

**SUMMARY:** The Legislative Analyst's Office has verified the ability for health reform, as proposed in AB x1 1, to pencil out for five years without any impact on the general fund.

While the LAO appropriately attempts to quantify the downside risk, it overstates that risk--in some areas significantly. In addition, the LAO acknowledges but does not seek to quantify the upside potential of the reform, including cost containment elements.

The analysis does not include a full assessment of the legislative oversight, administrative oversight, and general fund protections built into the proposal.

The analysis does not do the most crucial analysis of all—the comparison of the proposal with the status quo, and the downside risk, both financial and human, of leaving the current health system in place.

**LAO: AB X1 1 ADDS UP:** The LAO analysis found that assuming a starting baseline cost for health coverage (of \$250 per month per person), the health reform proposal pencils out for at least five years without general fund impacts.

\* **HIGH END ESTIMATES OF SPENDING OVERLOOKED:** The modeling provided by the proponents assumes 95% enrollment in public programs and tax subsidies in early years of the program as well as maximum crowdout of employer spending. Neither is likely so spending is over-estimated.

**DOWNSIDE RISKS OVERSTATED:** The LAO overstates some of the downside risks, particularly with the baseline premium assumption, the availability of federal funds, and the estimate of the uninsured.

\* **BASE PREMIUM ASSUMPTIONS IN LINE WITH PUBLIC PROGRAM**

**EXPERIENCE:** The \$250 per member per month premium baseline is significantly higher than California's current public programs, including Medi-Cal or Healthy Families, even taking into account significant provider rate increases.

\* **FEDERAL FUNDS AVAILABLE:** Every dollar of federal funds is based on a program element that is in place in other states. For example, 20 states have hospital provider fees and thirty states, including California, have nursing home provider fees.

**LEGISLATIVE OVERSIGHT PROTECTS THE GENERAL FUND:** The proposal includes ample legislative oversight, including recurrent appropriation authority plus an innovative approach that requires the Department of Finance and the Legislature to project spending and revenues three years out.

**UPSIDES NOT CONSIDERED:** Unlike the presidential candidates, the LAO does not book savings from cost containment measures. The report also overlooks positive economic impacts of \$4.4 billion in federal spending and enhanced productivity.

**RISK OF INACTION:** Failing to act also has significant budget risks. More uninsured means more general fund costs.

## **LAO AGREES THAT AB x1 1 ADDS UP**

The LAO analysis found that assuming a starting baseline cost for health coverage (of \$250 per month per person), the health reform proposal pencils out for at least five years without ever using general fund dollars.

- In comparison, the original projections of the Massachusetts proposal was only projected to be balanced for the first two years, and claimed general fund dollars in the first year. In contrast, the design of this proposal is not to have a general fund impact.
- Also unlike Massachusetts, this reform relies on a diverse mix of financing, from at least seven different funding sources, which in itself provides some stability.

## **The Plan Adds Up Despite Aggressive Assumptions on Enrollment, Crowd-Out**

The Legislative Analyst takes at face value the projections of enrollment in the purchasing pool and public programs but these were deliberately modeled at the high end in order to produce a cautious estimate.

- The Gruber modeling that serves as the basis for the analysis assumes full enrollment in public programs and tax subsidy in year three. This would be a far faster phase-in than either Medi-Cal or Healthy Families, and very few public programs ever reach 95%, even after many years of operation. This means that spending on coverage expansions and the tax credit are likely to be substantially lower in the first few years and even in later years.
- The modeling also assumes an upper bar for crowd-out: that is, the modeling maximizes the number of low wage employers not currently offering coverage which are projected to choose the purchasing pool. This will happen over time, generating larger surpluses in the early years of the program.
- These factors would create savings in the early years of the program, suggesting that the program could go longer than five years, without adjustments, and still have the general fund protected.

## **DOWNSIDE RISKS OF AB x1 1 OVERSTATED SIGNIFICANTLY BY LAO**

As is its duty, the LAO does raise questions about some assumptions of the proposal, from the premium rate to the ability to draw down federal funds. As is its job, the LAO appropriately identified the areas where there is "risk" that the costs may be higher than anticipated: these include that the cost of care or coverage is more than expected, or rises more than expected; if we find that there are more uninsured than estimated; and if there's a major cut in federal funds (although the LAO acknowledges that of those booked in the proposal, "most federal funds are accessible under existing rules.")

## **Base Premium Assumptions Fully In Line With Public Program Experience:**

According to the LAO Analysis, if the state's new purchasing pool was able to negotiate a starting cost of \$250 per month for premiums, the health reform effort would be fairly balanced and be financed for at least five years, without impacting the general fund. If the state, however, missed that target and negotiated a \$300 per month cost, then by year five of the reform effort would cost \$1.5 billion more than it took in annually.

The \$250 per month figure seems more than attainable, even high, based on the California's experiences with public program coverage to date. The current negotiated rate for Medi-Cal is \$103 per member per month. **The proponents increased the Medi-Cal rate to \$187/month to account for higher provider reimbursement rates, and then added another 30%. Healthy Families, a program that MRMIB has already successfully negotiated contracts for, is able to buy coverage for only 10% above Medi-Cal.** If anything, California's experience suggests that we can drive a better deal than \$250 per member per month.

The LAO uses employer-based coverage as a point of comparison. Is this a fair basis? Would a purchasing pool with 2.5 million enrollees have more bargaining power than employers with 20 or 50 or even 1,000 employees? **The purchasing pool would have more bargaining power than any single employer in California.** A better comparison is with public programs like Healthy Families or Medicare. The rate of increase for Healthy Families, Medicare and other public programs is significantly lower than the rate of increase for commercial coverage, whether employer-based or individually purchased.

Other proponents also note that the **state's new purchasing pool would be covering a younger, healthier (read: less expensive) population overall and would be twice the size of CalPERS' negotiating pool**, which must leverage on behalf of older, sicker workers and retirees, making costs higher.

In committee, the LAO was asked why a comparison to public programs was not appropriate. Their answer was that the pool would need to negotiate a Knox/Keene benefits package. **Both Medi-Cal managed care and Healthy Families provide at a minimum the basic Knox/Keene plan (doctors, hospitals, and preventive services) plus prescription drugs.**

**Finally, health plans have said they can do it.** In committee, the Local Initiatives, which would be included as an option in the purchasing pool, testified that they could provide coverage to this population at \$250 per member per month. We understand that since the LAO raised this concern, some health plans have done their own modeling, and believe that if they can negotiate Medicare-level rates with providers (which virtually all providers now take), they could meet the \$250 per member per month target.

## **Federal Funds Largely Secure: Risks Overstated**

Analyst Elizabeth Hill said she believed that while **most of the federal funds were attainable through existing rules**, she stated that about a quarter -- \$1.1 billion of \$4.4

billion in federal funding--was subject to risk. This definition of risk assumes that the federal government will deny California the same approvals that many other states have received.

**Most of the federal funding is dictated by formulas that require the government to match the state's investment into Medi-Cal and Healthy Families: the federal government literally has no choice but to match California's spending unless basic Medicaid law dating back to the creation of the program in 1965 is changed.**

Some of the federal spending also depends on California's ability to obtain a waiver from the federal government that would allow for the state to cover low-income adults without children living at home. A number of states already have received waivers from the federal government to cover childless adults.

California has existing provider fees on nursing homes, ICFs, and other Medi-Cal providers. Twenty states have hospital provider fees and thirty have nursing home provider fees. It is correct that the current hospital waiver precludes use of a provider fee but this waiver expires in a few years, as the new reforms take effect.

If the federal government does not allow some or all of the needed waivers, any necessary adjustments in the program would be made prior to implementation. **Also, the federal funds that are not mandatory are part of California's baseline fund—and no state has ever lost baseline funding in recent memory.** That includes in the current federal Administration, which has been more aggressive in cutting than most—and it is important to remember that this reform will be implemented under a new Administration.

The Legislative Analyst fails to acknowledge that California has for many years missed the opportunity for billions of dollars in available federal spending. The proposed reforms draw down over \$4 billion in new federal funds.

### **Estimates of the Uninsured Come from Best Possible Source**

We concur with the Analyst that if the number of uninsured is higher, costs would be higher.

However, there is no evidence to the suggestion that a different data source, the Survey of Income and Program Participation by the Census Bureau, may be more accurate. The methodology for this data source, **the Census Bureau, explicitly states that it should not be used for state-level estimates because the sample is not drawn to be accurate at the level of a state**, even one as large as California.

Most analysts in California, including the drafters of AB x1 1, rely on the California Health Interview Survey, done by UCLA, which has a much larger sample size than any of the Census Bureau surveys. **This survey has been funded by the State of California precisely because the various federal surveys consistently underestimated enrollment in public programs, thus providing inaccurate estimates for budgeting purposes.** That is, the federal surveys consistently

overestimate the number of uninsured, especially at any given point in time. This is driven by differences in survey methodology, including the precise questions asked as well as the sample size.

## **AB x1 1 INCLUDES SIGNIFICANT GENERAL FUND PROTECTIONS, INCLUDING BOTH ADMINSTRATIVE AND LEGISLATIVE OVERSIGHT**

**ONGOING LEGISLATIVE APPROPRIATIONS AUTHORITY:** The testimony in Senate Health Committee corrected a misperception that passage of this bill would be the only opportunity for legislative review.

To the contrary, the Legislature has full authority, and in fact responsibility, through appropriations and legislative oversight, to stop or modify the programs at any time. If the ballot measure with the financing is passed, the program cannot fully begin until the Legislature appropriates funding. The Legislature can continue to model projections, the status of negotiations with health plans and providers, and the benefits provided to Californians, and make adjustments as needed. AB x1 1 is amendable by majority vote.

**TRIGGER ON/TRIGGER OFF:** So then what happens if there is a shortfall projected? The measure provides for both "trigger on" and "trigger off" provisions, so the Department of Finance can warn that there are insufficient revenues to meet spending and so that the Legislature can act to provide Californians health care.

If the Legislature does not act by raising additional revenues, scaling back the program, controlling costs, finding new federal funds, or taking other actions, then the default is that most of the measure is repealed. This "safety valve" is for both the general fund and for Californians facing the individual mandate: the mandate is conditioned on the public program subsidies and guaranteed issue.

The LAO acknowledges this, although indicates that there would be "pressure on the General Fund" given the Legislature's likely interest in keeping the reforms in place. But that will be a decision by the Legislature to make. In the event of a shortfall where the \$15 billion in new revenue is not enough to make the commitments of the bill, the more likely result is for the Legislature is to find ways to scale down the commitments.

## **POSITIVE POTENTIAL IGNORED**

The LAO took into account some negative assumptions, and didn't take into account several positive assumptions, even acknowledging that the plan "contains several provisions that could help reduce health care costs over time."

## **Cost Containment Not Calculated**

A proposal that pencils out for five years would allow policymakers the time to see if the cost control provisions actually work--including the prevention and public health efforts, the impact of transparency efforts, the negotiating power of the purchasing pool, and even the impact of reducing the "hidden tax" of the uninsured.

The cost containment elements aren't "booked" as savings, because the LAO recognizes that they will take time to have an impact. We would note that most of the presidential candidates balance their reform plans by booking savings from cost containment measures, many of them included in this measure. Five years would give us that time, as well as to put forth and implement additional proposals to control and reduce costs.

Through these cost containment efforts and other provisions, AB x1 1 has tackled key cost drivers in the existing Medi-Cal program, so the potential savings is not just to the new programs, but is likely to generate general fund savings as well, savings that has not been factored into the equation.

### **The Employer Fee Brings in More Revenue Over Time**

The scaled employer fee will produce increased revenue over time as payrolls increase. As wages rise over time, more employers will climb over the thresholds to pay a higher percentage of payroll climbing up over \$250,000 to pay 4% of payroll instead of 1% in payroll and over \$1 million to pay 6% instead of 4%. This escalation in the employer fee is built into the scaling. We cannot determine from the LAO report whether this natural increase in revenue was taken into account or what magnitude of increased revenue it provides.

### **Other Positive Economic Impacts**

The proposal is estimated to bring \$4.4 billion in new federal dollars into the California economy, and reduce federal income tax payments from California residents. Expansion of access to coverage under the proposal would have positive effects on business productivity. Expanding health coverage would reduce job lock and improve skills matches between employees and employers. It would also reduce the amount of work lost due to poor health. Finally, it would increase individual financial security, since lack of adequate insurance is a leading cause of personal bankruptcy.

### **THE SIGNIFICANT RISKS OF INACTION**

As the LAO notes, "Any plan to reform the state's health care system, by the nature of its complexity, will involve financial risk over the long term. Many of the risks discussed above would be shared by any health reform plans that attempt to maintain the current system of employer-provided coverage while expanding public programs to cover the uninsured."

What the LAO left unsaid was the clear financial risk of the status quo. As noted by the San Jose Mercury News, January 25 editorial, inaction is the more costly option.

The Legislative Analyst fails to consider the status quo where as health care costs increase, the number of uninsured climb, creating pressure on the general fund through Medi-Cal and costs to county government as well as the economic drag created by

people living sicker and being one emergency room visit away from bankruptcy or homelessness.

The share of non-elderly Californian's with coverage through an employer fell 5 percent points between 2000 and 2007, with a corresponding increase in uninsurance and public program enrollment. This ongoing decline in job-based coverage is most pronounced among lower and middle-income families but is spread across the income spectrum. When employers do not provide health coverage, part of the cost of care to the uninsured is borne by other firms in the form of higher premiums. The New American Foundation estimates this cost to be \$14 billion a year. This is combined with the \$14 billion in lost revenue that would be generated through the proposal.

Another major portion of the cost of declining job-based coverage falls on taxpayers. Costs are shifted to taxpayers through increased take-up of Medicaid and State Children's Health Insurance Programs, increased use of public health facilities, and state and federal reimbursement to hospitals for uncompensated care. The combination of the cost containment mechanisms in the legislation and the creation of an employer contribution to the pool, with a credit for health spending will serve to help stabilize job-based coverage in the state and prevent a greater shift in costs onto the public.

The lack of health coverage also has a significant effect on workers' health and labor force participation. Individuals without health coverage are more likely to skip and delay needed care, less likely to receive treatment for chronic conditions like asthma and diabetes, and more likely to experience a debilitating health condition.

**There are real risks, both to the uninsured and insured, to the general fund and to the economy in general, of not taking these important steps for health reform at this time.**

In conclusion, AB x1 1 has the ability to add up, and has significant potential to do so; and the risks have been overstated. In the event of shortfalls, there are significant general protections, including ongoing legislative oversight and authority to "right-size" the program accordingly. The alternative is to leave millions of Californians uninsured, and let the health system continue to decline, with all the general fund and economic risks that such a situation would imply.

*For more information, contact the authors of this report, Anthony Wright and Beth Capell, at Health Access California, 1127 11<sup>th</sup> Street, Suite 234, Sacramento, CA 95814. Our website, with additional material on health reform, is:*

<http://www.health-access.org>