



THE AFFORDABLE CARE ACT: INITIAL IMPACTS OF IMPLEMENTATION

The California Health Benefits Review Program (CHBRP) responds to requests from the California Legislature to analyze bills related to health insurance.¹ Documents available on CHBRP's website provide additional information on CHBRP's analytic methods for medical effectiveness,² public health,³ and benefit coverage, cost and utilization.⁴ After the passage of the Affordable Care Act (ACA), CHBRP evaluated the impact of the ACA on CHBRP's efforts to project impacts of proposed health insurance legislation.⁵ This document, structured as answers to frequently asked questions, describes how CHBRP has altered its approach to address the initial implementation of the ACA.

How have CHBRP's analytic methods evolved to reflect the federal and state provisions of the ACA?

Of the three main components of CHBRP analyses:

- *Medical Effectiveness methods*, which rely on the review of scientific literature to determine whether a medical intervention works, did not change. CHBRP's evidence-based literature review process is unchanged by the ACA.
- *Public Health methods*, which analyze specific treatment/services' effect on the population, is only affected if the number of enrollees change. Particularly, more enrollees may utilize treatments available to them as a result of the ACA's expanded benefit coverage. Therefore, CHBRP's public health methodology is unchanged by the ACA.
- *Benefit Coverage, Cost, & Utilization (Cost) methods* are most affected by the ACA, which may change the size and composition of California's health insurance market. The following provisions affect CHBRP's estimates:
 - Requiring US citizens and legal residents to have health coverage, which may expand the number of individuals enrolled (baseline enrollment) in health insurance.

¹ Created in 2002, CHBRP's authorizing statute is available at <http://www.chbrp.org/faqs.php>.

² More information on CHBRP's approach to analyzing medical effectiveness is available at: http://www.chbrp.org/analysis_methodology/medical_effectiveness_analysis.php

³ More information on CHBRP's approach to analyzing public health impacts is available at: http://www.chbrp.org/analysis_methodology/public_health_analysis.php

⁴ More information on CHBRP's approach to analyzing cost impacts is available at: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php

⁵ Although jointly referred to as the Affordable Care Act, the law is actually a product of the Patient Protection and Affordable Care Act (P.L.111-148) and the Health Care and Education Reconciliation Act (H.R. 4872), both passed in 2010.

- Requiring health insurance plans and policies to cover certain health benefits through essential health benefits (EHB) or other federal mandates, which may affect benefit coverage.⁶
- Imposing new rules on the amount of premium dollars that must be spent on health care (medical loss ratio), limiting the difference in premiums charged based on age or geography (modified community rating), and capping out-of-pocket costs, may affect overall health care utilization and expenditures.
- Implementing Covered California, the state's health insurance market place where individuals and small groups could purchase subsidized health insurance, may be affected by the ACA's new rules on insurance premium costs.⁷

Importantly, CHBRP's key focus is to estimate the *marginal change* in costs resulting from specific benefit mandates. Depending on the mandate, CHBRP's estimates of marginal change in total insured premiums (per member per month) have ranged from as little as 0.0014% to as much as 2.059% in recent reports.

What are new approaches CHBRP is developing for its underlying model?

CHBRP's model is an actuarial model that uses a variety of data to project the number of Californians enrolled in state-regulated health insurance and the total health care expenditures.

Enrollment Projections: For CHBRP's 2014 model, CHBRP used CalSIM, a microsimulation model developed jointly by the UC Berkeley Labor Center and UCLA Center for Health Policy Research.⁸ CalSIM was created to project where people may enroll once the ACA's major provisions in 2014 took effect and to project the effects of the ACA on firms and individuals. CHBRP also used the 2011 California Health Interview Survey (CHIS) to provide additional data for Californians over age 65.⁹

Premium Projections: The ACA creates a number of changes that affect health insurance premium costs, particularly in individual and small group insurance market segments.

- Beginning in 2014, the ACA requires new health insurance plans and policies to cover EHBs.
- The ACA limits the differences in what health insurers can charge enrollees based on age and other factors (modified community rating), limits cost sharing, and specifies the percentage of premium dollars that must be spent on health services. CHBRP's cost team have adjusted premiums to reflect these changes. See Appendix D in CHBRP's bill analyses for more details.¹⁰

⁶ 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.

⁷ More information on Covered California is available at: <http://www.coveredca.com/about/>

⁸ CalSIM's methods can be found in the document, *Methodology and Assumptions*, available at:

http://healthpolicy.ucla.edu/publications/Documents/PDF/calsim_methods.pdf

⁹ More information on the California Health Interview Survey is available at:

<http://healthpolicy.ucla.edu/chis/Pages/default.aspx>

¹⁰ CHBRP's previous analyses are archived on CHBRP's website and available at:

http://www.chbrp.org/completed_analyses/index.php

How did you decide to use CalSIM for estimating health coverage?

CHBRP reviewed several regional and national microsimulation models and selected CalSIM for a variety of reasons. CalSIM, the product of two highly ranked University of California institutions, is California-specific. This characteristic is important since CHBRP's work is limited to the California population enrolled in state-regulated health insurance. Additionally, CalSIM uses many of the same data sources as CHBRP, such as CHIS and the California Employer Health Benefits Survey, which created synergies with our traditional model.¹¹

CalSIM's enrollment projections are different from others I have seen. Will that affect estimates?

In general, projections may differ depending on the baseline numbers used (including the data year), how the baseline data are calibrated, and assumptions made about the enrollment rate. These factors and other adjustments may cause microsimulation models to generate varied estimates.

Even CalSIM may generate different estimates over time because it continually updates its model to provide stakeholders with the best estimates as more evidence becomes available. To generate consistent estimates throughout CHBRP's analytic process, CHBRP uses data from CalSIM at a single point in time and will not update the data until the next legislative analysis season. Since CalSIM continually updates its model to provide policymakers with the best estimates, CHBRP's projections may likely differ from future CalSIM estimates.

Does CHBRP assume that all eligible individuals will have health insurance, as mandated by the ACA?

CHBRP relies on CalSIM's microsimulation model to determine whether Californians will obtain health insurance, and if so, how and through what source. When modeling an individual's likelihood to obtain a particular type of coverage, CalSIM takes into account multiple factors, such as an individual's income level, prior insurance status, and the potential cost of insurance.

¹¹ More information on the California Employer Health Benefits Survey is available from the California Healthcare Foundation at: <http://www.chcf.org/publications/2016/06/employer-health-benefits>