STRATEGIES FOR COVERING THE UNINSURED: HOW CALIFORNIA POLICYMAKERS COULD BUILD ON LESSONS LEARNED AT THE FEDERAL LEVEL

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The Economic and Social Research Institute is a non-partisan, non-profit research organization headquartered in Washington, D.C., and founded in 1987. Specializing in health and social policy research, ESRI conducts research and publishes studies directed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

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EXECUTIVE SUMMARY

Now that California's "pay or play" system for expanding employer-based coverage has been narrowly rejected at the ballot box, state policymakers are considering other methods to cover Californians without health insurance. This brief report explores whether recent federal attempts to expand health coverage can furnish useful ideas upon which Californians can build.

Two general lessons are apparent from recent federal history. First, bipartisanship and a focus on pragmatic effectiveness may be more productive than a partisan, ideological struggle. Such bipartisan pragmatism increases the chances that policy will be both enacted and implemented smoothly.

Second, innovative health policies can benefit from time for start-up and opportunities for early and mid-course correction. The State Children's Health Insurance Program (SCHIP) began full federal funding less than two months after the bill was signed into law. Significant amounts of early funding went unspent because the schedule for disbursing federal dollars did not take into account the time required for states to pass new legislation and take programs up to scale. By contrast, when the Trade Act of 2002 created Health Coverage Tax Credits (HCTCs) for certain displaced workers and early retirees, Congress gave the Internal Revenue Service (IRS) a year to establish a novel system of fully refundable income tax credits that could be paid directly to insurers each month as premiums came due, in advance of filing tax returns. That lead time was essential to creating an advance payment system. On the other hand, problems with low HCTC take-up and high administrative costs have emerged in part because of statutory inflexibility that created unforeseen obstacles to effective implementation. This suggests that significant administrative flexibility and opportunity for policy adjustment may be helpful to incorporate into the early phases of highly innovative policies.

Beyond these general lessons, several specific coverage expansion proposals have enjoyed either bipartisan sponsorship among federal policymakers or support from diverse outside analysts. These national proposals suggest corresponding possibilities for coverage expansion in California, such as the following:

1. Participating in the Health Coverage Tax Credit (HCTC) program, enacted in August 2002. More than 7,000 workers and their families in California are potentially eligible for HCTCs but are not using the credits through the advance payment mechanism established by the IRS. California is one of only 13 states that does not offer state-based HCTC coverage. If it began fully participating in the HCTC program, California could incorporate the best ideas from other states to provide effective

coverage to this small group without spending net General Fund dollars. In addition, the state could use federal HCTC resources to pilot-test innovative, market-based approaches, described in section 5. The resulting lessons could guide future health policy in California and nationally.

2. Enrolling eligible children into Medi-Cal and Healthy Families. The Bush Administration has expressed strong support for this goal. Unfortunately, current federal law has prevented California from fully implementing some of the most effective "Express Lane" strategies to cover these children by granting health coverage automatically based on eligibility determinations already made by other public benefits programs. State officials could seek waivers of these federal restrictions, thereby permitting California to demonstrate, either statewide or in particular localities, the impact of automatically enrolling low-income children into health coverage when their families obtain other means-tested benefits.

3. Strengthening the Major Risk Medical Insurance Program (MRMIP), California's high-risk pool*.* Toward the end of the last Congress, the Senate unanimously approved bipartisan legislation to expand such high-risk pools throughout the country. In California, MRMIP could lower its premiums, serve more people for a longer period of time before transitioning to higher-cost individual coverage, or cover more benefits if California followed the lead of certain "best practice" states that fund high-risk pools through surcharges to hospital bills. Through this approach, all private payers for health insurance (including self-insured employers) support the health insurance system of last resort for the high-risk insured.

4. Seeking Medicaid or SCHIP waivers to cover some of the poorest uninsured. Nationally, a remarkably broad range of analysts have agreed on the desirability of using public programs to cover the uninsured poor, including childless adults. New York, for example, obtained a waiver to cover all childless adults with incomes below poverty. In California, such a waiver would help a highly vulnerable group of uninsured while generating some offsetting General Fund savings. Federal matching dollars could substitute for some state and county spending or taxing authority now used to provide childless adults with health care, including county services, home care, and mental health treatment.

5. Providing tax credits or vouchers to help uninsured Californians enroll in purchasing pools that use market mechanisms to offer comprehensive coverage. Such mechanisms currently serve Federal employees, who are offered diverse plans, with both comprehensive and consumer-directed options. In the federal system, consumer choice, rather than detailed regulation, drives health plan decisions about quality and benefits, but coverage is community-rated, and enrollees have generous subsidies that nevertheless are structured to provide incentives to

select less expensive coverage. Nationally, such coverage is supported across the political spectrum and may have similar appeal in California.

Through PAC Advantage and California Choice, many California small businesses already have access to such coverage options, which could be extended to recipients of tax credits or vouchers. California policymakers interested in market-based, tax credit approaches could potentially begin with HCTC recipients, perhaps supplementing federal subsidies with state or foundation funding. To encourage participation by partners in the private sector, the state could subsidize reinsurance to cover high health claims for unusually costly enrollees -- another general approach endorsed by a diverse range of national leaders.

6. Making grants to counties to develop universal coverage systems. Prominent analysts from across the political spectrum support the federal government giving a number of states significant federal grants to provide universal coverage, testing diverse approaches to coverage expansion. State legislators in California could take a similar approach by providing grants for a number of counties to cover all their uninsured residents, building on the precedent established by the California counties that already cover all their uninsured children.

7. Providing financial incentives or mandates for individuals to purchase health insurance. This approach would be unprecedented, so gradual implementation and built-in opportunities to make mid-course corrections could be quite important. Accordingly, such incentives could be limited to Californians with relatively high incomes, who can afford health insurance but choose not to buy it. Alternatively, such mandates could apply to all Californians, perhaps reaching middle- and lower-income Californians via phase-in as subsidies come on line. Policymakers would need to provide substantial subsidies to make coverage affordable to the majority of uninsured Californians who have low family incomes. In addition, Californians subject to the mandate need an available health insurance marketplace in which to buy satisfactory coverage.

While significant further work is required for any of these general ideas to develop into full-blown proposals, it is already clear that policymakers willing to cover uninsured Californians have a number of promising strategies to explore.

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INTRODUCTION

Now that California's "pay or play" system has been rejected at the ballot box by a narrow margin, some of the state's policymakers have gone back to the drawing board to rethink strategies for covering uninsured Californians. The purpose of this issue brief is to assist such leaders by drawing on lessons from recent federal policymaking.

Of course, the educational process is a two-way street. The federal government has much to learn from the states in designing health coverage strategies; many national initiatives have collapsed; and the federal policymaking environment is quite different from California's. Nevertheless, some federal reform efforts have succeeded, and there are important lessons from both success and failure on the national stage.

Potentially useful lessons from the federal government's efforts to reduce the number of uninsured fall into two categories: general strategic guidance; and specific approaches that have shown promise at the federal level and that could potentially inspire state policy innovation. Each category is discussed in turn below.

GENERAL STRATEGIC GUIDANCE

Sustainable policy advance is more likely to result from pragmatic, bipartisan efforts than from partisan, ideological clashes.

The debate over health care in Congress in recent years has been marked more by ideological battles than by a pragmatic, bipartisan approach to covering the uninsured. Some describe Medicaid expansion as nearly ideal for all low-income uninsured and tax credits as fatally flawed, no matter how they are structured. Others characterize almost any expansion of government programs as "more big

government" and see such strategies as small tax credits usable in the individual market, new tax deductions for health expenses, limits on medical malpractice liability, and health saving accounts as the answer to the uninsured. Some on each side have furiously resisted the slightest move in the other's direction, fearing a precedent that could later shape the overall health care system.

This suggests a political lesson: *at least some bipartisan support and focus on pragmatic results, coupled with a commitment to avoid crossing the ultimate "red lines" for each major school of thought, may be needed for reform to succeed*. A "we win, you lose," 51-49 mentality will not carry the day in health care reform. Neither will a focus on ideological victory as opposed to practical effectiveness. States substantially reducing the number of uninsured have almost invariably built bipartisan coalitions to help achieve progress. The most successful federal initiatives, such as the State Children's Health Insurance Program (SCHIP), have likewise drawn support from both sides of the aisle, expediting enactment and facilitating successful implementation long after legislation was signed into law.

The Medicare prescription drug bill furnishes a cautionary tale showing some risks of a largely partisan strategy. Created with very little Democratic involvement, the legislation's execution has been made much more difficult by continuing opposition from some leading Democrats who have called for major policy revisions rather than implementation as adopted.

Incremental reform can be more productive if policymakers provide time for ramping up and allow for important mid-course corrections.

Novel programs to cover the uninsured can take significant time to implement and to reach their intended targets. In such cases, patience is needed, and policymakers may need to "go under the hood" to fix the engine and revise newly enacted policies from time to time.

For example, the SCHIP legislation signed in August 1997 made federal dollars available starting less than two months later, at the start of the next federal fiscal year in October 1997. Although unspent funding for any given year could be used during the two following years, the first year's allocation of federal SCHIP dollars was not diminished based on any expectation that the program might need time to ramp up. Few states could pass legislation and establish new programs in time to take advantage of more than a small amount of new federal funding during its initial availability.

Accordingly, during SCHIP's first fiscal year, states used only 3 percent of allotted federal SCHIP dollars. In fact, 39 states and the District of Columbia were projected to be unable to spend their first year's SCHIP allotment over the initial *three* years of

program operation.[1] In February 2000, one analysis concluded that, "Despite the creation of [SCHIP] to provide more resources to states, the number of children enrolled in Medicaid or [S]CHIP has actually declined in the 12 states with the largest number of uninsured children."[2] Other observers noted in early 2001, "Implementation of SCHIP has been a learning experience for both state and federal policymakers. Among the more difficult problems that states have faced are how to inform families that have always been outside the traditional welfare system that their children are eligible for coverage under this new public program, and how to simplify the enrollment process to make it easy for families to participate."[3]

Despite this slow beginning, by the time SCHIP reached its fifth birthday in 2002, the program was widely viewed as a tremendous success. States had achieved great progress improving outreach and simplifying enrollment.[4] Just during the brief interval from 1998-1999 (soon after adoption of SCHIP) to 2000-2001, the percentage of eligible, low-income children enrolled in Medicaid and SCHIP rose from 60.5 to 65.7 percent.[5] The proportion of low-income children without health coverage fell by a third, from 23 percent of children with family incomes under 200 percent of the Federal Poverty Level (FPL) in 1997 to 16 percent in 2002.[6] From 1997 through 2001, at the very time adults were suffering increasingly impaired access to care, the proportion of children whose health care was delayed or denied dropped by 19 percent, from 6.3 to 5.1 percent of all American children.[7] Other research found that, compared to uninsured children, those with SCHIP were significantly more likely to receive preventive care and significantly less likely to obtain care in hospital emergency rooms.[8]

By contrast, Health Coverage Tax Credits (HCTCs) established by the Trade Act of 2002 benefited from a one-year waiting period during which the Treasury Department developed an unprecedented system for paying such credits directly to insurers each month, in advance of beneficiaries' filing of annual tax forms. Some at the Internal Revenue Service (IRS) described this mechanism of advance payment to entities other than taxpayers as "revolutionary." The full year allowed by statute was needed for federal officials to develop a system to implement the statutory decree.

During the short life of HCTC, federal officials have often been creative and flexible in modifying program policy to address emerging problems. Nevertheless, the statute has, in some ways that were unforeseen when legislation was being adopted, constrained officials' flexibility and contributed to very high administrative costs and low take-up.[9] Accordingly, lessons drawn from these two, most recent national health coverage expansions are the need to build in early lead time to develop and implement sound policy and the potential benefits of significant administrative discretion during the early stage of program implementation. Such provisions can

provide useful freedom to innovate and respond to unexpected difficulties while innovative policy mechanisms are being established and refined.

SPECIFIC PROMISING STRATEGIES

In recent years, significant support at the national level has emerged for a number of policies, described in turn below. Some of these proposals have moved forward in Congress or the Administration, while others have earned broad support among diverse national policy analysts.

Each of the following sections describes the pertinent national policy discussion and explores the broad contours of potential California applications. However, the overall analysis begins by recognizing two limitations specific to California's health reformers. First, since California's budget crisis is far from over, enactment may not be likely for expansions in coverage that require substantial allocations from the General Fund, at least during the short run. Second, bipartisan support appears unlikely for reform strategies that depend on increased state taxes.

With those limitations in mind, our goals are limited, in several respects. First, some of these coverage expansions are quite modest in scope. Second, we do not intend to develop these policy options in detail. Rather, to help policymakers put together a menu of possible reforms for further exploration, we outline in general terms several opportunities for expanded coverage. Significant work would be required for any of these general concepts to mature into a detailed proposal.

1. Participating in the Health Coverage Tax Credit system under the Trade Act of 2002.

California is one of only 13 states (plus Puerto Rico) that do not offer state-based coverage to potential recipients of Health Coverage Tax Credits (HCTCs). In California, an estimated 7,600 workers displaced by foreign trade and early retirees potentially qualified for HCTCs in September 2004, along with their families, but only 264 enrolled into HCTC's advance payment system.[10]

After more than eighteen months of HCTC implementation, this would be an opportune time for California to move forward and incorporate emerging best practices from around the country. Although the number of potential beneficiaries currently appears tiny, in all likelihood more eligible workers could be found and enrolled.

Under this approach, the actual subsidies for health coverage are provided entirely by the federal government. Only a small amount of state dollars are needed to

establish the necessary health plan infrastructure and conduct outreach, and even these expenditures can be defrayed, in whole or in part, by funding from the U.S. Department of Labor. More detailed information about HCTCs is available at many locations on-line.[11]

In addition to helping thousands of vulnerable Californians without spending significant General Fund dollars, this approach could test market-based reforms that, after refinement, could be expanded to much larger uninsured groups following improvements in the state fiscal climate. Section 5, below, describes these reforms. Such a test could inform both California health policy and the development of innovative, market-based reforms across the country.

2. Using auto-enrollment strategies to cover uninsured children eligible for Medi-Cal and Healthy Families.

One sign of the national appeal of such enrollment is the Bush Administration's proposal to spend $1 billion over two years to reach uninsured, eligible children and enroll them into Medicaid and SCHIP.[12] Under current law, outreach and enrollment measures include out-stationing workers in schools, clinics, grocery stores, etc.; waiving requirements for face-to-face interviews and asset tests; simplifying application forms; providing training in linguistic and cultural competence; public service ads; establishing "express lanes" from other means-tested programs to health coverage; and many other strategies.

California's Medi-Cal and Healthy Families programs have already adopted most of these techniques. Indeed, California is one of the nation's leaders on Express Lane methods.[13] Such strategies offer the promise of "auto-enrollment," whereby parents applying for or receiving other benefits must consciously "opt out" of Medi-Cal and Healthy Families for their children to remain uninsured; according to a comprehensive review of take-up studies analyzing a broad range of public and private benefits, "it seems clear that automatic enrollment is the best way to increase take-up" of children's SCHIP and Medicaid coverage.[14]

Despite California's groundbreaking work on this issue, the technical differences in eligibility rules between health and non-health programs have presented significant obstacles, under current federal law, to full auto-enrollment of children whom non-health programs have found to have low family income. Moreover, the state does not have the information technology (IT) infrastructure needed to make efficient program linkages.[15] With federal authorities expressing significant interest in enrolling eligible children, it may be worth considering a waiver request to overcome these obstacles. Under Section 1115 of the Social Security Act, California officials could seek either a county- or state-level experiment testing the impact of true auto-enrollment strategies

that provide Medi-Cal and SCHIP to low-income children receiving other public benefits.

3. Strengthening the Major Risk Medical Insurance Program (MRMIP).

On November 16, 2004, the U.S. Senate unanimously approved legislation with substantial bipartisan co-sponsorship that would have increased federal funding to subsidize the operation of state high-risk pools serving the so-called "medically uninsurable," people whose health problems make it very difficult to obtain satisfactory coverage in the individual market.[16] The House did not take up the bill before the end of the legislative session, but the topic is expected to reemerge in 2005. In California, high-risk pool coverage is provided though the Major Risk Medical Insurance Program (MRMIP).

The two high-risk pools that offer the country's most generous coverage, operated by Maryland and Minnesota, rely on innovative funding strategies to furnish comprehensive, affordable coverage. Both of these states add a surcharge to provider bills, which ultimately is paid by self-insured large employers and health insurers. (Minnesota also uses other sources of revenue.)[17] Similar strategies could be pursued in California to reduce MRMIP premiums, broaden benefits or eligibility, or increase the period of time individuals receive MRMIP before they transition (under AB 1401) to potentially higher-cost individual coverage.

4. Using federal Medicaid or SCHIP waivers to expand coverage for some of the poorest uninsured.

Legislation to repeal the federal exclusion of Medicaid coverage for childless adults did not move forward during the past session of Congress. However, the concept of such an expansion has been endorsed by a remarkably broad range of policy analysts, including more conservative analysts who typically do not support expansions of federally-funded entitlement programs. Such analysts can make a principled distinction in the case of the poorest uninsured, whose unique needs are well-matched to many basic features of Medicaid. These Americans lack the income needed to pay for health care without jeopardizing other basic household needs, like food, shelter, and utilities.[18] Accordingly, Medicaid imposes no more than nominal costs, departing significantly from the design of most privately-funded coverage. Recognizing that the poorest Americans are unable to afford health care that is not covered by insurance, Medicaid provides more comprehensive benefits than many other forms of health coverage. A number of analysts with widely divergent views about expanding public programs to near-poor and moderate-income uninsured thus agree that the unique needs of the poorest uninsured make them appropriate for Medicaid coverage.[19]

In California, childless adults have been categorically excluded from Medi-Cal ever since 1982. From that point forward, the counties have been responsible for covering these poor and uninsured adults, with significant funding and taxing authority furnished by the state. California policymakers could consider requesting a federal waiver to cover childless adults, like those received by a number of other states. For example, New York obtains matching Medicaid dollars to cover childless adults with incomes at or below the FPL. Similarly, New Mexico and Arizona have obtained approval from the Center for Medicare and Medicaid Services (CMS) to allocate unspent SCHIP dollars to uninsured, childless adults. While some federal legislators have expressed concern about the practice of granting SCHIP waivers to cover childless adults, it remains acceptable under current CMS policy.

Of course, such waiver programs require state matching funds. But California could experience significant General Fund offsets if new federal matching dollars substitute for entirely state and local dollars that now finance health-related programs for low-income, childless adults. Such offsets could be felt in many areas, including Medically Indigent Adult funding, other funding for county health services, In-Home Supportive Services, mental health and substance abuse services, etc. Such federal funding could also free up state revenue currently delegated to counties to help finance health care for low-income, childless adults. Compared to the country as a whole, California devotes an unusually large proportion of state and local dollars to health care services for low-income people not receiving Medicaid, including childless adults.[20] Such offsets could help finance a significant improvement in access to health care for these vulnerable Californians.

Along similar lines, narrower waivers could address subsets of uninsured, childless adults. For example, the state could seek a waiver to use unspent SCHIP dollars to cover income-eligible young people ages 19 and 20. As a partial precedent, Medi-Cal now offers medically needy coverage, with no share of cost, to 19- and 20-year-olds with incomes up to 75 percent of the FPL.[21] Such a waiver of the normal age definitions for children might even extend through slightly older ages (e.g., 23). Such young adults are more likely to be uninsured than are any other age group.[22]

5. Providing tax credits to help Californians enroll into existing purchasing pools that use market mechanisms to offer comprehensive coverage.

As with the previous policy option, this one has not advanced legislatively at the federal level. Rather, proposals to provide the uninsured with refundable, advanceable tax credits to enroll in coverage like that offered by the Federal Employees Health Benefit Program (FEHBP) has been the subject of considerable interest and potential support from across much of the philosophical spectrum,

ranging from Senator John Kerry's Presidential campaign[23] to analysts at The Commonwealth Fund,[24] Centrists.Org,[25] and The Heritage Foundation.[26] In a nutshell, FEHBP-type coverage involves access to a purchasing pool offering community-rated health plans covering a variety of health benefits packages (including both comprehensive benefits and more recent "consumer directed" plan designs), with limited regulation, freedom for health plans to innovate new benefit designs, and generous subsidies that are structured to give consumers financial incentives to choose less generous coverage.[27]

The following table illustrates how these policy features appeal to diverse policymakers.

TABLE 1: POSITIVE ELEMENTS AND LIMITATIONS OF AN APPROACH COMBINING FEHBP-TYPE PLANS AND TAX CREDITS, AS POTENTIALLY SEEN BY TWO DIFFERENT SCHOOLS OF THOUGHT

	SUPPORTERS OF MARKET SOLUTIONS	SUPPORTERS OF GOVERNMENT PROGRAMS
Positive elements	▪ Tax credits ▪ "Largely run on the free market principles of consumer choice and market competition"[28] ▪ Financial incentives for consumers to select less expensive coverage ▪ Proportional subsidy may prevent adverse selection and risk segmentation[29] ▪ Flexibility for plans to develop innovative benefits ▪ Market discipline, not extensive regulation, promotes quality, efficiency, and good benefits	▪ Access to comprehensive benefits ▪ Group coverage ▪ Community rating (that is, premiums not affected by age, gender, health history, etc.) ▪ Guaranteed issue of coverage ▪ Large subsidies make coverage affordable
Limitations	▪ Group, not individual coverage ▪ Community rating translates into hidden cross-subsidies from younger and healthier workers to older and sicker ones	▪ No guaranteed benefits ▪ No entitlement ▪ Possible "cherry picking" by insurers ▪ Potential risks to employer coverage and public programs

A related policy initiative that has received substantial support from diverse quarters is the notion of publicly subsidized reinsurance, which limits private plans' exposure to high costs incurred by a small percentage of their sickest enrollees. In different forms, such a "safety net" for insurers has been proposed by both Senator John Kerry[30] and Senate Majority Leader William Frist,[31] signaling the possibility of bipartisan agreement. A number of states have pursued similar strategies, including New York, which uses reinsurance to encourage health plans to participate in Healthy New York, a program offering lower-cost insurance to small firms and low-income individuals.[32]

With such reinsurance limiting the risks for private-sector partners, California could establish pools with the FEHBP-like characteristics described above – namely, diverse plans, with both more and less comprehensive options, and market incentives that drive plan decisions about cost, quality, and overage. Fully refundable, advanceable tax credits could subsidize enrollment by low-income, uninsured Californians into these pools, perhaps with the highest subsidy amounts for those with the lowest incomes.

In fact, California already has several insurance markets that, in many ways, resemble FEHBP – namely, PAC Advantage and California Choice. Among the most effective purchasing pools in the country, these two privately-operated pools offer small employers a range of health plans, including both comprehensive coverage and high-deductible options supported by Health Savings Accounts (HSAs). Policymakers could explore the possible use of tax credits to give individuals access to such pools, coupled with safeguards to prevent adverse selection.

Some policymakers may view the impact on the General Fund differently for state income tax credits, which can be viewed as a tax reduction, than for a program involving new expenditures of taxpayer dollars. State could even try to obtain waiver approval from CMS for a novel policy of using federal matching dollars under Medicaid or SCHIP to partially defray state tax credit costs.

Limited state resources could be leveraged substantially by starting with HCTC-eligible individuals and perhaps supplementing federal tax credits with subsidies furnished by the state or funded by private foundations. Such supplementation could test whether the resulting lower premium cost for uninsured individuals significantly increases the proportion of individuals who enroll.[33] This strategy would make California the first jurisdiction in American history to test the combination of tax credits and purchasing pools, informing the development of future market-based reforms both in California and nationwide.

6. Providing counties with resources to cover all their uninsured residents.

Henry Aaron of The Brookings Institution and Stuart Butler of The Heritage Foundation have jointly proposed grants to states to support diverse methods of expanding coverage significantly.[34] For decades, Drs. Aaron and Butler have been among the nation's leading domestic policy thinkers, with very different basic policy perspectives. Their agreement on a series of large-scale state experiments to cover the uninsured suggests prospects for bipartisan support.

Under the Aaron/Butler plan, states could expand coverage using methods that range from single-payer health coverage to tax credits for use in a largely

unregulated individual market. To obtain federal resources, states would enter into binding compacts with federal authorities to meet defined benchmarks for coverage expansion.

Put more generally, when policymakers at one level of government are unable to resolve philosophical differences, such policymakers can limit themselves to providing resources to another set of decision-makers while specifying desired outcomes and methods of ensuring accountability. Actually resolving knotty philosophical and policy design questions is left to such other decision-makers. In the case of the Aaron/Butler proposal, states are the entities given resources and major responsibilities for policy design.

For California's state policymakers, a similar approach could be taken with counties, some of which already offer coverage to all children. The state could provide grants to a small number of counties to extend coverage to all resident adults as well as children, following the general lead established by the Aaron/Butler proposal. To minimize State General Fund costs, the counties could contribute funding, federal matching funds could be maximized (including through the use of waivers), and private foundations could continue or expand their participation in county-based coverage programs. This approach could test a number of different strategies for dramatically expanding coverage, providing a rigorous evaluation that could guide later reforms both in California and throughout the country.

7. Mandating coverage, particularly among higher-income uninsured.

A broad range of analysts have supported the notion of requiring individuals to obtain health coverage, potentially imposing tax penalties on those who could afford coverage but choose not to obtain it.[35] California's policymakers could choose from among several variants of this approach. One would limit the mandate to higher-income individuals who currently have access to coverage they can afford but choose not to purchase. The other would mandate coverage for the entire population. While these strategies have been discussed in health policy circles for decades, they have never been implemented in any state. Accordingly, California policymakers pursuing an individual mandate would be well-advised to provide for slow and careful implementation, with plenty of time for feedback and room for mid-course adjustments. For example, the initial phases could be limited to the highest-income uninsured Californians.

Variant A: Incentives or mandates for the higher-income uninsured.

State policymakers could penalize uninsured individuals who have incomes high enough to afford coverage. Tax penalty dollars could be allocated to help fund

indigent care. To illustrate the potential impact of such a policy, 15 percent of uninsured Californians had household income above $75,000 a year in 2003.[36]

Individuals subject to this approach would be identified through two criteria: first, penalties would apply only to uninsured individuals with household incomes above a specified level (such as 400 percent of the FPL); and second, uninsured individuals with such relatively high incomes could nevertheless avoid penalties by showing that the lowest-cost coverage available to them would consume more than a threshold percentage of household income (such as 5 percent). One measure of such costs could be plans available through MRMIP.

A safeguard like the latter provision would be needed to protect individuals who cannot afford coverage, despite above-average income. While roughly three in five uninsured California children with moderate- or higher-incomes (above 200 percent of FPL) appear to have access to employer-sponsored insurance (ESI), the same is not true of adults. At least 87 percent of uninsured California workers at these income levels either work for firms that do not provide ESI or are ineligible for ESI offered by their employers.[37] To gain coverage, such workers would be required to pay full premiums, without employer assistance, in the individual market (or MRMIP), where administrative costs are higher and premiums can increase based on age and prior health problems. Even with moderate or higher levels of income, people with chronic illness can therefore have difficulty affording health insurance.

One way to administer such an individual mandate would be to require taxpayers with incomes above the target level, when filing their returns, to prove either that all household members were insured throughout the tax year or that the lowest-cost available coverage would have consumed more than the target percentage of household income.

Variant B: Incentives or mandates for all residents.

Policymakers pursuing this second approach would need to provide substantial subsidies to make coverage affordable to low-income Californians, who comprise most of the state's uninsured.[38] Current public programs, like Medi-Cal or Healthy Families, could provide some of this assistance, both by enrolling more eligible Californians and by expanding eligibility criteria to include additional state residents. Also, policymakers could establish new subsidies, such as the tax credits or vouchers described above. Without large subsidies, regardless of how they are provided, a mandate to buy health insurance could be ignored by most of the uninsured or could require many currently uninsured households to sacrifice other necessities, such as food and prompt payment of utility bills.

In addition to subsidies, Californians subject to an individual mandate would need a place to buy health coverage. Alternatives include the individual market, perhaps supplemented by an enhanced MRMIP program, as discussed above; current purchasing pools (such as PAC Advantage, California Choice, or the public employee health coverage system run by CalPERS); a new purchasing pool modeled after FEHBP, as explored above; or an option to enroll in Healthy Families or Medi-Cal at full cost. Each of these alternatives involves challenging policy design questions with important trade-offs.

Other decisions face policymakers embracing this groundbreaking approach, starting with the kind of coverage to mandate.[*] While comparatively inexpensive high-deductible policies safeguard local emergency care infrastructure and prevent hospitals from shifting uncompensated costs to private and public payers, such policies would not improve access to outpatient care for individuals with chronic illness whose problems go undetected or untreated because they lack health coverage and who suffer grim consequences as a result.[39] High-deductible policies also could be problematic for children, some of whom can suffer serious, even life-long harm without a full range of health services that can rapidly detect emerging problems and allow the prompt initiation of treatment.[40]

[*] Following are some examples of additional questions that policymakers would need to answer. How would the mandate apply to immigrants? Would low-income, uninsured Californians whose immigration status disqualifies them from full-scope Medi-Cal be required to have health insurance? Would new subsidies (such as tax credits) have immigration status restrictions? Even if they qualify for subsidies in theory, how likely are immigrants to apply? If they are ineligible for subsidies or do not apply for them, how could low-income immigrants afford to purchase coverage? If a mandate would impose unaffordable burdens, what measures might such immigrants take to avoid those burdens? On a different topic, how would a universal mandate be enforced? Proof of insurance could be required while residents file their state income tax returns, but what about Californians whose low income exempts them from filing such forms? Would filing income tax returns be required of all California families, even those who owe no income tax? Or would proof of coverage be required when individuals seek care? If so, how would policymakers prevent individuals from avoiding the resulting premium costs by dangerously delaying their utilization of necessary emergency care?

CONCLUSION

The voters have narrowly overturned one innovative strategy for covering uninsured Californians, but the problem has not disappeared. At both the federal and state level, these are challenging times. Nevertheless, useful tools remain available for creative policymakers to expand coverage. While significant further work is required for any of these general ideas to develop into a full-blown proposal, it is already clear that policymakers willing to cover uninsured Californians have a number of promising strategies to explore.

NOTES

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