San Diego County Taxpayers Association

Targeting Waste • Promoting Efficiency

110 West C Street, Suite 714, San Diego, CA 92101
P: (619) 234-6423 • F: (619) 234-7403 • www.sdcta.org

Assembly Bill 1X 1: The Health Care Security and Cost Reduction Act

- **Introduced by Senator Perata (D – Oakland) and Assemblyman Nunez (D-46th District)**

Proposal Summary:

The proposed health care reform in AB X1 1 shares some characteristics found in 2007's AB 8,[1] most notably a "pay or play" funding mechanism imposed upon employers throughout the state and an extension of Medi-Cal and Healthy Families eligibility for individuals. While the required monetary contribution of employers differs from that of AB 8, the core principles behind any "pay or play" mechanism remain. Additionally, the proposal creates the CalCHIPP purchasing pool for workers whose employers choose to pay a percentage of total wages into the state pool rather than offer their employees health coverage.

New features to the legislation include an individual mandate on California residents and small group health insurance market reforms. The individual mandate ensures that all individuals maintain at least a minimum level of coverage set by the Managed Risk Medical Insurance Board (MRMIB), and would grant exceptions to individuals on the basis of affordability. Specifically, individuals would be exempt from the mandate if the "cost of minimum coverage exceeds 5 percent of family income or if paying for coverage would create severe financial hardship."[2]

The reforms to the insurance market specifically target small groups (defined as employees of firms with less than 100 employees) in that insurance companies' ability to charge individuals coverage rates in accordance with risk status is significantly diminished. The bill requires insurance companies to offer coverage to individuals employed by firms with 100 or less employees on a "guaranteed-issue basis," and allows insurance companies to determine rates according to only age and geography as risk factors, along with family size and level of benefits. (Currently, these restrictions apply to companies with 50 employees or less.)

Another major portion of the bill extends coverage through public programs Medi-Cal and Healthy Families (HFP) up the income scale. All children, including undocumented immigrants, of families at or below 250% of the federal poverty level (FPL) are covered under (HFP) and partially subsidized eligibility is extended to those up to 300% FPL. Single adults with incomes up to 250% FPL are covered under Medi-Cal and adults up to 450% FPL receive tax subsidies for the purchase of health insurance.

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[1] See SDCTA analysis of AB 8 at http://www.sdcta.org

[2] Wicks, Elliot. "Framework Assessment of ABX1 1 (Nunez/Perata)." Health Management Associates: Prepared for the California HealthCare Foundation, November 2007.

Table 1: AB X1 1 Coverage Expansions			
Group	**Income Group**	**Income**	**Program**
Children (family of 4)	0 - 250% FPL	$51,652	Healthy Families (HFP)
	0 - 300% FPL	$61,950	Premium-Capped HFP
Adults (family of 4)	0 - 100% FPL	$20,650	Medi-Cal
	101 - 250% FPL	$51,625*	Cal-CHIPP Healthy Families Plan
Childless Adults	0 - 250% FPL	$25,525*	Cal-CHIPP Healthy Families Plan
	0 - 400% FPL	$40,840	Receive Tax subsidies

*No premium contribution for adults 150 FPL and below. Premiums not to exceed 5% of income for adults 151-300% FPL.

Sources: Department of Helath and Human Services (www.hhs.gov) and Footnotes 2 and 5

Insurance Market and Business Effects:

AB X1 1 causes a significant effect on the insurance market because the firm size by which small groups are defined is expanded, and the relevant rating provisions imposed on insurance companies correspondingly apply to a greater number of individuals. Specifically, the insurance market rating restrictions concerning small firms apply to firms with 100 workers or less under AB X1 1, as opposed to the current rating restrictions that only apply to firms with 50 or less employees.

The change in the classification of small groups is significant due to the effects of guaranteed issue and restrictive risk rating provisions. As Kosali Simon shows, various levels of small group market reforms passed in 47 states in the 1990's that reduced the ability of insurance companies to charge premiums in accordance with customers' risk factors failed to increase the overall rates of coverage (their stated goal).[3] The more stringent reforms, specifically guaranteed issue, caused increases in premium prices for small firms, while overall employer rates of coverage for small group employees decreased by less than 2%. These findings are directly applicable to the insurance market reforms proposed in AB X1 1 because they clearly display the failure of restricting insurers' risk rating capabilities in increasing coverage rates. However, the imposition of an individual mandate adds a level of complexity not present in the reforms examined by Simon; further analysis is provided below.

AB X1 1's imposition of a sliding scale "pay or play" mechanism connects the size of the CalCHIPP insurance pool with the individual mandate and insurance market effects described above. The sliding scale calls for firms with annual payrolls of less than $250,000 to contribute 1% of payrolls to CalCHIPP if they do not offer employees coverage. Subsequently, firms with payrolls between $250,000 and $1 million are required to contribute 4% of S.S. wages, firms

[3] Simon, Kosali. "Adverse selection in health insurance markets? Evidence from state small-group health insurance reforms." Journal of Public Economics. Volume 89, Issues 9-10, September 2005.

with payrolls between $1million and $15 million contribute 6%, and firms with payrolls greater than $15 million are required to contribute 6.5%.

Table 2: Distribution of CA Employees by Firm Size and Corresponding Firm Incurred Costs[4]

Firm Size	0 to 4	5 to 9	10 to 19	20 to 49	50 to 99	100 to 249	250 to 499	500 to 999	1000 +
Number of Businesses	856,879	159,167	109,258	84,071	31,919	17,286	4,177	1,622	889
Avg. annunal payroll per business (in thousands):	48.44	248.70	524.35	1223.13	2934.94	6753.44	17283.59	37846.77	151302.83
Percent of CA Employees	13.64%		9.50%	46.94%			29.96%		
Required Fee	1%		4%	6%			6.5%		
Average Required Firm Expenditure	484	2,487	20,974	73,388	176,096	405,206	1,123,433	2,460,040	9,834,684

As Table 2 displays, on average, firms will be required to spend at least the amount given in the last row on employee health coverage *in addition* to their expenditures on payroll.

The impact on businesses is analagous to an increase in real wages. Firms not already offering coverage will be forced to lower wages (highly unlikely in the short-run due to "sticky wages," although the stagnation of wage growth may occur in the long run, effectively reducing wages), cut back on production, or hire fewer workers. An increase in unemployment will occur across all sizes of firms, although as the Wicks analysis explains, firms employing workers earning lower wages will be the least able to pass on these additional costs due to the imposition of minimum wage, and will be forced to employ fewer workers, even in the long run.

The labor market ramifications discussed directly above also impact the individual and small group market insurance markets discussed earlier. The combination of the additional stringency of expanded guaranteed issue requirements in the small group market with guaranteed issue requirements in the individual market result in increased average premium prices in these two sectors of the private insurance market. The net effect is an increased number of individuals forced to purchase health coverage at increased prices.

The exemption to the coverage mandate under AB X1 1 applies to individuals and families whose incomes are 250% FPL and below where the minimum mandated level of coverage exceeds 5% of income. As premium prices continue to increase, the number of individuals exempt from the mandate correspondingly grows as coverage premiums represent a greater proportion of incomes (certainly an unintended consequence).

Table 3: Point of Exemption from Mandate (250% FPL and below)

	Annual Cost	Monthly Cost
Individual	1276	106
Family	2582	215

[4] Employment Development Department, Labor Market Information Division. Payrolls extrapolated from 2006 Q3 data. http://www.labormarketinfo.edd.ca.gov/

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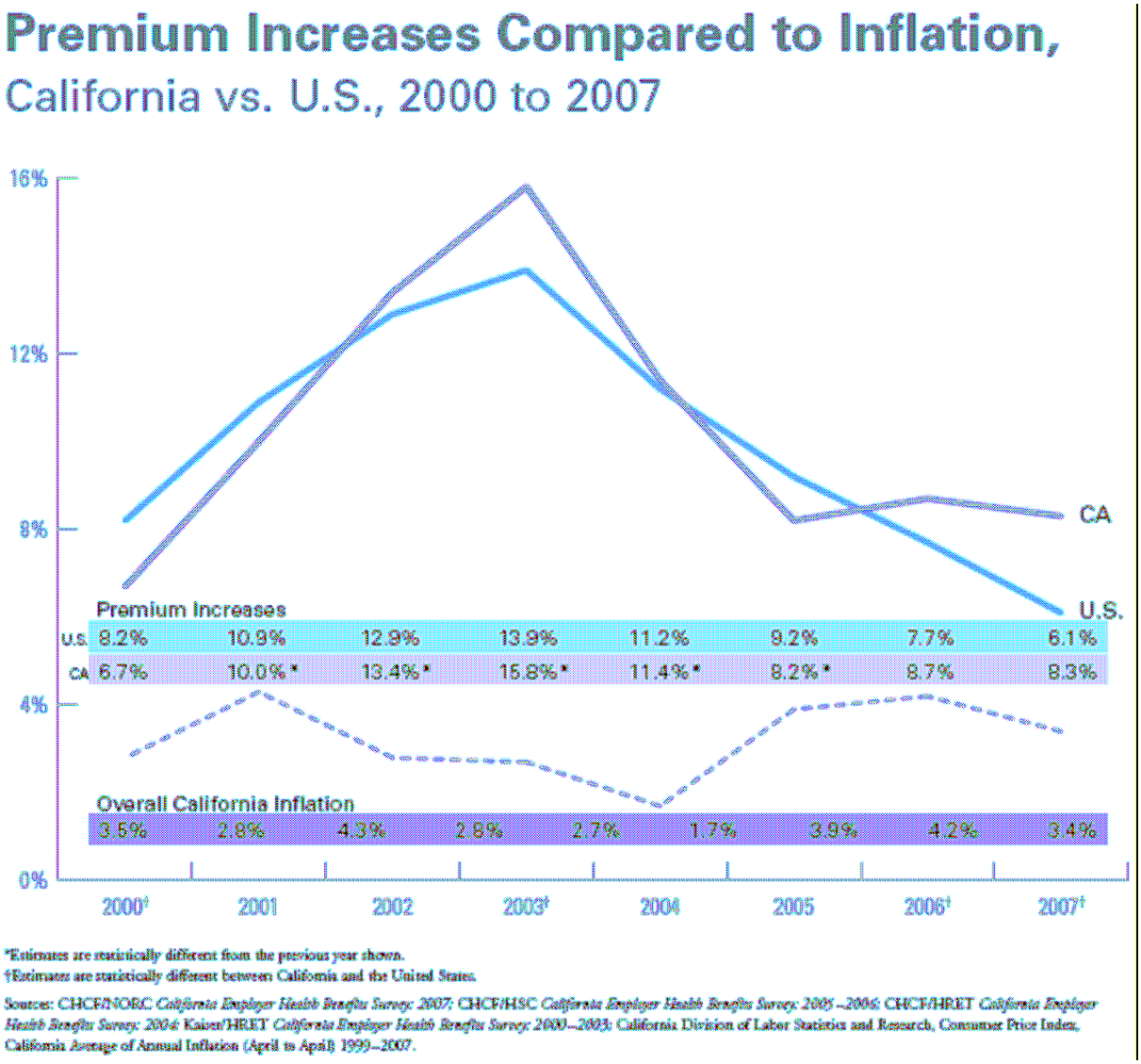
Table 4: Average Premiums in California, 2007		
	Annual Cost	Monthly Cost
Individual	4488	374
Family	12300	1025



Source: California Healthcare Foundation. http://www.chcf.org

The graph above shows the rate at which premiums have been increasing since 2000 in both California and the United States. The rates of premium increases are considerably higher than those of inflation; as an example, Californians experienced a 5.9% real increase in premiums from 2006 to 2007.

The market effects of AB X1 1 are summarized below:

- An increased number of low income individuals whose coverage is paid for entirely by the state, as well as an increased number of individuals in a slightly better position who receive state subsidies. This cost to the state is somewhat offset by federal matching funds.[5]
- Increases in health insurance premium prices. The bill places no cap on minimum premium prices in nominal terms or as an indexed income proportion. Therefore, upward pressure is put on prices in the private market due to increased rating reform stringency placed on insurance companies and increased demand for health coverage due to the imposition of the individual mandate. These effects are directly attributable to the proposal, and combine with the current trend of rising premium prices shown on the previous page to yield the strong conclusion that the price of health insurance premiums will significantly increase in the private market.
    - As prices rise, the number of individuals exempted from the mandate also rises, reducing the number of insureds in the individual and small group private markets.
    - The CalCHIPP pool is a substitute for the private coverage. As the price of coverage rises as described above, firms will substitute towards the cheaper of their options: the "pay" portion of "pay or play." This increases the size of the CalCHIPP pool, causing a corresponding increase in the liklihood of underfunding.

The CalCHIPP Perpetual Motion/Crowding-Out Insurance Machine (Revisited)

Recalling the vicious cycle effects discussed with AB 8's CalCHIPP insurance pool yields a similar forecasted result for AB X1 1. As coverage in the private market becomes more expensive due to increased average prices resulting from reducing insurers' ability to vary rates according to risk, an increased number of individuals will be exempt at the low end of the income scale, while the number of firms choosing to pay into the CalCHIPP fund rather than pay increasing private market coverage costs will correspondingly increase. As this occurs, the number of CalCHIPP enrollees increases, as does the risk of underfunding. As a result of underfunding, the pool can increase its revenue by increasing fees to employers or can underpay providers, causing further cost increases in the private market. Essentially, if underfunded, the state administered CalCHIPP pool causes crowding-out of the private insurance market, and increases the state's bills due to health coverage provision.

AB X1 1 through the Lens of the SDCTA Principles

- **Principle 1: Access to Quality Healthcare for All Californians**

  The SDCTA principles support the individual mandate concept present in AB X1 1; however, the mandate's effectiveness in terms of coverage expansion is highly likely to be exaggerated. Preliminary estimates show that the mandate will cover two-thirds of

[5] Floor Analysis, California State Assembly, December 17, 2007.

California's uninsured population. The potential pitfall of this estimate involves the low to moderate income scale of individuals. As average premium prices rise, the number of individuals exempt from the mandate increases. These individuals either remain uninsured, become newly uninsureds, or are enrolled in MediCal.

- **Principle 2: Minimize Costs to Taxpayers**

This principle focuses on the tendency of government-run insurance pools to underpay providers for services. AB X1 1 does include provisions that increase the rates of payment by MediCal. The newly created problem in AB X1 1 is the potential for the CalCHIPP pool to become underfunded and consequently forced to underpay providers for services rendered or increase employer fees to pay its bills. If underfunding occurrs, CalCHIPP may begin to crowd-out the private insurance market in a vicious cycle of underpayment and balooning enrollment, or it can continually increase its revenues collected from businesses by increasing the required payroll percentage contributions.

Many groups opposed to AB X1 1 cite the lack of appropriate funding as reason for their opposition. The cost of the proposal is estimated at $14 billion, funded in the manner shown below[6]:

Employer Fee of 1 to 6.5%	$2.6 billion
Tobacco Tax (up to $2 per pack)	$1.5 billion
Hospital Fee of 4% net patient revenues	$2.3 billion
County share of cost	$1.0 billion
Employee contributions	$2.1 billion
Federal Fund Participation	$4.6 billion
Total	**$14.1 billion**

Among the funding schemes, the tobacco tax has been frequently cited as a declining source of revenue likely to underfund the mandate.[7]

- **Principle 3: Preserve a Market-based Health Care System**

Two market-based issues caused by AB X1 1 include:

- The crowding out of private insurance caused by a large government run pool.
- The unintended increase in individual and private market insurance costs due to adverse selection resulting from guaranteed issue and risk rating restrictions on insurers.

As inurance companies' ability to charge consumers premium prices in accordance with their risk status is diminished, the average premium price in the private insurance markets increase. This has the effect of increasing currently insured individuals' premiums, and when combined with the imposed mandate, removes the individuals' ability to drop

[6] San Diego Regional Chamber of Commerce Joint Legislative Committee & Health Care Reform Task Force Agenda.
[7] Californians Against More Deficit Spending; SDCTA Prop 86 Analysis

coverage. The net effect on current private market insureds is an increase in rates or a decline in coverage. Additionally, as rating restrictions increase the market price of private coverage, an increasing number of individuals are exempted from the mandate as premiums increase above 5% of their incomes.

- **Principle 4: Incentivize Appropriate and Cost-Effective Consumption of Medical Services**

  If AB X1 1 descreses the uninsured population by two-thirds, it provides a clear benefit by reducing the occurrence of defacto emergency room universal insurance. AB X1 1 also includes "pay for performance measures" as a means of incentivizing appropriate and cost effective medical processes.

  As the Wicks analysis discusses, under the proposal, the state would develop "pay-for-performance" and best practices for "various medical conditions." These standards provide incentive driven pressure to providers "whose performance falls outside of accepted standards to alter their practice behavior."

- **Principle 5: Incentivize Preventative Care and Healthy Lifestyles**

  AB X1 1 includes incentives for healthy living in the form of "Healthy Action Incentives and Reward Programs." The legislative language requires these plans to "include any of a series of specified incentives or rewards for enrollees and insured persons to become more engaged in their health care and to make appropriate choices that support good health."[8]

- **Principle 6: Create a Fair and Equitable System**

  AB X1 1 is the authors' response to the Governor's veto of AB 8. Specifically, AB X1 1 reduces the burden on employers to pay for the program by creating the 1%-6.5% sliding scale pay or play requirement as opposed to the 7.5% requirement for all businesses present in AB 8. Fees on hospitals have been added to this legislation, as well as revenues from an additional tobacco tax, and the imposition of an individual mandate has also been added in an attempt to force lower-risk individuals who would otherwise be priced-out of the market to maintain coverage, resulting in a reduction of cost shifting.

[8] San Diego Regional Chamber of Commerce Joint Legislative Committee & Health Care Reform Task Force Agenda.