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Can California's Proposed Coverage Reform Be a Model for the District of Columbia?

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California developed two competing proposals for universal health coverage in 2007. Early in the year, Governor Arnold Schwarzenegger unveiled a universal coverage plan for the state with a focus on affordability and prevention.[1] The legislature passed a competing bill,[2] which the governor vetoed as promised. In October, the governor responded by putting his proposal into the form of a legislative bill, which the legislature was considering as of November.

The governor's proposal features an approach that is, in many ways, similar to the landmark legislation Massachusetts passed in 2006, although the size of the uninsurance problem facing California is far greater than that facing Massachusetts.[3] Almost 5 million people in California are uninsured on any given day, 20.7 percent of the nonelderly population, compared with a little over 500,000 (11.1 percent) in Massachusetts. Thus, California needs to solve a much larger problem. The share of the population that is uninsured in the District of Columbia, 13.5 percent in 2005–2006, is closer to that of Massachusetts than of California.[4]

The debate in California highlights both the strengths and weaknesses of the District's insurance system as a platform for expansion

This brief examines two fundamental questions that are addressed by the California proposals and would need to be addressed by the District if it chose to pursue universal coverage:

- how would coverage be expanded?
- how would the coverage expansion be financed?

We start by outlining the proposal put forward by the governor both initially and as modified in the legislative process, and compare its features to those in the legislature's proposal.[5] We then discuss how conditions in the District might affect the implementation of similar reforms here.

Coverage Expansion and Insurance Reform

The governor's proposal. The governor's proposal (figure 1) to achieve universal coverage relies on three key policy changes, with shared financing by the state, business, and individuals. The key components are:

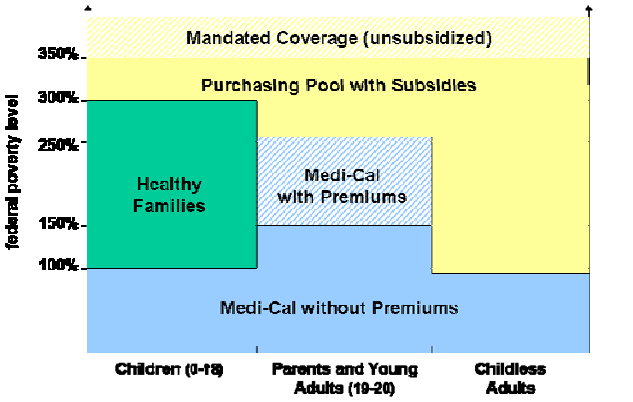
- Individual mandate for coverage
- Public program expansion
- Subsidies for private coverage

The governor's proposal would mandate that everyone in California have a minimum level of coverage, defined through the regulatory process. In addition, insurers would be required to structure benefits to promote prevention and wellness and to create diabetes, obesity, and smoking cessation initiatives.

Eligibility for Medi-Cal (California's Medicaid program) would be expanded to include nonparents with incomes under 100 percent of the federal poverty level (FPL) who are legal residents and also young adults (ages 19 and 20) and parents with incomes up to 250 percent of the FPL.[6] Adults enrolling in Medi-Cal who have income between 151 and 250 percent of the FPL would be required to pay 4 to 5 percent of their income toward premiums. In addition, income eligibility for children enrolling in Healthy Families``````````, California's SCHIP program, would be increased from 250 to 300 percent of the federal poverty level (FPL). The state would continue to require premiums for children enrolling in Healthy Families.[7]

For adults with incomes below 350 percent of the FPL who are not eligible for public coverage, the state

Fig. 1 California Governor's Approach To Universal Coverage

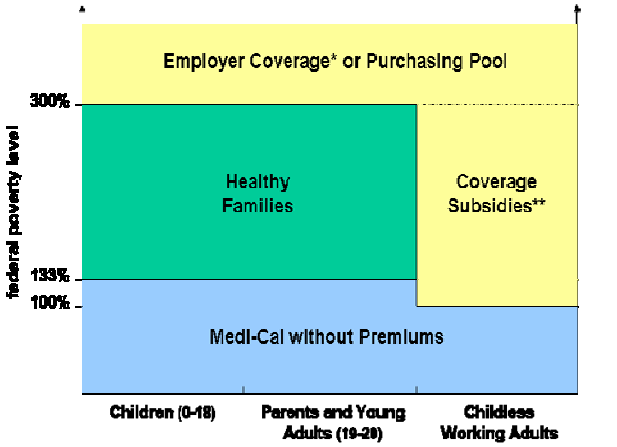


Source: Authors' illustration, based on Comparison of California Health Coverage Expansion Proposals, http://www.calhealthreform.org/pdf/comparison.pdf.

would provide subsidies in the form of tax credits to help them purchase coverage through a state-run purchasing pool. Subsidies would be set so that the family contribution toward the premium would not exceed five percent of gross family income. Individuals with income below 350 percent of the FPL who already have individual or employer-sponsored coverage would also be eligible to receive subsidies through the purchasing pool. Undocumented immigrant adults would not be eligible for either public coverage or subsidies.

The legislature's proposal. The legislative counterproposal (figure 2) was almost as ambitious as the governor's proposal. It called for a somewhat larger expansion of public coverage and opened Healthy Families to residents regardless of immigration status.[8] Specifically, the legislature's proposal would include all children and parents with incomes below 300 percent of the FPL in one of the public programs. In comparison, Schwarzenegger would end public coverage at somewhat lower income levels for adults, but provide subsidies for families with incomes up to 350 percent of the FPL.

Fig. 2 California Legislature's Approach To Expanded Coverage



Note: *Provided premium cost is below 5% of income **To keep premium contribution below 5% of family income if family income is under 300%; Source: Author's illustration, based on Comparison of California Health Coverage Expansion Proposals, http://www.calhealthreform.org/pdf/comparison.pdf.

Like the governor's proposal, the legislative proposal would establish a state purchasing cooperative. All employees and dependents eligible for coverage through one of the public programs would receive their coverage through the purchasing pool. Premium payments (required under Healthy Families) for these new eligibles would be set on a sliding scale and would not exceed 5 percent of family income. In addition, employees of firms that chose to pay a tax instead of providing health coverage (discussed below) would be required to enroll in a health plan through the cooperative. However, no employee would be required to enroll in a plan if the costs of coverage exceeded 5 percent of income.[9]

Insurance market reform. Under both proposals, California would implement insurance market reforms. Insurers would be required to guarantee issue of health insurance to individuals and small groups (i.e., they could not refuse to sell coverage to anyone) and insurers' administrative costs and profits could not exceed 15 percent of premiums. The governor's proposal would phase in elimination of medical rating restrictions, which would allow rates to rise as an individual's health status changed. Under the legislative plan, guaranteed issue would also be extended to mid-sized groups, and premiums would be set on a community-rated basis (i.e., using only age and geography as rating factors). In addition, the state's high-risk pool would be expanded, medical underwriting would be simplified, and insurers would be required to offer three uniform plans to facilitate price comparisons.

Financing of Coverage Expansion

The governor's early 2007 proposal was estimated to cost $12.1 billion annually, with funding coming from federal, state and local sources. The largest source of the revenues was to have come from a "provider coverage dividend" that would have required payments of four percent of gross revenues from hospitals and two percent from physicians. (The revised proposal dropped the physician payments.) These payments would be offset to some extent by a substantial increase in provider rates under Medi-Cal and Healthy Families. The state also expected to recoup an estimated $1.0 billion from counties because the county obligations to provide indigent care would be reduced. Another $1.0 billion in payments is anticipated from firms that pay a tax in lieu of providing coverage.

Less information is available about the overall price tag and sources of revenue for the legislative proposal, but it does acknowledge that the state would need to get federal approval of a waiver and to appropriate state funds to cover the costs of the expansions. The legislative proposal would not impose a tax on provider revenues but, instead, would rely on payroll taxes. All employers regardless of size would be required to provide coverage for full-time and part-time employees or pay a tax equal to 7.5 percent of Social Security wages, an arrangement generally referred to as "pay or play."

Projected Effects on Uninsurance

Simulations suggest that the governor's original proposal would move California closer to universal coverage than the legislature's plan, largely because of the individual mandate. Of the 4.9 million people estimated to be uninsured on any given day, about 4.1 million would have coverage under the governor's proposal.[10] The remaining 800,000 people are assumed to be undocumented immigrants who would receive care coordinated by California's counties. If county-provided care is viewed as "coverage," the proposal

achieves universal coverage. In contrast, simulations of the legislature's proposal suggest that only 3.4 of the 4.9 million uninsured would be covered.[11] Although the legislature would provide for free or highly subsidized coverage for people with incomes below 300 percent of the FPL, without a comprehensive mandate, it is not known how many people would take advantage of this coverage. Only workers and dependents in firms that do not offer coverage and pay the 7.5 percent tax would be mandated to buy coverage.

Could the District of Columbia Adopt Either of the California Plans?

Both California plans start with expansions of the public insurance programs. The District has already enacted fairly broad public coverage for its low-income population, up to 200 percent of the FPL. However, other aspects of the California proposals, particularly those related to purchasing pools and insurance market reforms, would represent significant changes for the District. In addition, because the District is a small jurisdiction rather than a large state, the implications of an individual coverage mandate or an employer tax on firms that do not provide health insurance would be quite different.

Available public and subsidized coverage. Both D.C. and California already provide extensive coverage through Medicaid and SCHIP/Healthy Families (the District's SCHIP program is also called Healthy Families). Even without expansions, the District's program already covers children and parents in families with higher incomes than proposed in California. D.C.'s programs cover children up to 300 percent of the FPL (versus 250 percent in California) and parents up to 200 percent of the FPL (versus 100 percent in California). Under current federal law, the District may be able to expand coverage for parents with incomes above 200 percent of the FPL, and the 70 and 79 percent federal matching rate available for Medicaid and Healthy Families, respectively, makes this a more attractive option than in California where the match is 50 percent for Medi-Cal and 65 percent for Healthy Families.

The District also already provides free coverage up to 200 percent of the FPL under its D.C. Health Care Alliance program that covers residents not eligible for Medicaid, including undocumented immigrants. It could build on the Alliance to expand coverage and could consider instituting sliding-scale premiums at higher incomes to help finance the expansion. Focus groups with uninsured residents have indicated willingness to pay for participation in the Alliance.[12] The Alliance also offers an administrative structure that could be useful for expanding subsidized coverage, particularly if it could be adapted to include access to private insurance offerings. Both of the California proposals would require the creation of new purchasing pool arrangements.

Employer role. Both California proposals have a significant "pay or play" role for employers. They either require that the employer provide coverage ("play") or pay a tax that would be used to offset the costs of their employees' purchase of coverage. An employer mandate in the District is likely to have quite different effects because of the District's size, its location, and the type of employers it has. Many employers in the District, including the federal and local governments, are large and already provide coverage. District employers that do not offer coverage are mainly smaller establishments. In addition, only about a third of employees in the District are District residents; the rest commute from the Maryland and Virginia suburbs.

The District could limit the liability of the smallest employers as in the governor's proposal, but many of the others could easily move across the District line to Maryland or Virginia to escape an employer mandate. Those that stay could be placed at a competitive disadvantage relative to similar firms across the borders. The competitive issues created by bordering areas are much more prominent in a jurisdiction such as the District than they are almost anywhere else in the country. If the District is committed to achieving universal coverage, requiring residents to have insurance is likely to be more effective than requiring employers to offer it.

Individual mandate. The city could impose an individual mandate on its residents, whereby all adults or all adults and children would be required to obtain coverage. Mandates can only be effective if available coverage is affordable. The Schwarzenegger proposal makes coverage affordable for people not eligible for free or subsidized coverage by allowing the regulatory process to define a minimum coverage. However, the very high deductibles and potentially large out-of-pocket payments that could be associated with such coverage might make it little different than no coverage at all for people with low incomes.

The legislative proposal did not mandate coverage for everyone, and it provided for subsidies that limited premiums to five percent of income for those it did require to have coverage. D.C. could follow either of these approaches. If affordable coverage is made available, an individual mandate could apply to all residents without imposing excessive financial burdens on individuals and families. However, unless effective coverage can be made affordable—either by the benefit design or the subsidy structure, a mandate would likely prove difficult to enforce and a larger-than-desired uninsured group would remain.

Program administration. The California proposals create a new administrative unit to implement the proposed reforms, which will require both income eligibility assessment and identification of appropriate public and private coverage options. In the District, the administrative structure for determining eligibility for

both the Alliance and Medicaid is the responsibility of the Income Maintenance Administration (IMA). The District could add a unit to IMA or to the Department of Insurance, Securities, and Banking (DISB), which regulates insurance, to identify eligible individuals for subsidies and to provide information on insurance plans to small groups and individuals without access to employer-based insurance or public coverage.

Insurance market. The District currently has little insurance regulation in the private nongroup market. For example, although coverage cannot be denied, there are no limits on what individual purchasers can be charged, and premiums can vary substantially based on health status, age, gender, and other factors.[13] Thus, private, nongroup insurers are able to exclude or limit coverage to those with health problems either directly or by pricing. Under these circumstances, the excluded individuals will have few options except the new free or subsidized coverage.

The resulting concentration of high-cost enrollees in the new coverage programs, a phenomenon known as "adverse selection," would result in above-average per enrollee costs. Healthier purchasers would be able to avoid sharing in these costs by continuing to obtain coverage outside of the program. Depending on the new program's subsidies and pricing rules, less healthy purchasers might be no better off than they are today. Such problems could be ameliorated by combining the individual and small group markets, by enacting the other types of insurance market reforms adopted by California and other states, by requiring all individual purchasers to obtain coverage through the Alliance or other public purchasing system, and/or by providing direct subsidies to offset the costs associated with higher-cost program enrollees.

Financing. California's proposals offer free coverage only to adults with incomes below 100 percent (governor) or 133 percent (legislature) of the FPL. The District could consider imposing a sliding scale premium schedule starting at incomes over 150 percent of the FPL for Alliance members, which would impose new costs on current Alliance members with incomes between 150 and 200 percent of the FPL. Although such an increase might be politically difficult, it would provide some of the funding needed to extend subsidized coverage above 200 percent of the FPL. Alternatively, the District could increase general revenue allocations to finance an expansion. Some assurance of continuous residency, for example, six months prior to enrollment in the new program, would probably be necessary to minimize border crossing into the District to obtain subsidized coverage. Rising enrollment and costs as well as difficulties in enforcing the residency requirement have been recent issues in discussions of the Alliance.

More broadly, subsidies for low-income purchasers of Alliance or other coverage could take the form of individual tax credits or direct subsidies paid to participating health plans. If adverse selection becomes a problem, subsidies for the excess costs associated with individuals with high medical needs could be paid directly to health plans through, for example, government-supported reinsurance. The District could finance subsidies and a coverage expansion by redirecting some of the revenues, such as Medicaid disproportionate share hospital (DSH) payments, that now flow directly to safety net providers for care of the uninsured since the number of uninsured will be greatly reduced.

If an individual mandate is imposed, an increase in general revenues would almost surely be required to finance the extended subsidies and the higher participation in the Alliance and Medicaid that would follow. The District would need to consider various sources for the new general revenues including dedicated income streams from increased income or sales taxes or from taxes on hospitals, as in Schwarzenegger's plan. Pay-or-play requirements on businesses are not likely to be effective for the reasons discussed above.

Summary and Conclusions

It is likely that the details of the proposals will continue to evolve in the legislative process, as they surely would in any similar initiative in the District. The differences between California and the District and how they affect the answers to the fundamental questions, however, remain. Because of the large differences in size, geography, employment, and insurance markets, the District cannot expect to draw directly on the California proposals as a model for its own health care reforms.

Nonetheless, the recent debate in California serves to highlight both the strengths (broad public coverage) and weaknesses (minimal insurance market regulation) that the District must take into account if it is to move forward toward universal coverage. The District has a smaller uninsured population and already has in place many of the components of the administrative framework proposed in California, which could be used to expand public and private coverage with subsidies tied to income.

On the other hand, the District has a largely unregulated insurance market that could create severe adverse selection problems for a greatly expanded Alliance. In addition, the District has a smaller financial base from which to finance reform. Existing payments to safety net providers are substantially lower than in California. Restrictions on new revenue streams are greater due to the dominance of the federal government in employment and federal constraints on new taxes. Finally, in all new initiatives, the District must consider the implications of border-crossing by both individuals and businesses for revenue generation and program participation.

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Endnotes

[1] http://www.calhealthreform.org/content/view/25/32/.

[2] http://www.calhealthreform.org/content/view/26/27/.

[3] See Linda J. Blumberg and John Holahan, "Can the Massachusetts Healthcare Reform work in the District of Columbia?" Health Policy Issue Brief, DC-SPG, forthcoming; Allison Cook and John Holahan, "Health Insurance Coverage and the Uninsured in Massachusetts: An Update Based on 2005 Current Population Survey Data," Kaiser Family Foundation, August 2007. http://www.bcbsmafoundation.org/foundationroot/en_US/documents/theUninsuredinMass.pdf

[4] The comparison is based upon Urban Institute calculations from the 2005–2006 Annual Social and Economic Supplement to the Current Population Survey. There are reasons to believe that the CPS overestimates the number of uninsured people in the District, so DC is probably even closer to Massachusetts than the text numbers suggest. See Allison Cook and Barbara A. Ormond, "Who Has Insurance and Who Does Not in the District of Columbia?" Health Policy Issue Brief, DC-SPG, forthcoming.

[5] Negotiations continued all fall, and each of the proposals was modified from its original form. This brief compares the proposals as of November 1, 2007.

[6] All adults in families with incomes below 100 percent of the FPL could enroll in Medi-Cal. Currently, only parents are eligible.

[7] Children up to age 19 would continue to be eligible for Medi-Cal if their family's income was below 100 percent of the FPL; Healthy Families would continue to require monthly premiums of $15 per child, up to $45 per family.

[8] It would (1) expand Medi-Cal to all children and parents with incomes up to 133 percent of the FPL; (2) expand Healthy Families to all children with incomes up to 300 percent of the FPL, regardless of immigration status; and (3) expand coverage "similar to that available through Healthy Families" to parents and caretaker relative with incomes between 133 and 300 percent of the FPL with premiums on a sliding scale.

[9] Coverage is here defined as having a maximum of $1,500 out-of-pocket costs annually.

[10] Jonathan Gruber, *Modeling Health Reform in California*, Report from the California Endowment and the California Health Care Foundation, February 2007. http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf.

[11] Jonathan Gruber, *Modeling Health Reform in California*, Addendum to the Report from the California Endowment and the California Health Care Foundation, May 2007. http://calhealthreform.org/pdf/GruberStudy062807Addendum.pdf.

[12] Barbara A. Ormond, "Insurance, Uninsurance, and Access to Care in the District of Columbia: Listening to the Stories," Health Policy Issue Brief, DC-SPG, forthcoming.

[13] CareFirst BlueCross BlueShield of the District of Columbia is required to offer open enrollment into one of their insurance policies (also called guaranteed issue). However, there is no limit on what an individual can be charged for this policy, and a 10-month preexisting condition exclusion period can apply to the guaranteed issue policy for those individuals who are not HIPAA eligible.