Testimony of Gerald F. Kominski, Ph.D.
Before the Little Hoover Commission
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I. Financing Mechanisms

- Governor's plan
  - Provider fees (hospitals and physicians) ($3.47 billion)
  - Employer fees (10 or more employees) ($1.00 billion)
  - Redirected funds that currently support uncompensated care ($1.00 billion)
  - Federal matching dollars for Medi-Cal and Healthy Families expansion ($5.47 billion)
  - Total cost: $12.15 billion, state cost: $5.68 billion, net state cost: $0, because proposal is self-funded by new fees, savings, and redirected funds
- Nunez Plan
  - Employer fees "based on a fair percentage of payroll"
    - Data shows that employers who currently offer insurance currently spend about 9.6% of payroll for health benefits
  - Cost unknown
- Parata Plan
  - Employer fees based on a percentage of payroll "to be determined"
  - Federal matching dollars
  - Cost unknown
- CalCare (Republican)
  - Changes in the tax code to provide tax breaks to individuals purchasing insurance equivalent to the tax benefits in the group market
  - Tax credits for providers to care for the uninsured
  - $2.2 billion from federal government for undocumented
  - $2.8 billion in redirected funds
  - Net cost: $0
- Halvorson Plan
  - Taxes
    - sales tax ranging from 1.2 to 9.1%
    - employer tax, for those who don't offer insurance, ranging from 2.2-10.1% of payroll
  - Safety-net savings
  - Federal matching dollars
  - Enrollee premiums
  - Total costs: Probably known, but uncertain from published documents
- Kuehl
  - Payroll taxes
    - 8.17% employer
    - 3.78% employee

- Tax on unearned income: 3.5%
- Additional 1% tax on income above $200,000
- Total costs
  - $25 billion in additional utilization
  - Offset by $33 billion in savings related to:
    - Primary care
    - Reduced fraud
    - Bulk purchasing
    - Administrative costs (~$20 billion)
  - Net costs: $8 billion savings!

In my opinion, payroll taxes are the most equitable form of financing, because they put employers on a level playing field with regard to health benefits, and remove some of the distortions in the current employer-based market. The Governor's proposal seems extremely low, relatively to the actual percentage of payroll spent on health insurance premiums by firms that provide insurance. By setting the employer fee so low, firms spending almost 10% on premiums will still be subsidizing firms that pay only 4%.

I am particularly concerned about proposals that rely on increased federal matching funds, the most equitable sources of financing, because these funds may not be forthcoming. These funds seem particularly vulnerable given the President's proposed cuts in Medicaid.

I strongly favor redirecting funds that are currently used to support hospitals and clinics that care for the uninsured, as specified in the Governor's proposal, since uncompensated care should be largely eliminated.

Finally, let me also point out that none of the current proposals provide estimates of the costs of not covering the uninsured, although the Governor's proposal does call attention to the fact that the insured subsidize the uninsured by paying higher premiums and prices for health care services. The costs of not insuring the uninsured are difficult, but not impossible to estimate, and are borne on a yearly basis by a significant portion of Californians. So, when we assess the so-called costs of reform proposals, please keep in mind that some proposals appear to be inexpensive because they ignore the health and productivity costs borne by uninsured individuals.

II. Affordability

There is no generally accepted standard of affordability of health insurance. In my judgment, however, the percentage of total family or individual income spent on health insurance is a reasonable place to start.

- Governor
  - Expands enrollment of low-income children in Medicaid and Healthy Families

- Expands eligibility of uninsured low-income adults in Medicaid and in newly established purchasing pool. Caps family premium contributions at:
  - 3% of gross income for 100-150% FPL
  - 4% of gross income for 151-200% FPL
  - 6% of gross income for 201-250% FPL
- Above 250% FPL, however, families could be spending 25% of family income on health insurance, which hardly seems equitable. So, some modification of the Governor's proposal is necessary to provide protection for families above 250% FPL.

Based on a study conducted by the Urban Institute for the state of Massachusetts in 2006, the median spending by individuals and families at 300% or more FPL who purchase insurance in the non-group market, where they of course receive no employer subsidy, is between 8.2% and 8.5% of income. This seems like a reasonable limit, particularly if used in combination with an absolute dollar catastrophic ceiling.

If the Governor's proposal is correct, and I happen to think it is, the magnitude of cost-shifting in California is substantial. So, is it reasonable to expect premiums in California to decline if the Governor's proposal is enacted? There is good reason to believe that health insurance premiums would experience a one-time decline in uncompensated care was virtually eliminated and as Medi-Cal payment rates were increased. These new sources of revenue should relieve the pressure on hospitals, doctors, and other providers to cross-subsidize losses from Medi-Cal and the uninsured by charging higher prices to the privately insured. Of course, it is illegal for providers to *charge* more for their services to different payers, but it is not illegal for providers to negotiate discounts with private insurers that are smaller than the effective discounts received by Medicare, Medi-Cal, and the uninsured. The competitiveness of California's market, combined with the requirement in the Governor's proposal that insurers and providers pay-out 85% of revenue in medical benefits, suggest to me that California could expect to see private premiums decline within 2-3 years of implementation. But I want to emphasize that this would be a one-time reduction.

III. Coverage of the Uninsured

Universal coverage is both a reasonable and achievable goal of health reform, and anything less perpetuates the inequities, cost-shifting, and hidden costs of the status quo.

One issue that continues to represent a continental divide among proposals for reform is whether undocumented residents should be included or not. My perspective is that the Governor, Speaker Nunez, and Senator Kuehl come down on the right side of this issue. Excluding any significant portion of California's population does not pave the road toward universal coverage, but instead creates an identifiable category of residents who can be further stigmatized and marginalized as either too expensive or undeserving of coverage because of their lack of citizenship. The Urban Institute has

conducted several studies in recent years showing that the undocumented contribute more in taxes to the U.S. economy than they use in social services, and I find this evidence compelling enough to justify inclusion of the undocumented. From an economic perspective, it is also less expensive over time to provide insurance and permit access to primary and preventive care than to rely on expensive hospital inpatient and emergency department care.

IV. Service Delivery Model

Managed care is an integral part of the health care delivery system in California, and therefore, in my judgment, should continue to have a role under health reform. Unfortunately, during the past decade, managed care plans have gone from being the next greatest hope for providing high-quality, coordinated care in the most efficient manner to being viewed by many experts as a failed experiment in health care delivery and financing. I agree with many of my colleagues that managed care has failed to realize the enormous promise it held in the early 1990s of transforming the American health care system. In my opinion, California and the nation can still benefit from health care organizations that provide high-quality care that is coordinated across settings, clinically effective, and economically efficient. But it isn't clear to me that today's HMOs will be those organizations. I suspect that health information technology could cause a revolution in health care delivery that produces both more freedom of choice and greater incentives for efficiency, perhaps through a new and improved version of the point-of-service plans that have grown in recent years combined with new organizations that enable individuals to manage their health more effectively.

Thank you for this opportunity to address the Commission this morning. I am happy to answer any questions you may have.