growth	Number of enrollees
	2014-2017	2014-2017	2017
Nevada	86%	302%	20,191
Plumas	38%	140%	5,024
Mono	30%	106%	2,802
El Dorado	27%	91%	30,564
Sacramento	22%	80%	531,240
Butte	23%	78%	66,175
Sutter	23%	77%	33,452
Calaveras	23%	75%	9,798
Amador	22%	75%	6,695
Placer	23%	75%	46,582
Yuba	22%	73%	25,663
Riverside	21%	73%	698,328
Colusa	20%	69%	7,318
Sierra	21%	68%	616

Stanislaus	34%	68%	202,815
Glenn	18%	62%	9,952
Humboldt	18%	61%	53,066
Tehama	19%	60%	20,635
Kern	17%	60%	326,311
Marin	18%	59%	39,342
Santa Clara	17%	59%	346,296
San Bernardino	17%	58%	712,189
San Diego	22%	58%	639,781
Contra Costa	17%	57%	210,978
Tuolumne	18%	57%	11,058
Monterey	16%	55%	157,924
Mariposa	17%	55%	3,770
San Francisco	17%	54%	156,870
Santa Cruz	16%	53%	69,458
Santa Barbara	16%	53%	123,929
Lake	16%	52%	30,488
Fresno	15%	52%	413,325

Ventura	15%	50%	205,677
Yolo	16%	50%	53,723
San Joaquin	21%	49%	242,997
Siskiyou	15%	48%	17,867
Los Angeles	14%	47%	3,018,011
Kings	14%	47%	47,165
Imperial	14%	46%	75,982
San Luis Obispo	15%	46%	55,127
Inyo	14%	45%	3,907
Sonoma	14%	44%	112,749
Napa	14%	44%	28,885
Madera	13%	44%	55,521
Merced	14%	43%	127,641
Mendocino	14%	43%	37,711
Modoc	14%	43%	3,053
Orange	14%	42%	772,896
Trinity	14%	42%	4,470
Solano	13%	42%	112,647

Tulare	12%	40%	208,414
Alameda	12%	39%	326,540
Alpine	14%	38%	253
Lassen	12%	38%	7,410
Shasta	10%	29%	60,193
San Mateo	9%	28%	112,550
Del Norte	8%	25%	11,310
TOTAL	16%	53%	10,723,623

Cattaneo and Stroud did not have Medi-Cal enrollment data for San Benito County in 2014, so it is excluded from the above list as the average annual percent change and total percent enrollment change from 2014 to 2017 could not be calculated. San Benito county had 8,289 Medi-Cal enrollees in 2017.

APPENDIX 4:

Medicare HMO Enrollment 2014-2017:

County	Averaged annual growth	Total growth	Number of enrollees
		2014-2017	
Monterey	62%	323%	2,700
Humboldt	41%	162%	207
San Benito	29%	93%	459
Merced	25%	90%	2,943
Tehama	27%	84%	127
Plumas	36%	39%	93
Yuba	10%	32%	665
Del Norte	10%	29%	22
Siskiyou	15%	29%	75
Sonoma	8%	26%	40,463
Kings	7%	24%	2,138
Ventura	7%	23%	39,271
Tulare	7%	21%	7,580
Napa	7%	21%	9,539
Solano	6%	20%	27,475

Colusa	9%	19%	68
Mendocino	6%	19%	943
San Luis Obispo	6%	19%	6,309
San Diego	6%	18%	206,978
El Dorado	6%	18%	12,377
Amador	5%	17%	1,942
Yolo	5%	16%	10,689
Sutter	6%	16%	298
Orange	5%	16%	201,280
Los Angeles	5%	15%	590,419
Tuolumne	5%	15%	429
San Bernardino	5%	15%	137,584
Mariposa	7%	15%	155
Marin	5%	14%	19,840
Placer	4%	14%	33,263
Sacramento	4%	14%	93,975
Santa Clara	4%	13%	91,877
Riverside	4%	13%	169,840

San Joaquin	4%	13%	34,412
Santa Barbara	4%	12%	10,237
Stanislaus	4%	12%	33,127
Fresno	4%	12%	35,187
Contra Costa	3%	10%	79,018
Alameda	4%	10%	86,849
Modoc	6%	9%	12
Glenn	3%	8%	28
Madera	2%	7%	6,873
San Mateo	2%	5%	38,790
Kern	2%	5%	36,438
Calaveras	1%	3%	572
Butte	5%	2%	294
Sierra	3%	0%	12
Lake	0%	-1%	512
Mono	-1%	-6%	16
Inyo	-4%	-11%	24
Trinity	-4%	-12%	30

San Francisco	-4%	-13%	41,269
Lassen	-6%	-19%	17
Nevada	-8%	-25%	2,713
Santa Cruz	-14%	-51%	1,535
Imperial	-37%	-86%	340
Shasta	-32%	-90%	212
TOTAL	4%	14%	2,120,540

Alpine County is excluded as the county had no reported Medicare HMO enrollees in the Cattaneo and Stroud data from 2014 to 2017.

APPENDIX 5:

Commercial HMO Enrollment in California 2014-2017:

County	Averaged annual growth	Total growth		Number of enrollees
		2014-2017	2014-2017	
Mariposa	23%	60	1,353	
Imperial	17%	53	17,779	
Yolo	14%	42	73,509	
Tulare	21%	41	18,829	
Mono	19%	38	33	
Yuba	11%	36	7,459	
Stanislaus	10%	33	120,496	
San Diego	7%	21	1,025,398	
Fresno	7%	21	131,428	
Sonoma	6%	19	178,276	
Tehama	23%	18	231	
Sacramento	6%	18	575,051	
Riverside	6%	18	662,653	
San Bernardino	4%	14	647,571	
Santa Clara	4%	13	608,775	
San Francisco	4%	11	255,156	
Contra Costa	4%	11	421,206	
Ventura	3%	10	181,044	
San Joaquin	3%	10	202,300	

Solano	3%	10	186,555
Alameda	3%	9	597,352
Los Angeles	3%	8	2,729,749
Orange	3%	8	837,017
Placer	3%	8	147,309
Butte	7%	4	7,130
Marin	1%	3	74,005
Siskiyou	56%	3	107
San Mateo	1%	2	234,856
Amador	0%	1	5,054
Madera	0%	0	16,907
Santa Cruz	1%	-1	33,482
San Benito	0%	-1	7,608
Napa	-1%	-4	48,418
Merced	0%	-5	16,607
Modoc	56%	-10	18
Mendocino	2%	-11	1,529
Kern	-4%	-12	129,143
El Dorado	-5%	-15	50,802
Trinity	5%	-16	48
Santa Barbara	-6%	-17	37,481
Shasta	21%	-23	413
Lake	-10%	-27	2,094
Colusa	-9%	-28	1,191
Humboldt	-7%	-30	3,778

Calaveras	-9%	-30	3,402
San Luis Obispo	-11%	-31	18,773
Inyo	75%	-32	73
Plumas	-5%	-33	94
Nevada	-12%	-36	9,145
Kings	-15%	-43	10,443
Del Norte	-1%	-46	40
Lassen	-9%	-47	47
Monterey	-16%	-54	5,866
Tuolumne	-19%	-56	1,034
Sutter	-19%	-68	4,610
Glenn	-32%	-75	676
Alpine	-52%	-95	4
Sierra	-40%	-95	74
TOTAL	3%	11	10,351,481

APPENDIX 6:

Commercial HMO Enrollment in California 2017-2020:

County	Average Yearly Increase	Total Enrollment Change	Number of enrollees
	2017-2020	2017-2020	2020
Alpine	33%	100%	2
Monterey	25%	80%	10,048
Modoc	20%	67%	25
Imperial	16%	53%	23,814
Humboldt	14%	46%	851
Del Norte	14%	39%	39
San Benito	10%	32%	10,101
Santa Cruz	9%	30%	56,448
Shasta	8%	27%	524
San Luis Obispo	8%	25%	21,970
Tuolumne	7%	22%	1,123
Mono	6%	18%	39
San Joaquin	6%	18%	240,830
Yuba	5%	17%	8,873
Lassen	7%	17%	69
Madera	5%	16%	18,201
Tulare	5%	14%	20,333
Fresno	4%	13%	134,293
Stanislaus	4%	13%	132,738
Glenn	8%	13%	99
Mendocino	4%	12%	977
Ventura	4%	12%	187,148
Placer	3%	9%	153,367
Kings	3%	9%	10,500
El Dorado	3%	9%	52,783
Riverside	3%	8%	657,678
Tehama	3%	8%	182
Sacramento	2%	7%	585,020
Calaveras	2%	7%	3,650
Contra Costa	2%	7%	441,701
Amador	2%	7%	5,418
San Bernardino	2%	6%	642,583
Alameda	2%	6%	613,757
San Diego	2%	5%	960,670
Yolo	2%	5%	73,017
Solano	2%	5%	189,884
Santa Clara	2%	5%	595,939
Lake	2%	4%	2,015
Orange	2%	4%	809,111
Los Angeles	1%	4%	2,549,181
Merced	2%	4%	15,478
Sonoma	1%	3%	178,002
Kern	1%	3%	135,613
Marin	1%	2%	74,436
Napa	1%	2%	48,713
Colusa	0%	0%	897
San Mateo	0%	0%	229,033
Siskiyou	0%	-1%	96
Mariposa	0%	-1%	1,002
Sutter	-1%	-2%	4,348
San Francisco	-2%	-5%	242,179
Santa Barbara	-2%	-7%	29,459
Nevada	-4%	-12%	6,382
Butte	-5%	-15%	1,677
Inyo	-8%	-24%	56
Plumas	-14%	-36%	44
Trinity	-23%	-55%	17
Sierra	-7%	-85%	4
Total	2%	6%	10,182,437

The data records commercial HMO enrollment of DMHC regulated plans on December 31 of the listed year. The data was obtained through a public records act request.

APPENDIX 7:

Total HMO Enrollment 2014-2017:

County	Averaged annual growth	Total growth	Number of enrollees
	2014-2017	2014-2017	2017
Plumas	36%	127%	5,211
San Benito	32%	106%	16,356
Mono	29%	103%	2,851
Butte	21%	66%	73,599
Yuba	18%	62%	33,787
Tehama	19%	60%	20,993
Mariposa	18%	54%	5,278
Humboldt	15%	49%	57,051
Siskiyou	15%	48%	18,049
Stanislaus	19%	48%	356,438
Monterey	13%	44%	166,490
Imperial	13%	43%	94,101
Yolo	13%	42%	137,921
Modoc	14%	42%	3,083

Colusa	13%	42%	8,577
Inyo	14%	42%	4,004
Lake	13%	41%	33,094
Fresno	12%	41%	579,940
Trinity	13%	40%	4,548
Nevada	12%	39%	32,049
Mendocino	13%	39%	40,183
Tulare	12%	39%	234,823
Sacramento	12%	39%	1,200,266
Riverside	11%	37%	1,530,821
Merced	12%	36%	147,191
Lassen	12%	36%	7,474
San Bernardino	10%	31%	1,497,344
San Diego	10%	31%	1,872,157
Amador	10%	31%	13,691
Tuolumne	9%	28%	12,521
Madera	9%	28%	79,301
Ventura	9%	28%	425,992

Sonoma	9%	28%	331,488
Kern	8%	27%	491,892
San Joaquin	10%	27%	479,709
Santa Cruz	9%	27%	104,475
Santa Barbara	8%	27%	171,647
Calaveras	8%	25%	13,772
Santa Clara	8%	25%	1,046,948
Los Angeles	8%	25%	6,338,179
Del Norte	8%	25%	11,372
Shasta	8%	23%	60,818
Contra Costa	7%	21%	711,202
Orange	7%	21%	1,811,193
Glenn	6%	20%	10,656
Solano	6%	20%	326,677
San Francisco	7%	20%	453,295
Placer	6%	18%	227,154
Alameda	6%	17%	1,010,741
Marin	6%	17%	133,187

Kings	5%	15%	59,746
Sutter	5%	14%	38,360
San Luis Obispo	5%	14%	80,209
Napa	3%	11%	86,842
San Mateo	3%	9%	386,196
El Dorado	3%	9%	93,743
Alpine	0%	0%	257
Sierra	-20%	-64%	702
Total	9%	27%	23,195,644

APPENDIX 8:

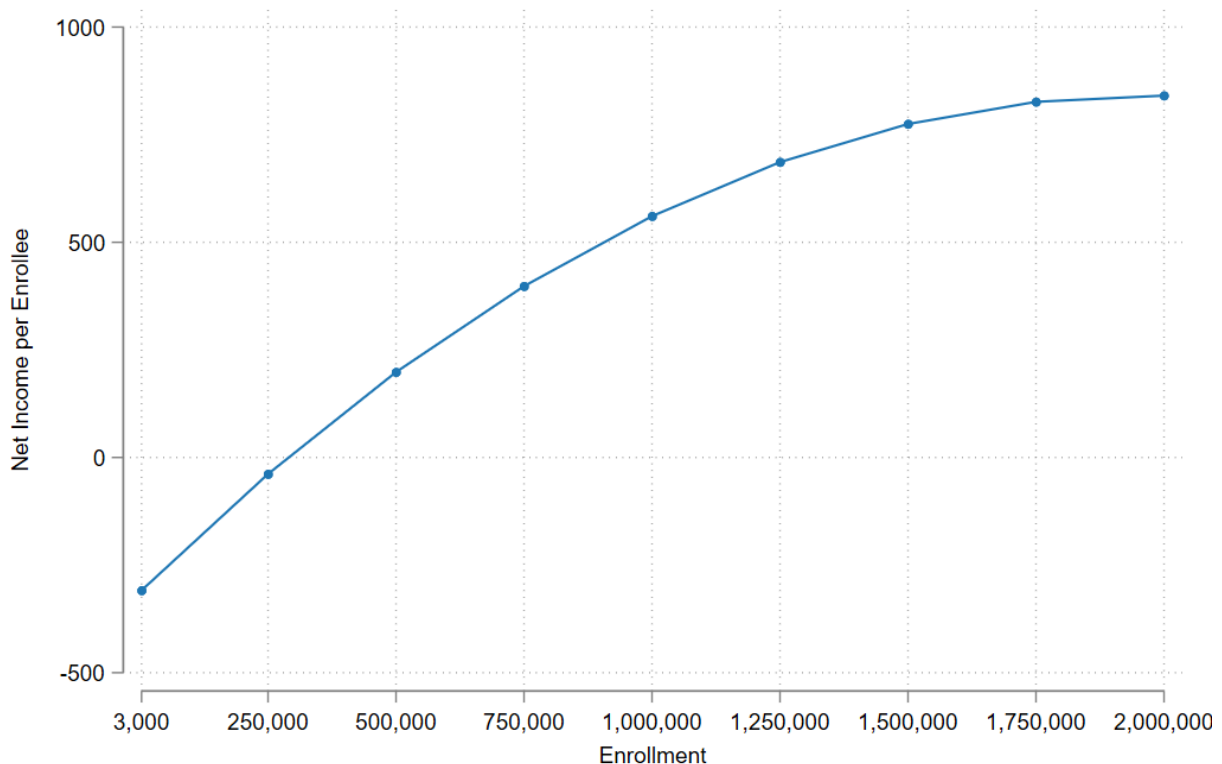
RKK Plans Enrollment 2014-2020:

Restricted Knox-Keene Plan	2014	2015	2016	2017	2018	2019	2020	Enrollment change 2017-2020
Bay Area Accountable Care Network, Inc. (Canopy)			14,265	14,647	25,246	45,373	43,432	197%
Brown & Toland Health Services, Inc.	10,001	9,615	9,332	9,722	10,045	13,287	18,609	91%
Choice Physicians Network, Inc.	7,289	9,538	14,805	13,147	15,460	14,942	13,942	6%
Dignity Health Provider Resources, Inc.			30,136	30,183	32,117	31,259	31,480	4%
EPIC Health Plan	67,494	58,140	58,380	64,382	71,951	71,434	68,015	6%
Heritage Provider Network, Inc.	501,526	534,020	594,664	658,949	697,088	704,744	672,430	2%
Inter Valley Health Plan	20,747	21,886	22,642	24,549	21,836	19,547	18,026	-27%
Monarch Health Plan	25,605	55,171	51,781	154,349	143,297	141,868	151,446	-2%
Optum Health Plan of California	532,455	519,262	495,189	481,689	477,134	472,647	469,442	-3%
PRIMECARE Medical Network, Inc.	218,455	206,592	201,715	193,501	209,488	217,384	228,381	18%
Prospect Health Plan, Inc.		4,761	8,188	51,354	51,394	49,803	55,265	8%
Sequoia Health Plan				7,544	8,387	9,422	10,912	45%
Total	1,383,572	1,418,985	1,501,097	1,704,016	1,763,443	1,791,710	1,781,380	5%

APPENDIX 9:

Though there are about 23 million enrollees in HMO Plans (Table 2), the size of these plans has a great deal of variation in enrollment. Figure A1 shows a fitted regression line of the relationship between enrollment in these plans and net income per enrollee in 2019. The horizontal axis spans from roughly the 5th percentile of enrollment (3,000) to the 95th percentile of enrollment (2 million). Kaiser Permanente — with its 9.1 million enrollees — is excluded from this analysis.¹⁶ Figure A1 below shows that going from 250,000 enrollees to 500,000 is associated with a \$237 increase in net income per enrollee. Diminishing returns eventually kick in as can be seen from the fact that going from 1,500,000 enrollees to 1,750,000 enrollees increases net income by \$52 per enrollee. But the message is clear: more enrollment means more net income per enrollee, and it takes about 250,000 enrollees to begin to show a profit. This relationship between enrollment and net income per enrollee is likely due to economies of scale and scope.¹⁷

Figure A1: Net Income Per Enrollee, 2017-2019



Notes: Petris Center analysis of data the Department of Managed Health Care. The figure goes from roughly the 5th percentile of enrollment (3,000) to the 95th percentile (2,000,000). Kaiser Permanente, with its 9.1 million enrollees, is excluded from this analysis.

¹⁶ Kaiser Permanente's net income per enrollee was \$816 in 2019.

¹⁷ Economies of scale refers to the cost advantages a company gains with an increase in production. Economies of scope refers to the decrease in the total cost of production when a range of products are produced together rather than separately.

APPENDIX 10:

IHA Data Benefits and Essential Health Benefits Information

Total cost of care measures in Table 1A describe full risk commercial plan data submitted to IHA. The [IHA Atlas](#) defines full risk as “capitation for both professional and facility costs.” Full risk plans operating in California are regulated by the Department of Managed Health Care (DMHC) pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). Medically necessary basic health care services must be covered by plans regulated by the DMHC, except specialized plans and plans granted an exemption by the director. The analyzed full risk plans must be in accordance with the Knox-Keene Act and are regulated by DMHC, therefore the plans must cover basic health care services unless they have are granted an exemption or are a specialized plan. According to the [Knox-Keene Act](#), these basic health care services include: “(1) Physician services, including consultation and referral; (2) Hospital inpatient services and ambulatory care services; (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services; (4) Home health services; (5) Preventive health services; (6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage... (7) Hospice care.” The benefit packages of the IHA commercial full risk plans analyzed therefore must cover the aforementioned services, unless granted an exemption by the director, meaning basic benefits of IHA plans are similar. According to IHA, basic benefits are similar across commercial plans within their data; however, certain plans have specific benefit exclusions such as dental and vision, which are generally offered through riders or carve-outs. Some employer groups have special coverage options for health care services like in vitro fertilization (IVF) that go above the basic benefits required by DMHC and covered by essential health benefits. Essential health benefits must be covered by plans offered through [Covered California](#). These benefits include “ambulatory patient services (outpatient care you get without being admitted to a hospital); emergency services; hospitalization (like surgery and overnight stays); pregnancy, maternity, and newborn care (both before and after birth); mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy); prescription drugs; rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills); laboratory services; preventive and wellness services and chronic-disease management; and pediatric services, including oral and vision care (but adult dental and vision coverage aren’t essential health benefits).” The basic health care services required by DMHC and the essential health benefits required to be offered on the exchange are thus quite similar, enabling comparable financial analysis to be done.

APPENDIX 11:

2021 Patient-Centered Benefit Designs and Medical Cost Shares



2021 Patient-Centered Benefit Designs and Medical Cost Shares

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

Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers 0% until out-of-pocket maximum is met	Covers 60% average annual cost	Covers 70% average annual cost	Covers 73% average annual cost	Covers 87% average annual cost	Covers 94% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	\$25,521 to \$31,900 (>200% to ≤250% FPL)	\$19,141 to \$25,520 (>150% to ≤200% FPL)	up to \$19,140 (100% to ≤150% FPL)	N/A	N/A
Annual Wellness Exam	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Primary Care Visit	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	\$65*	\$40	\$35	\$15	\$5	\$35	\$15
Urgent Care		\$65*	\$40	\$35	\$15	\$5	\$35	\$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	\$95*	\$80	\$75	\$25	\$8	\$65	\$30
Emergency Room Facility		40% after deductible is met	\$400	\$400	\$150	\$50	\$350	\$150
Laboratory Tests		\$40	\$40	\$40	\$20	\$8	\$40	\$15
X-Rays and Diagnostics		40% after deductible is met	\$85	\$85	\$40	\$8	\$75	\$30
Imaging			\$325	\$325	\$100	\$50	\$150 copay or 20% coinsurance***	\$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	\$18**	\$16**	\$16**	\$5 or less	\$3 or less	\$15 or less	\$5 or less
Tier 2 (Preferred Drugs)		40% up to \$500 after drug deductible is met	\$60**	\$55**	\$25**	\$10 or less	\$55 or less	\$15 or less
Tier 3 (Non-preferred Drugs)			\$90**	\$85**	\$45**	\$15 or less	\$80 or less	\$25 or less
Tier 4 (Specialty Drugs)			20% up to \$250** per script	20% up to \$250** per script	15% up to \$150** per script	10% up to \$150 per script	20% up to \$250 per script	10% up to \$250 per script
Medical Deductible	N/A	Individual: \$6,300 Family: \$12,600	Individual: \$4,000 Family: \$8,000	Individual: \$3,700 Family: \$7,400	Individual: \$1,400 Family: \$2,800	Individual: \$75 Family: \$150	N/A	N/A
Pharmacy Deductible	N/A	Individual: \$500 Family: \$1,000	Individual: \$300 Family: \$600	Individual: \$275 Family: \$550	Individual: \$100 Family: \$200	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	\$8,150 individual only	\$8,200 individual \$16,400 family	\$8,200 individual \$16,400 family	\$6,500 individual \$13,000 family	\$2,850 individual \$5,700 family	\$1,000 individual \$2,000 family	\$8,200 individual \$16,400 family	\$4,500 individual \$9,000 family

Drug prices are for a 30 day supply.

* 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.

** Price is after pharmacy deductible amount is met.

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

APPENDIX 12:

Simulations Ranking Average Gold and Silver Premiums against Prototype with 5% and 10% increase in cost

Table A12A. Exchange Premiums vs. 5% Increase in Total Cost of Care of Full Risk Commercial Plans, 2019

(1) Covered California Regions	(2) Average Gold**	(3) Average Silver*	(4) IHA rank vs. Gold (1=lowest)	(5) IHA*** rank vs. Silver (1=lowest)
1 - Northern Counties	\$8,456	\$7,843	1	1
2 - North Bay Counties	\$8,826	\$8,271	1	1
3 - Greater Sacramento	\$7,954	\$7,333	1	1
4 - San Francisco County	\$8,837	\$8,165	3	3
5 - Contra Costa County	\$8,555	\$7,995	1	1
6 - Alameda County	\$7,701	\$7,033	1	1
7 - Santa Clara County	\$7,825	\$7,019	3	2
8 - San Mateo County	\$9,237	\$8,612	1	1
9 - Central Coast - North	\$8,412	\$7,800	1	1

10 - Central Valley - North	\$8,038	\$7,497	1	1
11 - Greater Fresno Area	\$5,701	\$5,124	1	1
12 - Central Coast - South	\$6,751	\$6,017	1	1
13 - Eastern Region	\$6,866	\$6,389	3	3
14 - Kern County	\$6,217	\$5,557	1	1
15 - Los Angeles - East	\$5,483	\$4,916	6	6
16 - Los Angeles - West	\$6,184	\$5,574	4	3
17 - Inland Empire	\$5,865	\$5,197	2	1
18 - Orange County	\$6,418	\$5,718	1	1
19 - San Diego County	\$6,411	\$5,852	1	1
AVERAGE	\$7,354	\$6,732	1 - 13 regions 2 - 1 region 3 - 3 regions 4 or lower - 2 regions	1 - 14 regions 2 - 1 regions 3 - 3 region 4 or lower - 1 region

Source: Authors' analysis of data from [Covered California](#), [HIX Compare](#), and [IHA](#).

Notes: IHA = Integrated Healthcare Association. The annual gold premiums shown here are for a 36-year-old individual to align with the fact that the average age of enrollees in the IHA plans in 2019 was 36. IHA's risk adjustment was done using Johns Hopkins ACG System. See IHA's [data methodology](#) for details.

*Average Silver = Average Annual Silver Premium + 10% for out-of-pocket expenses

**Average Gold = Average Annual Gold Premium + 10% for out-of-pocket expenses

***IHA = The average risk adjusted total cost of care per member of full risk commercial plan enrollees in the region + 4% administrative expenses + 4.1% mental health + 3.75% listing fees.

Table A12B. Exchange Premiums vs. 10% Increase in Total Cost of Care of Full Risk Commercial Plans, 2019

(1) Covered California Regions	(2) Average Gold**	(3) Average Silver*	(4) IHA rank vs. Gold (1=lowest)	(5) IHA*** rank vs. Silver (1=lowest)
1 - Northern Counties	\$8,456	\$7,843	1	1
2 - North Bay Counties	\$8,826	\$8,271	1	1
3 - Greater Sacramento	\$7,954	\$7,333	1	1
4 - San Francisco County	\$8,837	\$8,165	3	4
5 - Contra Costa County	\$8,555	\$7,995	1	1
6 - Alameda County	\$7,701	\$7,033	2	1
7 - Santa Clara County	\$7,825	\$7,019	3	2
8 - San Mateo County	\$9,237	\$8,612	2	2

9 - Central Coast - North	\$8,412	\$7,800	1	1
10 - Central Valley - North	\$8,038	\$7,497	2	1
11 - Greater Fresno Area	\$5,701	\$5,124	2	2
12 - Central Coast - South	\$6,751	\$6,017	1	1
13 - Eastern Region	\$6,866	\$6,389	3	3
14 - Kern County	\$6,217	\$5,557	1	1
15 - Los Angeles - East	\$5,483	\$4,916	7	7
16 - Los Angeles - West	\$6,184	\$5,574	5	4
17 - Inland Empire	\$5,865	\$5,197	2	1
18 - Orange County	\$6,418	\$5,718	1	1
19 - San Diego County	\$6,411	\$5,852	2	1

AVERAGE	\$7,354	\$6,732	1 - 8 regions	1 - 12 regions
			2 - 6 regions	2 - 3 regions
			3 - 3 regions	3 - 1 region
			4 or lower - 2 regions	4 or lower - 3 regions

Source: Authors' analysis of data from [Covered California](#), [HIX Compare](#), and [IHA](#).

Notes: IHA = Integrated Healthcare Association. The annual gold premiums shown here are for a 36-year-old individual to align with the fact that the average age of enrollees in the IHA plans in 2019 was 36. IHA's risk adjustment was done using Johns Hopkins ACG System. See IHA's [data methodology](#) for details.

*Average Silver = Average Annual Silver Premium + 10% for out-of-pocket expenses

**Average Gold = Average Annual Gold Premium + 10% for out-of-pocket expenses

***IHA = The average risk adjusted total cost of care per member of full risk commercial plan enrollees in the region + 4% administrative expenses + 4.1% mental health + 3.75% listing fees.

APPENDIX 13:

We estimated the impact of the number of insurers on ACA premium growth from 2014 to 2021 using a fixed effects regression model. The variables included in the model were as follows:

- Dependent Variable: Change Log(Annual Silver Premium (\$))
- Independent Variables
 - Indicator variable for the market having 5 or more insurers offering coverage
 - Hospital HHI
 - Market and year fixed effects

The focus on Exchange premium growth rates instead of the level of premiums reduces concerns related to time-invariant differences in the risk profiles of plans or other characteristics that might be correlated with premium levels. Our approach of focusing on premium growth is similar to that used in an [earlier paper](#) by Dafny and colleagues. The number of insurers in a market is lagged by one year to account for the fact that premiums are set prospectively. The inclusion of “year fixed effects” captures average changes in California Exchange premium growth, while “market fixed effects” capture differences in average growth rates across markets.

Table A13. Coefficient Estimates from Regression Model

	Dependent Variable: Change in log(Annual Premium)
	Coefficient Estimate (Standard Error)
5 or more insurers (lagged by one year)	-0.0156* (0.0039)
Hospital HHI (lagged by one year)	0.0000122 (0.0000187)
Year	
2015	REF
2016	-0.0051 (0.0074)
2017	0.0944*** (0.0092)
2018	0.1826*** (0.0122)
2019	0.0176**

	(0.0082)
2020	-0.0620*** (0.0072)
2021	-0.0273*** (0.0084)
Number of Observations	542
R-squared	0.58
Market Fixed Effects	YES

Source: Authors' analysis of data from [Covered California](#) and [HIX Compare](#).

Notes: REF = reference group. Standard errors were clustered by market. * p<0.1 ** p<0.05 *** p<0.01

APPENDIX 14:

Table A14. Difference-in-differences model estimating the effect of LA Care becoming the lowest priced plan in 2018 on premium growth

	Dependent Variable: Change log(Annual Premium)
	Coefficient Estimate (Standard Error)
Average Treatment Effect	-0.048** (0.024)
Number of Observations	504
R-squared	0.78
Market, Insurer, and Year Fixed Effects	YES

Source: Authors' analysis of data from [Covered California](#) and [HIX Compare](#).

Notes: Standard errors were clustered by market. * p<0.1 ** p<0.05 *** p<0.01

FOOTNOTES

^a Professor Shortell is an uncompensated liaison non-voting member of the Integrated Healthcare Association.

Data were not available to make further adjustments than what was done. Additional analysis can be conducted as data on plan provider networks and more complete data on race/ethnicity become available.

L.A. Care:

The LA Times wrote an [article](#) in September 2020 prompting investigation by the state of California into LA Care. Upon investigation by the [state](#), DHCS put a [\\$20 million sanction](#) on L.A. Care and DMHC fined L.A. Care [\\$35 million](#), for a total penalty of \$55 million, the largest in state history. LA Care was [found](#) to have “systemic failure to issue resolution letters” by not responding to over 67,000 grievances in a timely manner and had “a significant backlog in processing requests for authorizations of health care services for members” with 92,854 instances of “prior authorization requests were not processed timely from January 1, 2019 through October 13, 2021.” L.A. Care self-reported the two compliance issues for which it was fined and has stated that it “understands and agrees with the need for corrective action and is working cooperatively with the state to address the compliance issues, however is contesting the amount of the proposed penalties as being disproportionate to the value L.A. Care brings to its members and network of safety net and community providers.” The analysis performed in this paper related to L.A. Care focuses on its competitive impact on premiums in the L.A. regions (Regions 15 & 16) of Covered California.

Kaiser Permanente:

Kaiser Health Plan holds a full service, non-restricted license from the DMHC under the Knox-Keene Act (PRA Request). Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and Permanente Medical Groups (PMG) form a mutually exclusive group collectively known as [Kaiser](#) Permanente with each component being legally separate. Kaiser Health Plan provides IHA data under the professional risk only category rather than full risk category due to the aforementioned structure of entities (IHA). Legally separate entities result in Kaiser Health Plan paying different hospital and physician networks capitated rates for physician services, thus falling under the professional risk category rather than the full risk category.

Underinsurance:

Underinsurance is a continued issue in the American health system. [The Commonwealth Fund](#) defines underinsured individuals in their Biennial Health Insurance Survey as “adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.” According to [The Commonwealth Fund](#) Biennial Health Insurance Survey, 21.3% of adults were underinsured in the United States as of early 2020. A primary issue faced by both the uninsured and the underinsured is inability to pay, resulting in missed follow-up appointments, prescription refills, and more. The public option would provide a lower cost alternative plan for individuals who are currently underinsured.

DCE PO:

The Centers for Medicare and Medicaid Services ([CMS](#)) Innovation Center is currently in the first performance year (PY) of testing a new model of global and professional direct contracting

through the use of direct contracting entities (DCEs). California has 11 DCEs participating in PY 2021 from April 1 to December 31 ([CMS](#), April 2021). The DCE model is intended to reduce traditional FFS Medicare costs through two risk sharing options designed to encourage new providers to work with [CMS](#) patients for the first time. DCEs act similarly to ACOs by reducing costs and increasing quality. DCEs focus on preventive care to minimize cost and mitigate negative outcomes for enrollees through access to PCPs and devices such as wearables and algorithms. Many DCEs contracting within California are newly formed entities and have little information available, others are subsidiaries of larger companies including: [Axceleran DCE1](#), a subsidiary of [Alignment Healthcare, Inc.](#) and Vively, a standalone subsidiary of [DaVita Health Solutions](#), a large player in the chronic illness space. [Regal Medical Group](#) is a DCE affiliated with Heritage Provider Network, which holds a restricted Knox-Keene (RKK) license. This is especially interesting as it demonstrates the possibility of forming DCEs with other RKKs within the framework of a public option. RKK plans have a direct contracting pilot bill, [AB 1124](#), which provides two RKK plans with an exception to contract directly to a self-funded payer for a 4-year period.

DCEs operating in CA:

360 Health DCE Inc <http://360health.md/>

Contact info:

Phone: (951)-637-9935

Fax: (951)-637-0608

360 Health DCE is a preferred provider organization.

ADVANCED VALUE CARE II <https://avcdc.org/>

Contact info: Tyrone Barnett, MBA

tbarnett@avcdc.org

Phone: (845)-205-2756

Fax: (845)-367-5503

Advanced Value Care II is focused on wellness as a preventative measure. Advanced Value Care II is a new company and does not have much information available on their website.

American Choice Healthcare, LLC <https://americanchoicehealthcare.com/>

Contact info: info@americanchoicehealthcare.com

Phone: (855)-391-2266

Fax: (786)-706-9244

American Choice Healthcare coordinates care between primary care providers and specialists/inpatient and outpatient facilities. American Choice Healthcare shares data and operational guidance to promote preventative care and effective disease management. Network is in Florida, Texas, Nevada, Arizona, Oregon, and California

Axceleran DCE1, LLC <https://www.alignmenthealthcare.com/>

Contact info for Alignment Healthcare:

Phone: 1-844-310-2247

There is no information available for Axceleran DCE1, LLC online. Axceleran DCE1 is a [subsidiary](#) of Alignment Healthcare, Inc. Alignment Healthcare uses a data driven approach to care with the predictive AI platform AVA (Alignment Virtual Application).

CareConnectMD DCE LLC <https://www.careconnectmd.com/>

Contact info:

Phone: (714)-992-1182

Fax: (562)-803-4500

CareConnectMD has more than 110,000 patients at skilled nursing facilities and long-term care facilities in Southern California (Orange, Los Angeles, San Diego, Riverside, and San Diego counties) and in Arizona.

CareMore Aspire Medical Innovation Partners, PC

<https://www.caremore.com/About/DCE.aspx>

Contact info:

CareMore Health DCE 12898 Towne Center Drive Cerritos, CA 90703

Phone: (877)-421-5777 (this phone number may just be for patients with plan questions)

Key leaders: Gregory Garza West Market President, David Hsieh VP Financial Strategy and Planning, Dr. Andrew Aronson CMO

Participating and preferred providers in Southern California:

Dr. Matthew Lefferman D.O Access Healthcare Associates and Dr. Jason Abney D.O Doctors Direct Medical Group

The CareMore group uses technology such as wearable devices to monitor health remotely and has an application utilized by CareMore clinicians and contracted clinicians to improve data sharing which will be expanded to include a mobile component to make it easier for clinicians to access data from anywhere enabling home-based care. CareMore utilizes case managers to coordinate care and uses prevention strategies such as dietician classes and smoking cessation programs in its care model.

Central Valley Community Partners LLC

New entrant, no information is available online.

Nivano Physicians, Inc. IPA <https://www.nivanophysicians.com/>

Contact info:

Phone: (916)-407-2000

info@nivanophysicians.com

Nivano Physicians, Inc. utilizes a technology driven approach. Nivano Physicians, Inc. is an Independent Physician Association (IPA) which works with health plan partners. A conglomeration of DBAs including Nivano Health, Nivano Care, Northern California Physicians Association and Sierra Nevada merged into one entity to form Nivano Physicians, Inc. IPA.

Regal Medical Group <https://www.regalmed.com/>

Contact info:

Phone: (818)-654-3400

Regal Medical Group is affiliated with Heritage Provider Network, an RKK we have been looking into. Regal Medical Group received a five-star rating in Standards of Excellence from America's Physician Groups. Preventative care is a feature of the group. Wide network of over 3000 PCPs with over 10000 specialists and many urgent care centers, hospitals, and labs.

United Physicians Association, Inc <http://www.npino.org/npi/united-physicians-association-inc-1710512298.html>

Contact info:

Phone: (213)-266-7777 primary practice address

Phone: (213)-369-9662 Jessica Nguyen, authorized official contact

Primary practice located at 14803 Badlona Dr, La Mirada CA 90638 which is a home address.

There is not much information available for United Physicians Association online.

Vively Health <https://www.davita.com/>

Contact info:

Phone: (720)-631-2100 DaVita World Headquarters

DaVita corporate office phone numbers in California:

El Segundo: (310)-536-2400

Irvine: (949)-930-4400

San Bruno: (650)-238-5695

Vively is a standalone subsidiary of DaVita Health Solutions, a chronic kidney care group, which cares for most vulnerable patients (MVPs). “Vively provides in-home primary care for the highest-risk, chronically ill patients,” according to an investor [press release](#). Vively is a full risk medical group featuring house call programs.