

Framework Assessment of  
ABX1 1

(as Considered and Rejected  
by the Senate Health Committee  
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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/](http://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.

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

## II. Features of ABX1 1

**General approach.** This coverage expansion bill, along with the voter initiative that was to be submitted to the ballot in November 2008, has five major elements. It requires all Californians (with affordability-related exceptions) to acquire coverage; extends eligibility for Medi-Cal and Healthy Families<sup>1</sup> up the income scale along with tax credits for others; establishes a purchasing pool to serve as a source of cost-effective coverage for employees of firms who do not offer coverage and some others; revises insurance market rules; and requires employers who do not spend a minimum amount for coverage to pay a fee to the state.

**An individual mandate.** Most California residents would be required to maintain a minimum level of coverage, which would be set by Managed Risk Medical Insurance Board (MRMIB). Affordability exceptions would be granted to people at or below 250% of FPL if the cost of coverage exceeded 5% of income. MRMIB could also grant exemptions for individuals or families if complying with the mandate would create financial hardship. To enforce the mandate, MRMIB would automatically enroll and pay the premium for people who failed to enroll voluntarily, and the Franchise Tax Board would collect unpaid premiums from those people.

**Extending subsidized coverage.** Most people with incomes up to 400% of the federal poverty level (FPL) who do not have access to employer coverage would be eligible for some assistance in purchasing coverage.

All children, including undocumented immigrants, with family incomes up to 300% of FPL (approximately \$62,000 for a family of four)<sup>2</sup> would be eligible for Medi-Cal or Healthy Families. Parents in families with income up to 250% of the poverty level would be eligible for new Medi-Cal or Healthy Families plans available through the new Cal-CHIP purchasing pool (see below). Childless adults with incomes up to 100% of FPL (medically indigent) would be covered through Medicaid. Those with incomes between 100% and 250% of the poverty level who do not have access to job-based coverage would be covered through a plan available through the new purchasing pool, with benefits like those offered through Healthy Families. Households with income below 150% of FPL would pay no premiums or out-of-pocket costs for the benchmark plan; those between 150% and 250% of poverty would pay premiums not to exceed 5% of family income (with no protection for out-of-pocket costs).

Individuals in the income range between 250% to 400% of FPL who do not have access to employer-based coverage would be eligible for a tax credit. The credit would be applied to the cost of a specific benefit plan purchased from the pool to ensure that the cost of coverage did not exceed 5% of income. (If the employer coverage excludes dependents, a family could claim the credit for dependent coverage.) An additional tax credit for people age 50 to 64 was also referenced in the bill for possible enactment at a later time.

**A new purchasing pool.** MRMIB would establish a purchasing pool—CalCHIP—to provide both subsidized and unsubsidized coverage. The pool would negotiate contracts with health plans to provide several benefit plans. The pool's benefit plans would be available to workers whose employers choose to not provide coverage (paying a fee instead) and to workers who receive

coverage through a Section 125 plan to which their employer contributes nothing. The pool would also provide coverage for some parents and childless adults eligible for the public programs described above. The plans' benefits would have to meet Knox-Keene Act requirements plus prescription drugs, but MRMIB would have some latitude in defining cost sharing levels and other benefits. Plans with several different benefit levels would be offered, but one plan would be equal to the minimum required to comply with the mandate.

**Insurance market changes.** In the individual market, insurers would be required to offer coverage to all applicants on a guaranteed-issue basis (except those exempted from the mandate because of lack of affordability). Insurers could vary rates based on only age, geographic region, family size, but not on any health status measure (this rating provision would be phased in over five years.) People with individual insurance would be limited in their ability to switch to more comprehensive plans from year to year (to prevent adverse selection against comprehensive plans). MRMIB would also define five classes of benefit plans (including the Healthy Families and Medi-Cal benchmark plans) that insurers and health plans would make available. Exclusions or waiting periods for coverage of prior medical conditions would be prohibited. However, people currently enrolled in individual plans that do not meet the definition of minimum coverage would be considered meeting the mandate requirement for as long as they stayed in their current plan.

Mechanisms would be developed to ensure fair sharing of risk among individual-market insurers, perhaps including a risk-adjustment mechanism and reinsurance. Insurers in all markets would be required to have "loss ratios" no less than 85%; that is, the non-medical portion of the premium could not exceed 15%.

**An employer/employee "play or pay" requirement.** Under the provisions of the initiative that was to be a complement to this legislation, employers (except the self employed) would pay a fee that would vary by employer payroll: those with aggregate Social Security payroll less than \$250,000 would pay 1%; those with payroll between \$250,000 and \$1 million would pay 4%; those with payroll between \$1 million and \$15 million would pay 6%; and those with payroll more than \$15 million would pay 6.5%. All employers would be given a tax credit equal to the amount they spend for health care for their employees; this would apply against their payroll tax liability. Employers would be required to offer Section 125 "cafeteria" plans to allow their employees to set aside income that could be used to pay employees' premium contributions with pre-tax dollars; that is, the set aside money would not be counted as income for tax purposes, thereby making the net cost of coverage less costly for employees.

**Financing.** If approved through public referendum, the program would be financed by federal matching funds for Medi-Cal and Healthy Families, employer contributions from non-offering employers, a 4% assessment on non-Medicare hospital revenue, county contributions, and a tobacco tax of \$1.75 per pack. (Medi-Cal payments rates to hospitals would be raised.)

**Cost containment.** The bill establishes a Health Care Cost and Quality Transparency Commission and requires it to adopt a plan that would result in public reporting of safety, quality, and cost efficiency. The objective is to provide information that allows health care purchasers, consumers, and data sources to identify and compare health plans and insurers, individual health facilities, physicians, and other health care providers. The state would develop

provider performance benchmarks and use the benchmarks to establish a pay-for-performance system for state-administered health programs, and it would promote fitness, wellness, and health promotion activities. Insurers would be required to offer health plans that include incentives and rewards for enrollees to engage in behaviors and take actions to promote good health. Electronic health records and “e-prescribing” for pharmaceuticals would be encouraged.

### III. Assessment

#### 1. Coverage

**People covered.** According to an analysis by Jonathan Gruber, Ph.D., of MIT, the program would extend coverage to 3.6 million (70%) of those who are now uninsured, leaving 1.5 million uninsured. It thus would be a substantial step toward achieving universal coverage.

**Portability of coverage and continuity of care.** Portability of coverage<sup>3</sup> 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 people could not be denied coverage in the individual market (except those exempted from the mandate) or the group market, so nearly 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 could choose from several plans that would probably be relatively comprehensive in terms of covered services but would likely 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. The development of performance measures, pay-for-performance mechanisms, and reporting of provider performance could reasonably be expected to put pressure on providers whose performance falls outside of accepted standards to alter their practice behavior. 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 about 70% of the uninsured, 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 would be high because of the substantial expansion of Medi-Cal and Healthy Families, the subsidies in the form of premium assistance and tax credits, and some loss of state tax revenue.

The bill would create significant new state budgetary entitlements/ commitments by expanding Medi-Cal and Healthy Families and by offering tax credits. Longer-run budget costs would be 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.

**Cost containment.** The proposal would put in place a mechanism to comprehensively measure and report on performance of health plans, physicians, health facilities, and other providers and to reward them for good performance. It would encourage an electronic personal health records system. These are steps consistent with current thinking by many experts about how to approach the problem of containing costs.

**Implementation and administration.** The amount of administrative change that would be required is substantial. MRMIB would be responsible for establishing the new purchasing pool, developing various health plan benefit structures, administering contracts with health insurers, and enrolling both subsidized and non-subsidized applicants for coverage. However, MRMIB already performs similar functions for other programs that the agency administers. The state's tax system would have to enforce 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 individual mandate by collecting premiums from non-compliers. 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, but it would add substantially to the scope of administrative tasks.

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 such 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 over time would pass back most of the costs to employees in the form of lower wages. However, many employers that do not offer coverage and would thus be required to pay the fee are lower-wage employers. But the proposal would vary the fee requirement depending on the size of the firm's payroll. So smaller firms, which are more likely to be lower-wage firms and more economically vulnerable would face a smaller burden (which would likely cause most of them to choose to "pay" rather than "play.") Because of minimum wage laws, 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.

The proposal does make major departures from the status quo, but most of the present institutions in the health care system would operate in a way similar to the present.

### 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 most lower-income people, including undocumented immigrant children, and the size of the subsidy is related to family income. The cutoff point for eligibility is 300% of FPL for public programs, which is close to the median income in the state. Low-income adults without children are also eligible. Others up to 400% of the poverty level could receive tax credits to relieve the financial burden of buying coverage. The financial obligation to pay for coverage varies with income and for lower- to middle-income people would be limited to no more than 5% of income. On the other hand, substantial numbers of people would remain uncovered because the mandate would not apply to them because the cost of coverage would exceed 5% of income. And because out-of-pocket expenses are not included under the 5% income cap for those with incomes between 150% and 250% of FPL, some lower-income people still might experience financial hardship. Part-time and low-wage employees who are eligible for employer-sponsored coverage could be excluded from pool-based coverage or tax credits, which could create hardships for those with low income and low employer contributions.

**Financing.** One source of state financing for the expansion is the new payroll assessment on non-offering employers. In general, payroll-based fees are a regressive form of financing. The fee would probably be shifted back to employees over time as lower wages or reduced compensation of other types. Since most non-offering employers are probably lower-wage employers, this fee is somewhat regressive compared to some other alternatives, such as the state income tax. However, this regressivity is substantially moderated by the provision that graduates the tax depending on employer payroll size with small employers paying only 1% of payroll. Another source of revenue, a tobacco tax, is regressive for smokers, since the tax represents a higher proportion of income for lower-income smokers than for higher-income smokers. Of course, anyone can avoid the tax entirely by not smoking and not using other tobacco products. The tax on hospitals would ultimately be passed back to public and private insurers and so have the same equity effects as the financing systems for those programs. The portion of the funding coming from federal sources is generally raised through moderately progressive taxes.

**Sharing of risks.** The proposal would implement several major steps to broaden risk. In the individual market, the requirement that all insurers provide coverage on a guaranteed-issue basis to nearly all applicants, using only age and geography as risk factors, substantially helps to broaden sharing of risk in the individual market. The implementation of a risk-adjustment mechanism or a reinsurance system would help to further broaden risk. Because most people are required to buy coverage, people cannot wait to buy coverage until they anticipate needing expensive medical care, eliminating the unfairness that occurs when such people do not contribute to the insurance pool when they are healthy and thus do not pay their fair share of the insurance bill. The fact that most people are required to have coverage also reduces the problem of “freeriders,” people who fail to buy coverage and then incur very high medical expenses that become uncompensated care, the cost of which is then passed on to the people who do buy coverage.

#### 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 five classes of benefit plans identified by MRMIB 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/regulation.** This approach involves a significant level of compulsion. Residents would be required to maintain coverage. 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.

## IV. Key Trade-Offs

This approach would substantially expand coverage, but it would entail a significant budgetary cost for the state. The cost would be offset by an assessment on employers, a tobacco tax, and a tax on hospital revenues; the first two are somewhat regressive<sup>4</sup> in their impact. Significantly more medical resources would be consumed by the newly insured. Positive effects on quality of care and portability are likely because many more people would have coverage and the access to services that that makes possible. In general, the level of compulsion is substantial for consumers, employers, and health plans. The administrative changes for government would be significant but relatively modest for insurers; and the approach, while bringing significant change, would not be highly disruptive to present practices and organizational structures. Whether the provisions to contain costs would prove sufficient to prevent longer-run cost escalation is uncertain.

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<sup>1</sup> The Healthy Families Program is California's version of the State Children's Health Insurance Program (or SCHIP), funded jointly by 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.

<sup>2</sup> 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. Department of Health and Human Services defines FPL for a family of four as \$20,650.

<sup>3</sup> "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.

<sup>4</sup> 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.