California Health Care Reform Legislation:

The Problems with Assembly Bill 8

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The High Cost of Health Care

- Health insurance is expensive because medical care is expensive.
- Miraculous medications, complicated surgeries, and high-tech diagnostic equipment save lives and give California the best health care system in the world.
- Costs associated with treating chronic illnesses related to **life style** (e.g., diabetes, heart disease, hypertension, stress, obesity) account for 75% of medical costs.
- AB 8 does nothing to reduce the cost of medical care and thus will not solve the problem of high health insurance premiums.

Major Problems of AB 8 & the Governor's Proposal

1. Expanding government health Insurance programs for low income children and adults will make a bad situation worse.

2. "Guarantee Issue" for individual health insurance will destroy California's very vibrant market for affordable health insurance. An "Individual Mandate" for health insurance is unenforceable.

3. A "mandatory employer contribution" (Pay or Play) will damage the economy and force job losses.

4. A newly created government-run Purchasing Pool won't lower rates but will create a huge under funded bureaucracy.

5. A "Medical Loss Ratio" limitation will increase the cost of health insurance and eliminate enrollment advise & assistance for individuals and small businesses.

1. Expansion of Government Programs for Low Income **Children**

- AB 8:
  - Expands Medi-Cal eligibility to all children ages 1-18 with income below 133% FPL.
  - Expands Healthy Families to all children 1-18 with income 133% - 300% FPL ($62,000/yr. family of 4)
  - Makes the full scope of Medi-Cal and Healthy Families available to undocumented children.
- Governor: Similar expansion

1. Expansion of Government Programs for Low Income **Adults**

- AB 8:
  - Expands Medi-Cal & Healthy Families to parents of children with income 100% - 300% FPL
  - Expands Medi-Cal to parents of children earning up to 133% FPL so they can obtain the same coverage as children.
- Governor: Expand Medi-Cal to include all legal residents up to 100% FPL ($10,212)

1. Expansion of Existing Government Health Plans- Problems

- Currently, over 1 million people are eligible for existing government health plans yet they are not enrolled
- Expanding the criteria for enrollment will not solve the problem of people not enrolling in essentially free health insurance
- A better solution would be to coordinate enrollment in government plans with enrollment in employer-based plans
- The government should pay for the distribution and enrollment in their plans the same way that the private sector health plans pay for distribution and enrollment – through the use of licensed insurance agents.

1. Expansion of Existing Government Health Plans: Cost Shifting – government doesn't pay its share

2005 Revenue to Cost of Care Ratios

- Private Payer 130.9% of cost
- Medicare 87.0% of cost
- Medi-Cal 83.8% of cost

Source: http://www.cfcepolicy.org/NR/rdonlyres/46C2B526-D9BF-4556-A310-37C3A7CDF53D/30/CFCE_Cost_Shift_Study.pdf
Cost Shifting in CA Hospitals: What is the effect on private payers?, table 2, CFCE, June 6,2007,

- Government under payment for services is the real "hidden tax" and results in higher health insurance premiums than the cost of uninsured people receiving medical care.

- Government should increase its funding of Medi-Cal & indigent care programs to cover the actual cost of care before expanding enrollment in these plans.

1. Expansion of Existing Government Health Plans: California should get more from the Federal Government

- California receives the lowest payments for Medicaid enrollees of all 50 states:

Medicaid Payments per Enrollee - 2004

State	Child	Adults	Total
CA	$1,109	$804	$2,535
NY	$1,869	$3,616	$7,500
U.S. Avg.	$1,531	$2,012	$4,248

Source: *Medicaid Payments per Enrollee, FY 2004,* StateHealthFacts.org, Henry J. Kaiser Family Foundation

- Federal allocations are based on a state's match – California pays little per enrollee and therefore receives little from the Federal government

2. Guarantee Issue & Individual Mandate

- AB 8:
  - Guaranteed issue for everyone in the individual market *without* serious medical conditions.
  - High risk pool for individuals with serious medical conditions, funded by a broad assessment on health plans.
  - No individual mandate.
- Governor: wants an Individual Mandate & Guarantee Issue.

2. Guarantee Issue (GI) & Individual Mandate (IM): Problems

- GI with no IM allows people to wait until they get sick or injured to enroll in health insurance.
- Removing the incentive to purchase health insurance while healthy creates a pool of very sick people (high utilization, adverse selection)
- Insurance companies either raise premiums to cover the high claims or they exit the market and people have little choice and high premiums
- States with guarantee issue health insurance (no medical underwriting) have very high rates for individual policies. New York & New Jersey are examples:

2. California Individual Health Insurance Premium Compared to States with Guarantee Issue

State	Average Annual Premium Individual	Family
New Jersey	$6,048	$14,403
Massachusetts	$5,257	$10,126
New York	$3,743	$ 9,696
National (USA)	$2,268	$ 4,424
California	$1,885	$ 3,972

Source: http://www.ahipresearch.org/pdfs/Individual_Insurance_Survey_Report8-26-2005.pdf

Individual Health Insurance: A Comprehensive Survey of Affordability, Access and Benefits, AHIP Center for Policy Research, 2004

2. Guarantee Issue & Ind. Mandate – Recommendation

- Currently 80% of Californians have health insurance.
- Once 90% of Californians have health insurance then require guarantee issue.
- This preserves the affordability of the current individual health insurance market and avoids adverse selection.
- Increased funding and expansion of the major risk pool (MRMIP) and effective enrollment of eligible people into existing government programs would get to 90%
- Individual Mandate is unenforceable – hospitals can not turn people away who don't have insurance

3. Employer Mandate to “Pay or Play”

- AB 8:
  - Employers must spent 7.5% of Social Security Payroll on health insurance or pay a 7.5% “fee” for employees to obtain coverage through state created “purchasing pool.”
  - “Fee” is a penalty for not complying with State law, therefore it is not a “tax” and does not require 2/3 vote of legislators
  - No exemptions for small businesses.
  - Gives MRMIB the authority to adjust (raise) the employer fee to ensure fiscal solvency.
- Governor:
  - 4% “fee” on employers or employees purchase from “purchasing pool.”
  - Exempt: Employers with fewer than 10 employees

3. Employer Mandate – Problems

- Tax vs. Fee: 2/3's legislative approval required for a new tax
- ERISA limits a state's ability to require employers to offer health coverage.
- Most uninsured workers are in low-wage jobs. 7.5% of a low wage will generate a low amount of money to pay for health insurance premiums – likely insufficient to cover the cost of their health insurance.
- MRMIB will manage the State's health insurance "purchasing pool" and will have to raise the "fee" to pay for coverage.
- All employers – not just those in the state purchasing pool would have to increase the amount they pay for health insurance to comply with the higher mandate.
- No legislative oversight on raising the "fee" on employers.
- This is taxation without representation.

4. Purchasing Pool

- AB 8:
  - Creates - The California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), a health insurance "purchasing pool" managed by MRMIB.
  - Will offer 3 plans: high, medium, low benefits.
  - Individual and group coverage offered
  - Like the model used by CalPERS, the Connector would develop standards for coverage and negotiate favorable rates by leveraging its purchasing power. Participating employees would be offered a choice of health plans that provide comprehensive health coverage including medical, hospital and prescription drug benefits."
    (source: 5/16/07 Memo, Sen. Perata, *California Health Care Coverage & Cost Control Act*)
- Governor: Creates a similar purchasing pool

4. Purchasing Pool - Problems

- AB 1672 (1992) created a pool for small group health insurance: HIPC/PacAdvantage which ceased operation 12/31/06 – pool premiums were higher than non-pool rates because of added administrative cost
- If an overwhelming number of young, healthy people enter the pool, rates will likely be low.
- If unhealthy people with chronic illness make up the pool then rates will be very high
- CalPERS is an example of a pool with very high rates – third largest health insurance “pool” in the country behind the Federal government & General Motors. Current 2007 HMO benefits $10 copay, 100% Hospital Rx5/15/45.

CalPERS "Pool" rates More than 100% Higher than Sample Mid-Size Group rates

	Monthly Premium July 2007	
Purchaser HMO	**Individual**	**Family**
CalPERS – Blue Shield (1)	$479.47	$1,246.62
CalPERS – Kaiser (1)	$436.25	$1,134.25
93 EE Group-Blue Cross Renewal (2)	$215.49	$ 708.02
93 EE Group-Health Net (2)	$199.09	$ 607.22
98 EE Group-Blue Cross Renewal (3)	$281.99	$ 874.21

Note: Benefits for all plans are similar: HMO, $10 per Dr. Office Visit; 100% In-Hospital Coverage;
CalPERS Rx: $5 generic, $15 brand formulary, $45 brand non-formulary
Mid-Size ER group Rx: $10 generic, $25 brand formulary, $40 brand non-formulary

(1) http://www.calpers.ca.gov/index.jsp?bc=/member/health/plan-phy-info/rates/2008-state-rates.xml CalPERS 2008 Basic Monthly Rates

(2) Beverage Distributor, Bell Gardens, CA. Group changed to Health Net after receiving a 14.5% rate increase from Blue Cross. Rates with Health Net are 3.6% below previous year's rates.

(3) Medical Group, Pasadena, CA. Group renewed with Blue Cross after receiving a 14.5% rate increase.

- Creating a huge "pool" can lead to VERY HIGH premiums

4. Purchasing Pool - Problems

- There is no evidence that purchasing pools lower health insurance premium
- A government run pool can only operate by limiting choices and flexibility for consumers (e.g., no HSA compatible plans in the pool)
- Each time MRMIP raises the employer “fee” those participating in the pool would have a health insurance rate increase. Each time an employer in the pool gave an employee a pay raise, the employer would pay more for health insurance.
- Unlike private sector health insurance, participants in the pool could not change plans or insurance companies to off-set increases in health insurance premiums. The “fee” increase would reduce company earnings and employee wages.
- There is no reason to create a government run purchasing pool for health insurance.

5. Medical Loss Ratio (MLR)

- AB 8:
  - Requires that 85 cents of every dollar of health insurance premium collected be spent on medical services
  - Conversely, Insurance companies can only spend 15% of health insurance premium on: customer service, provider contracting (lowering cost of care,) chronic disease programs, HIPAA & regulatory compliance, appeals, administrative costs, distribution & education for new products, taxes & profit and other costs.
- Governor: similar provisions

5.Medical Loss Ratio (MLR) – Problems

- Creates unfair advantage for not-for-profit health plans (Kaiser, Blue Shield) because they don't pay taxes – yet their premiums are the same as for-profit carriers
- Creates unfair advantage for multi-state carriers because they can spread administrative costs across states
- Creates unfair advantage for staff model HMOs (Kaiser) which owns hospitals and medical groups and can hide administrative costs in MLR

5.Medical Loss Ratio (MLR) – Problems

- Eliminates incentives for carriers to innovate, provide good service, or reduce costs since they would not reap the benefit of improvements
- Does not allow for future regulatory changes which could increase the administrative burden of carriers
- Creates perverse incentive for carriers to offer only high priced plans to increase profits and money available for administrative expenses
  - Ex: 15% x $500/month premium = $75
    15% x $100/month Premium = $15

5.Medical Loss Ratio (MLR) – Problems

- Insurance companies will eliminate commission payments to agents to enroll individuals and small groups because there will be insufficient money to service this portion of the market.
- Individuals & small business owners will not have an expert to help them make very important decisions when purchasing and using health insurance.
- Mandating a Medical Loss Ratio will not lower the cost of health care – which drives the cost of health insurance. It is not needed.

Four Truths about health insurance

1. Everybody wants health insurance (to get immediate access to the best medical care)

2. Nobody wants to pay for health insurance

3. Everybody wants someone else to pay for his/her health insurance (employers,employees, unions, government, self-insured/uninsured)

4. No matter who pays for it, health insurance is expensive because medical care is expensive. Shifting the cost to someone else does not reduce the cost of care.

Final Thoughts:
Understanding the high cost of health care

- -- The U.S. spends seventy-five percent of health care dollars on diseases caused by unhealthy lifestyles.

  "Beyond Health Promotion: Reducing Need and Demand for Medical Care," Health Affairs, March/April, 1998

- -- Ninety-one percent of all diabetes cases, 80-90% of all heart attacks and 30-70% of all cancers are completely preventable through lifestyle changes.

  Wellness Councils of America, 2004

- - Physical inactivity, and being overweight or obese are associated with 23% of health plan charges and 27% of national health care charges.

  Preventing Chronic Disease, CDC, 2005

- Sixty-four percent of adults in America age 20 and older are overweight. In the year 2000 alone, estimates for the total cost of obesity in the U.S. were $117 billion.

  The Principal Financial Group, 2004

- 9 out of 10 men and 7 out of 10 women will eventually become overweight.

  Annals of Internal Medicine, 2005