

Framework Assessment of ABX1 1 (Núñez/Perata)

November 2007

Prepared for the
California HealthCare Foundation

Prepared by
Elliot Wicks, Ph.D.
Health Management Associates

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 ABX1 1 (Núñez/Perata)

Assembly Speaker Fabian Núñez and Senate President Pro Tem Don Perata introduced this bill September 11, 2007, as an amended version of AB 8 (vetoed by Governor Schwarzenegger in October).¹

General approach. This proposal has five major elements: requiring all Californians (with some affordability-related exceptions) to acquire coverage, extending eligibility for Medi-Cal and Healthy Families² up the income scale and offering tax credits to others, requiring employers who do not meet a spending minimum for 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 and some others.

An individual mandate. Most California residents would be required to maintain a minimum level of coverage, which would be set by the Managed Risk Medical Insurance Board (MRMIB).³ Affordability exceptions would be granted if the cost of minimum coverage exceeds 6.5 percent of family income or if paying for coverage would create severe financial hardship.

Extending coverage for public programs. 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 four⁴—would be eligible for Medi-Cal or Healthy Families. Parents of these children would be eligible for new Medi-Cal or Healthy Families plans available through the new Cal-CHIP, the California Cooperative Health Insurance Purchasing Program (see below). Single adults with incomes up to 250 percent of FPL, considered medically indigent, would be covered through Medicaid. Individuals earning 250 to 450 percent of FPL would be eligible for tax subsidies. Households with income below 150 percent of FPL would pay no premiums; those between 150 percent and 300 percent of FPL would pay income-graduated premiums. Families eligible for either of the public programs who are also eligible for employer-sponsored coverage would be enrolled in a Cal-CHIP plan with coverage comparable to Medi-Cal or Healthy Families. Proponents envision a mechanism for firms to contribute to the cost of the benchmark plan in lieu of contributions to employer-sponsored plans.

An employer/employee “play or pay” requirement. Employers that choose to not offer coverage or fail to spend a specified amount for coverage would pay a fee. The fee or required amount would vary by employer payroll: Those with an aggregate Social Security payroll of more than \$250,000 would pay 6.5 percent; those with a payroll between \$100,000 and \$250,000 would pay 4 percent; and those with a payroll less than \$100,000 would pay 2 percent.

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 risk-rating factors to consider along with variations for family size and benefit structure. These restrictions would be extended to firms with up to 100 employees. Insurers would be required to maintain a minimum medical loss ratio—the proportion of premiums spent on health care services—of 85 percent.

In the individual market, insurers would be required to offer coverage to all applicants on a guaranteed-issue basis and could vary rates based on only 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 be limited to prevent adverse selection against comprehensive plans. MRMIB would define five classes of benefit plans, including the Healthy Families and Medi-Cal benchmark plans, that insurers would make available.

A new purchasing pool. MRMIB would establish a purchasing pool—CalCHIPP—to negotiate with health plans and insurers to provide a cost-effective source of coverage for families of workers whose employers choose to not offer coverage and for families who are eligible for Medi-Cal and Healthy Families and are offered employer coverage. Insurers and health plans with a million or more California enrollees would be required to offer a good-faith bid to MRMIB to offer coverage.

Financing. The program would be financed by federal matching funds for Medi-Cal and Healthy Families, employer contributions from non-offering employers, a 4 percent assessment on non-Medicare hospital revenue, and a tobacco tax of \$2 per pack; the latter two sources would require approval through referendum. Medi-Cal payment rates to hospitals would be raised.

Cost containment. The bill would establish a Health Care Cost and Quality Transparency Commission and require it to adopt a plan for 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, health facilities, physicians, and other health care providers. The commission would measure the following “performance domains”: safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness. The state would develop provider performance benchmarks and use them to establish a pay-for-performance system for all state-administered health programs, and it would promote fitness, wellness, and health promotion activities.

III. Assessment

1. Coverage

People covered. Preliminary estimates show this approach would cover approximately two-thirds of uninsured individuals if the individual mandate is effectively enforced. Some people would be exempted if the financial burden of buying coverage was too great, as would select groups such as those on Medicare or with military health coverage.

Portability of coverage and continuity of care. Portability of coverage⁵ and continuity of care would be improved for low-income people. Because coverage under the public programs would be extended higher up the income scale, fewer people would be faced with frequent changes in their eligibility status with slight variations in income. For most other people, portability would remain essentially the same, with people switching 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 100

employees), so anyone who lost coverage, for whatever reason, would be able to get new coverage.

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 probably would be relatively comprehensive in terms of covered services but would most 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 pressure providers whose performance falls outside of accepted standards to alter their practice behavior. The fact that many more low-income people would have financial access to care should improve the quality of care they receive. They would have 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. Because the plan would extend coverage to most of the uninsured, more medical resources would be used, since insured people consume more medical services than uninsured people. The bill includes some provisions designed to improve the cost-effectiveness of medical care.

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 proposed legislation 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 probably 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 establish 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. MRMIB would establish efficiency and cost standards for participating health plans. The state would develop 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. Substantial administrative change would be required. MRMIB would be responsible for establishing the purchasing pool, developing health plan benefit structures, administering contracts with health insurers, and enrolling the families of employees who work for firms that choose to pay rather than play. However, MRMIB already performs similar functions for other programs administered by the agency. The state’s tax system would have 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 to enforce the individual mandate, imposing a penalty on 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 probably would 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 the status quo. The exception is the new requirement for a minimum loss ratio.

Requiring employers to either offer coverage or pay a fee could affect 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 thus be required to pay the fee are lower-wage employers. Because the proposal would vary the fee depending on the size of the firm's payroll, smaller firms, which are more likely to be lower-wage firms and more economically vulnerable, would face a smaller burden and most would probably 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 wages or 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 high marks. Access to subsidized public programs would be available to all lower-income people, including undocumented immigrants, and the subsidy size is related to family income. The cutoff point for eligibility is 300 percent of FPL for public programs, which is close to the median income in the state. Low-income adults also would be eligible. Others up to 450 percent of FPL could receive tax credits to relieve the financial burden of buying coverage. The financial obligation to pay for coverage varies with income.

Financing. One source of state financing for the expansion is the proposed payroll assessment on non-offering employers. Payroll-based fees are generally a regressive form of financing.⁶ The fee probably would 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 with alternatives such as the state income tax. However, the regressive impact is substantially moderated by the provision that permits employers with lower aggregate payrolls to pay a smaller percentage 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—though anyone could avoid the tax by not smoking or by using other tobacco products. The tax on hospitals ultimately would be passed back to public and private insurers and so have the same equity effects as the financing systems for those programs.

Sharing of risks. The proposal would implement several major 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 be extended to employers with up to 100 employees, and adjusted community rating would soon be required in this market. 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 requirement that all insurers provide coverage to all applicants, using only age and geography as risk factors, would substantially help broaden sharing of risk. The fact that everyone would be required to have coverage eliminates the problem of "free riders," people who fail to buy coverage and then incur very high uncompensated medical expenses that ultimately are paid by 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, with one exception: 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. All 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 cover approximately two-thirds of the state's uninsured, but it would entail a significant cost for the state. The cost would be offset by an assessment on employers, a tobacco tax, and a tax on hospital revenue; the first two would be somewhat regressive in their impact. Significantly more medical resources would be consumed by the newly insured. Because virtually everyone would have coverage and access to services, quality of care and portability of care would probably improve. 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.

¹ This analysis is based on the elements outlined in the document “Speaker/Pro Tem Compromise Proposal” issued by Senator Perata’s office.

http://dist09.casen.govoffice.com/index.asp?Type=B_PR&SEC={42B6205A-0002-4B2A-8F1D-300E16EEBB0E}&DE={C114EBD4-D6EF-4408-8939-B7769BDADDB6}

² 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 incomes up to 250 percent of FPL.

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 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.

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.