October 31, 2006

Hon. Bill Lockyer
Attorney General
1300 I Street, 17th Floor
Sacramento, California 95814

Attention: Ms. Patricia Galvan
Initiative Coordinator

Dear Attorney General Lockyer:

Pursuant to Elections Code Section 2005, we have reviewed the proposed statutory initiative entitled, "The California Health Insurance Reliability Act" (A.G. File No. 06-0035). This measure would establish the framework for a "single-payer" health care system administered by the state through a new California Health Insurance Agency (CHIA).

BACKGROUND

Health Coverage and the Uninsured. The majority of Californians receive health coverage through (1) insurance provided through their employer or the employer of a family member, (2) the purchase of individual health insurance policies, or (3) government programs such as Medi-Cal or Medicare. However, based upon a 2003 survey, approximately 6.5 million California residents lacked health insurance coverage at some point during that year.

Some persons who lack health coverage are eligible to enroll in health coverage provided by government programs such as Medi-Cal, but have chosen not to participate in them. Other uninsured persons are not eligible to enroll in such coverage. Currently, those persons without health insurance coverage receive medical care through a number of different programs and providers. Some persons who are uninsured may qualify to receive free or low-cost medical assistance from counties, which are generally responsible under state law for providing health care for low-income persons who lack health coverage. Other uninsured persons rely on free or low-cost health care from medical providers, including private clinics, hospitals, or physicians, which often is referred to as charity care.

PROPOSAL

This measure creates the framework for a single-payer health care system administered by the state, called the California Health Insurance System (CHIS). The concept of a single-payer system is to provide health care benefits to all eligible residents of California through a single source of coverage instead of the many existing sources. If implemented, the CHIS would be funded by premiums levied upon income earners and employers, as well as the transfer of federal, state, and local funds currently used to pay for existing health care benefits to the extent that these resources were made available. The major provisions of the measure are described below.

Framework for a Single-Payer Health Care System

As previously mentioned, this measure establishes a framework for a single-payer health care system administered by the state. In order for this framework to actually become effective, several legislative and administrative steps, which we discuss later, would have to be taken. Thus, it is possible that a single-payer system would not be established even if this initiative was approved by the voters. If and when CHIS actually went into operation, it would replace the current system of private health coverage and public health care programs with the new single-payer system described below.

Eligibility. Generally, all residents of California, including residents who are temporarily residing out of state, would be eligible for health care benefits under this proposed new system. In the event of a large-scale migration of new residents entering California to join the new system, this initiative specifies that new residents would be required to wait a period of time and be subject to other eligibility criteria determined by CHIA.

Benefits. The proposed single-payer system would generally provide all medical care benefits deemed medically appropriate by a participating health care provider, including doctor and hospital visits, inpatient and outpatient services, diagnostic and testing services, durable medical equipment, prosthetics, vision aids, immunizations, rehabilitative care, dental care, mental and behavioral care, home health services, and prescription drug coverage. Cosmetic surgery and other services undertaken for purely cosmetic reasons would be excluded unless these procedures would be to correct a congenital defect or disfigurement resulting from an injury.

Program Administration. The initiative would create a new state agency, CHIA, to administer the CHIS. Within the agency, separate entities for patient advocacy, policy, quality control, and payments would be created. The initiative would create a new state position, appointed by the Governor and subject to confirmation by the state Senate, called the Health Insurance Commissioner. The commissioner would oversee most

aspects of implementing the new single-payer system. The commissioner's duties would include:

- The creation of health-planning regions to provide local and community-based care. (A regional planning director and regional planning boards would administer each region.)
- The creation and allocation of the CHIS budget, including allocation and distribution of funding to health planning regions.
- The negotiation of rates to be paid to participating health care providers.
- The negotiation of rates and prices paid for prescription drugs and durable medical goods, such as wheelchairs.
- The administration of CHIA's personnel, including hiring and firing of staff and decisions regarding salary compensation.
- The implementation of eligibility standards and program enrollment rules.
- The implementation of cost-containment measures, if needed.

The initiative would also create: (1) an advisory group on how best to transition from the current health care system to CHIS, (2) a Health Insurance Policy Board of various state officials who would determine the scope of medical services and set guidelines to evaluate the performance of CHIS, (3) a Public Advisory Committee of citizens who would advise that policy board, (4) an Office of Patient Advocacy to help persons who encounter problems in obtaining the health benefits for which they are eligible, (5) an Office of Health Planning to conduct health planning and set certain program standards, (6) an Office of Health Care Quality to support the delivery of high-quality health care, (7) a Payments Board to establish a uniform system of payments for health care providers, and (8) a Premium Commission to recommend a premium structure to fund the new system.

Financing. The new single-payer health care system would be financed in part by premiums levied upon all income earners and employers. If the Legislature and Governor took action to enact such premiums, they would eventually largely replace the current spending by employers and individuals for private health insurance coverage. The Premium Commission established by the initiative would be appointed and convened to recommend a premium structure to the Legislature and the Governor by no later than January 1, 2009. The measure requires that the premiums be affordable and consistent with existing funding sources for health care to the greatest extent possible.

Funds generated by the collection of premiums would be placed in a newly created state fund, called the Health Insurance Fund, and could be used only for the support of

CHIS. The measure would also create a reserve fund to insure against temporary revenue shortfalls.

Additionally, CHIS would be funded by the transfer of federal, state, and local funds currently used to pay for existing health care programs, to the extent that these resources were made available by future actions of those government agencies. The measure specifically directs the commissioner to seek permission from the federal government, including any needed changes in federal laws and rules, to incorporate funding from health care programs currently funded by the federal government (such as the Medi-Cal Program for low-income persons and the Medicare Program for the elderly and disabled).

The state would be authorized to recover costs from various public and private entities for providing health care as the new system was being phased in. Also, a loan would be made from the General Fund to fund transition costs incurred during the switch from California's current system to the new single-payer system. The commissioner could also use other private sources of funding for this purpose.

This initiative would not require user co-payments or payments of deductibles by patients to obtain medical services unless required by cost-containment provisions discussed below.

Provider Rates. Unlike current law, this measure would allow certain groups of physicians to nominate representatives of their medical specialties to negotiate payment rates with CHIS. It would also allow health care providers to negotiate rates with CHIS to cover the costs of providing services. This measure seeks to exempt these rate-negotiating activities from antitrust laws. The measure also specifies that providers must be paid for the services they provide, regardless of whether the patient is later deemed ineligible for the system.

Cost Containment. Under the measure, the commissioner would be authorized to implement certain cost-containment measures if projected expenditures for the single-payer system ever exceeded expected revenues. For example, the commissioner could improve the efficiency of the new health care system, delay the introduction of new benefits, adjust provider rates, or impose co-payments or deductibles on patients to contain costs. However, the measure would not provide the commissioner the authority to limit existing benefits, to increase premiums, or to increase other state financial support. If budget shortfalls still existed after the implementation of cost-containment measures, the commissioner could request the Legislature to enact a premium increase to address any remaining shortfall in funding.

Activation of CHIS Depends on Availability of Funding

As mentioned earlier, the implementation of the CHIS framework would occur only if and when the Legislature and the Governor passed a state law that imposed the premiums needed to finance a single-payer health care system. This initiative specifies that the implementation of CHIS would not begin until after the Secretary of the California Health and Human Services Agency, the existing state official who supervises state health and social services programs, had determined that sufficient revenues were available for this purpose. Once this determination has been made, the measure specifies that the new system would be implemented within two years.

FISCAL EFFECTS

This measure would have a number of fiscal effects on state and local governments. The major identifiable net fiscal effects are discussed below.

Fiscal Impacts if Single-Payer System Is Not Implemented

As noted above, implementation of the single-payer health system would depend on future actions by the Legislature and Governor. If they decided against imposing the premiums needed to finance the new health care system, most of the provisions of this measure would not be implemented and, therefore, would have no fiscal effect.

Establishment of the Premium Commission would probably result in one-time state costs in the low millions of dollars.

Fiscal Impacts if Single-Payer System Is Implemented

Increased State Revenues for Operation of CHIS

If the Legislature and Governor took the steps necessary to ensure that CHIS was implemented, the measure could eventually result in an increase in state revenues of roughly $155 billion annually beyond the amount of funds it already receives for the operation of existing health care programs (for example, beyond the federal funds received for the Medi-Cal Program).

New Source of Revenues for CHIS. The increase in state revenues consists of two sources, premiums and the incorporation of funding from existing federal programs (primarily Medicare). As regards premiums, the state could eventually collect additional state revenues in the general magnitude of $115 billion annually from employers (including both state and local government employers) and income-earning individuals.

If funding from certain federal programs, such as Medicare, were incorporated into CHIS, the state could gain up to approximately $40 billion in federal revenues for

operation of the new single-payer system. Our analysis assumes no initial change in the amount of federal funding now provided for the Medi-Cal Program that, with federal approval, would be redirected to CHIS.

State Could Receive Contributions From Local Agencies. Under the terms of this measure, the state could collect contributions from local governments to offset the cost of local current government health care programs for low-income individuals which would be replaced by this measure. These contributions from local agencies would be in addition to the employer premiums paid into CHIS by local agencies.

One-Time Transfer of Health Care Reserves. This measure provides that health care monies held in reserve by the state, counties, and cities would be transferred to CHIS if and when it assumed financial responsibility for providing health care. We estimate that several billion dollars could be transferred to the state, depending on the implementation of CHIS and the extent to which such transfers would be permitted under existing laws and contracts.

State Expenditures for Operation of CHIS

If implemented, this measure would result in an unknown but significant increase in state spending, potentially in the range of $155 billion annually, for the administration and provision of benefits to persons receiving services under the new single-payer health care system. Total spending for CHIS would amount to roughly $190 billion annually, including both the revenue sources described above and the redirection of roughly $35 billion in funding from existing state health coverage programs, such as Medi-Cal.

Net Fiscal Impact on State From CHIS Operations

State Could Experience Positive or Negative Fiscal Impact. The net state expenditures for CHIS administration and benefits could be greater or lesser than the $155 billion annual increase in state revenues discussed above. Whether the new system results in a positive or negative net fiscal impact for the state would depend on a number of major factors, including the following:

- Which federal, state, and county health care programs were incorporated into the single-payer system.
- The cost of transitioning to the new system and repaying loans made from the state General Fund for this purpose.
- How implementation of the new system changed the specific benefits available to health care consumers, including state employees, as well as consumers' access to those benefits.

- How the new system affected the utilization of health care services and the health outcomes of individuals, including by those who are currently uninsured.
- The magnitude of administrative savings and other efficiencies that could be achieved under the system, such as through reduced use of emergency rooms due to better access to primary care physicians, or better prices on prescription drugs due to bulk purchasing arrangements.
- The extent to which the Health Insurance Commissioner took actions to contain the costs of the new health care system.
- Future decisions by the Legislature and Governor to increase or decrease the level of funding available to support the system (such as changing the level of premiums).
- The outcome of any legal challenges to the implementation of this measure, such as the transfer of reserve funds from the state, counties, and cities to CHIS.

Different Scenarios Possible. The measure calls for the new health care system to be managed so that it grows in line with the economy and population increases, which would be a slower growth trend than experienced in California and the nation in recent years. This could be accomplished in several ways, such as through improvements in the coordination of health care or the implementation of cost-containment measures such as tighter limitations on payments to physicians or hospitals. Under such a scenario, this measure could result in a positive net fiscal impact for state government.

Depending on how CHIS was implemented, however, other scenarios are possible that could result in a net increase in state costs. This could occur, for example, if utilization of medical services increased dramatically due to improved access to care resulting from the implementation of CHIS. If premiums did not increase in line with increased costs, perhaps in order to keep premiums affordable for individuals and employers as this measure requires, the result might be increased state subsidies to support the new system.

Other State Revenue Impacts

The measure would affect state revenues in other ways as well. For example, the state now charges a tax on premiums for health insurance sold in California by for-profit companies. Since most private health insurance would be eliminated, the measure would reduce premium tax revenues to the state. In addition, profits could be reduced for firms who currently assist in the management of self-insurance programs or health plans (often called health maintenance organizations, or HMOs). The combined

premium tax and corporate income tax revenue reductions associated with such factors are unknown, but could potentially be several hundred million dollars annually.

Fiscal Impact on Local Governments

The measure would likely affect the finances of local government agencies, especially counties, who under current state law are providers of health care for low-income persons. It is likely that these health coverage programs would be discontinued if CHIS became operative because these persons would most likely be eligible for health care coverage under CHIS. As a consequence, local governments would experience health care savings. However, as mentioned earlier, local governments could be required to pay CHIS a contribution to offset the cost of providing coverage to these persons. Therefore, the net fiscal impact of these costs and savings on local governments is unknown.

State and Local Government Employee Health Benefits

The effect of the measure on state and local agencies in regard to spending for public employee health benefits would depend on whether the premiums paid by governments into the new system were greater or lesser than their current costs for employee health benefits. The net effect on state and local governments as employers is unknown.

Indirect Impact on the State's Economy

Overview of Economic Impact. This measure could have a number of effects on the state's economy which would have both positive and negative implications for state and local revenues. The magnitudes of these different impacts are difficult to predict, and would depend in part on the behavioral responses of businesses and individuals to the measure. The main two forces driving these impacts are how the measure would affect the costs of providing health coverage to eligible individuals and how it would change the number of individuals receiving benefits.

The measure's economic effects could include both broad economy-wide impacts and significantly differing effects within various sectors of the economy, since the effects on different businesses and individuals could vary widely. For example, as regards the various sectors of the economy, there could be changes in labor markets involving employment levels, wage rates, worker productivity, and labor mobility. Likewise, business decisions about location, personnel, and prices could be affected. From a broader perspective, there could be changes in the statewide levels of income, profits, and production, and in the mix of health-related versus other expenditures. The measure would result in economic "winners" and "losers," and the economic effects would tend to differ by industry, by type of medical provider, by size of firm, and by

category of employee. Some of these economic effects would be long-term in nature, whereas others would be short-term.

Short-Term Effects on the Economy. At least initially, the net revenue effect of all of the foregoing economic changes probably would be negative. This is largely because employers who are not currently providing health coverage or who are less able to pass on the costs of the premiums to consumers would likely reduce the number of their employees and/or the wages they pay. This, along with the various uncertainties and temporary short-run adjustments and dislocations that would accompany the measure initially, would tend to negatively affect statewide economic activity, particularly in the lower-wage sectors of the economy where most uninsured people are employed. This would in turn reduce state and local revenues. The net state revenue loss during the first few years is unknown but could potentially be as much as several hundred million dollars annually.

Long-Term Effects on the Economy. After several years, the measure's effect on overall state economic performance and state revenues is uncertain. The net effect would depend on the significance of the measure's positive economic effects relative to its ongoing negative effects. The ongoing negative effects could include reduced employment and wages, primarily in the low-wage sector, and incentives to downsize certain firms in order to reduce their payroll tax rate under the measure. This could in some cases reduce economic productivity.

The positive effects would include reduced labor costs for certain employers for whom the health-related premium costs are less than current health costs. This would benefit the economy in several ways, such as increasing corporate profits, stimulating employment, and raising wages. There also would be certain benefits from the increased labor mobility that would result from individuals being able to retain health benefits when changing employers and potentially fewer lost work days due to illness.

In addition to the fiscal effects discussed above, it is possible that the measure could, depending on its implementation, result in a greater share of California's health-related costs being deductible for federal income tax purposes than is currently the case. This is because, although California employers currently can deduct their costs of providing employee health benefits when computing their taxable income for state and federal income purposes, the out-of-pocket health-related expenditures incurred by individuals are *not* fully deductible. If this measure was implemented by imposing a premium charge to fund health costs that was deductible for federal income tax purposes, this could reduce annual California federal tax liabilities by as much as a few billion dollars, depending on the income characteristics and health expenditures of the taxpayers involved. The resulting increase in after-tax incomes could, in turn, potentially benefit

the state's economy and eventually state revenues as this income is spent and/or invested.

Summary

The measure would have the following major direct fiscal impacts:

- One-time increase in state spending in the low millions of dollars to establish a Premium Commission.
- If the measure is enacted and future actions were taken to fully implement a single-payer health care system, state revenues and spending could increase by roughly $155 billion annually. Revenues to the system could be greater or lesser than its costs, depending on various factors.
- Unknown but potentially significant increase or decrease in the cost to state and local governments of purchasing health coverage for public employees.
- Unknown reduction in state insurance premium tax and corporate income tax revenues of potentially several hundred million dollars annually.

Sincerely,

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Elizabeth G. Hill
Legislative Analyst

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Michael C. Genest
Director of Finance