

Framework Assessment of AB 8 (Núñez)

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I. Introduction to the Framework

To help understand the trade-offs and draw comparisons among the various health reform proposals before the California Legislature, 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.

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 and Efficiency:** Is the proposal efficient and economically practical?
3. **Fairness and Equity:** Does the proposal promote fairness and equity?
4. **Choice and Autonomy:** How much choice does the proposal permit?

Designing a coverage expansion policy is essentially a 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. 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.

II. Features of AB 8 (Núñez)

The legislation by Assembly Speaker Fabian Núñez was modified to include some key aspects of legislation by Senate President Pro Tem Don Perata. The amended bill was passed by the Assembly and the Senate, but was vetoed by Governor Schwarzenegger on October 12, 2007.

General approach. This bill had five major elements: extending eligibility for Medi-Cal and Healthy Families¹ up the income scale, requiring employers who did not meet a spending minimum for coverage to pay a fee to the state, requiring employees to acquire coverage for themselves and their dependents, 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 percent of the federal poverty level (FPL)—approximately \$62,000 for a family of four²—would have been eligible for Medi-Cal or Healthy Families. Parents of these children (except undocumented) would have been eligible for Medi-Cal or Healthy Families plans available through the new California Cooperative Health Insurance Purchasing Program, or Cal-CHIPP (see below). The maximum premium payments for families could not have exceeded 5 percent of income. Families who were eligible for either of the public programs and employer-sponsored coverage would have been enrolled in a Cal-CHIPP plan with coverage comparable to Medi-Cal or Healthy Families; their employers would have contributed the same amount as they would for coverage under the employer plans.

An employer/employee “play or pay” requirement. Employers that did not spend at least 7.5 percent of Social Security wages (wages up to \$97,500 in 2007) for health coverage for employees would have been required to pay 7.5 percent of payroll to the state (the required percentage could have been changed over time). Their employees and their employees’ dependents would have been required to get coverage through the new state purchasing pool administered by the Managed Risk Medical Insurance Board (MRMIB)³ unless they had other coverage. Those whose family incomes were below 300 percent of FPL would have paid sliding-scale premiums to MRMIB, with the maximum not to exceed 5 percent of family income. Workers whose employers did offer coverage would have been required to accept it unless the employee cost exceeded 5 percent of income or they had other coverage. All firms would have been required to establish a Section 125 plan, also known as a flex or cafeteria plan, allowing employees to pay for coverage with before-tax dollars, thereby taking advantage of the federal tax “subsidy.”

Insurance market changes. In the small-group market, 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 along with variations for family size and benefit structure, plus or minus a 10 percent individual employer adjustment for other factors. The 10 percent adjustment would have been eliminated and the rating restrictions that apply to firms with 50 or fewer employees would have been extended to firms with up to 100 employees. Insurers would have been required to maintain a minimum medical loss ratio (the proportion of premiums spent on health care services) of 85 percent.

In the individual market, the Managed Risk Medical Insurance Board would have identified serious, expensive medical conditions (based on insurance applicants' answers to a questionnaire) that would automatically have qualified 3 to 5 percent for eligibility in the high-risk pool.⁴ Insurers would have been required to offer coverage to all other applicants on a guaranteed-issue basis and could have varied rates based only on age, geographic region, family size, and "health improvement discounts," but not on any health status measure. Policyholders' ability to switch to more comprehensive plans from year to year would have been limited to prevent adverse selection against comprehensive plans. MRMIB would have defined five classes of benefit plans—including the Healthy Families and Medi-Cal benchmark plans—to be provided by insurers and health plans.

A new purchasing pool. MRMIB would have established a purchasing pool—Cal-CHIP—to negotiate with health plans and insurers to provide a cost-effective source of coverage, but only for families of workers whose employers chose to not offer coverage and for families that were eligible for Medi-Cal and Healthy Families and were offered employer coverage. Insurers and health plans with a million or more California enrollees would have been required to offer a good-faith bid to MRMIB to provide coverage. The subsidized premium for plans offered through MRMIB would have been financed by an assessment on health plans.

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

Cost containment. The bill would have established a Health Care Cost and Quality Transparency Commission and required it to adopt a plan for public reporting of safety, quality, and cost efficiency. The objective was to provide information that would allow health care purchasers, consumers, and data sources to identify and compare health plans and insurers, health facilities, physicians, and other health care providers. The commission would have measured the following "performance domains": safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness. The state would have developed provider performance benchmarks used to establish a pay-for-performance system for all state-administered health programs, and would have promoted fitness, wellness, and health promotion activities.

III. Assessment

1. Coverage

People covered. This approach would have provided universal coverage for children and their parents (except undocumented) if their family incomes were at or below 300 percent of FPL. It would not have covered childless adults with low income. Essentially everyone who was employed and above 300 percent of FPL would have been required to buy coverage, unless the cost to the employee exceeded 5 percent of income. The program would have fallen short of achieving universal coverage.

Portability of coverage and continuity of care. Portability of coverage⁵ and continuity of care would have been improved for low-income people. Because coverage under the public programs

would have been extended higher up the income scale, fewer people would have faced frequent changes in their eligibility status with slight variations in their income. For most other people, portability would have remained essentially the same, with people switching health plans when they changed jobs. But no one could have been denied coverage in the individual or group markets (for firms with up to 100 employees), so anyone who lost coverage, for whatever reason, would have been able to get new coverage—although some would have been able to do so only through the high-risk pool.

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

Quality of care and effect on delivery system. The bill would have assigned 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 direct effect on the way physicians practice or on the extent to which the delivery system is more fully integrated. However, the development of performance measures, pay-for-performance mechanisms, and reporting of provider performance could have pressured providers whose performance fell outside of accepted standards to alter their practice behavior. Because the proposal would have extended 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 have been inadequate. Of course, the fact that many more low-income people would have had financial access to care probably would have improved the quality of care they received. They would have had a much better chance of establishing a “medical home,” a regular source for care and oversight of medical needs.

2. Cost and Efficiency

Resource cost. The plan would have extended coverage to many low-income people and some employed people and their families. Because insured people consume more services than uninsured people, more medical resources would have been used. The bill included some provisions designed to improve the cost-effectiveness of medical care.

Budgetary cost. The budgetary cost of the program was 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 earlier but similar proposal would have cost the state \$4.66 billion. This cost would, according to Gruber, have been more than offset by the \$5.04 billion of revenue from the fee assessment of 7.5 percent on Social Security wages of employers not offering coverage; the state would have realized a net savings of \$3.8 million. Substantially more people would have been eligible for coverage through the state’s high-risk pool.

The proposed legislation would have created significant state budgetary entitlements/commitments by expanding Medi-Cal and Healthy Families, including to some undocumented immigrants for whom the state would not have received matching federal funds. Longer-run

budget costs probably would have risen because health care costs are certain to rise, probably at a pace that exceeds growth in the economy as a whole. The bill appeared to address this contingency by giving MRMIB the authority to increase the required employer contribution for employers who chose to “pay” rather than “play.”

Cost containment. The proposal would have put in place a mechanism to comprehensively measure and report on performance of health plans, physicians, health facilities, and other providers and reward them for good performance. It would have encouraged an electronic personal health records system. MRMIB would have established efficiency and cost standards for participating health plans. The state would have developed best practices for treatment of expensive chronic conditions, representing the consensus of current thinking about how to approach the problem of containing costs.

Implementation and administration. Significant administrative change would have been required. MRMIB would have been responsible for establishing the new purchasing pool, developing health plan benefit structures, administering contracts with health insurers, and enrolling the families of employees working for firms that chose to pay rather than play. However, MRMIB already performs a number of similar functions for other programs administered by the agency. The state’s tax system would have had to enforce the collection of fees from non-offering employers, which would entail gathering data regarding their full-time and part-time workers and their total payroll. The state also would have had to enforce the requirement that the employees who work for those firms enroll in the purchasing pool and that other employees accept provider-sponsored coverage unless the cost is more than 5 percent of their income. This would not be a trivial administrative task. The state would have had to identify best practices for certain medical conditions, develop pay-for-performance standards, and collect and report on provider performance. Once the system was fully implemented, the administration of the program probably would not have been overly burdensome.

Although insurers and health plans would have been required to conform to certain new regulations, for the most part the regulatory changes would have been similar to the status quo. The exception was the proposed requirement for a minimum loss ratio.

Requiring employers to either offer coverage or pay a fee could have affected employee wages and employment levels: the larger the fee as a percentage of payroll, the larger the likely effects. Economists generally argue that employers eventually pass most of the cost of a new payroll assessment to employees in the form of lower wages. However, many of the employers that do not offer coverage and would have been 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 would have been equivalent to a 7.5 percent increase in wages. Because of the minimum wage constraints, some of these employers would not have been able to shift the costs back to employees in the form of lower wages or pass costs forward to customers. They might, therefore, hire fewer workers.

For the most part, the proposal did 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 would have been available to all lower-income children, including undocumented immigrants, and the size of the subsidy was related to family income. The cutoff point for eligibility was 300 percent of FPL, which is close to the median income in the state. Low-income adults also would have been eligible, but with two important exceptions: All undocumented immigrant adults and other adults without children were not covered. These exceptions violated the standard of equal treatment of equals (horizontal equity). The bill did not require employees to accept employer-sponsored coverage if the employee cost would have exceeded 5 percent of income; while this protected employees from bearing a burdensome cost, it did not ensure them coverage. Equity would have been better served by a mechanism that ensured everyone was covered but put a reasonable limit on employees' financial exposure by providing sliding scale subsidies (which would, of course, have been more costly to the state).

Financing. The source of state financing for the expansion of Medi-Cal and Healthy Families appeared to be the new payroll assessment on non-offering employers. This is a somewhat regressive form of financing.⁶ The fee probably would have been 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 was somewhat regressive compared with alternatives such as the state income tax. The fact that the fee applied only to income up to the Social Security limit in theory also made the fee less progressive than it would have been if it applied to all income without limits. However, since most higher-income employees probably already have employer-sponsored coverage and their employers would not have been subject to the assessment, this theoretical limitation may not have had much practical effect.

The requirement that all employers establish Section 125 plans allowing employees to pay for premiums with before-tax dollars probably would have benefited 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 Section 125 plans also shifted some of the cost to the federal government. The foregone federal revenue would have required more federal revenue, which, as noted, is collected from progressive taxes.

Sharing of risks. The proposal would have implemented several steps to broaden risk. Existing limits on carriers' ability to vary premiums based on risk and the current prohibition on denying coverage that applies to employers with 50 or fewer employees would have been extended to employers with up to 100 employees, and adjusted community rating would soon have been required. In essence, risks would have been 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 for other applicants, using only age and geography as risk factors, would have helped broaden sharing of risk. It is possible that these provisions could have caused some adverse selection against the individual market as a whole if

low-risk people experienced a substantial rate increase because of insurers' limited ability to vary rates based on health status, and therefore dropped out of the market.

4. Choice and Autonomy

Consumer choice of providers and health plans. The proposal apparently would have had little effect on consumer choice of providers.

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

Government compulsion/regulation. This approach involved a modest level of compulsion. Employers that continued to choose to not offer coverage would have been required to pay a fee and their employees would have been required to get coverage through the new purchasing pool. Employees whose firms offered coverage would have been required to accept it, provided the employee cost did not exceed 5 percent of income. Insurers would have had to change some of their underwriting and risk-rating policies, and some would have been forced to lower administrative costs and/or profit margins.

IV. Key Trade-Offs

This approach would have achieved substantial coverage expansion (perhaps covering 3.4 million out of 4.9 million uninsured), but it would have entailed a significant cost for the state (about \$4.66 billion). The cost would have been offset by an assessment on employers not offering coverage (generating \$5.04 billion), which would have compelled them to do what they would otherwise not do and is a somewhat regressive form of financing. Significantly more medical resources would have been consumed by the newly insured—although with no change in payment rates for providers serving public patients, the provider supply for public patients could have been inadequate. The reporting of provider performance probably would have had a positive effective on both costs and quality of care. Quality of care and portability would very likely have improved for those who were newly insured. The level of compulsion was modest; the administrative changes required for government would have been substantial but relatively modest for insurers; and the approach would not have been highly disruptive to present practices and organizational structures. Whether the provisions to contain costs would have proven sufficient to prevent longer-run cost escalation is uncertain.

¹ The Healthy Families Program is California's version of the State Children's Health Insurance Program (or 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 percent 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, 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 The state’s high-risk pool makes coverage available to people who have been turned down for 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 percent more expensive than standard coverage.

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.