Framework Assessment of Major Health Reform Proposals in California

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I. Introduction

Four major proposals offer different approaches to expanding health care coverage to Californians: AB 8 (Núñez), SB 48 (Perata), SB 840 (Kuehl), and the Governor's plan.

It is often difficult to evaluate and choose the best proposal. Each reform model gives priority to certain attributes and objectives, but requires compromises with respect to others. Too often, the debate about policy options is confusing because the choices—or trade-offs—between competing attributes and objectives are not explicit or clear.

To help understand the trade-offs and draw comparisons among the proposals, the California HealthCare Foundation and the Economic and Social Research Institute developed a "framework" that analyzes coverage expansion proposals using four criteria: level of coverage achieved, cost and efficiency, fairness and equity, and choice and autonomy.

This paper reviews each proposal's general features; uses the framework to provide an in-depth assessment; and summarizes the key trade-offs. The following is a summary of this analysis:

Health Reform Plan	Key Advantages	Key Concerns
Governor's Proposal	Universal coverage could be achieved; builds on the existing health insurance structure; broadened risk-sharing.	High budgetary cost to state; future costs may lead to state budget pressures; some disruption to existing system; significant element of compulsion in individual mandate to have coverage.
AB 8 (Núñez)	69% of uninsured would be covered; little disruption to existing industry; purchasing pool improves affordability of health insurance.	High budgetary cost to state; unchanged reimbursement may lead to inadequate doctor participation; new rules for insurers; possible long-run increases in health care costs.
SB 48 (Perata)	69% of uninsured would be covered; little disruption to existing industry; purchasing pool improves affordability of health insurance.	High budgetary cost to state; higher-income people required to maintain coverage; new rules for insurers; unchanged reimbursement may lead to inadequate doctor participation; possible long-run increases in health care costs.
SB 840 (Kuehl)	Universal comprehensive coverage; substantial increase in efficiency and cost-savings; much easier navigation for providers and consumers and full portability; eliminates problem of uncompensated care.	Very high budgetary cost to state; highly disruptive to insurance industry; less autonomy for providers (limits on payment rates, investment, additional regulations); could attract chronically ill from other states; dramatic departure from status quo and major new government administrative mechanisms.

II. The Framework

Millions of Californians lack health insurance. Proposals for expanding health coverage can range from modest expansions of public insurance programs to an all-encompassing single-payer insurance system that covers everyone automatically. A major challenge, however, is that the process of evaluating expansion proposals is typically filled with confusion and conflict.

A significant reason that it is so difficult to evaluate and choose the best proposal is that each reform model gives priority to certain attributes and objectives, but requires compromises with respect to others. Too often, the debate about policy options is confusing because the choices—or trade-offs—between competing attributes and objectives are not explicit or clear.

This paper analyzes the four major proposals being debated in California in 2007 within a "framework" for assessing and comparing coverage expansion proposals. The framework is a valuable tool for policymakers and other stakeholders—in California or elsewhere—who are developing solutions. (See www.chcf.org/framework/ for further information and resources.) The framework is made up of four primary attributes that are typically of concern:

1. **Coverage:** Who is covered and how comprehensive is the coverage?
2. **Cost & Efficiency:** Is the proposal efficient and economically practical?
3. **Fairness & Equity:** Does the proposal promote fairness and equity?
4. **Choice & Autonomy:** How much choice does the proposal permit?

Designing a coverage expansion policy is essentially the process of making choices about trade-offs. If trade-offs were not necessary, almost everyone would approve of a reform that covered all needy people, cost little, had comprehensive benefits, ensured high quality, treated everyone equitably, maximized choice and autonomy, and involved minimal government regulation or compulsion. But, of course, there is no such policy because many of these objectives conflict. Listed below are some typical trade-offs that may affect the design of coverage expansion.

Coverage vs. Cost	Covering more people increases real resource costs and budgetary costs.
Benefits vs. Cost	More comprehensive benefits normally add to total costs.
Cost vs. Choice and Autonomy	Controlling costs may reduce consumer choice and provider autonomy.
Equity vs. Cost	Equal subsidies for equally needy people (including those already covered) are more costly than subsidizing only those not already covered.
Equity vs. Regulation	Equitable risk-sharing may require more regulation for insurers and employers.
Coverage vs. Regulation	Universal coverage may require increased regulation for individuals, employers, and insurers.
Quality vs. Regulation	Greater quality of health care services may require increased regulation for providers.

III. Governor's Proposal

Features of the Governor's Proposal

General approach. This comprehensive proposal (not yet in legislative language) seeks to achieve universal coverage by establishing an individual mandate for all residents, extending eligibility for Medi-Cal and Healthy Families[1] up the income scale, providing subsidies for other lower-income people, requiring employers who do not provide coverage to pay a fee to the state, requiring doctors and hospitals to pay a fee, and establishing a purchasing pool to serve as a source for cost-effective coverage.

Individual mandate. All Californians are required to have coverage. To meet the requirement, a minimum benefit level of $5,000 deductible, with out-of-pocket maximums of $7,500 per person ($10,000 per family), must be maintained. The penalty for non-compliance is not specified, but the tax withholding and state income tax filing would be utilized to promote compliance.

Making coverage affordable. Adults and children (including undocumented children) with incomes below 100% of the federal poverty level (FPL)[2] would be enrolled in Medi-Cal. (In 2007, the federal poverty level for a family of four was approximately $21,000). All children with incomes between 100% and 300% of FPL would be covered by Healthy Families. Adults with incomes between 100% and 250% of FPL would be eligible for partially subsidized coverage; they would qualify for subsidies after paying from 3% to 6% of gross income for premiums. Adults in this income range who have employer coverage would also eligible for subsidies if the employee contribution exceeds the income limits. Adults with incomes above 250% of FPL and children above 300% of FPL are assumed to be able to afford coverage. Counties would have responsibility for ensuring access for undocument immigrant adults who do not have employer coverage or other coverage. All employers would be required to establish Section 125 (Flex) plans, allowing employees to pay for coverage with before-tax dollars and thereby receiving a federal "subsidy." Employers with 10 or more employees who choose not to provide coverage would pay a fee equal to 4% of payroll, which would help fund the subsidies.

Insurance market changes. The Managed Risk Medical Insurance Board (MRMIB)[3] would establish a purchasing pool to negotiate with health plans and insurers to provide a cost-effective source of coverage for people eligible for subsidies and some others. Health plans and insurers would be required to provide coverage on a guaranteed-issue basis in the individual as well as the small-group market, and they would be limited in how much they could vary rates, using only age and geography as rating factors. Insurers' administrative costs and profits could not exceed 15% of the premium price.

Financing. The plan is expected to cost $12.1 billion annually, with the funding responsibilities being widely shared. Employers with more than 10 employees who choose to not offer coverage would be required to pay a fee equal to 4% of payroll, which is expected to yield $1 billion. Hospitals would pay a fee equal to 4% of net patient revenue. Physicians would be assessed a fee equal to 2% of gross receipts. However, Medi-Cal payment rates would be substantially increased for hospitals and physicians. The provider fees would yield $3.5 billion. Federal

matching funds for Medi-Cal and Healthy Families would produce $5.5 billion. Counties would be expected to provide $1 billion for undocumented immigrants and return $1.2 billion to the state from savings they would realize by not having to pay for other uninsured people who would be covered.

Cost containment. Subsidized products would incorporate a "Healthy Action Incentive/Rewards Program," which all health plans are required to offer. The state would sponsor public health efforts to reverse obesity trends and continue smoking cessation efforts. The state would reduce regulatory requirements on health plans and on hospitals to promote certain delivery models, such as retail health clinics. A pilot program would be introduced to combine workers' compensation health benefits with traditional health coverage.

Framework Assessment of the Governor's Proposal

1. Coverage

People covered. If the mandate is strictly enforced, almost everyone, including undocumented immigrants, should be covered after a short period of time. However, as written, the proposal does not specify what penalty would be imposed for non-compliance. Assuming the penalty is financial in nature, if it is substantially less than the cost of buying coverage or if enforcement is lax, some people would probably choose not to acquire coverage. According to estimates by Jonathan Gruber,[4] of the 4.9 million uninsured, 1.2 million would be covered by Medi-Cal and Healthy Families, 0.9 million would move to employer-sponsored coverage, 1 million would buy individual insurance, and 1 million would be covered under the purchasing pool, while 0.75 million undocumented immigrants would receive care through counties.

Portability of coverage and continuity of care. Everyone would be required to have coverage all the time; so if people conform to the law, coverage would be essentially continuous, but since many people would still have employer-based coverage, coverage would not be portable[5] for those people in the sense that they could take their coverage with them when they switch jobs. However, many people receiving subsidies would be getting it through the MRMIB pool, and that coverage would be portable. Because no one could be denied coverage in the individual market or group market, everyone would always be able to get new coverage if they lost their previous coverage for whatever reason.

Continuity of care with specific providers would not be appreciably affected except, of course, it would be greatly improved for those who were previously uninsured.

Benefits. To meet the mandate requirements, the minimum services covered would be relatively comprehensive, consistent with the Knox-Keene requirements (physician services, hospital inpatient and outpatient, diagnostic lab and radiology services, preventive health services, home health services and emergency health care including ambulance, out of area coverage and hospice care) plus prescription drugs. However, the minimum plan allows substantial cost sharing: a $5,000 deductible and a maximum out-of-pocket payment of $7,500 per individual or $10,000 per family. For higher-income people, these cost-sharing provisions should not pose problems because they could afford the out-of-pocket expenses or, more likely, would choose

coverage with lower cost sharing. For people just above the cut-off for subsidies—250% of the federal poverty level—these cost-sharing requirements could cause financial hardships and might cause some to postpone needed care. The provisions could also cause some hardship for adults between 100% and 250% of the poverty level, who would have to pay 3%, 4%, or 6% of income toward the premium before being eligible for subsidies and then also be liable for cost-sharing if they use services. (If the cost-sharing requirements were reduced so that out-of-pocket payments were more limited, the state would, of course, have to bear to higher costs to subsidize coverage for lower-income people.)

Quality of care and effect on delivery system. The plan includes a number of elements to improve quality and cost-effectiveness of the delivery system, including efforts to further the practice of evidence-based medicine. It should increase the supply of providers willing to serve Medi-Cal patients because it would raise reimbursement rates for these patients. Millions of people now without insurance will have coverage. That should increase the likelihood that people will establish a "medical home" to serve as a regular source of care and oversight of their medical needs and avoid inappropriate and expensive use of emergency departments. Because the plan does not appear to contain inducements that would promote one form of delivery over another, it would appear to be neutral with respect to greater integration and coordination among parts of the delivery system, although the promotion of health information technology might be expected to improve coordination.

2. Cost and Efficiency

Resource cost. If the plan were to work as intended, nearly everyone would be covered; so there would be a substantial net increase in the real resource cost. Although the uninsured, estimated by Gruber to be 4.9 million people, consume substantial medical resources now (somewhat more than half what insured people consume), they would be certain to consume more once they have coverage. But, of course, this is the purpose of the proposal—to eliminate financial barriers to care. The proposal supports a number of efforts to make it possible to produce services more efficiently, which should help to reduce the real cost below what it would otherwise be.

Budgetary cost. The total budgetary cost is estimated to be $12.1 billion annually, of which the state would pay $5.7 billion. The increased costs are related to extension of eligibility for Medi-Cal and Healthy Families, increased payments to Medi-Cal providers, and subsidies for people between 100% and 250% of the federal poverty level. The revenue for the state's portion of new expenditure is expected to come primarily from fees on providers and non-offering employers and contributions from counties.

The increase in state and federal budgetary cost resulting from covering more people and paying higher Medi-Cal reimbursement rates would reduce if not eliminate the so-called "cost shift." Because provider uncompensated care costs would be greatly reduced or eliminated, providers would no longer be covering the revenue shortfall by shifting costs to private insurers and health plans, and the insurers' employer customers would presumably realize savings in the form of lower premiums than they would otherwise pay.

Longer-run state budget costs are likely to rise because health care costs are certain to rise. But there is less danger than with some other approaches that costs will outpace revenues because a

source of revenue is the assessment on providers. Payments to physicians and hospitals account for well more than half of health care costs. As health costs cost rise, so will payments to physicians and hospitals, and so will fee revenues based on gross receipts of these providers. So revenues from the provider fees should rise roughly in proportion to the increase in health care costs. But the other source main source of new state revenue, fees paid by non-offering employers, may not keep pace with rising costs of funding the program.

The plan expands entitlements and creates new ones, and their cost is likely to rise over time, perhaps at a greater rate than economic growth. As noted above, the provider fee does help to cover such excess cost growth over time. But in times of economic downturns, the fiscal pressures created could be significant, since state revenues fall at such times while expenditures for public programs and subsidies rise when people's incomes fall, making them newly eligible. However, the reliance on provider fees as a revenue source also helps in weather such troughs in the business cycle, because people do not substantially reduce their use of medical services when overall economic activity tails off; so fee revenues do not fall either.

The plan appears to achieve a balance between increasing coverage in both the private and public sectors. Children would be in public programs if they live below 300% of FPL. For adults, public coverage would be available only if they live below 100% of FPL. For adults between 100% and 250% of FPL, subsidies would be available to make purchase of private coverage affordable. People with incomes above the levels that would make them eligible for subsidies or public program would be required to purchase private coverage. Since a significant portion of them are now without coverage, this would be a major expansion of private insurance.

Cost containment. The proposal includes a number of elements to address the cost issue, including better use of health information technology (HIT) and encouraging evidence-based medicine and preventive health. Administrative costs plus profit/surplus are limited to 15% of total costs for health plans, insurers, and hospitals. It seems certain, however, that the cost escalation problem will need further attention in the long run; and some of cost-limiting policies, such as technology assessment, is best done at the national level. It is difficult for states, even one as large as California, to impose severe cost containment controls or limits if the same steps are not being taken elsewhere.

Implementation and administration. Some significant administrative changes will be required initially, such as establishing the new purchasing pool within MRMIB and setting up the structure to enforce the mandate, presumably within the state tax collection agency. Insurers will have to provide proof of coverage to all enrollees. The state will also have to require employers to report how many people they employ (since those with 10 or fewer employees are not subject to the assessment) and whether they provide coverage; and employers that do not provide coverage will have to document what their payroll is, and the state will have to ensure that they pay the 4% assessment. The state will have to establish a mechanism for providers to report gross revenues and a method for enforcing the collection of the 2% fee on physicians and 4% assessment on hospitals. There will need to be a mechanism for establishing eligibility for the various subsidies, which require verification of income, and well as a mechanism for dealing with the situation when someone's income level changes substantially during the year. Once the system is established, on-going administrative tasks should be relatively routine.

Federal waivers would be required related to Medicaid. The legislation would presumably include the necessary changes in state law and regulation.

Since the 4% payroll assessment on employers not providing coverage does not apply to employers with fewer than 10 workers, and a high proportion of other employers already provide coverage, the assessment is not likely to have a large impact on labor costs in the state. However, for those employers that do have to pay the fee, the 4% added labor cost would likely cause them to reduce other forms of compensation for their workers over time. Some employers subject to the assessment that employ workers earning the minimum wage or just slightly more would not be able to pass back the cost in the form of lower wages and thus might hire fewer workers.

The combination of the new provider fee and increased Medi-Cal reimbursement rates would have important effects on providers' bottom lines. Both the aggregate effects on the system as a whole and the different effects on different providers need to be considered.

Providers serving Medi-Cal patients will receive a substantial increase in reimbursement, presumably sufficient to cover at least the marginal cost of serving these patients plus the new assessment. Thus uncompensated care costs associated with underpayment by Medi-Cal will be greatly reduced, if not eliminated. Since nearly everyone will have coverage, other sources of uncompensated care will be greatly reduced also. In the aggregate, if the new provider fee on gross receipts is no more than the reduction in uncompensated care costs, providers on average would probably be no worse off even if other payers do not increase their compensation rates to providers. If the fee exceeds the reduction in uncompensated care costs, whether providers on average will be worse or better off depends upon whether private payers will increase payment by the amount of the shortfall. The distributional effects—that is, how individual providers will be affected—is a complicated question.

Physicians that serve a substantial number of Medi-Cal patients will likely gain: the increased reimbursement is likely to more than offset the 2% assessment. For physicians who previously provided care for other patients that did not pay the full costs of that care, if the cost to physicians was equal to or greater than 2% of their revenues, they would probably be no worse off and perhaps better off after paying the 2% fee. For physicians that provided very little uncompensated care, they will probably be worse off than they were before having to pay the assessment. But in a sense, they were previously enjoying a "windfall gain." Private payers were paying reimbursement rates that included an amount to cover uncompensated care costs for physicians that served patients whose payments did not cover costs (the cost shift); but they were paying these rates to physicians regardless of whether they provided uncompensated care. So physicians providing little or no uncompensated care were receiving a payment for costs they did not incur. The new fee would reduce or eliminate this "bonus."

The distribution of paying the new fee could leave some hospitals with an extra burden, depending on how the fee is structured. Those with many Medi-Cal patients should be better off; because of the increase in reimbursement, they should have the means to pay the new fee with money left over. Likewise, hospitals previously providing care to non-paying patients should not be worse off because they can use the savings from not having to cover these costs to pay the new fee. (This assumes that virtually everyone is enrolled in a plan; vigorous enforcement of the mandate is thus important.) Hospitals with few Medi-Cal patients and little previous

uncompensated care would presumably try to recover the cost of the 4% fee by shifting the cost to other payers. If payers do not adjust payments to these hospitals, the hospitals could experience a shortfall. The fact that insurers will be expanding their business by millions of enrollees may make them willing to accept the legitimacy of these costs. In addition, to the extent that private insurers were being cost-shifted against to make up for shortfalls in reimbursement for Medi-Cal patients and uninsured patients, the private insurers will now need to pay some providers less. The "savings" could be used to fund increased costs for providers for whom the reimbursement changes and the new fee represents a net increase in costs.

The locus of accountability for quality and efficiency would remain largely as it is now.

3. Fairness and Equity

Access to coverage and subsidies. The proposal generally scores quite well when measured against the standard of equity. With respect to equal treatment of equals (horizontal equity), the proposal would provide premium subsidies for people between 100% and 250% of FPL regardless of whether they already have coverage or not. Those with employer coverage are eligible for subsidy also but only if their employer contributes to the premium, and only the employee's part of the contribution is assumed to represent a cost to the employee, even though most economists would argue that the employee also bears the real cost of the employer contribution (in the form of lower wages). Undocumented immigrants would also be eligible if their incomes fell below specified levels.

The combination of eligibility standards for public programs and the subsidies for other lower-income people generally are consistent with the principle of ability to pay (vertical equity). The amount of public subsidy varies with income, diminishing from 100% subsidy to those below the poverty level and gradually diminishing until subsidies are eliminated for those above 250% of FPL (except for children, who are covered up to 300% of FPL). However, as noted above, the financial burden for families around 250% of the poverty level could be onerous, especially if they incur significant medical expenses.

Financing of costs. However coverage expansion is financed, the cost is ultimately borne by households—in the form of higher premiums, higher out-of-pocket payments, lower wages or higher prices for non-medical services (if employers pass on premium increases to employers and/or customers), higher taxes, or lower profits passed on in the form of lower dividends and lower returns on investment. It is this ultimate "incidence" of the cost burden of the expenditure increase that counts from the standpoint of fairness. So it is not sufficient to simply look at who pays a given amount initially. Because this proposal involves many sources of new funding, it would probably produce all of these effects, although it is not easy to trace exactly how all of it would play out.

The federal share of funding (in the form of new Medicaid and SCHIP match) is probably consistent with equity, since the primary source of federal funds is the personal income tax, which is progressive. The requirement that all employers establish a Section 125 plan so that employees can pay for coverage premiums with before-tax dollars probably generally benefits lower-income employees, since higher-wage firms now are more likely to offer such plans already. However, the ability to pay with before-tax dollars in general is a regressive[6] provision,

since the amount employees save is greater for higher-income people because they have higher marginal tax rates. The addition of more Section 125 plans also shifts some of the cost to the federal government. The foregone federal revenue requires more federal revenue, which, as noted, is collected from progressive taxes.

The fee that will be assessed on employers not offering coverage will probably be shifted back to employees over time as lower wages or reduced compensation of other types. Since most such employers are probably lower-wage employers, this fee is somewhat regressive compared to some other alternatives, such as the state income tax.

Eventually, if the cost of paying the new provider fee exceeds what hospitals and physicians "save" as a result of not having uncompensated care, the provider may be shift the excess cost forward to private payers, mostly private insurers, who in turn will shift the cost to those who pay premiums. The burden of both employer and employee premiums shares is ultimately borne primarily by employees, in the view of most economists. Since premiums are a larger portion of total compensation for lower-wage workers, this effect would be somewhat regressive. If physicians are unable to shift all the cost and have to bear some of the cost in the form of lower net income, the result would be generally progressive, since physicians have incomes that put them in the upper range of the income distribution.

Of course, most people covered by private insurance are themselves a source of financing—they pay part of the premiums as well as out-of-pocket costs for which they are liable until the deductible and other cost-sharing requirements are met. Some people may argue that for people just above the level at which subsidies are cut off (250% of FPL) and who have the minimum coverage plan, the proposal does not meet the test of ability to pay. The minimum plan coverage would have an individual deductible of $5,000, with out-of-pocket costs limited to $7,500 per person and $10,000 per family. The description of the proposal suggests this should be available for a premium of no more than $100 per month per person. The issue is whether the premiums and cost sharing are affordable for people at this income level. If this is seen an inequitable, the problem could be addressed by raising the threshold level for premium subsidies above 250% of the poverty level, reducing the amount of cost sharing, or by including both premiums and cost sharing in calculating a family's maximum financial liability. The trade-off is that any of these changes would substantially increase the budgetary cost for the state. They would also make it more likely that some employers would drop coverage.

Sharing of risks. The proposal does broaden risk sharing in a number of ways. Most importantly, it pays for subsidized care by apportioning the costs (i.e., sharing risk) across a broad cross section of the population through the various revenue-raising measures just discussed. Within the individual insurance market, risk is broadened by making it unlawful for insurers to turn down anyone regardless of their risk level. Insurers would also be limited in the factors they can consider when varying rates based on an insured person's characteristics. As it now stands, the proposal does not specify what the limits will be. Unless the range is variation is restricted to a major degree—for example, a maximum variation of 3:1—some higher-risk people who are not eligible for subsidies are very likely to find coverage to be unaffordable.

4. Choice and Autonomy

Consumer choice. The proposal, if implemented, would not restrict consumers' choices of health plans or providers, nor would it restrict employers' choice of health plans. Since MRMIB would be offering a new form of coverage, one could say that options would be expanded.

Provider autonomy. The proposal would increase reimbursement substantially for providers serving Medi-Cal patients. It would indirectly put new restrictions on the prices hospitals could charge by limiting administrative costs and profits to 15% of prices. It requires providers to pay a fee of 4% for hospitals and 2% for physicians, which would likely be reflected in higher charges.

The proposal would have only minor effects on providers' autonomy in terms of the practice and delivery of medicine, primarily by encouraging the use of practice guidelines. Hospitals would be required to implement electronic prescribing by 2010 and would be required to report data to make possible a reduction in medical errors and hospital-acquired infections. There will be a general push to make greater use of health information technology, which could have cost implications for hospitals. The requirement for meeting state regulations regarding seismic standards would be modified, generally postponing the deadline for many hospitals.

To the extent that some of the quality improvement and cost containment features are able to move the system toward evidence-based medicine, some providers might be under pressure to alter their practice patterns.

Government compulsion and regulation. This approach involves considerable compulsion relative to the status quo, since individuals are required to acquire coverage, employers not offering coverage are required to pay a fee of 4% of payroll, and providers are required to pay a fee as a percentage of gross revenue. Insurers will be restricted on their ability to set rates and must provide coverage for anyone. Their loss ratios cannot be lower than 85%. Hospitals' administrative costs would also be limited to 15%. But steps would be taken to reduce regulation of hospitals and insurers to promote efficiency.

Key Trade-Offs of the Governor's Proposal

The major trade-off is that this proposal, if well implemented, would achieve universal coverage but also would impose a significant element of compulsion, primarily because of the individual mandate. Compulsion is also considerable because of the requirement that non-offering employers and hospitals and physicians pay a fee to help finance the system, and the limitations on insurers' ability to risk rate or deny coverage. It assures coverage for everybody, including undocumented immigrants, but as a result, the budgetary cost is high—$12.1 billion. It includes cost containment provisions, but they may not be sufficient to avoid future budgetary pressures. The system scores well in terms of fairness and equity with respect to both subsidies and financing, although the financing system would be more progressive if more of the state share were financed by general revenues. The proposal achieves a nice balance of expanding coverage in both the public and private sectors. Apart from having to pay fees, provider autonomy is little affected, and consumer choice would not be limited. The disruption to the status quo is not great and administrative burdens are modest though not insignificant.

IV. AB 8 (Núñez)

Features of AB 8

General approach. This bill has four major elements: extending eligibility for Medi-Cal and Healthy Families up the income scale, requiring employers who do not provide coverage to pay a fee to the state, revising insurance market rules, and establishing a purchasing pool to serve as a source of cost-effective coverage for employees of non-offering employers.

Extending coverage for Medi-Cal and Healthy Families. All children, including undocumented immigrants, with family incomes up to 300% of the federal poverty level (approximately $62,000 for a family of four) would be eligible for Medi-Cal or Healthy Families. Parents of these children would be eligible for either Medi-Cal or a new "benchmark" plan available through the new purchasing pool (see below). The maximum premium payments for families at various income levels are specified. Families eligible for either of the public programs who are also eligible for employer-sponsored coverage would be enrolled in the benchmark plan and mechanism would be put in place to have the employer contribute to the cost of the benchmark plan the amount that they employer would have contributed had the person enrolled in the employer plan..

An employer "play or pay" requirement. Employers choosing not to offer coverage would be required to pay 7.5% of Social Security wages (wages up to $97,500 in 2007) to the state, and their employees and their dependents would be required to get coverage through a new state purchasing pool. The employees whose incomes are below 300% of the federal poverty level would be eligible for subsidies. The "play or pay" requirement would not apply to businesses with payrolls of less than $100,000 or to new businesses for three years. Firms with more than one employee would be required to establish a Section 125 (Flex or "cafeteria") plan, which would allow employees to pay for coverage with before-tax dollars, thereby taking advantage of the federal tax "subsidy."

Insurance market changes. Current law requires health insurance carriers to provide coverage to firms with 50 or fewer employees on a guaranteed-issue basis (an applicant cannot be denied coverage) and limit insurers' ability to vary rates, using only age and geography as rating factors. These restrictions would be extended to firms with up to 250 employees. Insurers would be required to maintain a minimum medical loss ratio (the proportion of premium spent on health care services) of 85%. The Managed Risk Medical Insurance Board (MRMIB) would identify certain medical conditions as automatically qualifying people buying coverage in the individual market to be eligible for the high-risk pool.[7] Insurers would be required to offer coverage to all other applicants for individual coverage on a guaranteed-issue basis. MRMIB would also define three uniform benefit plans that all insurers would be required to offer. (They could offer others as well.)

A new purchasing pool. MRMIB would establish a purchasing pool to negotiate with health plans and insurers to provide a cost-effective source of coverage, but only for employees whose employers choose to not offer coverage.

Financing. The program would be financed by employer contributions from non-offering employers and federal matching funds for Medi-Cal and Healthy Families.

Cost Containment. Various state agencies would be required to develop best practice standards for care and to develop "pay for performance" standards to be used in state programs. Fitness, wellness, and health promotion programs would be promoted.

Framework Assessment of AB 8

1. Coverage

People covered. This approach would provide universal coverage for children and their parents if their family incomes are at or below 300% of the federal poverty level. It would not cover childless adults with low income. For people above 300% of the poverty level, only those whose employers choose to not offer coverage and therefore contribute to a state fund would be mandated to buy coverage. Thus the program would fall substantially short of achieving universal coverage. According to estimates by Jonathan Gruber, this proposal would newly cover 3.4 million of the current 4.9 million uninsured, leaving 1.5 million uninsured.

Portability of coverage and continuity of care. Portability of coverage and continuity of care would be improved for low-income people. Because coverage under the public programs is extended higher up the income scale, fewer people would be faced with having their eligibility status change frequently as their income varies slightly. For most other people, portability would remain essentially as now, with people having to switch health plans when they change jobs. But no one could be denied coverage in the individual market or group market (for firms with up to 250 employees), so everyone would always be able to get new coverage if they lost their previous coverage for whatever reason (although some could do so only through the high-risk pool).

Benefits. The benefit levels for people newly eligible for Medi-Cal and Healthy Families would be comprehensive. Families covered under the new purchasing pool could choose from three plans that would probably be relatively comprehensive in terms of covered services but would vary with respect to consumer cost-sharing.

Quality of care and effect on delivery system. The bill would assign state agencies responsibilities for developing pay-for-performance standards and best practice standards for various medical conditions. Apart from these provisions, nothing in the bill would seem to have a significant effect on the way physicians practice or on the extent to which the delivery system is more fully integrated. Because the proposal would extend eligibility for the two major public programs to substantially more people without changing the reimbursement rates for providers (which are low relative to what other payers pay), the number of providers willing to serve these patients might not be adequate. Of course, the fact that many more low-income people would now have financial access to care should, by itself, improve the quality of care they receive. The probability that they would be able to establish a "medical home" (a regular source for care and oversight of medical needs) would be far greater than now.

2. Cost and Efficiency

Resource cost. Because the plan would extend coverage to many low income people and some employed people and their families, more medical resources would be used, since insured people consume more medical services than uninsured people. But, of course, that is the intent of the program. The bill includes some provisions designed to improve the cost-effectiveness of medical care. Some provisions of the bill aimed at improving practice patterns might have cost saving consequences.

Budgetary cost. The budgetary cost of the program is high because of the substantial expansion of Medi-Cal and Healthy Families, the subsidies in the form of premium assistance, and some loss of state tax revenue. According to the Gruber estimates, the state cost would be $4.66 billion. This cost would, according to Gruber, be more than offset by the $5.04 billion of revenue from the fee assessment of 7.5% on Social Security wages of employers not offering coverage; so that the state would realize a net savings of $0.38 billion. Substantially more people would be eligible for coverage through the state's high-risk pool, but the bill does not indicate how the subsidies for such people would be financed. It seems likely that state government would have to provide some funds for this purpose.

The proposed legislation would create significant new state budgetary entitlements and commitments by expanding Medi-Cal and Healthy Families. Longer-run budget costs are likely to rise because health care costs are certain to rise, probably at a pace that exceeds that of the growth in the economy as a whole. The bill does not appear to address this contingency.

Cost containment. The proposal would assign responsibility for identifying practice guidelines and for establishing pay-for-performance standards to several state agencies. The state would also promote healthful lifestyles and modification of behaviors that have a negative impact on health. Otherwise, there are not strong provisions to control costs.

Implementation and administration. The amount of administrative change that would be required is significant. MRMIB would be responsible for establishing the new purchasing pool, developing various health plan benefit structures, administering contracts with health insurers, and enrolling the families of employees that work for firms that choose to pay rather than play. However, MRMIB already performs similar functions for other programs that the agency administers. The state's tax system would have to administer the collection of fees from non-offering employers, which would entail gathering data from the employers regarding their full-time and part-time workers and their total payroll. The state would also have to enforce the requirement that the employees who work for those firms enroll in the purchasing pool. The state would have to identify best practices for certain medical conditions and develop pay-for-performance standards. Once the system is fully implemented, the administration of the program would probably not be overly burdensome.

Insurers and health plans would be required to conform to certain new regulations, but, for the most part, the regulatory changes are similar to those already in force. The exception is the new requirement for a minimum loss ratio, since loss ratio requirements are not part of the present system.

Requiring employers to either offer coverage or to pay a fee could have some effects on employee wages and employment levels. The larger the fee as a percentage of payroll, the larger the likely effects. Economists generally argue that, in response to a new assessment on payroll, employers would over time pass back most of the new cost to employees in the form of lower wages. However, many of the employers that do not offer coverage and would thus be required to pay the fee are lower-wage employers. For low-wage employers who now spend nothing for health care for their employees, the payroll assessment is equivalent to a 7.5% increase in wages. Because of the minimum wage constraints, some of these employers would not be able to shift the costs back to employees in the form of lower hourly wages or to pass them forward to customers. They might, therefore, hire fewer workers.

For the most part, the proposal does not make such major departures from the status quo as to be significantly disruptive.

3. Fairness and Equity

Access to coverage and subsidies. When measured against the standard of ability to pay (vertical equity), the approach generally gets good marks. Access to subsidized public programs is available to all lower-income children, including undocumented immigrants, and the size of the subsidy is related to family income. The cutoff point for eligibility is 300% of the federal poverty level, which is close to the median income in the state. Low-income adults are also eligible, but with two important exceptions: all undocumented immigrant adults and other adults without children are not covered. These exceptions violate the standard of equal treatment of equals (horizontal equity).

Financing. The sources of state financing for the expansion of Medi-Cal and Healthy Families appear to be the new payroll assessment on non-offering employers. This is a somewhat regressive form of financing. The fee will probably be shifted back to employees over time as lower wages or reduced compensation of other types. Since most such employers are probably lower-wage employers, this fee is somewhat regressive compared to some other alternatives, such as the state income tax. Because the requirement would not apply to firms with payrolls of less than $100,000 per year, the regressive effect is reduced. The fact that the fee applies only to income up to the Social Security limit in theory also makes the fee less progressive than it would be if it applied to all income without limit. However, since most employees with higher incomes probably already have employer-sponsored coverage and hence their employers would not be subject to the assessment, this theoretical limitation may not have much practical effect.

The requirement that all employers establish a Section 125 plan so that employees can pay for coverage premiums with before-tax dollars probably generally benefits lower-income employees, since higher-wage firms already are more likely to offer such plans. However, the ability to pay with before-tax dollars in general is a regressive provision, since the amount employees save is greater for higher-income people because they have higher marginal tax rates. The addition of more Section 125 plans also shifts some of the cost to the federal government. The foregone federal revenue requires more federal revenue, which, as noted, is collected from progressive taxes.

Sharing of risks. The proposal would implement several steps to broaden risk. The current limits on carriers' ability to vary premiums based on risk and the prohibition on denying coverage that applies to the employers with 50 or fewer employees would be extended to employers with up to 250 employees. In essence, risks would be spread over a much larger number of employees, with particular benefits to the higher-risk larger firms and their employees. In the individual market, the combination of automatic assignment of high-risk individuals to the high-risk pool along with the requirement that all insurers provide coverage on a guaranteed issue basis for other applicants helps to broaden sharing of risk in the individual market.

4. Choice and Autonomy

Consumer choice of providers and health plans. The proposal would appear to have little effect on consumer choice of providers and health plans except that the requirement that all health plans offer the three specific benefit plans that MRMIB is to identify should make it easier for people to make judgments about the relative value of plans offered by different insurers.

Provider autonomy. To the extent that best practices standards and pay-for-performance standards are developed and enforced, some providers might be under pressure to alter their practice patterns.

Government compulsion and regulation. This approach involves a modest level of compulsion. Employers that continue to choose not to offer coverage would be required to pay a fee, and their employees would be required to get coverage through the new purchasing pool. Insurers would be required to change some of their underwriting and risk rating policies, and some would be forced to lower administrative costs and/or profit margins.

Key Trade-Offs of AB 8

This approach would achieve substantial coverage expansion (covering 3.4 million out of 4.9 million uninsured), but it would entail a significant budgetary cost for the state ($4.66 billion). The cost would be offset by an assessment on employers not offering coverage (generating $5.04 billion), which compels them to do what they would otherwise not do and is a somewhat regressive form of financing. Significantly more medical resources would be consumed by the newly insured, although because no change in payment rates for providers serving public patients is included, the provider supply for public patients could be inadequate. Positive effects on quality of care and portability are likely to be limited primarily to those who are newly insured. In general, the level of compulsion is modest; the administrative changes required for government would be significant but relatively minor for insurers; and the approach would not be highly disruptive to present practices and organizational structures. But the offset may be that the provisions to contain costs may prove insufficient to prevent longer-run cost escalation.

V. SB 48 (Perata)

Features of SB 48

General approach. This bill has five major elements: extending eligibility for Medi-Cal and Healthy Families up the income scale, requiring employers who do not provide coverage to pay a fee to the state, requiring higher-income people to have coverage, revising insurance market rules, and establishing a purchasing pool to serve as a source of cost-effective coverage for employees of non-offering employers.

Extending coverage for Medi-Cal and Healthy Families. All children, including undocumented immigrants, with family incomes up to 300% of the federal poverty level (approximately $62,000 for a family of four) would be eligible for Medi-Cal or Healthy Families, with the state paying the full cost for undocumented children. Working parents and certain other adults with incomes up to 300% of the poverty level would be eligible for either Medi-Cal or Healthy Families.

Individual mandate for high-income people. Taxpayers with incomes equal to or greater than 400% of the federal poverty level (approximately $84,000 for a family of four in 2007) would be required to get coverage with a minimum benefit level defined by MRMIB unless the cost of coverage was greater than 5% of their income or retirement income was their only source of income. People subject to this provision who failed to acquire coverage would lose their state income tax exemption ($91 for a single individual and $182 for a married couple).

An employer "play or pay" requirement. Employers who do not spend at least 7.5% of Social Security wages (wages up to $97,500 in 2007) for health care expenditures for workers would be required to pay that amount to the state. The employees and their dependents would be eligible to get coverage through a new state purchasing pool (the "Connector"). The employees would also be required to pay a fee that would vary by the kind of plan they choose to buy through the Connector and the number of dependents covered. Workers whose incomes are below 300% of the FPL would be eligible for subsidies that would vary with income; those with the lowest incomes would pay nothing, whereas those at 300% of FPL might pay as much as 5% of income (after taking account tax savings related to Section 125 plans). Non-offering firms (those paying the fee) would be required to establish a Section 125 (Flex or "cafeteria") plan, which would allow employees to pay for coverage with before-tax dollars, thereby taking advantage of the federal tax "subsidy." Employers that choose to "pay" rather than "play" must pay the fee (rather than offer coverage) for at least two years, and if they then choose to buy coverage on their own, they could not then choose to "pay" rather than "play" for two years.

Insurance market changes. Current laws require health insurance carriers to provide coverage to firms with 50 or fewer employees on a guaranteed-issue basis (an applicant cannot be denied coverage) and limit insurers' ability to vary rates, using only age and geography as rating factors plus or minus 10% for health status. These restrictions would be extended to firms with up to 199 employees. Insurers would be required to maintain a minimum medical loss ratio (the proportion of premium spent on health care services) of 85%. Insurers in the individual market would be

required to offer coverage to all applicants for coverage on a guaranteed-issue basis (no one could be denied coverage)—initially for just the lowest-priced plan and ultimately for five different tiers of standard plans (which will be the only plans offered). However, insurers could "cede" high-risk applicants to a new individual market reinsurance mechanism. In the small group market (firms with 2 to 199 employees), insurers must community rate beginning in 2011; that is, they cannot vary premiums on the basis of any rate adjustment factors.

New purchasing pool. MRMIB would establish a purchasing pool (the Connector) to negotiate with health plans and insurers to provide a cost-effective source of coverage, but only for employees whose employers choose to not offer coverage.

Financing. The program would be financed with a combination of employer contributions from non-offering employers and federal matching funds for Medi-Cal and Healthy Families.

Cost containment. Cost containment is not directly addressed apart from caps on insurers' administrative costs and profits.

Framework Assessment of SB 48

1. Coverage

People covered. This approach would provide universal coverage for children and their parents if the family incomes are at or below 300% of the FPL (approximately 800,000 people would be newly covered, according to estimates by Jonathan Gruber). It would not cover childless adults with low incomes. Only people with incomes above 400% of the FPL would be required to buy coverage. However, the requirement would be waived if the cost of coverage exceeds 5% of income. Moreover, the penalty for failing to acquire coverage is very weak: those not complying with the requirement would lose the state income tax exemption, which is only $91 for an individual and $182 for a married couple. Since the cost of coverage would far exceed the penalty, many people might choose to pay the penalty and not get coverage. On the other hand, many might comply because they choose to obey the law. Undocumented adults are also not covered. Because the purchasing pool is open only to people whose employers choose not to offer coverage, any price advantage the pool might realize by negotiating with health plans would not be available to other people who might have difficulty finding affordable coverage.

The program would fall substantially short of achieving universal coverage. According to Gruber, this proposal would newly cover 3.4 million of the current 4.9 million uninsured, leaving 1.5 million uninsured.

Portability of coverage and continuity of care. Portability of coverage and continuity of care would be improved for low-income people. Because coverage under the public programs is extended higher up the income scale, fewer people would be faced with having their eligibility status change frequently as their income varies slightly. For most other people, portability would remain essentially as now, with people having to switch health plans when they change jobs. But no one could be denied coverage in the individual market or group market (for firms with up to 199 employees), so everyone would always be able to get new coverage if they lost their previous coverage for whatever reason.

Benefits. The benefit levels for people newly eligible for Medi-Cal and Healthy Families would be comprehensive. Families covered under the new purchasing pool would probably be able to buy coverage that was quite comprehensive, although the bill does not yet precisely define the benefit package.

Quality of care and effect on delivery system. The bill does not contain provisions that would seem to have a significant effect on the way physicians practice or on the extent to which the delivery system is more fully integrated. Because the proposal would extend eligibility for the two major public programs to substantially more people without changing the reimbursement rates for providers (which are low relative to other payers), the number of providers willing to serve these patients might be inadequate. Of course, that many more low-income people would now have financial access to care should, by itself, improve the quality of care they receive. The probability that they would be able to establish a "medical home" would be far greater.

2. Cost and Efficiency

Resource cost. Because the plan would extend coverage to many low-income people and some employed people and their families, more medical resources would be used, since insured people consume more medical services than uninsured people. But, of course, that is the intent of the program. The bill includes few provisions to influence the cost-effectiveness of medical care, so it is unlikely that program would produce any offsetting resource savings. Of course, having access to timely care and early detection might obviate the need for later expensive care.

Budgetary cost. The budgetary cost of the program is high because of the substantial expansion of Medi-Cal and Healthy Families, the subsidies available to some people through the purchasing pool, and some loss of state tax revenue. According to the Gruber estimates, the state cost would be $6.02 billion. This cost would, according to Gruber, be more than offset by the $6.64 billion of revenue from the employer fee assessment of 7.5% on Social Security wages; so that the state would realize a net savings of $0.610 billion.

The proposed legislation would create significant new state budgetary entitlements and commitments by expanding Medi-Cal and Healthy Families. Longer-run budget costs are likely to rise because health care costs are certain to rise, probably at a pace that exceeds that of the growth in the economy as a whole. The bill does not appear to address this contingency.

Cost containment. The proposal contains no strong provisions to control costs.

Implementation and administration. The amount of administrative change that would be required is modest but not trivial. MRMIB would be responsible for establishing the purchasing pool, developing various health plan benefit structures, administering contracts with health insurers, and enrolling the families of employees that work for firms that choose to pay rather than play. However, MRMIB already performs similar functions for other programs that the agency administers. The state's tax system would have to collect the fees from non-offering employers, which would entail gathering data from the employers regarding full-time and part-time workers and their total payroll. Likewise, the state tax system would need to put in place new structures to verify that high-income people had purchased the required coverage. Once the system is fully implemented, program administration would probably not be overly burdensome.

Insurers and health plans would be required to conform to new regulations, but, for the most part, the changes are similar to those already in force. The exception is the new requirement for a minimum loss ratio, since loss ratio requirements are not part of the present system.

Requiring employers to either offer coverage or to pay a fee could have some labor market effects. The larger the fee as a percentage of payroll, the larger the likely effects. Economists generally argue that, in response to a new assessment on payroll, employers would over time pass back most of the new cost to employees in the form of lower wages. However, many of the employers that do not offer coverage and would thus be required to pay the fee are lower-wage employers. For low-wage employers who now spend nothing for health care for their employees, the payroll assessment is equivalent to a 7.5% increase in wages. Because of the minimum wage constraints, some of these employers would not be able to shift the costs back to employees or to pass them forward to customers and therefore might hire fewer workers.

For the most part, the proposal does not make such major departures from the status quo as to be significantly disruptive.

3. Fairness and Equity

Access to coverage and subsidies. When measured against the standard of ability to pay (vertical equity), the approach generally gets good marks. Access to subsidized public programs is available to all lower-income children, including undocumented immigrants, and the size of the subsidy is related to family income. The cutoff point for eligibility is 300% of the federal poverty level, which is close to the median income in the state. Low-income adults are also eligible, but with two important exceptions: all undocumented immigrant adults and other adults without children are generally not covered. These exceptions violate the standard of equal treatment of equals (horizontal equity).

Financing. The sources of state financing for the expansion of Medi-Cal and Healthy Families and the subsidies for people purchasing through the Connector appear to be the new payroll assessment on non-offering employers. This is a somewhat regressive form of financing. The fee will probably be shifted back to employees over time as lower wages or reduced compensation of other types. Since most such employers are probably lower-wage employers, this fee is somewhat regressive compared to some other alternatives, such as the state income tax. The fact that the fee applies only to income up to the Social Security limit in theory also makes the fee less progressive than it would be if it applied to all income without limit. However, since most employees with higher incomes probably already have employer-sponsored coverage and hence their employers would not be subject to the assessment, this theoretical limitation may not have much practical effect.

The requirement that all employers establish a Section 125 plan so that employees can pay for coverage premiums with before-tax dollars probably benefits lower-income employees, since higher-wage firms now are more likely to offer such plans. However, the ability to pay with before-tax dollars in general is a regressive provision, since the amount employees save is greater for higher-income people because they have higher marginal tax rates. The addition of more Section 125 plans also shifts some of the cost to the federal government. The foregone federal revenue requires other revenue, which, as noted, is collected from progressive taxes.

Sharing of risks. The proposal would implement several steps to broaden risk. The current limits on carriers' ability to vary premiums based on risk and the prohibition on denying coverage that applies to the employers with 50 or fewer employees would be extended to employers with up to 199 employees. In essence, risks would be spread over a much larger number of employees, with particular benefits to the higher-risk larger firms and their employees. Further, in the year 2011 insurers in this market would be required to offer coverage on a community rated basis, which would produce greater risk sharing—that is, lower rates for high-risk groups and higher rates for low-risk groups. In the individual market, the requirement that all insurers provide at least some offerings on a guaranteed issue basis and that insurers use only age and geography as risk-rating factors would help to broaden sharing of risks.

4. Choice and Autonomy

Consumer choice of providers and health plans. The proposal would appear to have minimal effects on consumer choice of providers and health plans. However, in the individual market, after a transition period, only five standard health benefit plans would be available. While this provision might limit the choice of health benefit plans, it is presumably designed to make value comparisons among plans easier for consumers and to avoid the situation where the availability of many different kinds of plans creates adverse selection problems.

Provider autonomy. There appear to be no provisions that would limit provider autonomy.

Government compulsion and regulation. The level of compulsion is relatively modest in this approach and primarily affects employers that do not now offer coverage and their employees and high-income people. The employers that continue to choose not to offer coverage would be required to pay a fee. Insurers would be required to change some of their underwriting and risk rating policies, and some would be forced to lower administrative costs and/or profit margins. People with incomes of 400% of the poverty level or higher would be required to buy coverage.

Key Trade-Offs of SB 48

This approach would achieve substantial coverage expansion (covering 3.4 million out of 4.9 million uninsured), but it would entail a significant budgetary cost for the state ($6.02 billion). The cost would be more than offset by an assessment on non-offering employers (generating $6.64 billion), which involves compulsion for them and is a somewhat regressive form of financing. Significantly more medical resources would be consumed by the newly insured, although because no change in payment rates for providers serving public patients is included, the provider supply for public patients could be inadequate. Positive effects on quality of care and portability are likely to be limited primarily to those who are now insured. In general, the level of compulsion is modest; the administrative changes required would be significant for government but relatively minor for insurers; and the approach would not be highly disruptive to present practices and organizational structures. But the offset is that because there are no provisions to contain costs, over time, costs may outpace revenue.

VI. SB 840 (Kuehl)

Features of SB 840

General approach. Senate Bill 840 would establish a single payer health insurance system for California. A new government-administered system would replace all private health insurers and existing government insurance programs, including Medicare. An elected Health Insurance Commissioner would oversee all aspects of the new system, including contracts with health care providers, the allocation of health care workforce and capital equipment, and the introduction of new technologies.

Eligibility and benefits. All residents of California—defined as those with a physical presence in the state with intent to reside—would automatically be covered under the system. The benefit package would be very comprehensive, including not only the usual range of inpatient and outpatient services, diagnostic and laboratory services, and prescription drugs, but also mental health services, dental and vision care, chiropractic services, adult day care, and 100 days of skilled nursing care following hospitalization. Long-term care would not be covered. Copayments and deductibles could be established for other than preventive care. Patients could choose to receive services from any willing provider and providers would determine what services are medically necessary. Each person would have a primary care physician responsible for approving care to be received from specialists. People could choose to enroll with an integrated health care system, which would be responsible for all their care.

Administration. The health insurance commissioner, elected to eight-year terms, would be independent and have very broad powers, assisted by a Health Insurance Policy Board, which would help to set system goals and priorities and determine the scope of services provided. A number of other new agencies and offices would also be established, including a public advisory committee, an office of consumer advocacy, offices of health care planning and quality, a technology advisory committee, a chief medical officer, and an officer of the Inspector General with broad powers to protect against financial misconduct. The commissioner would have major responsibility for controlling total expenditures and allocating resources. He or she would annually set a total health system budget as well as regional budgets, taking into account growth in state gross domestic product, demographic factors, technological change, etc. The commissioner would use the state's purchasing power to negotiate for provider services and would implement cost controls to ensure that the system remains financially viable. The state would acquire drugs and medical devices on a bulk-purchasing basis. Cost control measures would include making decisions about which new technologies would be introduced, setting limits on health provider reimbursement rates, and requiring changes in the delivery system to improve efficiency and quality. The commissioner would negotiate payment rates with providers, but if agreements were not reached within a specified time, the commissioner would set binding rates. System administrative costs would be legally limited, initially to 10% and later to 5%. If the system experienced a revenue shortfall, benefits could be temporarily reduced. The commissioner would also be responsible for establishing evidence-based standards to guide the delivery of care, creating a formulary for prescription drug and medical equipment, and

implementing advanced electronic technology for maintaining medical records, payment administration, etc.

Regionalization. Although the commissioner would have overall responsibility for guiding the system, up to ten regional health insurance systems would be established to decentralize some activities. The regional entities would be responsible for assessing local health care conditions and needs and establishing plans and budgets to meet those needs.

Financing. A companion bill, SB 1014, has been introduced to address financing. The funding sources in this companion bill would replace premiums, co-pays, and health related out-of-pocket expenses, according to the bills' author. SB 1014 would levy a tax on wages (including those of the self-employed), paid equally by employer and employee; but it would exempt wages below $7,000 and above $200,000. An additional tax on personal income above $200,000 would be imposed. The tax rates are not yet specified. The expectation is that all of the funds that support California public programs at the state, county, and federal level—including Medi-Cal, Healthy Families, and Medicare—would be redirected to the Health Insurance Fund.

Framework Assessment of SB 840

1. Coverage

People covered. This approach ensures universal coverage for all people in California who intend to reside there, including undocumented immigrants.

Portability of coverage and continuity of care. Problems related to portability virtually disappear under this approach since all residents would be covered under the same system all the time. Changes in marital status, job status, geographic location within the state, etc., would not require any change in coverage. Continuity of care should be very great because people could choose any provider participating in the system and because virtually no providers could afford to stay outside the system. Changes in individual circumstances except for moving into a different geographic area should not require a change in providers.

Benefits. The benefit package is very comprehensive, including dental, vision, chiropractic, and mental health services but excluding long-term care. Consumer cost sharing would be permitted.

Quality of care. Because the state, in essence, would be the only buyer of medical services for the standard benefit package, the state would have access to extensive, uniform encounter data that would have the potential to be used to detect quality problems and develop solutions. The Commissioner would be charged with the responsibility to assess performance, to hold providers accountable, and to institute changes to improve quality.

Integration and coordination of care. Whether this approach would encourage integration of care would depend upon how many people choose to join multi-specialty, prepaid group practice plans rather than selecting a fee-for-service option.

2. Cost and Efficiency

Resource and real costs. Newly insured people, as well as those who are now underinsured, would consume substantially more medical resources than they do now, which would add to real costs. But, of course, this is the logical result of the desired policy.

Real costs could increase for other reasons. If many people now in prepaid, integrated plans were to switch to the fee-for-service option, costs could rise. Integrated plans are generally thought to be more efficient; fee-for-service payment is generally thought to encourage providers to prescribe more services. The consumer cost-sharing provisions should partially offset this tendency, however.

Another potential source of cost increases would be an influx from other states of people who need expensive medical care but lack good insurance coverage. To a degree, California is protected more than other states from in-migration of unhealthy people because it is not bordered by states with large population concentrations close to California's borders, which would make moving to California much easier. In addition, the cost of living is such that many people would not be able to easily relocate to the state. Nevertheless, there would be a temptation for people with chronic diseases or other needs for expensive medical services to move to the state to become eligible for coverage under the single-payer plan. While it might be possible to impose some residency restrictions to limit eligibility—as is done for people seeking in-state tuition rates at California's universities—the administrative and enforcement problems could be imposing. The proposed legislation requires the Commissioner to address this problem.

Other aspects of the reform would reduce real resource costs. Many of the administrative economies that the single payer system would produce, as described below, would be reflected in real resource cost reductions. This conclusion is based on the evidence that shows that administrative costs for the Medicare program are substantially lower than those for even large firms that offer health coverage and much lower than the administrative costs associated with providing coverage for small employers and individuals. In addition, the large amount of administrative duplication that is a result of having many different insurance companies would be eliminated, as would all the functions around medical underwriting, determining eligibility, collecting premiums, coordination of benefits, etc. Providers would also realize savings by not having to deal with multiple payers. The sum of these savings should be quite large.

The extensive cost containment elements of the plan, outlined below, should also produce significant savings over time. (The bill's sponsor asserts, based on a study by The Lewin Group, that implementation would be possible without any net increase in total health care spending.)

Cost containment. This bill contains many elements to control costs. A global budget places a constraint on total spending, and various sub-global budgets apply to geographic regions and other cost elements. The Commissioner, regional planning directors, and various entities within the system are responsible for ensuring that budgets, which cover a three-year period, are not exceeded. New capital expenditures would be controlled through the Commissioner and regional planning directors. The Commissioner would set or negotiate payment rates for providers and use the state's purchasing power to "achieve the lowest possible prices" for pharmaceuticals and durable medical equipment. Facility performance would be monitored, and the Commissioner

could take actions to correct deficient practices. Administrative costs for the new system are limited by law, initially to 10% and later to 5%. Appropriate ratios of primary care physicians to specialists would be established, and incentives would be put in place to achieve those ratios. The Commissioner could also temporarily adjust benefits and lower provider reimbursement if a revenue shortfall is expected.

Budgetary cost. This single-payer approach would cause a very large increase in the state's budget because nearly all the costs now financed by private sources—except out-of-pocket cost sharing—would be shifted to state government. What were private household and employer premiums would now be financed through government (funded by a payroll tax and some income tax). In addition, people now covered through Medicare would be covered by the state, and the funding would go through the state budget. And, of course, many more people would be covered, which would also raise the total budgetary cost.

Ease of implementation and departure from the status quo. This approach represents a very large departure from the status quo. Existing insurers (except for integrated plans with which the state would choose to contract), insurance agents and brokers, third-party intermediaries, and most of the businesses and the individuals associated with the sale and administration of insurance and employer-sponsored plans would have a greatly reduced role or no role at all in the new system. The state might contract with some of these business entities to administer parts of the new program, just as Medicare depends upon fiscal intermediaries for administration. Most if not all employers would choose to get entirely out of the business of providing health insurance. While this would relieve employers of burdens that many find onerous, it would affect the administrative and employment structures of these firms, which would be somewhat disruptive, especially for the individual workers whose jobs would be eliminated.

Counties' responsibilities would be reduced, since they would no longer serve as administrative entities for Medi-Cal eligibility, nor would they provide as many services directly. Some jobs would be lost in the public sector: state employees working within the Medi-Cal and Healthy Families programs would have to find new jobs. New government jobs would be created under the Commissioner and the regional planning authorities.

The state would have to establish extensive new machinery to administer the program. The Commissioner and the regional planning authorities would have to perform many entirely new, complex functions. Negotiating with the federal government to contribute to the plan in lieu of the federal matching amount for Medicare, Medi-Cal, and SCHIP would probably be a difficult process, and an outcome favorable to the state is not assured.

Ongoing administrative costs. Once this program was underway, the ongoing administrative costs should be quite low, probably comparable to those experienced under Medicare. Administrative costs for providers should be reduced because they would be dealing with only one payer and one set of administrative requirements. Households would also be relieved of the considerable administrative burdens associated with dealing with multiple insurers, filing claims, changing carriers when they change jobs, etc. The system would be much less complex to navigate.

Locus of control and accountability. The Commissioner has very broad powers and extensive responsibilities and is thus ultimately accountable for the system's performance and with the power to hold others accountable as well. The potential for holding providers accountable is great because the state would be collecting uniform data on virtually all provider encounters. Such a vast data source would make it possible to detect outlier practice behavior, both in terms of quality problems and inefficient use of resources. It is less clear how the state, as essentially the only buyer of provider services, would be held accountable to ensure that it was using its power in an appropriate way. Mechanisms to provide oversight for state activities would be desirable.

Accountability for cost control rests directly with the Commissioner. If costs rise more rapidly than the rate at which the state economy grows, the Commissioner would have to take actions, which would be very visible and probably controversial. In some ways, this makes the problem of health care cost escalation highly visible to the public and makes it more likely that the alternatives for controlling costs would be seriously considered and debated and that the response would reflect some public consensus. The present mixed public and private financing arrangement makes it easier for people to overlook the critical need to find fair and rational ways to limit utilization of scarce resources.

3. Fairness and Equity

Access to coverage and subsidies. By generally accepted standards of fairness, this approach rates high. It achieves universal coverage on a uniform basis for everyone. Income is no barrier to receiving care.

Financing of costs. Assessing the equity of the financing is difficult because it represents such a major departure from the status quo and because some important elements are not yet specified. Premiums, co-payment, and out-of-pocket expenditures would be entirely replaced by the new tax on wages (paid equally by employer and employee) and by some additional income taxes on high-income people. Premiums, co-payments, and out-of-pocket costs of the present system probably represent, on averaged, a higher proportion of income for lower-income people that for higher-income people, which means they are a "regressive" financing source. Replacing these with the proposed employer/employee payroll tax would be more "progressive" overall: Wages up to $7,000 would not be taxed, which is progressive. Wages between $7,000 and $200,000 would pay the same tax rate (presumably), which makes the tax "proportional" over this range. Wages above $200,000 would not be subject to the payroll tax (presumably to prevent high-wage *employers* from having to pay much more than they do now for health coverage), but personal incomes above $200,000 would be taxed by a special income tax, presumably at a rate at least equal to the payroll tax rate. Though the cumulative effects depend on the final tax rates, which are not yet specified, it seems likely that the overall effect would be that higher-income people would pay more than they do now and lower-income people would pay less. This is consistent with ability-to-pay (vertical equity).

The approach would greatly increase horizontal equity (equal treatment of equals), since the financing would be identical for everyone at the same income level.

Sharing of risks. This approach represents the broadest possible sharing of risk because everyone is in a single pool and because contribution to funding does not relate in any way to risk. The risk is spread across all who pay to finance the program. In other words, this is social insurance.

4. Choice and Autonomy

Consumer choice. Because anyone can choose the fee-for-service option, choice of providers is unlimited. Consumers can instead opt to enroll in integrated health plans. Their choice of plans would be limited to those that the state chooses to contract with. Because of a need to limit costs, the state would impose controls on the acquisition of new equipment and facilities. Presumably efforts would focus on limiting acquisitions of expensive technologies and avoiding excess capacity of costly equipment and facilities. This could result in consumers' having less freedom to consume the medical resources they might otherwise choose, or they might have to wait a bit longer to get access to some technologies.

Provider autonomy. All providers would be subject to negotiated or set fees for all of their patients, so they would have less control over payment rates than they do now. The Commission has responsibility to ensure that money is spent in a cost-effective way and to promote best quality practices. It seems likely, therefore, that the new system would put pressure on providers to adopt accepted practice guidelines and to practice in a cost-effective way, and the authorities would have the data to detect anomalous practices and take steps to correct deficiencies.

Government compulsion and regulation. By most people's standards, this approach embodies a high degree of compulsion. Although everyone is automatically covered—so that technically speaking there is no individual mandate to buy coverage—everyone has to pay for this coverage in one way or another through some kinds of taxes. People with relatively low health risks (and the employers that hire them) can no longer gain any financial advantage by paying lower premiums. Many insurers and associated businesses would be forced out of business. Government oversight and monitoring of health care financing and the quality of care would replace private oversight and monitoring. Providers would have substantially less autonomy than they do now. As the single buyer of health care, state government would have great market power, although subject ultimately to the check that the Commissioner is elected.

Key Trade-Offs of SB 840

The single-payer approach achieves universal coverage; greatly reduces ongoing administrative burdens and costs; is highly equitable in terms of treating equals equally; and produces the broadest possible sharing of risk. The trade-offs are that it has a very high budgetary cost because it covers everybody; it substitutes public dollars for financing now financed privately; and it involves a major departure from the status quo—by eliminating most private insurers—and a large extension of government authority and control. From a provider's standpoint, the approach eliminates problems related to uncompensated care and the complexity of dealing with many payers, but it limits their autonomy with respect to payments rates and capital investment and subjects them to additional regulation regarding data reporting.

Endnotes

[1] The Healthy Families Program is California's version of the State Children's Health Insurance Program (SCHIP), funded jointly with the federal government. Healthy Families provides low-cost health, dental, and vision coverage to California children in families with income up to 250% of FPL.

[2] Federal Poverty Level (FPL) is the minimum amount of income that a family needs for food, clothing, transportation, shelter, and other necessities. For 2007, the U.S. Health and Human Services defines FPL for a family of four as $20,650.

[3] The Managed Risk Medical Insurance Board (MRMIB) manages California's Healthy Families program, the Access for Infants and Mothers program, and the Major Risk Medical Insurance Program.

[4] Jonathan Gruber, an MIT economist, estimated the cost and coverage effects of AB 8, SB 48, and the Governor's proposal. The results of Gruber's microsimulation are in "Modeling Health Reform in California," May 16, 2007, www.calhealthreform.org.

[5] "Portability" refers to the ability to maintain the same health plan when changing jobs or experiencing other changes in life circumstances, such as marriage or divorce, ending student status, etc.

[6] A financing source is said to be "regressive" if the assessment represents a larger portion of income for lower-income people than for higher-income people. The result is to leave higher-income people with a larger share of the total income pool net of the assessment. A financing method is "progressive" if the assessment is a higher proportion of income for high-income people than for low-income people.

[7] The state's high-risk pool makes coverage available to people who have been turned down coverage by insurers because of a medical condition that makes them "uninsurable" in the eyes of insurers. The high-risk pool coverage rate is between 125% and 137% more expensive than "standard" coverage.