California Health Benefits Review Program

Issue Brief:
Estimates of Sources of Health Insurance in California for 2018

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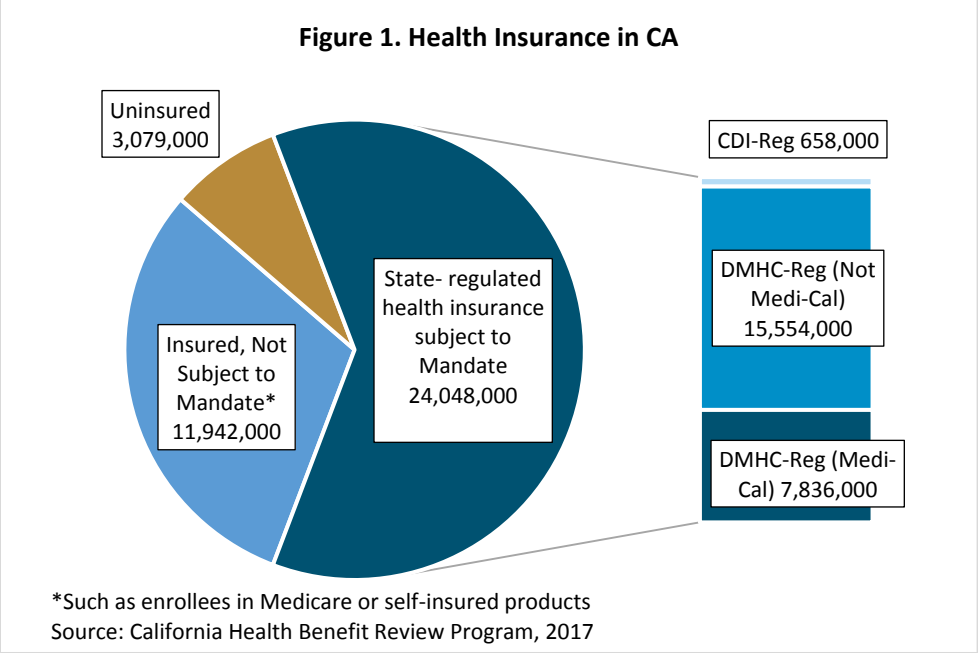
HEALTH BENEFITS REVIEW PROGRAM

OVERVIEW

The California Health Benefits Review Program (CHBRP) responds to requests from the California Legislature to analyze bills related to health insurance.[1] As part of the analyses, CHBRP annually updates its Cost and Coverage Model, which includes estimates of sources of health insurance in California. This brief discusses CHBRP's 2018 estimates.

As shown in Figure 1, most Californians will be enrolled in health insurance regulated by either the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). Other Californians will have other types of health insurance or will remain uninsured.

Figure 1. 2018 Health Insurance by Regulator in California



In 2018, CHBRP estimates that California's population will be 39.1 million. Figure 1 presents several key elements regarding the sources of health insurance in California:

- 62% will be enrolled in DMHC-regulated health care service plans or CDI-regulated health insurance policies. This figure includes beneficiaries of Medi-Cal (California's Medicaid program) who are enrolled in DMHC-regulated plans.
- 31% will have health insurance associated with some other regulator. Primarily, these are Californians who are Medicare beneficiaries or who are enrolled in self-insured products. This figure includes enrollment in Medi-Cal Fee-For-Service (FFS) or in County-Organized Health System (COHS) managed care. These Californians will have health insurance that is not subject to state-level health insurance laws. Only DMHC-regulated plans or CDI-regulated policies may be subject to state-level health insurance laws.

ESTIMATES OF SOURCES

Annually, CHBRP updates its Cost and Coverage Model (CCM) to estimate baseline health insurance enrollment and to project marginal, incremental impacts on benefit coverage,

[1] Established in 2002, CHBRP's authorizing statute is available at: http://www.chbrp.org/faqs.php.

utilization, and cost of proposed health insurance legislation.[2] The California Legislature generally proposes laws that would take effect in the following calendar year or later (if enacted, bills proposed in 2017 would generally take effect in 2018). For this reason, CHBRP annually projects the state's future distribution of health insurance by market segment.

Figure 2 describes the analytic timeline for bill introduction; preparation for and completion of bill analyses; and effective period of legislation if the bill is enacted.

Figure 2. Analytic Timeline

Despite the temporal challenges noted in Figure 2, CHBRP must project future estimates to analyze proposed bills. Table 1, which appears on the following page, presents CHBRP's detailed estimates of sources of 2018 health insurance in California.[3]

This document explains the categories used in Table 1 and provides a brief discussion on the importance of various market segments in analyzing proposed state-level health insurance legislation.[4]

Enrollment Estimates and the Affordable Care Act

Although CHBRP is monitoring federal developments relevant to the Affordable Care Act (ACA), until any proposed changes are implemented, CHBRP will continue to anticipate impacts of the ACA on health insurance in California, including the following:

- Continued expansion of Medi-Cal eligibility.
- Continued presence of Covered California (the state's health insurance marketplace, through which subsidized health insurance may be available).
- Continued presence of some "grandfathered" plans and policies (privately funded plans and policies in existence before the ACA was signed). Grandfathered plans and policies are substantially unchanged and are exempt from some of the ACA's requirements.[5]

[2] Information on the CCM is available at: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.
[3] Additional documents describing CHBRP's approach to developing baseline projections as well as cost impact analyses are available at: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.
[4] For a more detailed discussion of data sources and approaches, see CHBRP's *2017 Cost Impact Analyses: Data Sources, Caveats, and Assumptions*, available at: http://www.chbrp.org/analysis_methodology/docs/2016%20Cost%20Impact%20Analysis%20Final.pdf.
[5] A grandfathered health plan is "a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make

Table 1. 2018 Sources of Health Insurance in California

Publicly Funded Health Insurance

	Age	DMHC-regulated	Not regulated by DMHC or CDI	Total
Medi-Cal	0-17	2,722,000	621,000	3,343,000
	18-64	3,852,000	879,000	4,731,000
	65+	63,000	19,000	82,000
Medi-Cal COHS	All	-	1,471,000	1,471,000
Other public	All	-	-	556,000
Dually eligible Medicare & Medi-Cal	All	1,199,000	343,000	1,542,000
Medicare (non Medi-Cal)	All	-	-	4,054,000
CalPERS	All	884,000	296,000	1,180,000

Privately Funded Health Insurance

		DMHC-regulated		CDI-regulated		
	Age	Grand-fathered	Non-Grand-fathered	Grand-fathered	Non-Grand-fathered	Total
Self-insured	All	-	-	-	-	3,703,000
Individually purchased, Subsidized CovCA	0-17	-	50,000	-	-	50,000
	18-64	-	1,203,000	-	3,000	1,206,000
	65+	-	-	-	-	-
Individually purchased, Non-Subsidized CovCA and Outside CovCA	0-17	33,000	234,000	44,000	11,000	322,000
	18-64	101,000	725,000	137,000	35,000	998,000
	65+	4,000	29000	5,000	2,000	40,000
Small group	0-17	94,000	682,000	-	35,000	811,000
	18-64	286,000	2,068,000	1,000	108,000	2,463,000
	65+	4,000	29,000	-	1,000	34,000
Large group	0-17	580,000	1,662,000	14,000	54,000	2,310,000
	18-64	1,758,000	5,032,000	42,000	163,000	6,995,000
	65+	25,000	71,000	1,000	2,000	99,000

Uninsured

Age	Total
0-17	291,000
18-64	2,730,000
65+	58,000

California's Total Population **39,069,000**

Source: California Health Benefits Review Program, 2017
Key: CDI = California Department of Insurance; CalPERS = California Public Employees' Retirement System; COHS = County-Organized Health System; CovCA = Covered California (the state's health insurance marketplace); DMHC = California Department of Managed Health Care

certain significant changes that reduce benefits or increase costs to consumers." Accessed at: http://www.healthcare.gov/glossary/grandfathered-health-plan.

The continued presence of grandfathered plans and policies is relevant to CHBRP's analyses of health insurance bills because these plans and policies are not subject to the same requirements as are others (and so could be differently affected by a new health insurance law). For example, grandfathered plans and policies are not required by the ACA to: (1) cover specific preventive services without cost sharing; (2) restrict cost sharing for emergency services; and (3) cover essential health benefits (EHBs).[6,7]

As displayed in Table 1, of the 15.4 million Californians enrolled in DMHC-regulated plans or CDI-regulated policies, 20% of these enrollees will be enrolled in grandfathered plans or policies.

Enrollment by Market Segment and Purchaser

As noted in the overview, health insurance available through DMHC-regulated plans and CDI-regulated policies may be subject to state-level benefit-related legislation written into one or two sets of laws: the Health and Safety Code (enforced by DMHC) and/or the Insurance Code (enforced by CDI). However, such legislation may be written to exempt some health insurance market segments or to exempt health insurance associated with certain purchasers. To correctly determine the impact of proposed legislation, CHBRP projects: (1) the number of Californians enrolled in health insurance market segments and (2) the number of purchasers that might be of interest to the California Legislature (including, but not limited to, health insurance associated with Medi-Cal, California Public Employees' Retirement System [CalPERS], and Covered California). Similar to Figure 1, Table 1 indicates enrollment in DMHC-regulated plans and CDI-regulated policies. However, Table 1 provides further information, such as age of enrollees and details of market segments and purchasers.

Key elements of information from Table 1 include:

- 15.4 million Californians will be enrolled in privately funded DMHC-regulated plans or CDI-regulated policies.
    - 61% will be associated with the large group market (101+ enrollees). A majority of these enrollees will be in DMHC-regulated plans.
- 11.2 million Californians will be Medi-Cal beneficiaries.
    - 70% will be enrolled in DMHC-regulated plans. The rest will be enrolled in County-Organized Health System (COHS) managed care or associated with the Fee-For-Service (FFS) program.

[6] As indicated in federal and California state law, non-grandfathered group and individual health insurance plans and policies must cover certain preventive services. See CHBRP's brief *Federal Preventive Services Mandate and California Benefit Mandates*, available at: http://chbrp.org/other_publications/index.php.

[7] The essential health benefits categories are: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, including behavioral health treatment, prescription drugs, rehabilitation and habilitation services and devices, laboratory services, preventive and wellness services and chronic disease management, pediatric services, including oral and vision care. See CHBRP's brief *California's State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits,"* available at: http://chbrp.org/other_publications/index.php.

- 1.2 million Californians will have health insurance associated with CalPERS.
    - 75% will be enrolled in DMHC-regulated plans. The remaining CalPERS enrollees are associated with CalPERS' self-insured health insurance products, which are not subject to state-level health insurance legislation.
- 3.7 million Californians will be enrolled in privately funded self-insured products, which are not subject to state-level health insurance legislation.

CONCLUSION

To estimate potential impacts of health insurance-related legislation that will take effect in the future, CHBRP develops forward-looking estimates of health insurance enrollment in California. Annual updates to CHBRP's Cost and Coverage Model are necessary to project insurance enrollments by market segment and various purchasers.

The resulting projections of health insurance market segments in California may be of use to the Legislature and to others interested in California health policy, in addition to CHBRP's analytic work.