Stakeholder and Key Informant Interviews

Supplement G to the Report:

Challenges and Alternatives for Employer Pay-or-Play Program Design: *An Implementation and Alternative Scenario Analysis of California's "Health Insurance Act of 2003" (SB 2)*

For the
California Health Care Foundation
and the
California Managed Risk Medical Insurance Board

Project Team Led by the
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The primary authors of this supplement were Bob DiPrete, consultant to the Institute for Health Policy Solutions (IHPS) and lead on stakeholder interviews, and Rafe Forland of IHPS. The interviews were conducted by Bob DiPrete, Rafe Forland, Rick Curtis of IHPS, and Tom Davies, a consultant to the project. Rick Curtis, Ed Neuschler and Lynn Taylor of IHPS provided invaluable editorial guidance, as did Tom Davies.

Approximately thirty stakeholders and key informants gave generously of their time in cooperating with this investigation. In many cases, they met with interviewers more than once, either in person or by phone. They also, in many cases, provided the Institute for Health Policy Solutions interview team with written materials relating to the implementation of Senate Bill 2 (SB 2), either "pre-existing" or prepared for the purposes of this project. Their observations and opinions are the basis for this supplement, and the authors have endeavored to reflect their thoughts as faithfully as possible.

These interviews were conducted with the explicit understanding that observations and opinions would not be attributed to any single stakeholder or key informant and that the report would not be released until after the November 2nd referendum. It was this understanding that made it possible for those interviewed to speak freely despite the impending referendum and the exigencies of having a stake in the outcome. Without this understanding, the insights gained would have been both fewer in number and less forthrightly expressed.

Any information in this supplement that proves useful to the development and implementation of future health reform programs is to be credited to the Californians who generously consented to be interviewed, and to those who commented on this work in progress.

The project team is grateful to Deborah Kelch, President of Kelch Associates and our liaison with the Foundation, who provided substantial assistance with the interview process and whose project management skills helped keep us on track. Last, but not least, Jill M. Yegian, Ph.D., and Marian R. Mulkey, M.P.H, M.P.P., of the California HealthCare Foundation provided analytic insights, helpful comments, and other support throughout the project. Without the assistance of the Foundation and its staff, this project would not have been possible.

Note: an earlier version of this report was released to the California Health Care Foundation in October of 2004.

Executive Summary

The objective of these interviews was to elicit the observations and opinions of stakeholders and key informants regarding the barriers to successfully implementing California's Health Insurance Act of 2003 (also known as Senate Bill 2 or SB 2). Those interviewed represent the perspectives of those who would have been directly and indirectly impacted by SB 2 (stakeholders), as well as those who were party to the drafting of the bill or would have been responsible for some aspect of its implementation (key informants). In many cases, stakeholders interviewed were also participants in the process of drafting the bill and so can reasonably be counted in both categories.

The interviews took place in a context framed largely by political and legal factors. At the time of the interviews, the legislation faced several challenges. The first of these was a public referendum on November 2, 2004. Had SB 2 survived this political test, two legal challenges are likely to follow closely behind: one based on ERISA, the federal law prohibiting states from regulating employers who self-insure for health coverage, and the other based on Sinclair, the California Supreme Court decision that is used to define what is a tax and what is a fee (or other non-tax assessment). We asked the interviewees to look beyond these political and legal challenges and to discuss the barriers to implementation relating to policy and procedures rather than to politics and the law.

Since the interviews took place, SB 2 was undone through the narrow defeat of Referendum 72 on Nov. 2, 2004. California voters defeated this referendum by a margin of approximately 1%. This defeat means, of course, that the ERISA and Sinclair legal challenges mentioned in stakeholder and key informant comments are obviated, and that the program envisioned by SB 2 will not be implemented. However, there are signs even as of this writing that alternative approaches to expanding health insurance are being considered, and that some of these alternatives would build on key concepts underlying SB 2.

In light of these developments, it is hoped that this supplement will provide valuable perspective on subsequent efforts in California - and in other states - towards effective health reform.

The following are the key findings from these interviews, limited to topics deemed most important to policy makers. A more extensive list of findings from the interviews and written materials provided by interviewees can be found in the final section of the supplement.

- There was near unanimity that health reform is needed and that building on employer-sponsored insurance for working families is a reasonable approach. Some felt that if this approach proves unworkable and the current pressures continue, a single-payer system might be the next option.
- Most said that they expect that SB 2 will require some amendment before it can be successfully implemented.
- There was disagreement about how the success of SB 2 should be measured. Some thought the measure should be the number of Californians who become newly

insured, and some thought the measure should be the degree of stability in the health insurance market.

- There was disagreement about the role of the state administered pool (for employers choosing to "pay"). Some thought it should be large enough to affect market trends; others thought it should only be as large as is necessary to provide a "residual option" for those employers unable to find acceptable insurance products in the market.
- There was widespread confidence in the ability of MRMIB to address appropriately through administrative rule a range of important considerations left largely unaddressed in the statute.
- There were widespread concerns that adequate resources would not be available to state agencies responsible for implementing SB 2, and that even with adequate resources the January 2006 implementation date was unrealistic.

Supplement G:

Stakeholder and Key Informant Interviews

Background

California's Health Insurance Act of 2003 (also known as Senate Bill 2 or SB 2) entailed a reform of the composition and financing of the state's employer-sponsored health insurance, to be implemented in phases beginning in 2006. At the core of the SB 2 approach was a play-or-pay model that called for a benefit package meeting minimum standards to be offered (but not exclusively—other coverage options are permitted) to full-time employees and dependents of medium and large employers. Affected employers were given the option of choosing either to purchase health coverage in the market that complies with the requirements of SB 2, or to pay a fee to cover the cost of insuring their eligible employees (and dependents) through a state-administered health insurance pool.

Since the interviews took place, SB 2 was undone through the narrow defeat of Proposition 72 on Nov. 2, 2004. California voters defeated this referendum by a margin of approximately 1%. While the program envisioned by SB 2 will not be implemented, it is hoped that this supplement will provide valuable perspective on subsequent efforts in California—and in other states—towards effective health reform. Other states (notably Hawaii, Massachusetts, and Oregon) have passed legislation requiring that employers contribute toward the cost of covering employees and/or dependents. However, only Hawaii has implemented such a program, and California's particular approach is untried.

The California Health Care Foundation commissioned a study of the issues central to the successful implementation of SB 2. A team headed by the Institute for Health Policy Solutions (and also including RAND and the Actuarial Research Corporation) is analyzing and reporting on the issues that would have been associated with implementing SB 2 in light of the policy objectives underlying the legislation.

As part of this analysis, interviews were conducted with a representative sample of stakeholders and key informants from various vantage points. This supplement describes the observations and opinions of those interviewed. The scope and complexity of SB 2 would have meant significant changes for most major segments of California's various health care finance and delivery systems. Among those directly or indirectly impacted by these changes would be:

- insurance brokers and agents;
- legal services and consumer advocates;
- labor;
- business;
- managed care plans and insurers;
- hospitals;

- physicians; and
- safety net providers.

Stakeholders representing these perspectives were selected and interviewed by the project team, including: Bob DiPrete, consultant to the project and lead on the stakeholder interview component; Rick Curtis, President of the Institute for Health Policy Solutions; Tom Davies, consultant to the project, and Rafe Forland, Senior Analyst with the Institute for Health Policy Solutions. Over 30 interviews were conducted over a period of approximately 3 months, and written materials relating to the implementation of SB 2 were requested and reviewed. In addition to these "primary interviews," there were follow-on interviews with the objective of obtaining more detailed or more technical information from stakeholders with direct responsibility for some aspect of program implementation.

In addition to stakeholders identified above, we also interviewed "key informants" such as include state agency staff and state legislative staff. It is important to note that the distinction between stakeholders and key informants is not hard and fast. Many stakeholders were involved in the drafting of SB 2 and so are in a position to provide first-hand information on both the policy debate that preceded passage of the bill and the likely implications for and impacts on various segments of the health care systems.

It is also important to note that this supplement does not attribute any observation or opinion to any particular stakeholder or key informant. The interviews addressed in this report were conducted with the explicit understanding that there would be no such attribution. However, where appropriate, a general stakeholder or key informant description (e.g., "insurer" or "provider" or "consumer advocate" or "state agency staff") may be given in order to inform the reader of the particular perspective(s) from which a point is being made.

Throughout this supplement, the views expressed by interviewees have been reported as faithfully as possible. This means that no attempt has been made to "correct" statements that may express a decidedly minority viewpoint. Only when empirical evidence clearly controverts an interviewee's statement has that statement been annotated (with the interviewee's knowledge) to reflect the facts. Care has been taken in preparing this report to assure that the views expressed herein are always and only a reflection of the perspectives offered by the stakeholders and key informants interviewed.

Political and Legal Context: One Referendum and Two Legal Challenges[1]

Several stakeholders commented on the urgent need for health care reform and the importance of California's having passed an ambitious reform bill in SB 2. Interviewees representing providers and purchasers in particular pointed out that it is unreasonable to expect the status quo to continue for more than a few years without running a substantial risk that there will be a fundamental and systemic break-down with dire consequences for all. Both business and consumer stakeholders pointed out that worsening problems with the financing of health care have serious implications for both the economy as a whole and the economic well-being of

[1] All statements in this progress report regarding legal challenges to SB 2 are expressions of stakeholder/key informant perspective and do not represent legal opinion.

health care consumers as individuals. Concomitant with this general expression of support for a bold attempt at health reform, many interviewees expressed grave concern about whether SB 2 can survive the political and legal hurdles it faces.

The defeat of the legislation via public referendum means, of course, that the ERISA and Sinclair legal challenges mentioned below are obviated, given that the program will not be implemented. Nonetheless, the discussion of the potential legal hurdles are instructive for other states considering this type of approach.

Stakeholders nearly universally identified two hurdles (in addition to the referendum) that SB 2must clear to be successfully implemented: first, a legal challenge under the Employee Retirement Income Security Act (ERISA), which limits the ability of states to regulate employer-sponsored health plans, particularly self-funded ones (states can regulate the insurance employers purchase, but not the underlying plans they offer); and second, a legal challenge under Section 3, Article 13A of the California Constitution, which requires a two-thirds vote of both houses of the legislature in order to enact a tax increase. (The latter legal challenge is often referred to as "Sinclair," after the California Supreme Court case that interpreted when a revenue measure is a "tax" subject to the constitutional provision and when it is a "fee" and therefore not subject to the "two-thirds-majority requirement".)

No stakeholders interviewed predicted that the anticipated legal challenges would precede the November 2, 2004 referendum. Stakeholder consensus was that, prior to the referendum vote, it would be difficult to make the case that harm was imminent and establish the need for remedy. If the referendum vote were to keep SB 2, then nearly all stakeholders anticipate that both ERISA and Sinclair legal challenges would be mounted very shortly after the vote was decided, with the Sinclair challenge likely (but by no means certain, depending on alternative legal strategies) to come first. Despite this general supposition that a Sinclair challenge would come first, one stakeholder pointed out that an affirmation in the referendum might be seen as weakening the Sinclair argument, and if so, an ERISA challenge might come first.

Business stakeholders felt that the ERISA challenge would likely come on two fronts: (a) that SB 2 would place on employers an administrative burden so severe as to be unsupportable in practice and therefore illegal, and (b) that the requirement that the benefit package of self-insured employers who "play" by offering a self-funded plan must meet minimum standards would violate the ERISA preemption of state regulation of self-insured employers.

Stakeholders from several perspectives believed that the Sinclair challenge would rest on the structure and amount of the "pay" fee and the argument that this fee was for all intents and purposes a tax and might well collect more money than would be needed to fund the state-administered health insurance pool. Sinclair was broadly viewed by stakeholders as requiring that the employer and employee contributions toward the state insurance pool raise only enough revenue to fund the program as called for in the bill. However, there were differences of opinion among the various stakeholders regarding specific implications, such as the structure of the pool fee. Some stakeholders felt that requiring an individual employer and that employer's employees to make contributions above the cost of their own health insurance would in effect result in a tax and so violate the 2/3s vote requirement. Other stakeholders felt that so long as the total amount

collected through the “pay” fees was no more than the amount needed to fund the actual costs of the SB 2 program, the fee would not constitute a tax.

No stakeholder ventured an opinion on the outcome of any of these three challenges, nor did any venture to predict the legal points on which the ERISA or Sinclair decisions will ultimately be determined. Regarding the referendum, one stakeholder opined that the level of effort mounted to defeat SB 2 in the referendum might indicate uncertainty on the part of SB 2 opponents that Sinclair and ERISA challenges would prevail if put to the test.

Policy Considerations

Comments from stakeholders who were also party to the drafting of SB 2 indicated that that process involved conflicting views about the best approach for achieving a set of basic policy objectives. But there was little or no disagreement that the fundamental aims of the bill included the following:

- Increase the number and proportion of Californians with adequate health insurance.
- Bring greater accountability, stability, and utility to the health care market for both employers and employees.
- Offer a viable alternative to employers who are unable to find acceptable health insurance products in the market.
- Keep the cost of employer-based health insurance and access to needed health care within tolerable limits for employees to assure affordability as well as availability of coverage.
- Reduce cost shifting in order to increase health care financing equity and efficiency for purchasers and providers of health care

According to key informants, debate on these and other policy objectives led in turn to proposed strategies and compromises that helped to shape the basic provisions of SB 2. These provisions include:

- setting the employer contribution at 80% of the cost of family coverage;
- capping the employee contribution at 5% of wages;
- establishing a minimum benefit package that must be offered to all qualifying employees in affected businesses;
- requiring medium and large employers who currently do not offer health insurance to begin doing so (at least for workers if not for dependents as well) through a phased implementation; and
- exempting small employers as well as all part-time and seasonal employees.

One key informant said that the real achievement of SB 2 is that it places a marker indicating that California is committed to reforming health care. This same informant noted that there had been from the start an expectation that the bill will have to be modified in order to address the necessary issues and build the necessary political will to be successfully implemented. A very

different view was voiced by a health plan stakeholder who argued that SB 2 was a "half-measure" that might well make things worse by placing unsupportable financial burdens on vulnerable businesses and costing California needed jobs in a well-intentioned but misguided attempt to expand health insurance.

Another interviewee pointed out that, although the setting of the fee for buying into the state-administered pool might arguably be the critical implementation issue, "all implementation issues beg the question of what we are trying to accomplish in the first place. Is the primary goal to make health coverage affordable to employees? To employees and employers? Is it something else?" This same person noted that the weaknesses in the bill as written have as much to do with what is left out as with what is included but perhaps not optimally addressed. The example offered was cost containment, and the comment was that without naming cost containment as a policy objective and without some effective mechanism for containing the rising costs of health insurance, affordability could not be sustained without sinking below an acceptable benefit level.

A recurring theme in these interviews was the need for explicit and adequate subsidies to assure that the health insurance offered would be affordable to all working families and individuals.

More than one stakeholder noted that health reform must always compete with other major policy objectives, each with its own constituencies and each staking claim to a high priority for public resources.

The Market: Where Is It Now and Where Is It Headed?[2]

Stakeholders directly involved in the provision of health insurance believe that the market is in a state of flux and will continue to be for some time unless there is meaningful health reform. Both premiums and cost sharing are increasing substantially each year. Largely in response to these increases, new products with higher consumer cost sharing are being developed by plans and offered by employers. These include high deductible plans that are compliant with requirements under federal tax policies for Health Savings Accounts (HSAs) and other savings account approaches. Stakeholders representing insurers and business see these new products as evidence of purchasers' desire for provider and/or consumer accountability as a step toward greater cost control. Even stakeholders representing health plans with strong historical association with managed care approaches acknowledged intense market pressure to respond to growing employer interest in high deductible plans and related products.

Several insurer and health plan stakeholders voiced the opinion that SB 2 is an appropriate general approach to health reform given the prospect of continuing severe cost pressures on the market. However, stakeholders in general indicated that they have not devoted significant resources to anticipating and planning for the impact of SB 2 on the market and did not foresee doing so unless the referendum passed.

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[2] The reader is referred to a separate report prepared under this project by the Institute for Health Policy solutions and RAND, entitled "Implementing the Health Insurance Act of 2003: The Health Insurance Market Context and Demographic Profile". This report was also based in part on a set of separate but overlapping interviews with stakeholders and key informants.

Business stakeholders also expected the market to continue to change substantially, with increasing pressure on employers' ability to maintain current contribution levels toward the cost of employee/dependent health insurance. Some business representatives expressed concern that the state-administered pool might introduce new disequilibrium into the market if it is not designed so as to present a viable option (i.e., one that is sustainable and sensible as a business proposition) to purchasers of employer-sponsored insurance. Business stakeholders also voiced concern that SB 2 requirements for employer contributions to employee and dependent coverage might threaten the viability of vulnerable firms not currently offering.

Labor stakeholders believe the linkage between health insurance and employment has been jeopardized by recent increases in the cost of health care and health insurance. They also expressed the concern that if these increases continue apace, labor/ management negotiations will face insurmountable constraints on setting total compensation at an acceptable level. Some labor stakeholders expressed the hope that the state-administered pool would provide a sort of counter-weight to recent market trends that have exerted extreme pressure on employers and employees as purchasers of health insurance. While less concerned about the possibility of adverse selection than some other stakeholders (notably representatives of insurers and health plans, and of business), labor stakeholders generally feel that, to achieve this counter-balancing effect and to be sustainable over time, the state-administered pool would have to be substantial in size and attract healthy workers and dependents. Labor stakeholders also expressed the belief that the "pay" fee would need to be carefully designed to avoid increased legal risk under Sinclair and ERISA legal challenges.

Provider stakeholders stated that providers of care to all California populations—especially physician providers—are increasingly concerned that the market is losing its ability to sustain affordable health insurance for lower-wage employees. These stakeholders believe that the increase in the number of uninsured is resulting in severe and perhaps unbearable economic pressure on physicians and hospitals as uncompensated care grows in comparison with total revenue. It was noted that, at the most recent annual meeting of the California Medical Association, physicians voted to determine what criteria should be used to gauge the acceptability of single-payer proposals. It was also noted that some physicians saw SB 2 as perhaps the last chance to reform health care without facing severe pressure to convert to a single-payer system.

The relationship between the pool and the market is an area of significant disagreement among stakeholders. All stakeholders who spoke to the issue pointed out the importance of the "viability" or "sustainability" of the state-administered pool; however, they differed on what role the pool ought to play in the new (post SB 2) health insurance world. Some stakeholders (notably employers, insurers, and insurance agents) tended to see the pool as a sort of residual mechanism for insuring employees "left over" after most employers (including nearly all who currently offer health insurance) decide to "play" rather than "pay" into the pool. Others (notably labor and some consumer and provider stakeholders) envisioned a larger pool and with a larger role than would result from a "residual" pool. This second group of stakeholders spoke of the possibility that the pool might have a substantial impact on the market, even to the extent of helping to determine market trends in benefits and cost sharing.

Among stakeholders viewing the pool as playing a "residual" role and so enrolling more than its share of higher risk employees and dependents, the issue of financing was generally acknowledged as problematic. Both state agency staff and non-government stakeholders mentioned the possibility of using the "pay" fees collected as a means of building a risk reserve fund. State agency staff in particular voiced concern that, if the pool experienced the adverse selection that is bound to occur in a "residual" mechanism, costs in excess of fees collected could threaten the financial viability of the pool early on, perhaps as early as the first or second year of program operation.

Benefits

Although the issue of benefits (what is covered, with what level of cost sharing for the insured) is addressed throughout this supplement, three points are worth noting in a separate section:

- First, there was no consensus as to what level of benefits should be offered.
- Second, the question of benefits led directly to the issue of how, under SB 2, employer-sponsored insurance would connect with Medi-Cal (Calfornia's Medicaid program) and Healthy Families (California's SCHIP program).
- Third, any perceived differences between premium cost and benefits available through the state-administered pool and those available in the market would help to determine the size and characteristics of the population enrolled in the pool

On the first point, consumer and labor stakeholders emphasized that, in their opinion, legislative intent would not be met if SB 2 benefit requirements did not provide an adequate level of coverage. Opinions among stakeholders in general differed as to what constitutes an adequate level of coverage. One key informant pointed out that if the minimum benefit level permitted under SB 2 were defined as the benefits required under the Knox-Keene Act plus prescription drug coverage, then nearly all employees currently covered through employer-sponsored insurance would already have SB 2 compliant coverage. Some stakeholders feel that benefit standards equivalent to current market levels would be inadequate, particularly if cost sharing were too high for physician visits or if the deductible is set near the $1,500 level. Others—primarily but not exclusively business stakeholders—warned against setting the benefit standard too high, because of the risk that medium employers might stop contributing toward family coverage and simply meet the requirement that they contribute to the cost of employee coverage. One key informant said that his concern was not that SB 2 benefit standards include every Medi-Cal/Healthy Families benefit, even for low-income families. Instead, his concern was that the most important benefits be covered adequately, with cost sharing provisions set low enough so as not to constitute a barrier to accessing needed care.

On the second point, one business stakeholder warned against "torturing" employer-sponsored insurance to make it look like Medi-Cal. And a consumer advocate stakeholder expressed the hope that the employee notification process would be effective enough that adequate benefits can be assured for low-income families and individuals through Medi-Cal and Healthy Families, rather than through the insurance market and regulations.

On the third point, stakeholders representing business and insurer/health plan perspectives noted that the market might well react with new products if the pool offerings were perceived to be significantly different from what the market offers. One key informant noted that, if benefits upgrade options were made available in the pool so that employees could choose different benefit/cost-sharing levels, the dynamics would become even more complicated between the pool and the market and between the pool and Medi-Cal and Healthy Families.

The Pool, The Fee, The Choices Implied

Stakeholders uniformly expressed the view that how the state sets and administers the pool fee will be critically important to the successful implementation of SB 2. Stakeholders representing labor, consumers, providers, and insurers pointed out that both the structure and amount of the fee (charged for employees of businesses opting to "pay" into the pool rather than to "play" in the market) would have a bearing on both the ERISA and Sinclair lawsuits, and will be a determinant of programmatic success if SB 2 is implemented. Stakeholders also agreed that the question of how the fee varies according to demographic characteristics of employees would be a key factor, but there was no agreement on what the impact might be on the legal challenges. In particular, some stakeholders believe that, if the individual worker's earnings were a factor in the amount of the fee, there may be stronger grounds for an argument that the fee was a tax under Sinclair. Others disagreed with this view. Stakeholders representing business and insurers/health plans noted that whether or not demographic factors were used in setting the fee would help to determine the degree (if any) of adverse selection into the pool.

Stakeholders were generally in agreement that the structure and amount of the fee would influence the decision-making of both employers and employees. Employers were expected to make a business decision whether to "play" or "pay" based on the perceived cost (and perhaps upon the perceived value and/or perceived administrative burden) of both options. Employees were expected to make family budget decisions about whether to accept the coverage the employer had chosen to offer for dependents, if any. (Note that, although the contribution for employees would be automatically deducted without declaration, dependent coverage and contribution would depend upon declaration by the employee.)

Consumer stakeholders and state officials noted that low-income workers would also face an important decision relating to application for state-sponsored health insurance programs: Medi-Cal and Healthy Families. The dynamics of this decision (discussed below) would be important in relation to fee structure, benefit options, and the possibility of adverse selection into the pool.

Stakeholders were nearly unanimous in their belief that the amount and structure of the fee, in comparison with the market, would determine the viability of the state pool. However, some were also skeptical that the pool could develop any pricing strategy that would assure its viability.

For example (assuming the fee is uniform across employers), if the fee were priced and structured so that it cost significantly more than options offered by the market for healthy employee groups, then it is very likely that those businesses choosing to "pay" into the pool would be insuring a population with high service utilization patterns and high costs. But even if the fee were set so that the pool represented a good business choice for businesses with healthy

employees (i.e., priced competitively with comparable products in the market, given the risk profile of a given employer group), business and insurance stakeholders predicted that the market would respond immediately with even lower-priced comparable products to attract healthy employed populations to the market rather than "lose" these populations to the pool.

Expanding on the latter point, business and insurance stakeholders both noted that, although lower prices for coverage through the pool would attract a better risk profile, the market would not likely tolerate for long the diversion of lower-risk employees into the pool. The reason given for this prediction was that insurers would not want the pool either to divert a significant portion of the lowest risk enrollees away from the market or to become so large that it would be able to shape the market in ways that would constrain insurers in developing or marketing products. These stakeholders were also of the opinion that the market would be able to react quite swiftly with new products to "meet or beat" whatever the pool might offer. One business stakeholder posited a danger that competition between the pool and the market to offer the most price-attractive product allowed under SB 2 could lead to a "race to the bottom," resulting in reduced benefits for many workers and dependents and reduced funding for health care in some sectors.

On the other hand, some stakeholders (including state officials and provider representatives) speculated that the pool might, if sufficiently large and viable over time, act as a counterweight to some troublesome market trends. These stakeholders noted that the market seems to have the tendency to avoid rather than manage risk, and that resources do not consistently go toward adequate payments for health care provided. It was noted that, for the pool to provide such a counterweight, it would need to be large enough to attract a substantial proportion of healthy enrollees. Otherwise, if the pool remained fairly small and attracted a disproportionate share of unhealthy enrollees, it would be vulnerable to the sort of worsening adverse selection that results in a "death spiral" (in which higher-than-predicted utilization forces premium increases which in turn repel healthy enrollees but do not dissuade sick enrollees, leading to yet higher utilization which forces more premium increases, and so on).

One stakeholder without any direct economic stake in the implementation of SB 2 pointed out that the pool, if it were to aim to influence the market and not simply to protect the market from risk through its "residual mechanism" role, would need to attract its "fair share" of relatively healthy employees and dependents with relatively low patterns of service utilization. This same stakeholder also voiced the concern that, even with attempts to improve risk selection, the pool might well require funding beyond what was collected from employers and employees, especially in the early going.

Stakeholder predictions as to the size of the SB 2 pool when fully implemented varied considerably. As noted earlier in this supplement, some stakeholders anticipated that the pool might serve as a sort of residual mechanism, enrolling only the employees of businesses who could find palatable insurance products in the market. In this case, the pool might end up functioning de facto as an SB 2 risk pool, providing risk protection to the market.

No stakeholder specifically suggested that the SB 2 pool should function by design as a high-risk "safety valve" program diverting more costly employees and dependents away from the market. While some labor and consumer stakeholders believed that the per-worker fee should be a flat amount (regardless of employee group characteristics), a number of other stakeholders expressed

concern that a flat-fee construct would inevitably mean that the pool would be attractive only to relatively high-cost groups.

One stakeholder voiced deep concern that because SB 2 provided neither sufficient subsidies for lower-income workers nor an external source of funds to subsidize the pool, the construct was unlikely to be successful in extending affordable coverage to low-income workers not eligible for Healthy Families or Medi-Cal.

Business stakeholders expressed the concern that SB 2 would increase employer costs significantly regardless of whether a business chose to "play" or to "pay." A major business concern was that many vulnerable employers would be required by SB 2 to cover employees and dependents for whose coverage they do not currently pay. An employer choosing to "play" would be required to contribute 80% of the premium cost for coverage meeting SB 2 requirements, and business representatives were concerned that this would add significantly to the cost of doing business. (It is worth noting that business stakeholders appeared to be somewhat unclear on the fact that SB 2 required employers to offer only one option meeting SB 2 requirements, but left them free to also offer additional options not in compliance with SB 2.) The same stakeholders expressed a concern that the "pay" option might be priced even higher than market products that were SB 2 compliant, so that either option could well be dangerous for the viability of many businesses.

Some stakeholders expressed the concern that the increased employer contributions required for low-wage workers might in some cases result in wage, hour or job reductions and so result in a net liability rather than a net benefit to these low-wage workers. In addition to the premium costs associated with SB 2, business stakeholders also expressed substantial concern about administrative costs associated with SB 2 compliance.

Interfaces among the Pool, the Market, and Public Programs

Some state agency staff and stakeholders believed that SB 2 might make low-income working families more aware of how employer-sponsored health insurance affects their household budgets, and thus lead to increased enrollment in Medi-Cal and Healthy Families. They noted that this could occur either because these families had a new or increased financial obligation associated with their share of premium/fee, or because of the attention surrounding implementation and the requirement that these families be notified of their potential eligibility for Medi-Cal or Healthy Families.

Both "play" and "pay" employers were authorized by SB 2 to collect up to 20 percent of the premium/fee for health insurance from the employee. Where this authorization led to an increase in the workers' contribution (which may be infrequent given recent increases in worker contribution for existing coverage, especially family coverage), there might have been an incentive for employees to enroll in Medi-Cal or Healthy Families in order to receive reimbursement for nearly all their contribution amount. (Such reimbursement was also authorized, and required, by SB 2.)

The SB 2 requirement that employees be notified that they might be eligible for these two state programs might have had a greater effect. That is, employees not seeing an increase in their

contribution level as a result of SB 2 might still have been prompted by this notification to apply for Medi-Cal or Healthy Families. If eligible, these families would remain enrolled in employer-sponsored insurance, but at a much lower cost to them and with additional benefits provided through Medi-Cal or Healthy Families.

SB 2 limited to 5% of wages the amount employers could charge low-wage workers as the employee contribution for health coverage. Even with this limitation, however, consumer-advocate stakeholders noted that the premium contribution requirement would impose a proportionately greater financial burden on families with less disposable income. Consumer-advocate stakeholders emphasized the importance of effective notification and even outreach to low-income working families who might be eligible for either Medi-Cal or Healthy Families, with much larger subsidies.

(NOTE: Technically, SB 2 specified that eligible working families associated with employers opting to "pay" the fee might enroll directly into Medi-Cal or Healthy Families, as applicable, and thus not receive pool coverage. If cost-effectiveness requirements were met, families associated with employers who opt to provide coverage directly would remain enrolled in that coverage, but Medi-Cal or Healthy Families would pay any cost-sharing charges that exceed what the public programs might impose and would provide directly any services covered by the public program but not covered by the employer plan. As described below, these additional program costs and administrative responsibilities might have significant budget implications for both the Medi-Cal and Healthy Families programs.)

For these reasons, some state agency staff anticipated a significant increase in Medi-Cal and Healthy Families enrollment as a result of SB 2. Such an increase would mean an increased financial burden for the cost of services and an increase in administrative activities. The increased program costs would include paying for services not covered by employer-sponsored insurance and reimbursement for cost sharing above Medi-Cal and Healthy Families limits. The increased administrative burden would include coordination of benefits and tracking and reimbursing for excess cost sharing. State officials expressed concern about the implications of increased pressure on the budgets of these programs in a time of severely constrained state resources.

State agency staff also noted, however, that SB 2 called for the pool (not the state general fund) to pay the state share of the cost of covering eligible workers and dependents through Medi-Cal and Healthy Families (as applicable). For this purpose, it was anticipated that the pool would use all or some portion of the employer contributions (the 80%-plus of the "fee" paid into the pool by "pay" employers) made on behalf of such workers and dependents. If employer fees could qualify for federal matching funds, there would be a substantial federal funds off-set to the state's increased budget liability for families coming into Medi-Cal and Healthy Families through the SB 2 pool. It was noted that negotiating waivers that would allow federal matching funds for employer contributions to the SB 2 pool might prove extremely difficult.

Given the issues remaining to be resolved, state agency staff felt that it was an open question whether employer and employee contributions toward the cost of ESI coverage would be sufficient to pay for additional benefits through Medi-Cal/Healthy Families and for increased administrative costs.

Both state agency staff and provider stakeholders raised another issue relating to the impact of SB 2 on Medi-Cal and Healthy Families: health service capacity. Capacity (and therefore access to care) is currently perceived as a problem in Medi-Cal, and provider stakeholders opined that this is due primarily to the fact that Medi-Cal and Healthy Families provider payments are relatively low compared with payments under private insurance.

Put briefly, the concern expressed by provider stakeholders was as follows: if SB 2 increased Medi-Cal and Healthy Families enrollment without an increase in payment levels, the strain on health services capacity available to these two programs might be worsened and access to care might become even more problematic. On the other hand, provider stakeholders noted that the strain on capacity would be reduced to the extent that SB 2 converted patients from uninsured to insured, since even relatively low Medi-Cal and Healthy Families provider payments are better than self-pay levels for low-income, uninsured families. (Low "self-pay" payment levels for the low-income uninsured are a large contributing factor to uncompensated care). Provider stakeholders acknowledged that a net gain in the number insured and a reduction in the number uninsured would mean less uncompensated care. However, safety net providers noted that a reduction in federal funding available for treating the uninsured could be expected if there were a significant reduction in the number of uninsured.[3]

Dependent Coverage

As noted above, SB 2 authorized employers to collect from employees (through payroll deduction) up to 20 percent of the premium cost (if "play") or the state pool fee (if "pay"). For employees of "large" employers as defined by SB 2, this employee contribution rate applied to coverage for dependents as well. In many cases, an employee would share dependents with a spouse or partner who was also an employee. In these cases, the dependents might be eligible for coverage through both employers, so to avoid duplicate coverage (and duplicate contributions by both employees and both employers), there would need to be a system for determining that one and only one job was the basis for SB 2 coverage for dependents. Employer stakeholders generally expressed the view that some straightforward mechanism of the kind already used in the market could be used to make this assignment. For example, the employee with the earlier date of birth might be the designated contributor. These stakeholders indicated that this approach is familiar to employers and insurers and seems to work well enough currently.

It is worth noting that, even with an effective mechanism for determining which of two employed spouses/partners will make the contribution for dependent coverage, there probably still would be a certain percentage of families in which some dependents were not declared by either parent and so were not covered. While SB 2 appeared to assume that all dependents (of workers at large employers) would be covered, several stakeholders reported that there was no evident legislative intent to force workers to cover their dependents. In addition, SB 2 did not specify an approach to prevent an employee from "opting out of dependent coverage," nor was

[3] One key informant offered a suggestion that would fundamentally change the relationship between employer-sponsored insurance and Medi-Cal/Healthy Families. In very general terms, the concept is that Healthy Families and Medi-Cal funding might be incorporated into the pool through new 1115 waivers, and that federal matching funds might then be used to subsidize both employers and employees as needed to assure affordability. In effect, Healthy Families and Medi-Cal dollars would subsidize employer-sponsored insurance for low-income individuals and families in the SB 2 pool.

there any readily available mechanism that could have prevented workers from simply not reporting dependents to their employers. Stakeholders generally agreed that this absence of a mandate might mean that a certain number of uninsured dependents would remain uninsured even after successful implementation of SB 2.

In addition, it was noted by some stakeholders that tracking and accounting for duplicate coverage was an issue left largely unaddressed by SB 2. Without an effective means to track and compensate for duplicate coverage, it seemed reasonable to assume that some duplicate coverage would still exist after implementation of SB 2. Presumably, this remaining duplicate coverage would be addressed through coordination of benefits by the relevant health plans and state programs.

However, it was noted by one stakeholder that the bill might include an opportunity for the shifting of responsibility from small and medium employers to large employers. That is, smaller employers could potentially shift employees to larger employers when the smaller-firm worker was also the spouse of someone who worked for a large employer who was required to cover both workers and dependents.

Administrative Requirements

Stakeholders representing consumer advocates, business, providers, and health plans and insurers all raised the issue of substantially increased administrative responsibilities for state agencies. SB 2 called for new or enhanced administrative systems to address the following functions:

- monitoring and tracking of enrollment of SB 2 eligible populations into SB 2-compliant health insurance,
- collecting and tracking payments for coverage through a new state insurance pool,
- complex financial tracking across private/state/federal funding sources,
- reimbursing Medi-Cal and Healthy Families enrollees for SB 2 premiums and cost sharing above the limits permitted by those public programs,
- certification of coverage and health plans as SB 2 compliant, and
- evaluation and monitoring of the effectiveness of a complex new program spanning the public and private systems for financing and delivering health care.

The bill, these same stakeholders noted, was largely silent as to how these critical program components would be implemented. Many of the most important program issues were left entirely to administrative rule-making. All stakeholders who spoke to this point agreed that the capabilities of the MRMIB board and staff made it the logical choice to take the lead on addressing these issues. However, they also agreed that the capabilities of all state agencies involved would be tested severely by the challenge of implementing SB 2.

Many of these stakeholders expressed concern that state agencies involved might not have the management resources necessary to fulfill these responsibilities if adequate additional resources were not provided. One health plan stakeholder raised the possibility that MRMIB might well

find itself over-extended if actually called upon to manage the implementation of SB 2, and suggested that the state consider "contracting out" for this critical responsibility.

Many stakeholders felt that, even with adequate additional resources, the degree of coordination and collaboration required would severely challenge the ability of state agencies to move quickly enough to meet implementation requirements and timelines.

In addition to the administrative burden it placed on state agencies, SB 2 also placed increased administrative responsibilities—and costs—on medium and large businesses. Business stakeholders expressed concern that, for some vulnerable employers not already offering health insurance (or offering it to the employee only), SB 2 might pose formidable problems both financially and administratively. And, for employers previously not offering who opted to "pay" rather than "play," collecting and remitting the appropriate fee for all employees and dependents would be an additional administrative burden.

Impact on Providers

Provider stakeholders in general held two views of SB 2 and its probable impacts. First, they supported the policy objective of expanding health coverage to millions of working Californians who are currently uninsured. (And, in most cases, they supported using employer-sponsored insurance as a platform for this expansion). Second, they were hopeful that SB 2 might result in substantial additional resources to pay for healthcare but were somewhat apprehensive that those resources would be inadequate to cover the cost of additional care, given the increased patient load.

Provider stakeholders were hopeful that SB 2 would mitigate or even reverse the erosion of employer-sponsored insurance, at least in mid-to-large size employers. This is important to them since the greater the proportion of the population that is uninsured, the greater the uncompensated care costs that must be passed along to paying customers or absorbed by providers, and the more dangerous the level of premium inflation to the health care industry as a whole.

Provider stakeholders representing physicians, hospitals, and clinics all expressed the hope (if not the conviction) that SB 2 might mean more money available to pay for health care to Californians. However, all provider types expressed concern that the current trends (notably, increasing numbers of uninsured, and provider payments falling behind increases in the cost of care) might still mean loss of needed capacity and decreased access to needed care, especially for lower-income individuals and families.

Physician stakeholders viewed SB 2 as holding the possibility for enhanced physician revenue both through reductions in the number of uninsured and through increases in the number of privately insured. These same stakeholders also expressed the hope that SB 2 might result in an increase in physician payments in Medi-Cal and Healthy Families.[4]

[4] No mechanism was identified by which this might be accomplished.

Hospitals and clinics primarily serving vulnerable populations were concerned that SB 2 might render safety net providers unavailable to increased numbers of low-income workers if they became enrolled in private insurance that did not include safety net providers in its provider panels. The further concern expressed by these stakeholders was that this would mean disruption and discontinuity of care and would threaten the financial viability of safety net providers. It was pointed out that, to a much greater extent than other providers, safety net providers often lose patients entirely when populations gain insurance. This unintended consequence of insurance expansion results when safety net providers are not included in the provider panels available to safety net patients who are newly insured, and these patients change providers to maximize coverage.

Safety net stakeholders mentioned steps that could be taken to maintain access to safety net providers for those newly insured through SB 2 and to strengthen safety net viability. Examples of these suggestions are noted below.[5] In some cases, these suggestions were already stated or implied in Sections 3 and 4 of SB 2.

- Establish an indigent care subsidy fund from SB 2 funding streams (either employer fees or a fee on health plans) to support care provided by safety net providers to the remaining 5 million uninsured.
- Ensure no reduction in Medicaid supplemental funding (DSH or SB 1255) to safety net hospitals as a result of SB 2 implementation; e.g., put teeth back into safety net provider language in SB 2 to require the state to ameliorate any negative fiscal impacts of SB 2 implementation on safety net providers.
- Ensure/require that the state purchasing pool contract with all Local Initiatives that want contracts for their area.
- Provide incentives to encourage businesses to contract with Local Initiatives to provide direct employer-sponsored coverage.
- Give priority/benefit to health plans in the pool that contracted with and utilized safety net providers.
- Define the "reasonable efforts" to contract with safety net providers that SB 2 required health plans to make.

Safety net provider stakeholders noted that SB 2 would not expand health coverage to dependents in medium businesses, employees or dependents in small businesses, nor to the unemployed and their dependents. These stakeholders also noted that many of those uninsured not covered by SB 2 —and therefore likely to remain uninsured—are among the patients at safety net providers who pay less than the cost of care.

[5] One safety net stakeholder provided by email a more extensive list of these suggested steps to maintain access.

Net Effect of SB 2 on the Uninsured[6]

Stakeholders representing consumers, providers, and insurers and health plans appeared to share the opinion that the success of SB 2 would be measured in terms of the net gain in health insurance among low-income populations. Stakeholders disagreed, though, on the benchmark for assessing this success. For some, a reduction of several hundred thousand in the number of uninsured might be considered a success. For others, the ranks of the uninsured would have to be reduced much more dramatically for success to be declared.

However, one stakeholder representing insurers and health plans noted that another way of measuring the success of SB 2 would be in terms of its impact on market stability and the potential for loss of health coverage by workers and dependents. This same stakeholder pointed out that many (if not most) of the arguments brought forward for voting (in the referendum) to keep SB 2 were concerned with stabilizing the offering of employer-sponsored insurance and its affordability. In much of the referendum debate as of mid-September 2004, reducing the number of uninsured seemed of less import than stabilizing the market.

These two contrasting stakeholder views on how to measure the success of SB 2 point out an important issue: What are the benchmarks that might have been used to determine the success of SB 2? These benchmarks might be based on the policy objectives underlying the bill, and they might also be amended to reflect the political discussion and legal decisions relating to the referendum and/or lawsuits following the referendum.

Some business stakeholders and one health plan representative expressed the concern that an unintended consequence of SB 2 might be the loss of jobs if the financial impact of having to contribute toward the cost of health coverage causes some businesses to fold or to leave California.

Advocates for low-income individuals and the uninsured generally agreed that, on balance, SB 2 would result in a net improvement in the availability of health insurance to the employed. Affordability, however, remained a concern—especially in the absence of substantial subsidies for many low-income working families—and there was also concern that the state pool's benefits might not be comprehensive enough (and the cost sharing low enough) to assure access to needed care. The deductible amount and co-payment levels were of particular concern. This combination of concerns goes to a crucial issue in the design of the state pool: How can price and benefits be balanced to meet the potentially conflicting policy objectives of the bill—effective health care access for workers and dependents at a cost employers can afford within the context of a voluntary state pool?

Stakeholders from business, insurers and health plans, and insurance brokers/agents spoke to the importance of the financial and other incentives that would influence choices by employers and employees. For example, how many employees decide to declare and enroll all their dependents

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[6] Note that this report summarizes stakeholder and key informant opinions about the impact of SB 2, while a separate report entitled "Implementing the Health Insurance Act of 2003: The Health Insurance Market Context and Demographic Profile" addresses this issue specifically with estimates of the impact of SB 2 on the number of uninsured Californians.

who would otherwise remain uninsured would help to determine how many of California's uninsured gained coverage with the implementation of SB 2.

The stakeholders who spoke to this issue agreed that it is very difficult to estimate the effects of the worker's decision whether or not to declare eligible dependents. Most stakeholders did agree that how many SB 2-eligible dependents go undeclared and remain uninsured would depend on issues relating to privacy and affordability. One stakeholder emphasized that the question of immigration status motivated much of the concern for employee privacy in the drafting of the bill. More than one stakeholder representing consumers emphasized that many working families with modest incomes might feel that their 20% share of the family coverage premium is unaffordable. SB 2 did not include either an individual mandate per se or effective subsidies for all lower-income individuals and families, but relied instead on the fact that the employee contribution would be collected automatically for the worker and for all declared dependents. This would still leave room for some SB 2-eligible dependents to go undeclared and to remain uninsured.

Stakeholders also noted that the question of affordability for low-income families would be addressed in part by the effectiveness of notification/outreach/education about the availability of Medi-Cal and Healthy Families. Even if nearly all SB 2 families eligible for these public programs enrolled and so fell under the much lower premium and cost sharing limits, affordability might remain a significant issue for families of modest income.

Key Findings and Implications

The following are key findings from stakeholder interviews, follow-on conversations, and written materials provided by interviewees. These findings represent important points on which there was substantial consensus, or on which one or more interviewees offered particularly insightful comments. The full text of this supplement includes many additional points that may be significant to policy makers. (Note that the numbering of these findings is for ease of reference and does not imply relative importance.)

- Many stakeholders mentioned that they would not undertake serious analysis of the implementation implications of SB 2 unless it passed in the November 2 referendum, and even then they would watch the legal challenges closely. Several characterized their comments as preliminary thinking, pending resolution of the referendum and legal challenges. Even stakeholders who were familiar with the development and basic components of the bill voiced an unwillingness to invest significant resources in planning for implementation until it was certain that implementation would happen.
- There was widespread concern among stakeholders that state agencies would be unable to fulfill the responsibilities set out for them in the bill. Some stakeholders were primarily concerned that available resources would be insufficient; others were concerned that even with sufficient resources the state bureaucracy would prove inadequate to the task of administering SB 2 both on the "pay" side and on the "play" side. One stakeholder wondered whether any administrator, state or private, could successfully manage the implementation and operation of SB 2 given the complexity and ineffectiveness of the entire constellation of underlying health care systems and programs.

- Stakeholders frequently mentioned MRMIB as a critical determinant of the state's level of success in implementing SB 2. In particular, several stakeholders mentioned the strength of the MRMIB board as reason for comfort with the fact that much of how SB 2 would be implemented is not specified in the bill but is left to the administrative rulemaking process.
- Stakeholders do not agree on what the role of the state pool should be. In general, there are two camps on this issue. The first camp believes that the pool should be large—perhaps as the larger the better—in order to affect trends in the market for both benefits and cost sharing. The second camp believes that the pool should be just large enough to indirectly provide some market discipline, but should have no direct effect on the market aside from relieving the market of responsibility for many of the higher risk groups.
- Provider stakeholders generally felt beleaguered by increases in the number of uninsured and by payment levels they perceive as lagging behind increases in the cost of care. These stakeholders perceived SB 2 as holding promise for higher prevalence of insurance and perhaps even higher payment levels, resulting in less uncompensated care, reduced cost shifting, and a healthier financial picture for purchasers, providers, and consumers of health care.
- In contrast to "mainstream providers," safety net stakeholders, both clinics and public hospitals, expressed concern that SB 2 might damage the safety net and its patients even while expanding insurance to many Californians who are now uninsured. A key concern expressed by these providers was whether they would have sufficient opportunity to participate on the panels of insurers enrolling current and prospective safety net patients. If the net gain in insurance resulting from SB 2 did not include the availability of safety net providers, these providers foresaw a substantial disruption of both provider revenue and patient access, resulting in reductions in needed capacity and in continuity and effectiveness of care. Safety net stakeholders made specific suggestions as to how these problems can be addressed.
- Stakeholder opinion varied substantially on how the SB 2 program design would be most vulnerable to legal challenges under ERISA and Sinclair. The structure and amount of the "pay" fee for participation in the state pool were mentioned as issues bearing high legal risk. However, there was little or no consensus as to how this might be addressed in implementation planning so as to reduce the legal risk.
- Business stakeholders were concerned that the premium and administrative costs associated with SB 2 would jeopardize the economic viability of some California employers. Business stakeholders also mentioned as potential ERISA issues the administrative burden on employers and state regulation of self-insured employers.

  Business stakeholders were largely unaware that SB 2 only requires employers to offer one health coverage option compliant with SB 2's minimum benefit standards and contribution requirements and permits employers to offer other options that are not compliant. One stakeholder also noted that an 80% contribution toward an SB 2-compliant insurance product might actually cost employers less than they are now paying for some products offered in the market.

Some stakeholders indicated that this provision was intended by design to mitigate the financial impact of the program on businesses.

- Most stakeholders (regardless of perspective) indicated that it is likely and appropriate that SB 2 would be revised before implementation. A number of issues, ranging from structure and amount of the pool "pay" fee to administrative roles and responsibilities of state agencies, were mentioned by stakeholders as being addressed ambiguously or incompletely in the statute as it stands. A second reason given for revising the bill was that, if SB 2 were to survive the referendum and face ERISA and Sinclair legal challenges, there might be opportunities for amendments to address specific points made in any resulting legal decisions.
- Consumer stakeholders and some key informants were concerned that lower-income workers would not be able to afford the coverage offered under SB 2 without subsidies, and that this would prevent the program from meeting legislative intent.
- Stakeholders were not in agreement on how the success of SB 2 should be measured. Some believed that a simple measurement of the net gain in number and percentage of Californians who are insured would be the best gauge of success. Others felt that the question of success should be answered in terms of how the pool affected premium costs and stability in the market and what changes in benefits and cost sharing followed the implementation of SB 2.

Perhaps the central question emerging from the interviews was the following: *How can price and benefits be balanced to meet the twin policy objectives of the bill—availability of effective health care coverage for workers and dependents, and affordable costs to employers, employees, and the state?*