

The President's Health Care Reform Proposal A Review of Its Implications for California

EXECUTIVE SUMMARY

As with any comprehensive and complicated proposal for change, the President's health reform plan will have both direct and indirect fiscal impacts on California. In the short term, the direct impact of the plan is likely to be a savings, potentially several hundred million dollars annually, to California state and local governments. If the state opts to participate in a new long-term care program, these savings could be reduced, possibly resulting in net costs to the state in the long run, depending on how the state structures the program.

The indirect fiscal effects on California are more difficult to predict because they depend on behavioral responses by individuals—particularly employers—to the plan's provisions. In the short run, however, the plan probably will reduce employment somewhat below what would otherwise occur.

From a policy standpoint, the plan imposes a difficult choice for the Legislature: the state must choose between a single-payer system, which relies on extensive governmental intervention in a large portion of the state's economy, and a version of managed competition—a theory with which there is little experience on a large scale. We lean toward a managed competition approach with a system of health alliances because, in our view, a competitive market system ultimately will prove to be more efficient than a regulatory approach.

We have reviewed the cost-containment provisions envisioned by the President's managed competition approach. We conclude that these provisions need to be strengthened if this plan is to be a successful strategy for California in the long run. We have identified a number of actions that the Legislature might take to do so.

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INTRODUCTION

On October 27, 1993, the President presented to the Congress his proposal to reform the nation's health care system. If enacted, this legislation (introduced as H.R. 3600 and S. 1757) would dramatically reshape the delivery of health care in California. Accordingly, it would have far-reaching effects on existing state and local government programs that provide health services to indigent persons. The plan also would affect expenditures by state and local governments for health care benefits provided to their employees, and some state revenue sources.

In this review, we summarize the key features of the plan and its potential effects on state and local governments in California. We also identify the major policy choices the plan presents for the Legislature, and offer recommendations on a number of issues.

Why Reform Health Care?

Advocates of health care reform generally cite two fundamental problems with the United States health care system: relatively high total costs and a paradoxically high number of uninsured individuals. In the view of many economists,

relatively high total costs are a cause for concern. They argue that, to the extent high costs for medical care are due to inefficiencies in our existing financing and delivery system, spending is diverted from more productive uses. In addition, since government is a purchaser of health services, unnecessarily high total costs for these services add to federal budget deficits and the national debt. This, in turn, reduces the pool of capital available for private investment, which is needed for long-term economic growth.

A number of factors explain relatively high costs in the United States. Clearly, one of them is that the United States enjoys per capita incomes that exceed those of most other countries, and its residents are able to spend some of their higher incomes on more elaborate health care.

However, many economists point to other factors that account for relatively high health care expenditures. These other factors generally fall into the broad category of “market failures.” Examples of these market failures include:

- ***Lack of Incentives For Consumers to Consider the Costs of Health Care.***
Because most people are insured, they have little

incentive to consider the relative costs of different treatment options—even if they had the information necessary to do so.

- ***Expenditures on Health Insurance Are Subsidized.***
Under federal law, the amount of employer-provided health insurance is not taxed as income to the employee, thereby encouraging employees to choose more generous insurance plans than they would otherwise.
- ***Lack of Good Consumer Information About the Costs and Benefits of Health Insurance and Health Care.***
As a consequence, it is difficult for individuals to choose the best insurance plan. Similarly, people often defer to health care professionals (the “sellers” of health care) about the extent of care they should receive.
- ***Insurers Do Not Compete Entirely on the Basis of Efficiency and Quality.***
Insurers face strong incentives to select individuals who are less likely to require extensive medical care and to refuse coverage of preexisting medical conditions. Accordingly, insurers tend to

compete on the basis of avoiding risks, rather than by offering more cost-effective services.

- ***Costs of “Free Riders” Shifted to Paying Consumers.*** Many individuals who do not pay for health care nevertheless receive it. In 1991 this “free-rider” problem was estimated to cost \$13 billion nationally for uncompensated hospital care. Much of this cost was almost certainly reflected in the hospital bills of those who purchased coverage.

OVERVIEW OF THE PRESIDENT'S PLAN

The President's plan attempts to address the shortcomings of the current health care system. It does this by requiring states, to establish by January 1, 1998, a system to ensure that health care coverage is made available to virtually all state residents. To provide this coverage, the state would have two options. First, it could establish a “single-payer” system, under which the state would directly provide, or reimburse for the cost of, health care services for its residents. Generally, single-payer systems rely heavily on regulation to control costs.

Alternatively, the state could establish a system of "managed competition" with one or more regional "health alliances" that would contract with private health care providers and insurers for coverage of residents in each region. Under this approach, the alliances would make available to residents in their geographic area a choice of insurance plans and would collect

payments from employers, individuals, and the state and federal governments to cover the resulting premiums. Accordingly, this approach relies more on competition among private-sector providers under certain "ground rules" to ensure coverage and control costs. Figures 1 and 2 summarize the basic provisions of the President's plan.

Figure 1

Basic Components of the President's Health Care Reform Plan

Universal coverage

- Each state must establish an approved system by January 1, 1998, to provide health care coverage to nearly all its residents.
- States have two options: a "single-payer" approach or a system of "health alliances."
- Existing health care delivery systems generally are replaced by the plan.
- Existing programs provide coverage for undocumented persons, veterans, military employees, and Indian Health Services beneficiaries.
- Medicare beneficiaries could be included in the new system at the state's option.

Benefits

- A "comprehensive benefits package" must be provided in every state.
- Coverage includes physician, hospital, and most laboratory and diagnostic services; prescription drugs; some mental health and substance abuse services; and dental and vision care for children.
- States may establish a new home- and community-based long-term care program with federal matching funds.
- Medicare recipients would receive prescription drug coverage through the Medicare Program.

Figure 2

Structure and Financing of Health Care Through Alliances

Regional alliances

- States establish one or more regional health alliances to contract with health care providers and insurers for coverage of residents in the geographic area served by each alliance.
- The alliances collect employer and individual contributions, and funds from the state and federal governments, to make premium payments to the plans.
- Alliances must offer a choice among three types of coverage: a "fee-for-service" arrangement, a group of "preferred providers," and a "health maintenance organization."

Corporate alliances

- Firms with more than 5,000 employees may provide the required coverage independently of the regional alliances.
- Firms must provide the same benefits package, a similar choice of plans, and would have to meet cost-control targets.

Financing

- Employers:
 - Pay 80 percent of the average cost premium and could elect to pay more.
 - Private employer costs are limited to 3.5 to 7.9 percent of payroll, depending on firm size.
- Individuals:
 - Pay the difference between the employer's contribution and the cost of the plan they choose.
 - If self-employed, individuals pay 100 percent of the cost. This expenditure would be fully tax-deductible.
- Subsidies:
 - Provided to small employers and persons with incomes below 150 percent of the federal poverty level.
 - Funded through an increased federal surtax on cigarettes (\$0.75 per pack), and some of the assumed federal savings in the Medicare and Medicaid Programs.
- National expenditure targets:
 - Overall health care expenditures could not increase by more than specified rates each year.
 - Targets would be enforced by reducing payments to providers.

"The plan would dramatically change existing state and local programs that provide health care to indigent persons."

Programmatic Effects on California's State and Local Programs

The plan would dramatically change existing state and local programs that provide health care to indigent persons. If California enacted a single-payer system, most of these programs would be folded into an all-encompassing system run by the state. Alternatively, if the state establishes a system based on regional health alliances and private providers, the President's plan defines a different role for the Medi-Cal Program in particular, and would effectively change or eliminate other programs. The following discussion emphasizes the role and programmatic effects of the alliances because this is the primary focus of the President's plan.

Medi-Cal. The existing Medi-Cal Program essentially acts as an insurance company that reimburses the costs of health services provided to certain low-income persons. Most of this responsibility would be assumed by the alliances. However, the Medi-Cal Program would have three remaining functions under the President's plan. The program would:

- Make premium payments to alliances on behalf of recipients of Aid to Families with Dependent Children (AFDC) and Supplemental Security Income/State Supplementary Program (SSI/SSP) for their health coverage.
- Cover emergency and pregnancy-related services for undocumented persons, certain additional benefits for low-income children, and long-term care services, as under current law.
- Continue to cover "wrap-around" services (such as the existing optional benefits) for AFDC and SSI/SSP recipients that are not included in the national benefits package, *at the state's option*. If the state chose to provide these services for AFDC and SSI/SSP recipients, they would be funded according to existing federal and state cost-sharing ratios (50 percent General Fund, 50 percent federal funds). If the state chose to continue Medi-Cal coverage for these services for low-income persons who do *not* receive AFDC or SSI/SSP payments (primarily persons who would qualify under the current Medically Needy

and Medically Indigent categories), the state would do so *only* at its own expense.

groups of low-income persons under current law and the responsibilities it would have with respect to these groups under the President's plan.

Figure 3 summarizes how the Medi-Cal Program serves various

Figure 3

The Medi-Cal Program Under Current Law and The President's Health Care Reform Plan

Eligibility Group	Existing Medi-Cal Program	Medi-Cal Under President's Plan
AFDC and SSI/SSP recipients	Covers services, including optional benefits such as adult dental services.	<ul style="list-style-type: none"> • Medi-Cal makes a payment on behalf of these individuals to health alliances for services covered under the national benefits package. The payment is based on costs incurred by Medi-Cal for these services in 1993. • Recipients select a plan through alliances in the areas where they live and receive care under that plan. • Medi-Cal <i>could</i> continue to cover some services that are not part of the national benefits package for these groups. If it did so, costs would be funded 50 percent General Fund, 50 percent federal funds.
Low-income persons (generally employed) who meet eligibility criteria	Covers services under "medically needy" and "medically indigent" programs, including optional benefits such as adult dental.	<ul style="list-style-type: none"> • Individuals would receive coverage through alliances, and would be eligible for subsidies (to cover premium costs) based on income. • Employers generally would pay 80 percent of the health plan these individuals choose. • For services not covered under the national benefits package, Medi-Cal <i>could</i> continue to provide these services <i>only</i> at state expense.
Undocumented persons	Medi-Cal covers emergency and pregnancy-related services.	No change (50 percent General Fund, 50 percent federal funds).
Long-term care	Medi-Cal covers skilled nursing and personal care services for those who meet eligibility criteria.	No change (50 percent General Fund, 50 percent federal funds).

County Indigent Health Programs. Indigent persons who currently rely on county programs for health care (persons not eligible for Medi-Cal) would be covered under the health

alliances. They would choose from among the various plans offered by the alliances, and would be eligible for subsidies to offset their share of a health plan's cost if their family income

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is less than 150 percent of the federal poverty level. If they are employed, as the majority are, their employer would share in the cost of the premium. As a result of these provisions, county indigent health programs generally would be required only to provide care to undocumented persons.

Other Programs. Currently, there are a number of additional state programs that provide health care services to Californians directly, or that provide mechanisms for these services to be purchased at reduced costs. Among these are:

- Access for Infants and Mothers (AIM).
- The Major Risk Medical Insurance Program (MRMIP).
- The Child Health and Disability Prevention Program (CHDP).
- The California Health Care for Indigents Program (CHIP).
- The Health Insurance Plan of California (HIPC).

Generally, the services provided by these programs would be included under the national benefits package, and the individuals they serve would receive coverage through the alliances.

Other programs provide some services that would be covered under the President's plan and other services that would not be covered. Generally, these programs provide an array of medical and social services to severely disabled individuals or are focused on outreach activities to those who do not traditionally receive adequate primary and preventive medical care. Accordingly, services that would continue to be provided by these programs will have to be coordinated with those provided through the alliances.

Among the programs that fit this description are:

- The Office of Family Planning.
- The Women, Infants, and Children Supplemental Food (WIC) Program.
- Maternal and Child Health (MCH) Program.
- The Office of AIDS.
- California Children's Services (CCS).
- Regional Centers and Developmental Centers for the Developmentally Disabled.
- County mental health and substance abuse programs.

Fiscal Effects on California State and Local Programs

The plan's fiscal effects on state and local governments in California fall into three broad categories. The plan will affect:

- Governments as employers.
- Government programs that provide health care services to indigent persons.
- Revenue sources.

It is important to note that there are considerable uncertainties in estimating the plan's fiscal effects (that is, comparing spending under the plan against current law) for each of these areas. For example, forecasting baseline expenditures for the county indigent health programs in the absence of the President's health plan is difficult because we have no information regarding the extent to which these expenditures have been affected by recent statutory changes. One such change was the shift of property tax revenues from counties to schools in 1993-94, which reduced their fiscal capacity and may have resulted in reducing their expenditures on indigent health programs.

In addition, a number of state policy choices will affect the fiscal impact of the President's plan. Among these are decisions regarding the continuation of optional benefits for non-cash-grant Medi-Cal recipients and whether or not to implement a new home- and community-based long-term care program.

For purposes of this analysis, we have assumed that the state would elect to enter the system described in the President's plan on January 1, 1996. We used current state law and practice as the basis of comparison for estimating the plan's fiscal effect. Based on these and a number of other assumptions, we estimate net savings for state and local governments in 1995-96 and 1996-97, probably in the range of several hundred million dollars annually. If the state elected to fully implement a new long-term care program, however, these savings could be reduced, possibly resulting in net costs, particularly in later years, depending on how the state might structure this program.

Figure 4 summarizes the major fiscal effects of the President's plan on California governments.

Figure 4

Major Fiscal Effects of the President's Plan in California

Summary: Net savings to state and local governments, potentially several hundred million dollars annually in 1995-96 and 1996-97 and increasing thereafter. If the state fully implements a new long-term care program, these savings could be reduced, particularly in later years, possibly resulting in net costs.

Governments as employers

- Requires state and local governments to purchase a standard package of health benefits through regional health alliances. **Costs or Savings.** Depends on whether costs resulting from alliance premiums will be higher or lower than those currently negotiated by PERS and other governmental entities.
- Requires coverage for part-time employees. **Costs.** \$50 million to \$75 million annually to the state; probably in excess of \$100 million annually for local governments.
- Increases premiums annually by a medical inflation factor. **Savings.** Unknown, depending on the extent that the medical inflation factor results in lower premium increases than would otherwise occur.
- Transfers 80 percent of health benefit costs for early retirees to the federal government. **Savings.** \$200 million annually to the state; probably in the hundreds of millions annually for local governments.

Indigent health programs

- Provides universal coverage to legal California residents. **Savings.** About \$1.4 billion net annually to indigent health programs:
 - \$350 million state funds.
 - \$1.1 billion realignment and county funds.
- Eliminates federal payments to hospitals with a disproportionate share of the uncompensated care burden. **Revenue Loss.** About \$700 million annually in reduced federal funds that currently offset indigent health care costs (see above).
 - \$150 million state funds.
 - \$550 million county funds.
- Requires the state to (1) make payments to alliances on behalf of AFDC and SSI/SSP recipients, based on 95 percent of 1993 Medi-Cal costs for these recipients, and (2) make annual lump-sum payments in lieu of other Medi-Cal costs. **Savings.** About \$100 million annually for the first few years, probably increasing over time. Savings depend on how the required annual increases in state expenditures compare with what would otherwise occur in the Medi-Cal Program.
- Eliminates federal funding for Medi-Cal optional benefits to persons not receiving AFDC or SSI/SSP payments. **Potential Costs.** At least \$100 million annually if the state continues these services.

Revenue effects

- Reduces state cigarette and tobacco products surtax (C&T) receipts because increased federal surtax will reduce consumption. **Revenue Loss.** At least \$200 million annually from the C&T Fund.
- Increases insurance premium tax receipts by requiring health care coverage for virtually all state residents, but reduces receipts by encouraging greater use of tax-exempt HMOs. **Revenue Gain or Loss.** Unknown, depending on the extent that the universal coverage requirement results in a net increase in expenditures for health insurance through for-profit providers who are subject to this tax.

Continued

New long-term care program

■ Enacts a new federal program for home- and community-based long-term care, and requires the state to share in the program's costs if it chooses to participate.

Potential Costs. Up to \$200 million in 1996 and significantly higher amounts annually thereafter if fully implemented. Initially, these costs probably could be met by current General Fund expenditures from programs that provide similar services.

State and Local Governments As Employers

The plan's requirement that employers pay at least 80 percent of the average cost of health insurance premiums available through the alliances would apply to state and local governments. Because the plan does not allow state and local governments to provide health coverage independently of the alliances, the state's Public Employees' Retirement System (PERS) could no longer serve as the purchaser of health insurance solely for state employees. Similarly, teachers and employees of local governments would receive coverage through alliances.

The primary fiscal effect of the President's proposal on state and local governments as employers will depend on whether the resulting cost of premiums in plans selected by employees through the alliances will be higher or lower than those which would be used under existing arrangements. Initially, some aspects of the President's proposal will tend to result in

higher premiums, while others will tend to reduce them.

Over time, however, it appears that premiums will be lower. This is because the plan limits the annual growth of premium costs to a medical inflation factor based on the Consumer Price Index (CPI). This provision would most likely benefit state and local governments in the long term because premium increases under the current system are unlikely to be as low as the general rate of inflation reflected in the CPI.

Aside from its potential effect on premiums, the plan would have two contrasting effects on state and local governments as employers. On the one hand, governments would benefit because under the plan, the federal government would assume 80 percent of private and public employer costs for health care benefits provided to early retirees (retired persons who are between the ages of 55 and 65). This provision will result in savings to the state of about \$200 million annually, and additional savings to local governments, probably in the

hundreds of millions of dollars annually.

In contrast, the President's plan would result in costs to state and local governments because it requires that health care be provided to all employees, including those who work on a part-time basis. The state and many local governments do not currently cover part-time employees and therefore would experience costs to do so. The state's costs as a result of this provision would be about \$50 million to \$75 million annually, and local governments would face costs probably in excess of \$100 million annually.

Expenditures for Indigent Health Care

Indigent Health Programs. The plan's universal coverage provisions would result in savings in a number of state- and county-funded indigent health programs.

Based on data provided by counties for 1991-92, and on amounts appropriated in the 1993-94 Budget Act, we estimate that annual expenditures for these programs (including health services to undocumented persons) will exceed \$2.3 billion by 1995-96. However, because the plan does not cover undocumented persons, and

because it requires a maintenance of effort for disproportionate-share hospital payments (discussed below), we estimate the plan would result in annual net savings to state and local government indigent health programs of about \$1.4 billion (\$350 million state General Fund and Cigarette and Tobacco Products Surtax Fund, and \$1.1 billion in county and realignment funds).

It is important to note, however, that this estimate could vary in either direction by \$200 million or \$300 million. This is because there are no firm estimates regarding (1) county indigent health expenditures for 1992-93 or 1993-94 or (2) county costs for providing health services to undocumented persons.

Medi-Cal. The plan would have three major fiscal effects on the Medi-Cal Program. First, for individuals who receive a cash grant under the AFDC Program or SSI/SSP, Medi-Cal would pay a premium to the alliances for their health care. The amount of the premium would be based on the state's expenditures in federal fiscal year 1993 for services covered under the national benefits package. (The state's premium would not be affected by the cost of the plan chosen by the recipient.) In addition, the premium amounts would be

adjusted annually by caseload and a medical inflation factor based on the national CPI.

We estimate that the state would realize savings from this provision over time, possibly about \$100 million annually, primarily because the annual medical inflation factor included in the President's package is likely to be lower than the rate of non-caseload cost increases for Medi-Cal, based on the experience in recent years. This assumes, however, that the national inflation rate remains relatively low—as most economic forecasts predict—for the next several years. To the extent that inflation increases to a rate above 4 or 5 percent annually, however, this provision could result in costs to the state as compared to what would otherwise occur in the Medi-Cal Program, where overall reimbursement rates have tended to increase by less than the inflation rate.

Second, California has elected to provide optional benefits under Medi-Cal (such as dental services for adults) to all beneficiaries who are eligible to receive them under federal law. Like other Medi-Cal services, these benefits currently are funded equally by the state General Fund and federal funds. Under the President's plan, the state could continue these

benefits, but would receive federal funding to offset the cost of providing them to AFDC and SSI/SSP recipients only.

Accordingly, if the state chose to continue providing these benefits to persons who are not eligible to receive a cash grant under the AFDC Program or SSI/SSP, it would no longer receive federal funding to offset the cost of these services. We estimate this provision would result in a General Fund cost of about \$100 million annually if the state elected to continue these benefits for all groups of individuals who are currently eligible to receive them.

Finally, the plan eliminates existing provisions in federal law authorizing federal Medicaid funds for hospitals with large (or a "disproportionate share" of) uncompensated care costs for serving indigents. These payments result in about \$750 million in federal revenues to hospitals operated by counties, special districts, and the University of California and, in effect, about \$150 million to the General Fund. Accordingly, state and local governments would experience a revenue loss of about \$900 million annually due to the plan's elimination of this program.

However, the plan establishes new programs for these hospitals

“The President’s plan imposes several ‘maintenance-of-effort’ expenditure requirements on state governments.”

and for services not covered under the plan (such as services for undocumented persons). We estimate that the state and counties could receive up to \$200 million annually under these provisions, which would effectively limit the revenue loss related to disproportionate-share

hospital payments to about \$700 million annually.

Maintenance-of-Effort Provisions. The President’s plan imposes several “maintenance-of-effort” expenditure requirements on state governments. These provisions are summarized in Figure 5.

Figure 5	
Maintenance-of-Effort Provisions	
Initial Year	Later Years
<p>AFDC and SSI/SSP recipients</p> <p>Medi-Cal makes payments to alliances on behalf of these recipients based on adjusted 1993 expenditures for services covered in the national benefits package.</p>	<p>Payments are increased annually by:</p> <ul style="list-style-type: none"> • AFDC and SSI/SSP caseload growth. • A medical inflation factor.
<p>Non-cash-grant recipients</p> <p>State provides alliances with funds equal to adjusted 1993 expenditures for Medi-Cal services covered in the national benefits package.</p>	<p>Payments are increased annually by:</p> <ul style="list-style-type: none"> • US population growth for persons under age 65. • A medical inflation factor.
<p>Disproportionate-share hospitals</p> <p>State provides alliances with funds based on adjusted 1993 expenditures for these hospitals.</p>	<p>No change.</p>
<p>Long-term care</p> <p>State continues current long-term care services for individuals receiving them at the time the President’s plan is enacted.</p>	<p>No change.</p>

There are essentially four requirements. First, the plan requires Medi-Cal to make premium payments to the regional health alliances on behalf of AFDC and SSI/SSP recipients, as described above.

Second, the state would make annual lump-sum payments to alliances for individuals who

were eligible for Medi-Cal but who were not eligible for AFDC or SSI/SSP payments. (These non-cash-grant recipients are referred to in Medi-Cal as the “medically needy” and “medically indigent.”) These payments would be based on the state’s 1993 expenditures (adjusted for the date that the

state enters the new system) for medically needy and medically indigent persons. The lump-sum payments would be adjusted annually to reflect United States population growth for persons under age 65 and a medical inflation factor.

We estimate that this provision would probably have a minimal fiscal effect in the first year, but would result in savings to the state, probably in excess of \$150 million annually within a few years of implementation, and increasing amounts in later years. This is due largely to the plan's adjustment factor, which would increase state expenditures based partly on overall United States population growth rather than by the historically much higher rates of increase in the Medi-Cal Program's medically needy and medically indigent categories.

We note that the maintenance-of-effort provision effectively locks in a relatively high funding requirement for California as a result of providing services to these individuals, compared to those states which have chosen to provide less extensive coverage. Similarly, the use of 1993 as the base year is disadvantageous to California in comparison to some other states. This is because the recession has been relatively severe in California, resulting in higher caseloads and

expenditures in the Medi-Cal Program.

Third, the plan would require the state to make a lump-sum payment to the alliances based on the state's share of payments to disproportionate-share hospitals in federal fiscal year 1993, adjusted to the year in which the state enters the new system. (In California, these funds are provided by counties, special districts, and the University of California.) Under this provision, the state would pay to the alliances approximately \$700 million annually if the state entered the national system in 1996. If the state did not enter until 1997 or 1998, its annual obligation would increase significantly—to about \$775 million or \$860 million, respectively. Once the state enters the system, this lump-sum payment would not increase over time. The obligation to make these payments has been reflected in our fiscal estimate of net savings to county indigent health programs.

Finally, if the state elects to participate in a new federal program that would provide expanded home- and community-based long-term care services (discussed below), the plan requires the state to continue to provide long-term care services under the Medi-Cal Program to

“... the plan will have a number of indirect effects on the state's economy.”

beneficiaries who are receiving those services when the President's plan is enacted.

New Program

Home- and Community-Based Long-Term Care. The plan establishes a new federal program to provide home- and community-based long-term care. It would be similar in many respects to California's In-Home Supportive Services (IHSS) Program and Regional Centers for the Developmentally Disabled, though the new program would have no eligibility limits related to income. The program would make services available to persons with certain disabilities, including individuals who require assistance in three or more “activities of daily living” (for example, bathing, dressing, and eating). Individuals with family incomes above 150 percent of poverty would pay up to 25 percent of the cost of services, depending on their income.

Under the plan, the federal government would pay approximately 78 percent of the program's cost in California, and the state would contribute the remaining 22 percent. States have the option of participating in this program, and could elect to do so beginning January 1, 1996.

Based on the expenditure levels the plan proposes for this program, the state's share of costs would be up to \$200 million in calendar year 1996. Under the plan's phase-in schedule, expenditures would increase by up to \$150 million annually for each of the following seven years to about \$1.6 billion in 2003. (These costs are net of copayments.)

If the state implements this program, it may be able to meet its cost in the initial years by current General Fund expenditures in programs such as IHSS and the regional centers, which serve individuals who would be eligible for services under the new program. In later years, actual costs will depend on how the state structures its participation in the program. Based on the plan's estimate of the costs for a fully implemented program nationwide, the state would need to make General Fund expenditures that are nearly \$1 billion higher than those for existing long-term care programs in order to meet its share of costs in 2003.

Revenue Effects

Cigarette Surtax Revenues. The plan would increase federal cigarette taxes by \$0.75 per pack. Based on our review of the relevant economic literature and

on the experience of Canada (which has imposed similar surtaxes), we estimate that an increase of this magnitude would reduce California's existing revenues from this source by as much as \$200 million or more annually, due to lower consumption. Among other factors, the extent of the revenue loss would depend on whether and to what degree tobacco companies reduced their prices to preserve sales volume.

Gross Premium Tax Revenues. Currently, California levies a 2.35 percent tax on insurance premiums, including those for health insurance purchased from for-profit carriers. However, health insurance offered by nonprofit carriers, including most health maintenance organizations (HMOs), is exempt from the tax.

The plan would affect receipts from the Gross Premium Tax in contrasting ways. First, its requirement that virtually all California residents purchase health insurance—either individually or through their employers—would increase tax receipts. In contrast, other provisions of the plan seek to encourage individuals to choose less costly forms of health insurance, including tax-exempt HMOs.

Because it is difficult to predict the extent to which the plan will encourage consumers to secure health insurance through HMOs, as opposed to other carriers that are subject to the tax, we are unable to estimate the net effect of the plan on revenues from this source.

Indirect Effects

The President's plan is certain to have a number of indirect fiscal effects on state and local governments. For example, it is likely that a portion of the current AFDC caseload is due to individuals who go on aid or remain on assistance primarily to qualify for health care through the Medi-Cal Program. Accordingly, because the plan would make health care available to virtually all state residents, it could reduce state costs in the AFDC Program.

Most significantly, the plan will have a number of indirect effects on the state's economy. Its requirement that employers contribute to the health care costs of their employees probably will reduce low-wage employment below what would otherwise occur. This is because the minimum wage law effectively prohibits employers of low-wage individuals from offsetting the cost of health insurance premiums by reducing the wages

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of those employees. Accordingly, such businesses may attempt to recoup these costs by charging higher prices, which could reduce the demand for their services and, therefore, employment.

In the mid- and higher-wage sectors of the economy, it is unlikely that there will be a significant long-term effect on employment. Businesses likely will compensate for any increased cost of contributing to insurance premiums for these individuals by offering somewhat lower wages or lowering other benefits.

On the macro-economic level, to the extent that health reform is successful in reducing federal expenditures for health care, and thereby federal budget deficits, the state's long-term economic prospects would be enhanced. Economic changes such as these ultimately will affect the performance of state revenues. However, their net effect on revenues is extremely difficult to determine.

Summary of Fiscal Effects

We estimate that the plan will result in net savings to state and local governments of several hundred million dollars annually in the first two years of state implementation. These savings will increase over the long term, relative to what the state and

local governments would otherwise spend, for two reasons. First, we estimate that the plan's Medi-Cal and maintenance-of-effort provisions will result in state expenditures increasing more slowly over time than they would otherwise. Second, the national expenditure targets, to be enforced by caps on premiums paid by the alliances, will—if they take effect—limit the expenditures of state and local governments in their role as purchasers of health insurance for their employees. (We discuss the premium caps in more detail later in this report.)

If the state fully implements the new long-term care program, however, these savings would be reduced, particularly in later years, and could result in net costs, depending on how the state structures this program.

ASSESSMENT OF THE PRESIDENT'S PLAN

The President's plan attempts to address the problems of the current health care system through managed competition. Below, we review briefly how managed competition attempts to address these problems, and some of the key elements many believe must be incorporated into a managed competition approach for it to be successful. Finally, we

“There are a number of areas . . . where the President’s plan does not contain the elements that would foster maximum cost containment.”

offer our assessment of the President's plan in light of that discussion.

Managed Competition as a Strategy to Control Costs.

Managed competition seeks to facilitate cost control by spurring competition among health care providers on the basis of price. To do so, it would restructure existing incentives for both consumers and providers of health care in an attempt to override the sources of market failure in the current system. The Congressional Budget Office recently convened a panel of health economists to identify key features that should be incorporated in a delivery system based on managed competition in order to maximize its potential for achieving cost containment. The elements they identified are summarized in Figure 6.

How the President's Plan Stacks Up. The President's plan includes many of the key elements that advocates of managed competition argue are necessary to achieve maximum cost containment. For example, the plan embraces the concept of regional health alliances as an organizing force in the health care market, requires a standard benefits package, provides

guaranteed issuance and renewal of coverage, and prohibits exclusions based on preexisting medical conditions. It also provides for the development of risk-adjusted payments to providers and uniform measures of plan performance in order to monitor quality. Finally, it provides nearly universal coverage through subsidies to lower-income individuals. Taken together, these are significant steps that should expand the access to health care coverage and probably slow the rate of increase in health care expenditures.

There are a number of areas, however, where the President's plan does not contain the elements that would foster maximum cost containment. First, the plan allows insurance to be provided outside the alliance structure for individuals insured through large employers, the Veterans Administration, and the military, among others. By allowing a significant portion of the United States population to be insured outside the alliance framework, the effectiveness of the alliances is somewhat reduced, and the potential for some degree of cost-shifting among different purchasers of health insurance would continue.

Figure 6

Key Features of Managed Competition to Achieve Cost Containment

Establish regional health insurance purchasing groups

- Facilitates open access to health insurance.
- Provides consumers with clearer information regarding the price and quality of different plans, thereby forcing providers to compete more on the basis of cost-effective medical care.

Limit employer contributions for employee health insurance to the least expensive plan

- Encourages employees to be more price-conscious in their choice of health plans because they would pay the additional costs for more expensive premiums.

Require a standard benefits package and allow only two copayment arrangements

- Minimizes differences among plans that are unrelated to price.
- Prohibits plans from offering supplemental insurance covering copayments, additional benefits, or other forms of coverage outside the structures available through the purchasing group.
- Individuals pay more for fee-for-service plans and, accordingly, for the higher utilization levels that tend to result.

Provide uniform information regarding costs, outcomes, and quality of care

- Allow consumers to judge effectively whether or not higher-priced plans reflect commensurate improvements in quality.

Ensure access to coverage by restructuring insurance markets

- Ensures access by requiring insurers to offer open enrollment periods, premiums based on the expected cost of serving a community (rather than an individual), full coverage irrespective of pre-existing conditions, and guaranteed renewal of coverage.

Assure universal coverage

- Forces the entire health care sector of the economy to face competitive pressures thereby enhancing the system's cost-effectiveness.
- Only practical way to eliminate the "free-rider" problem of individuals receiving health care even though they may have paid little or nothing to receive it.

Adjust payments based on medical risks

- Discourages insurers from competing by pursuing low-risk individuals and also would protect insurers when the pool of individuals they attract is relatively less healthy.

Encourage providers to join only one health care organization

- Provides incentives to physicians to change their practice patterns to become more cost-effective.

More seriously, the plan allows employers to contribute much more toward the cost of insurance than the amount necessary to purchase the lowest-cost plan, and to offer more

generous benefit packages. Specifically, while the plan requires employers to pay 80 percent of premium costs, it permits them to pay up to 100 percent of these costs, as

many currently do. In addition, individuals would continue to receive an income tax deduction for more generous benefit packages for ten years. As a result of these provisions, consumers would in many cases continue to be insulated from the cost of more expensive health insurance with little incentive to make cost-conscious decisions when selecting a health insurance plan.

The plan also allows three (rather than two) types of insurance coverage—a fee-for-service arrangement, an HMO, and a preferred provider organization (PPO)—and would not prohibit supplemental insurance policies. Moreover, the plan allows individuals to go “out-of-network”—that is, to receive services outside the plan they choose—in cases where they have chosen HMO or PPO coverage. These additional options appear problematic because they would result in a potentially confusing array of choices for consumers, thereby reducing the ability of individuals to select plans based on quality and price. In addition, by allowing the individuals enrolled in an HMO to receive “out-of-network” coverage and by allowing supplemental policies, albeit for additional fees, consumers would have at their

disposal a means to skirt the utilization control mechanisms that such plans employ.

The President's plan also does not encourage the development of non-overlapping networks of providers. On the contrary, it requires that doctors be permitted to join any number of provider networks. This provision reduces the pressure on physicians that would otherwise be present to modify their practice patterns to be more cost-effective.

Finally, the plan relies on national expenditure targets as a “backstop” in case its other provisions fail to slow the rate of increase in health expenditures. The targets would be enforced by reducing payments from alliances to providers through the imposition of “premium caps.” This provision would limit overall premium increases to slightly above the national inflation rate initially, and to no more than the inflation rate within four years. Many economists believe it is unlikely that the plan's other provisions will succeed in containing medical expenditures at the levels assumed by the national expenditure targets. This is because there is no precedent among major industrialized countries for such low medical inflation rates. Thus, it appears

"We lean toward a system of managed competition . . . instead of a single-payer system . . ."

likely that the premium caps will take effect.

Some observers have expressed concern that premium caps would reduce the quality of medical care because they arbitrarily limit the amount of health care resources. However, we agree with those economists who believe that there is significant excess capacity in some sectors of the health care economy (for example, hospital beds) and significant excess utilization generally. Accordingly, the premium caps would simply force efficiencies to occur sooner than they might otherwise. However, in later years—when possible efficiencies have already been achieved—the caps could affect the quality and overall supply of medical care in the United States.

ISSUES FOR THE LEGISLATURE

The President's plan raises a number of issues for the Legislature. In this section, we identify some of these issues and comment on them.

Single Payer or Managed Competition

The first issue the plan poses for the state is whether to enact a single-payer system or the President's concept of "managed competition"—a combination of

insurance market reforms, employer and individual mandates, premium caps, and a network of regional health alliances to expand access and control costs.

Much has been written about the relative merits of managed competition and the single-payer systems. In general, advocates for the single-payer approach cite the administrative savings that would result, the ability to directly limit expenditures and services, and the fact that it has successfully controlled health care costs in a number of industrialized countries. Canada, Great Britain, France, and West Germany all have adopted single-payer systems, and devote a much lower percentage of their gross domestic product to health care than does the United States. In addition, the rates of increase for health care expenditures in these countries are significantly below those in the United States.

In contrast, advocates of managed competition are drawn to its reliance on market forces to control costs and preserve quality. Many cite concerns that a single-payer approach would be less efficient than a market-based system, and would result in long waits for certain medical procedures, a general rationing of care, and inadequate investments in research and technological

development. We lean toward a system of managed competition (with its health alliances) instead of a single-payer system because we think that a competitive market system will prove to be more efficient in the long run than a regulatory approach.

Options for Improved Cost Containment

Although we believe that a managed competition approach is preferable to a single-payer system, we have identified above several shortcomings with the managed competition system envisioned in the President's health proposal. There are, however, a number of steps available to the Legislature to strengthen the cost-containment potential of the President's plan if it is enacted. We believe that it is important to focus on the plan's cost-containment provisions because weaknesses in this area increase the possibility that reduced costs will be achieved through lower-quality medical care rather than through a more efficient delivery system.

We believe that the following options deserve further review and consideration by the Legislature.

- *Integrate the health coverage currently provided through workers' compensation and*

automobile insurance, and possibly Medicare. In general, steps such as these that increase the proportion of health expenditures subject to market-based discipline should improve the overall cost-containment potential of the health reforms. In addition, these steps would result in administrative savings. With respect to Medicare, we believe that similar improvements in the cost-effectiveness of the system would result from including the program in the system. However, due to the high costs of serving the medical care needs of persons eligible for Medicare, the ability of the state to negotiate an acceptable risk-sharing arrangement with the federal government would be a very important factor in determining whether to include this group in the state's system.

- *Prohibit certain supplemental insurance policies.* As with "out-of-network" services, these policies undermine the potential for cost containment among all plans because they offer a way around utilization controls. In addition, depending on

"... the Legislature should explore strategies to discourage employer contributions beyond the lowest-cost, basic benefits plan."

how they are structured, supplemental policies could allow plans to attract lower-risk individuals. Finally, these policies add to the confusion confronting consumers, thereby making it more difficult to choose the least expensive high-quality plan.

- *Discourage employer contributions that exceed the lowest-cost plan in any given region.* The President's plan allows employers to pay 100 percent of the cost of health plans, and maintains the tax-deductibility for more extensive health benefit packages. To the extent that employers pay 100 percent of employees' health plan costs, there is little incentive for these consumers to make price-conscious decisions when utilizing health services. Accordingly, the Legislature should explore strategies to discourage employer contributions beyond the lowest-cost, basic benefits plan. One option would be to eliminate the state tax deduction for such payments. Without corresponding federal action, however, this step alone would probably have a

relatively minor impact on consumer behavior.

- *Discourage "out-of-network" services when consumers have selected an HMO or PPO coverage.* The state could attempt to restore the protections against excess utilization that these types of plans provide by discouraging out-of-network services—for example—through the use of a state surcharge for these services.
- *Increase taxes on products, such as alcohol and tobacco, that are linked to behavior that increases costs to the health care system.* There are a number of factors to consider when setting tax levels on any product or service, including potentially adverse economic effects. However, it is likely that the full "social cost" of alcohol and tobacco products is not reflected in their price and that incorporating this social cost would reduce burdens on the health care system.

State and Local Governments As Employers

The President's plan highlights a choice that always exists for state and local governments as employers: how much to

contribute to public employee health plans. If the Legislature enacts the managed competition system of regional health alliances envisioned in the President's plan, however, this choice will become more important because governmental entities will no longer have the ability to negotiate premiums with health care providers and insurers, nor will they have many other avenues to directly control their costs for health care benefits.

Accordingly, we recommend that the state limit its contribution to the minimum 80 percent of the average cost plan available through the alliances and require local governments to do the same. This will encourage public employees to be more price-conscious in their decisions, thereby controlling utilization and facilitating cost containment for state and local governments for health care benefits.

Optional Benefits For Non-Cash-Grant Recipients

The President's plan permits states to provide optional benefits to Medi-Cal recipients but does not provide federal funding for non-cash-grant individuals (those who do not qualify for AFDC or SSI/SSP). In the current Medi-Cal Program, California has elected to provide optional benefits for non-

cash-grant individuals. Examples of such benefits include adult dental services, nonemergency transportation, and other services. As in the past, this is a policy decision for the Legislature that raises trade-offs regarding the relative benefits of these services versus others that may be more preventive in nature.

Need for Additional Health Care Providers

If enacted in its current form, the President's health care plan would result in universal health coverage. Such coverage will increase the demand for medical care and in turn lead to higher prices if there is no concomitant increase in the supply of health care providers. Accordingly, we recommend that the Legislature take steps to increase the supply of health care providers, particularly of nonspecialized physicians, physician assistants, nurse practitioners, and other primary care and prevention-oriented providers. For example, we believe the Legislature should consider strategies to encourage the University of California to train more primary care physicians rather than specialists.

Similarly, we believe the Legislature should review barriers that prevent these providers from serving the widest

"A key decision for the Legislature will be whether or not to participate in the new home- and community-based long-term care program."

number of individuals whom they are qualified to serve.

New Long-Term Care Program

A key decision for the Legislature will be whether or not to participate in the new home- and community-based long-term care program. As we have indicated, the program will result in significant long-term costs to the state if fully implemented, assuming no "rationing" of services. If the state elects to participate in this program, it will face additional choices regarding its integration with existing programs that provide similar services, such as the IHSS Program, the Regional Centers for the Developmentally Disabled, and possibly county mental health programs.

We also note that the state could structure the program to avoid any additional costs or to achieve savings. Because eligibility for the new program may not be limited based on income, the state essentially can take two actions to control costs: limit enrollment on a first-come, first-served basis or limit the level of services.

Integration of Other State Programs With Alliances

Similarly, the state will face choices regarding how to

integrate some existing state programs with the services provided through the alliances. In general, programs such as county mental health programs, California Children's Services, and a number of maternal and child health programs offer a mix of medical and social services. Many of the medical services will be available to program enrollees through the alliances, but some of the social services may not be, or may be available to a more limited extent. Thus the state will have to decide how it will provide these services.

Implementation Date

If the President's plan is enacted with few changes to its proposed Medi-Cal and maintenance-of-effort provisions, we recommend that the state implement the plan in the first year it is allowed to do so. We recommend this because the plan is structured in such a way as to fiscally benefit the state if it does so (potentially by more than \$100 million annually).

Conclusion

The President's plan, if enacted, will pose a number of significant policy issues for state and local governments in California. These choices will determine the plan's fiscal effects on state and local government, and are likely to

have indirect effects on the state's economy. Accordingly, we have focused much of our discussion on cost-containment issues and

have provided a number of options that may strengthen the plan's cost-containment features.

This report was prepared by Bill Wehrle, under the supervision of Chuck Lieberman. For additional copies, contact the Legislative Analyst's Office, State of California, 925 L Street, Suite 1000, Sacramento, CA 95814, (916) 445-6061.

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