California HealthCare Foundation

Massachusetts-Style Coverage Expansion: What Would it Cost in California?

ISSUE BRIEF

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Introduction

Massachusetts' enactment of legislation (H 4850) to extend coverage to all residents has received much attention in California and nationally. The aspect of this legislation that has been of particular interest is the mandate that all individuals have coverage, which will move Massachusetts closer to universal coverage for its residents.

The Massachusetts approach may be a model California (and other states) could use to cover the uninsured, but at what cost? Substantial differences in California's income and health-coverage patterns suggest that state costs would be substantially higher in California than in Massachusetts. For example, the proportion of the non-elderly population that is uninsured and low-income (under 250 percent of the Federal Poverty Level (FPL)) is only 6.4 percent in Massachusetts but 13.5 percent in California (100 percent FPL in 2006 is $9,800 for a single person and 250 percent FPL is $24,500). Further, Massachusetts' existing charity care funds are much larger, relative to the size of its uninsured population. The re-channeling of such funds also allows Massachusetts to afford coverage of the uninsured more easily.

This issue brief addresses the key question: If California adopted a construct similar to Massachusetts, how much might it cost employers, individuals, and the public purse? This analysis, authored by the Institute for Health Policy Solutions (IHPS), draws on a broader ongoing analysis that explores the costs of mandatory coverage options for California involving a range of alternative individual and employer responsibilities. Key provisions of the Massachusetts legislation are provided here, along with a similar illustrative individual-mandate model for California, an estimate of its costs, and discussion of its implications.

Examining the Massachusetts Model

H 4850 aims to achieve nearly universal health insurance coverage by creating a requirement that "everyone who can afford health insurance must obtain it,"[1] and by adopting a range of other provisions and subsidies to assure that coverage is affordable. Key provisions of the bill that relate to the individual mandate and subsidies for low-income people include:[2]

- All state residents must obtain health insurance coverage or pay a penalty on their state income taxes. (Individuals for whom affordable products turn out not to be available, according to a sliding affordability scale to be set by the Connector's Board, will not have to pay any penalty.) Employers with more than 10 employees must offer section 125 plans that allow workers to purchase health insurance with pre-tax dollars.
- Creation of the Commonwealth Health Insurance Connector Authority, a pool to connect individuals and small businesses (with 50 or fewer workers) with health insurance products. The authority will also

operate a program of sliding-scale premium subsidies for people with incomes less than 300 percent of the FPL[3] (not eligible for public or employer-subsidized coverage[4]). People with incomes below the FPL will have no premium contribution, no deductible, and only modest co-payments.[5]

- Funds for the new coverage system come from a combination of redeployment of some existing uncompensated care and similar funds, federal matching funds, and $125 million from the state General Fund.[6]
- The legislation also includes a small fee on employers with 11 or more full-time equivalent employees that do not offer and contribute toward health insurance for their employees.[7] In signing the bill, Governor Romney line-item-vetoed this fee, but legislative leaders indicate they intend to override his veto.[8]

How Would the Massachusetts Model Look in California?

This California model was developed by the Institute for Health Policy Solutions as part of a larger project to develop and analyze approaches that require participation in coverage and are of real interest to California policy makers. The project looks at approaches ranging from an individual mandate with no required financial role for employers, through one involving fees on all employers and workers. In between are hybrid approaches that involve both individual mandates and minimum employer contributions. Each approach assures that all workers receive the full federal and state tax benefits available for health insurance contributions they make by payroll deduction. Doing so reduces the net cost of coverage for uninsured workers and their families and thus also reduces the state's costs for premium subsidies needed by many lower income working families. A report giving the results of this broader analysis is expected to be publicly available in the summer of 2006.

The central feature of the California model discussed in this issue brief is an individual mandate: All residents must obtain health insurance. The state would set up a pool through which individuals not offered health insurance through employment could obtain coverage, and low-income people would be eligible for premium subsidies. Employers would be required to coordinate with the pool, but would not be required to contribute toward the cost of coverage for workers.

The proposed individual mandate model for California includes the following components:

1. Like Massachusetts, everyone (including children) must have health insurance and, for purposes of illustrating its potential costs, coverage of all state residents was assumed.
2. Like Massachusetts, low-income people get sliding-scale health insurance subsidies. People below the poverty level pay nothing, and most low-income people get coverage equivalent to Healthy Families (or to Medi-Cal, if they meet current Medi-Cal eligibility rules).[9]
   - Low-income is defined as a family income of no more than 250 percent percent of FPL. The 300-percent-of-FPL subsidy threshold used by Massachusetts is not used in the California model because the 250-percent threshold already encompasses a larger share of the population than Massachusetts proposes to subsidize.[10]
3. Similar to Massachusetts, a state-authorized pool, or exchange, contracts with private health plans to provide coverage for people who do not have access to employer-sponsored coverage. The pool bills worker's employers, or the individuals themselves if they have no employer; bills the state for subsidy

amounts due; handles enrollment functions; and transmits premium payments to participating health plans.

- Low-income people who enroll in coverage through the state-designated choice pool get subsidies according to the schedule shown in the Appendix.
- People eligible for employer coverage are not eligible to enroll through the pool and may or may not be eligible for subsidies. Given the ambiguities in the Massachusetts legislation, the California model includes both a lower-bound estimate and an upper-bound estimate. Under the lower-bound estimate, people with access to group coverage with an employer contribution are not eligible for subsidies unless they meet current Medi-Cal eligibility criteria.
- Under the upper-bound estimate, low-income people with employer coverage qualify both for premium assistance and for state-paid supplemental coverage to assure they receive the same benefits they would receive if they were enrolled through the pool. The premium assistance they receive toward their share of the employer-plan premium is proportional to what they would have received if they had enrolled through the pool.[11]

4. Like Massachusetts, employers that do not directly sponsor and contribute to coverage would be required to coordinate with the pool to assure their workers receive the full tax benefits available for worker contributions to health insurance coverage.
5. For estimation purposes, employers that currently offer coverage are assumed, but not required, to continue doing so. Like Massachusetts employers, they would be required to sponsor section 125 plans. They are also required to coordinate with the pool for workers who are ineligible for the employer's own plan (e.g., part-time, temporary workers).

Additional details of the specifications and assumptions used to prepare cost estimates for this illustrative approach are given in the Appendix, along with a more detailed comparison to the Massachusetts approach.

Underlying Differences Between California and Massachusetts

If Massachusetts estimates that its individual mandate for health insurance with significant subsidies for low-income people is "almost free" (i.e., requires minimal new state funds), why do the estimates show that a similar approach would require between $6.8 and $9.4 billion in additional state funds in California (or between $4.8 and $7.4 billion if all $2.0 billion of current DSH funds could be re-directed for this purpose)?

The answer lies in the different economic characteristics of the two states and the proportionate difference in pre-existing state spending on care for the uninsured.

Although per capita income in California ($24,420) and Massachusetts ($28,509) are both above the U.S. average,[12] there are substantial pertinent differences in the income and health coverage characteristics of their non-elderly populations, as shown in Table 1. A much higher proportion of the population is uninsured and low income in California than in Massachusetts. Thus, a much larger share of California's population would need financial assistance in order to afford coverage.

California's higher uninsured rate is *not* because the state covers a lower proportion of its residents through its public programs for low-income populations—in fact California covers a higher proportion than both Massachusetts and the national average. Importantly,

the percentage of the population with employer coverage is lower in California. This is in part because a higher proportion of workers are self-employed (9.3 percent v. 7.1 percent) or unemployed (8.5 percent v. 7.4 percent) in California than Massachusetts (2003).[13] And, as discussed later, a greater share of California's workers are employed by firms with a majority of low-wage workers. Coverage rates among such firms are generally much lower than in other firms.

Table 1. Insurance and Poverty Status of the Non-Elderly Population in California, Massachusetts and the U.S., 2004

NON-ELDERLY IN 2004	CA	MA	U.S. Total
Uninsured	20.7%	13.1%	17.8%
Employer Coverage	55.6%	69.4%	63.2%
Medicaid	16.8%	14.5%	13.3%
Under 250% FPL	42.8%	28.7%	38.8%
Among those Under 250% FPL, % Uninsured	31.6%	22.4%	29.3%
Uninsured and Under 250% FPL	13.5%	6.4%	11.4%

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2005. Author's tabulations using online Table Creator at www.census.gov/hhes/www/cpstc/cps_table_creator.html.

Another highly pertinent distinction between Massachusetts and California is the relative amount of existing state spending on care for the uninsured.

One reason the Massachusetts approach is touted as "almost free" is that the state is re-directing almost $1 billion available from its uncompensated care pool and other related spending toward the low-income subsidies established under the legislation. That amount equates to between $1,300 and $1,800 per uninsured person per year (depending on which estimate of uninsured people in Massachusetts is used). If re-directed, California's $2 billion in DSH funds, on the other hand, would provide only about $300 per uninsured Californian per year.

If California were currently allocating as much as Massachusetts to care for the uninsured, that would translate to an amount in the range of $8.5 to $11.5 billion. This would be substantially more than is needed to cover estimated costs under the lower-bound state-cost estimate, and about the amount needed to cover the upper-bound state-cost estimate.

Cost Estimates for a California Model

Total cost estimates for the individual mandate structure to employers, individuals, the federal government and the State of California reflect several key assumptions:

1. The mandate is fully phased in and everyone participates.
2. Despite increases in enrollment among eligible workers who had previously declined coverage, employers that currently offer coverage would continue to do so and to contribute on the same terms as they do now.
3. Universal coverage leads to a 3 percent reduction in premiums for employer coverage, because providers will have less uncompensated care costs to recover.[14]
4. Except for this 3 percent reduction in premium levels, employer health benefit plans remain unchanged. All people who are eligible for them enroll in them. Other benefit-level and premium assumptions include:
   - People who enroll through the pool who meet current Medi-Cal eligibility criteria receive direct Medi-Cal coverage at current capitation rates.
   - Other low-income children receive the current Healthy Families benefit package at current Healthy Families capitation rates.
   - Low-income adults not eligible for Medi-Cal get Healthy Families adult benefits (i.e., those planned under the never-implemented Healthy Families expansion to parents) at negotiated capitation rates that, for estimation purposes,

are expected to produce per-capita costs equivalent to those expected under the Healthy Families parental expansion, adjusted to 2006. The rate is approximately $2,700 per year per adult (or a little more than twice the Healthy Families per-child rate).

- People above 250 percent of FPL choose coverage with a deductible of no more than $5,000 and an out-of-pocket limit of no more than $10,000—the minimum necessary to meet the mandate—unless they already purchase coverage with a lower deductible. Due to group-like administrative costs through the pool, the community-rated high-deductible plan costs about $1,900 per year per adult.

For purposes of allocating subsidy costs among the state and federal governments, it is assumed that federal Medicaid matching funds are available for low-income parents and children but not for childless adults, that current rules governing use of federal funds for coverage of immigrants continue to apply, and that, once the state's federal S-CHIP allocation is fully used, ways will be found to obtain federal Medicaid matching for additional expenditures on low-income children. Some additional assumptions are included in the Appendix.

Because the change in the cost to different parties is usually of greater interest than the absolute level of expenditure, estimates of spending under the illustrative mandate were compared to estimates of spending under the current system in 2006 (called the baseline).[15]

Health Care Spending and Tax Savings

If all Californians had coverage under this Massachusetts-style plan, health care spending by Californians for premiums and out-of-pocket costs (for the civilian, non-institutionalized, non-Medicare population) would increase by approximately $10.6 billion or 9.9 percent, from $106.6 billion to just over $117 billion (see Table 2).

Perhaps surprisingly for an individual mandate, under the assumption that employers would maintain current contribution policies, it is estimated that contributions from employers would increase by 8.8 percent.[16] The increase in employer spending derives from increased enrollment by workers and dependents who had

Table 2. Lower-Bound State Cost Estimate for Health Care Spending and Tax Savings under California Model

CATEGORY OF SPENDING	Baseline Spending (2006 dollars in billions)	Spending Under Individual Mandate (2006 dollars in billions)	Change from Baseline (in billions)	Percent Change from Baseline
Premiums paid by employers	$58.6	$63.8	+$5.1	+8.8%
Premiums paid by individuals (net of tax savings)	$15.2	$16.8	+$1.6	+10.4%
Contribution to premiums paid by individuals from tax savings	$3.6	$6.3	+$2.7	+74.4%
Premiums paid by public programs	$15.9	$22.6	+$6.7	+42.0%
TOTAL Premiums	**$93.3**	**$109.5**	**+$16.1**	**+17.3%**
Out-of-pocket spending by individuals at time of service	$13.3	$7.7	−$5.5	−41.6%
TOTAL Premiums and Out-of-Pocket Costs (excluding Medicare, CHAMPUS, etc.)	**$106.6**	**$117.2**	**+$10.6**	**+9.9%**
Taxes avoided by individuals because employer premium contributions are excluded from personal income	$22.4	$24.3	+$1.9	+8.6%

Note: Estimates are for the civilian, non-institutionalized, non-Medicare population and exclude payments by Medicare, CHAMPUS and the military, as well as Medicaid payments for long-term care. Details may not add to totals and percentage increases may appear to vary, due to rounding. Under the lower-bound state-cost estimate, people eligible for employer coverage are not eligible for state premium assistance unless they also meet Medi-Cal eligibility criteria.

previously declined employer coverage for which they were eligible. This increased enrollment substantially reduces state costs that would otherwise be incurred if such individuals were enrolled in the pool.[17]

The net increase in individual contributions is reduced very substantially by the tax savings, which increase significantly because the model requires that *all* employers adopt measures to allow their workers to tax-shelter their payroll deductions for health insurance. This includes workers above the 250 percent FPL subsidy threshold who are not eligible for employer contributions. Though these workers would pay the entire premium amount they would also have their costs reduced by tax sheltering of the full amount.

As mentioned previously, under the Massachusetts legislation it is not clear whether low-income workers and families eligible for employer coverage might be eligible for premium assistance. For this reason, we provide lower- and upper-bound state-cost estimates:

- The lower-bound state-cost estimate (Table 2) assumes that no premium assistance is provided for employer coverage (except for people eligible for Medi-Cal).
- The upper-bound estimate (Table 3) assumes that low-income people with employer group coverage *do* receive premium assistance, as well as state-paid supplemental coverage.[18]

Under the lower-bound state-cost estimate, net premiums paid by people increase by an estimated $1.6 billion dollars, or 10.4 percent. This is after a $6.7 billion increase in public program payments for low-income people not eligible for employer coverage, and after a $2.7 billion dollar increase in tax savings on people's contributions.

This estimate assumes that all persons eligible for employer coverage, including those who had previously declined such coverage, pay the entire worker contribution amount with no premium assistance. It assumes tax sheltering and savings that directly offset these people's contribution costs. (Tax sheltering does not apply for some very low-income people who would not benefit from it). Before taking the tax savings into account, gross individual contributions increase by 22.8 percent, from $18.8 billion to $23.1 billion.

The estimates provided here are the aggregate increase across all individuals: a number of individuals would experience substantially higher percentage increases. For example, a lower income worker with a part-time or nonworking spouse who had previously declined available employer coverage might be faced with a $4,000 worker-contribution requirement (or even more, depending on employer-plan family tier and contribution structures). Even with tax savings (which would vary, depending on the couple's precise circumstances), the financial impact would be substantial.

Table 3. Upper-Bound State-Cost Estimate for Individual Premium Contributions, Associated Tax Savings, and Public Subsidy Costs, California Model

CATEGORY OF SPENDING	Baseline Spending (2006 dollars in billions)	Spending Under Individual Mandate (2006 dollars in billions)	Change from Baseline (in billions)	Percent Change from Baseline
Premiums paid by individuals (net of tax savings)	$15.2	$13.2	−$2.0	−13.2%
Contribution to premiums paid by individuals from tax savings	$3.6	$5.1	+$1.5	+41.4%
Premiums paid by public programs	$15.9	$27.4	+$11.5	+72.1%

Note: Estimates are for the civilian, non-institutionalized, non-Medicare population and exclude payments by Medicare, CHAMPUS and the military, as well as Medicaid payments for long-term care. Details may not add to totals, and percentage increases may appear to vary, due to rounding. Under the upper-bound state-cost estimate, people eligible for employer coverage are eligible for state premium assistance and state-paid supplemental coverage.

The lower-bound state costs are almost certainly much less than could realistically be expected under the associated policy assumptions. Those policies would likely cause many more low income workers to become ineligible for employer coverage over time, as both workers and employers adjusted to the denial of subsidies for low-income workers whenever an employer contributes toward coverage.[19] This loss of employer coverage in turn would increase state costs for coverage through the pool, quite possibly to higher levels than the upper-bound state-cost estimate discussed next.

Under the upper-bound state-cost estimate, low-income individuals in employer group plans would receive premium assistance toward their share of the employer-plan premium proportional to what they would have received if they had enrolled through the pool. This approach would involve higher estimated public subsidy costs and lower premium payments by individuals, as shown in Table 3. However, subsidy costs would not increase by as much as they would if all low-income individuals were enrolled in public coverage through the pool.

Under this option, there is a 13.2 percent reduction in (after-tax) spending by individuals on premiums. This reduction comes from two sources: First, the tax contribution increases by $1.5 billion or over 41 percent. Second, our mandate model incorporates public subsidies for low-income people so that they do not have to spend more than a specified (sliding-scale) proportion of income on health coverage. Under the upper-bound state-cost estimate, these subsidies pertain whether or not low-income people had coverage before the mandate became effective and regardless of whether they obtain their coverage through their employer or through the state-authorized pool.

The lower-bound state-cost estimate assumes that those eligible for employer coverage pay the entire worker contribution amount with no assistance other than standard tax savings. Under an individual mandate, this would mean that low-income people who had struggled to pay for health insurance would be required to continue to spend a disproportionate share of their limited income on health insurance. Given that these individuals opted to purchase coverage in a voluntary environment where they could at least drop coverage if necessary to meet other basic needs, this mandate places an undue burden on them. Under affordability standards to be developed by the Board, the Massachusetts plan exempts individuals who face unaffordable premium costs, relative to income, from any penalties otherwise imposed on the uninsured. Since no standards are specified at this point, there was no basis to estimate the impact of this exception.

Further, it is unclear whether or how often people eligible for employer coverage might be eligible for subsidies through the Connector under the Massachusetts legislation. The legislation indicates that people are ineligible for subsidies if they are eligible for employer contributions of 20 percent or more of the cost of family coverage or 33 percent or more of the cost of individual coverage. (The vast majority of *all* employer plans meet these criteria.) But the Connector Board is also authorized to waive this limitation and provide subsidies if the low-income worker's employer will re-direct its normal contribution toward coverage through the Connector.[20] How this waiver authority might be used and the extent to which employers will be willing to so re-direct contributions remains to be seen.

The Massachusetts law also specifies that any such employer contribution must first be used to reduce the state's subsidy payment; this requirement seems likely to discourage employers with many low-income workers from making contributions to coverage (since the

possible annual $295-per-worker fee for non-offering employers is minimal relative to the cost of coverage). In our upper-bound state-cost approach, employer contributions reduce *both* the state subsidy payment *and* the worker's contribution. By allowing employer contributions to benefit the employer's own workers, this approach is designed to encourage employers with many low-income workers to continue contributing toward coverage. The ultimate state cost likely would be no more, and quite possibly less than under the Massachusetts approach per se. Unless and until a state has alternative revenues available to replace employer contributions, it is sensible to consider coverage policies like this that have the potential to parlay, rather than crowd-out, financial contributions by employers.[21]

Massachusetts officials have indicated such issues are of relatively little concern because so few of the Commonwealth's employers have mostly low-wage workers. As seen in the data below, this issue is more significant for California than for Massachusetts:

- A substantially greater share of workers is employed by firms with a majority of low-wage (under $9.50/hour) workers in California (17.7 percent) than Massachusetts (10.4 percent).[22]
- While most workers in low-wage firms do not have direct employer coverage, those who do constitute 7.8 percent of all California workers with such coverage—almost triple the proportion in Massachusetts (2.8 percent).[23]
- Given that the 250 percent FPL subsidy threshold translates to almost $12/hour (rather than $9.50/hour) for a single full-year, 40-hour/week worker, and considerably more for a sole-earner parent (e.g., almost $20/hour for a full-year, 40-hour/week worker with two dependents), a more sizeable portion of California workers have coverage from employers that could well respond to the incentives created by such subsidy policies.

Finally, the exclusion of employers' health insurance contributions from taxable personal income saves Californians a significant amount in federal income and FICA taxes. This model is structured to assure that these available savings are captured in a way that reduces state subsidy costs, as well as non-subsidized worker and employer contributions.

Costs to the State

In our model approach, public funds are used to subsidize coverage for people with incomes below 250 percent of FPL. As detailed in the Appendix, people below 100 percent FPL and those eligible for Medi-Cal are fully subsidized. People between 100 percent and 250 percent of FPL are partially subsidized, on a sliding-scale. Under the lower-bound state-cost option, only those covered through the pool receive subsidies; those with access to employer coverage are not eligible for subsidies unless they meet current Medi-Cal eligibility requirements. Under the upper-bound state-cost option, those with employer coverage also receive subsidies if under 250 percent of FPL.

As seen in Table 4, total public subsidy costs increase substantially even under the lower-bound state-cost version of our illustrative subsidy structure—by $6.7 billion or 42 percent. The overall federal contribution declines slightly (by less than $0.01 billion), so the net cost to the state is $6.8 billion—a 79 percent increase over current state spending. This estimate of the federal contribution is conservative, because it assumes that *no* federal funds would be available for coverage of childless adults, regardless of income. Federal funds *might* be available for childless adults under a section 1115 waiver. Obtaining federal Medicaid matching funds for parents is a realistic assumption because, under section 1931 of the federal Social Security Act, the state may set the eligibility standard for coverage of families under Medi-Cal.

Table 4. Lower-Bound State-Cost Estimate for Total Subsidy Costs and Costs to the State under California Model

CATEGORY OF SPENDING	Baseline Spending (2006 dollars in billions)	Spending Under Individual Mandate (2006 dollars in billions)	Change from Baseline (in billions)	Percent Change from Baseline
Subsidies for low-income individuals in the pool (includes direct coverage through Medi-Cal or Healthy Families)	$15.9	$20.4	+$4.5	+28.4%
Subsidies for employer coverage for individuals who are eligible for Medi-Cal	$0	$2.2	+$2.2	N/A
TOTAL Public Subsidies under Lower-Bound Estimate	**$15.9**	**$22.6**	**+$6.7**	**+42.0%**
Federal Medicaid match for direct Medi-Cal coverage	$6.8	$4.9	−$1.9	−28.2%
Federal S-CHIP match for direct Healthy Families coverage of children	$0.6	$0.5	−$0.1	−21.6%
Federal Medicaid contribution for low-income parents in pool	$0	$0.9	+$0.9	N/A
Federal Medicaid match for Medi-Cal eligibles with employer coverage	$0	$1.1	+$1.1	N/A
TOTAL Federal Contribution under Lower-Bound Estimate	**$7.4**	**$7.3**	**−$0.1**	**−$0.9%**
NET COST TO STATE under Lower-Bound Estimate	$8.5	$15.3	+$6.8	+79.1%

Note: Estimates are for the civilian, non-institutionalized, non-Medicare population and exclude payments by Medicare, CHAMPUS and the military, as well as Medicaid payments for long-term care. Details may not add to totals and percentage increases may appear to vary, due to rounding. Under the lower-bound state-cost estimate, people eligible for employer coverage are not eligible for state premium assistance unless they also meet Medi-Cal eligibility criteria.

Federal matching would certainly be available for subsidies to people eligible for Medi-Cal under current rules. Note, however, that total subsidies for these individuals decline, because some people that currently receive Medi-Cal directly will now be required to take the coverage their employer offers, with state-paid premium assistance and supplemental benefits. This approach reduces total public costs and the associated federal matching funds.

It is also important to note that these estimates of current public spending include *only* public subsidies paid on behalf of specific individuals. In particular, federal and state payments made under the "disproportionate share hospital (DSH)" provisions of Medicaid are *not* included. To the extent universal coverage removes the need for such payments, all or some portion of current DSH payments might be re-channeled to fund subsidy payments for low-income people. Similarly, California county payments for care of indigent adults might be re-allocated for this purpose, although there would be formidable political and implementation challenges in redirecting these funds. Such payments total, respectively, about $2.0 billion and about $1.8 billion per year.

If the full $2.0 billion in DSH funds could be made available toward subsidies for low-income people, the net state cost under the lower-bound estimate would be reduced to $4.8 billion.

Table 5 displays estimates for the additional costs of the upper-bound state-cost approach, which provides sliding-scale subsidies for all low-income people, including those who are enrolled in employer-provided coverage. Because there is no spending for these groups in the baseline, comparisons to baseline spending are omitted from Table 5.

The additional subsidies provided under the upper-bound state-cost approach raise the total cost of public subsidies to $27.4 billion, an increase of $11.5 billion or 72 percent over baseline spending. The state share of these costs is $17.9 billion, an increase of

Table 5. Upper-Bound State-Cost Estimate for Additional Subsidies and State Costs under California Model

CATEGORY OF SPENDING	Additional Public Subsidies (2006 dollars in billions)	Federal Contribution from S-CHIP (2006 dollars in billions)	Federal Contribution from Medicaid (in billions)	Net Additional State Cost
Subsidies for employer coverage for children in HFP income range	$2.4	$0.5	$0.8	$1.1
Subsidies for employer coverage for parents in subsidy income range	$2.4	$0	$0.8	$1.6
Additional Public Subsidies under Upper-Bound Estimate	$4.8	$0.5	$1.6	$2.7

Note: Estimates are for the civilian, non-institutionalized, non-Medicare population and exclude payments by Medicare, CHAMPUS and the military, as well as Medicaid payments for long-term care. Details may not add to totals and percentage increases may appear to vary, due to rounding. Under the upper-bound state-cost estimate, people eligible for employer coverage are eligible for state premium assistance and state-paid supplemental coverage.

$9.4 billion or 110 percent over the state's baseline spending.

One reason that the state spending increase is larger, proportionally, than the overall spending increase is that many low-income people do not qualify for federal matching funds because of their immigration status. For this reason, and because we again did *not* assume federal matching funds would be available for childless adults, we believe our estimates of federal financial participation are more likely too low than too high. Also, the federal S-CHIP contribution is limited in the estimates to the amount expected to be available to the state for the current fiscal year (including carry-over of unused allotments from previous years). Since S-CHIP must be re-authorized in 2007, any projection of future allotments would be entirely speculative. However, it is assumed that, once the state's federal S-CHIP allotment is fully committed, the state would be able to take steps to obtain federal Medicaid matching funds for any additional low-income children it subsidizes. The assumed federal Medicaid contribution for these children is shown separately.

In addition to direct subsidy payments, the state would also incur revenue losses related to increased tax-sheltering of workers' health insurance contributions. These revenue losses are estimated to be between $0.94 and $1.09 billion, representing increases of $0.29 to $0.43 billion over the baseline estimate of $0.65 billion, depending on the option selected. By comparison, the federal government would incur revenue losses of $5.2 to $6.6 billion, an increase of $1.5 to $2.9 billion from the $3.7 billion base.

Contributions from Non-Offering Employers

Another way to help reduce state subsidy costs would be to impose some minimum fee or tax on employers that do not offer and contribute (more) toward coverage.

If a Massachusetts-style "head tax" were imposed on currently non-offering California private-sector employers with 10 or more workers, about 1 million workers would be affected—about two-thirds of them full-time and the remainder part-time. A $295 annual fee per FTE employee, therefore, would generate only about $250 million.[24]

How Would Employers Respond?

Partly in order to be consistent with the assumptions underlying the Massachusetts model, these estimates assume that California employers would not change their health plan eligibility, contribution, or benefit policies in response to an individual mandate. Moreover, there is no reliable basis for predicting actual employer response to such a policy construct. On the one hand, employers generally provide health

coverage because their workers value this benefit, and it seems logical to assume that more workers would value a benefit that they are otherwise required to obtain on their own. This suggests employer coverage could expand in response to an individual mandate. On the other hand, in some cases, many of an employer's workers would likely prefer a wage increase to health benefits, because they would also be eligible for heavily subsidized coverage through the pool. In such cases, the employer is likely not to offer coverage. As noted earlier, there are many more such employers in California than in Massachusetts.

Given the substantial state cost implications, this is an issue which should be monitored, and policy adjustments made to the extent deemed appropriate and necessary. It seems likely that at least larger employers (who provide most employer coverage) would respond gradually, allowing time for adjustments before the implications might become too large to accommodate.

Summary and Conclusion

Under the assumptions outlined herein, it is estimated that the adoption of a Massachusetts-style coverage construct in California would cost the state more than the lower estimate of $6.8 billion in additional state spending, and as much as $9.4 billion (less any amount available from current DSH payments). The cost estimates would be low to the extent that employers reduce their eligibility, contribution, or benefit policies in an effort to avoid the almost 9 percent increase in outlays that could result from this state coverage construct. A forthcoming report by the Institute for Health Policy Solutions will include an estimate of the state cost impact of the potential employer response to a similar state coverage construct.

While substantially more than suggested by budget assumptions in Massachusetts, the $9.4 billion cost estimated here translates to a state cost of only about $1,450 per uninsured Californian.

Key features of the Massachusetts coverage construct, and of the alternative constructs that the Institute will cover in its future report, reduce state costs per uninsured person covered:

- One is the arrangement to use federal tax subsidies that are available for coverage paid for through payroll deduction at work.
- A second is the requirement that all persons participate in coverage. This means that modest income people contribute a fair and relatively affordable amount towards their coverage, while assuring that people are in the coverage pool when they have low health care costs, as well as when they have higher costs.

In contrast to this mandate approach, voluntary coverage expansions need to offer very low contribution costs in order to attract participation of significant numbers of modest-income persons. And since such contribution amounts are much lower than many workers of like income already pay for coverage (e.g., for family coverage at work), over time they encourage people who were already insured to switch to publicly financed coverage with no employer contribution. This increases state costs per uninsured person covered, and frustrates efforts to cover most or all of the uninsured.

For these reasons, coverage approaches that require participation in coverage show greater promise than voluntary approaches for achieving coverage of California's uninsured. The forthcoming report by IHPS will outline and estimate alternative mandatory coverage constructs involving varying combinations of individual and employer responsibilities.

Appendix: Specifications and Assumptions for an Illustrative Individual-Mandate Approach to Health Insurance in California.

AN ILLUSTRATIVE PROPOSAL FOR CALIFORNIA

1. Everyone must have health insurance. Specifically how this would be enforced is not addressed, but for illustrative purposes estimates assume a fully phased-in mandate and 100 percent compliance.

2. Subsidies in the "Pool"

a. People below the poverty level or eligible for Medi-Cal pay nothing toward premiums. Other people under 250 percent FPL get sliding-scale subsidies.

b. The sliding scale specifies the percent of family income, determined after deducting tax savings, that subsidized people are required to contribute toward their coverage. (Only tax savings that can be realized immediately through reduced tax withholding are used in this calculation.)

c. The estimate uses the following contribution schedule:

Poverty Range	Percent of Income
<101% FPL	0.0%
101%–125%	1.0%
126%–150%	2.0%
151%–175%	3.0%
176%–200%	4.0%
201%–225%	5.0%
226%–250%	6.0%
Over 250%	no subsidy

3. Subsidies for and Use of Employer Coverage

a. Subsidy-eligible people, including those eligible for Medi-Cal or Healthy Families under current rules, must enroll in employer coverage that is available to them. Under the upper-bound estimate, subsidies are available to help all low-income people enroll in employer coverage. Under the lower-bound estimate, subsidies are available only to Medi-Cal eligibles who enroll in cost-effective employer coverage.

b. The state pays the same proportion of the worker's premium for employer coverage as it would pay of the premium for coverage through the pool.

- This reduces costs for both the state and the worker.
- People below the poverty level, or eligible for Medi-Cal under current rules, pay nothing toward premiums for employer coverage.

4. Benefit Levels and Public-Program Status

a. People eligible for Medi-Cal under current rules continue to receive all Medi-Cal benefits and services, either directly or as a state-paid supplement to their employer-plan benefits.

For cost-estimation purposes, current Medi-Cal capitation rates are used.

b. Under both options, children enrolled through the pool receive Healthy Families coverage. Under the upper-bound estimate, children in the current Healthy Families income range (i.e., up to 250 percent FPL) with employer coverage (which they are required to use) receive all Healthy Families benefits and services, using a state-paid supplement to their employer-plan benefits if necessary.

For cost-estimation purposes, current Healthy Families capitation rates are used for coverage through the pool.

HOW THE MASSACHUSETTS APPROACH DIFFERS

1. Everyone must have health insurance. (Current language does not include children, but the mandate is apparently intended to apply to them.) Enforced through income-tax penalties. Penalties do not apply to individuals for whom coverage is not "affordable," according to a sliding scale to be set by the Connector's Board, or to those with religious objections. Anticipates 95 percent coverage of uninsured within 3 years.

2. Subsidies in the "Connector"

a. People below the poverty level pay nothing toward premiums. Other people under 300 percent FPL get sliding-scale subsidies.

b. Generally same. Relationship of subsidy amount to tax savings not specified.

c. The contribution schedule is to not specified. It is to be set by the Connector's Board in 50 percent FPL increments. Governor Romney's original proposal included the following illustration:

Poverty Range	Percent of Income
<100%	superseded
150%	2.5%
200%	3.2%
250%	4.0%
300%	5.8%

3. Subsidies for and Use of Employer Coverage

a. Subsidies for employer coverage are available only through prior-law public programs ["MassHealth"—Medicaid/S-CHIP—and the (expanded in this bill) "Insurance Partnership" for small businesses]. Otherwise, subsidies are available only for coverage offered through the Connector.

b. People with access to employer-paid coverage are not eligible for subsidies through the Connector unless the Board waives this restriction. The Board could do so only where an employer agrees to forward the employer's regular contribution to the Connector. (The employer's contribution is to offset the subsidy payment first, then is applied to reduce the worker's contribution.)

4. Benefit Levels and Public-Program Status

a. People eligible for Medicaid get Medicaid.

(Pre-existing law requires adults eligible for Medicaid to accept employer coverage when offered, with full premium assistance, if doing so is cost-effective for the state. Supplemental coverage is provided.)

b. Children under 300 percent FPL (raised from 200 percent FPL under prior law) and not on Medicaid or employer coverage get S-CHIP.

(Pre-existing law requires them to enroll in employer coverage, with full premium assistance, if it is available and cost-effective for the state. Cost-sharing help is provided, but not supplemental services.)

AN ILLUSTRATIVE PROPOSAL FOR CALIFORNIA	HOW THE MASSACHUSETTS APPROACH DIFFERS
4. Benefit Levels and Public-Program Status, cont.	**4. Benefit Levels and Public-Program Status, cont.**
c. Under both options, adults below 250 percent FPL and not eligible for Medi-Cal who are enrolled through the pool receive Healthy Families "adult" benefits (i.e., those planned under the never-implemented Healthy Families expansion to parents). Under the upper-bound estimate only, adults in this income range with employer coverage (which they are required to use) also receive all Healthy Families benefits and services, using a state-paid supplement to their employer-plan benefits if necessary. For cost-estimation purposes, negotiated rates for this "tight network" coverage are expected to produce per-capita costs (in the pool) equivalent to those expected under the previously planned Healthy Families parental expansion, adjusted to 2006. The rate is approximately $2,700 per year per adult.	c. Details of subsidized coverage not yet specified, but people below 100 percent FPL buying through the Connector get "comprehensive coverage" and no one below 300 percent FPL buying through the Connector is subject to a deductible. The enacted legislation does not specify or limit premium costs. Illustrations for Governor Romney's original proposal used a per-adult premium of $3,600 per year for the subsidized population.
d. People above 250 percent FPL must have, at a minimum, coverage with a deductible of no more than $5,000 and an out-of-pocket limit of no more than $10,000. (Cost estimates for this coverage assume community rates and group-like administrative costs through the pool and generate estimated premiums of about $1,900 per year per adult.) However, for estimation purposes: • People who now have employer coverage are assumed to keep it, and the design of that coverage is assumed not to change. • People who are eligible for employer coverage but did not previously enroll in it are assumed to enroll now, in order to meet the mandate. • People who now purchase individual coverage with a lower deductible are assumed to keep what they now have.	d. The Board of the Connector will establish a definition of "minimum creditable coverage" for individual and group health plans. Plans made available through the Connector must meet all state requirements for health plans, except delivery-network-design provisions and required-provider-contracting provisions. • Illustrations for Governor Romney's proposal anticipated that plans would be available through the Connector for as little as $2,400 for non-subsidized adults, but his proposal also permitted the Board to waive some mandated benefits. This provision is not included in the final legislation. The Board will also define special plans to be made available only to 19- to 26-year-olds through the Connector. These will also qualify as "creditable coverage" for purposes of meeting the mandate. Qualifying (college) student health plans (under prior law) will also meet the mandate.
5. Employer Definitions, Requirements and Assumptions	**5. Employer Definitions and Requirements**
a. All employers, whether or not they offer coverage, must establish section 125 plans to enable their workers to pay health insurance premiums with pre-tax dollars.	a. Employers with more than 10 FTE employees must establish section 125 plans to enable their workers to pay health insurance premiums with pre-tax dollars.
b. Employers that currently offer coverage are assumed, but not required, to continue doing so. We estimate approximate state revenues if a fee of $295 per FTE worker per year were imposed on employers with 10 or more workers that do not offer and contribute toward health insurance coverage.	b. Employers with more than 10 FTE employees must offer and contribute toward coverage or pay a "Fair Share Contribution" of up to $295 per FTE worker per year. Governor Romney vetoed this "Fair Share Contribution" section, but the legislature may override the veto.
c. Employers are required to cooperate with the pool with respect to enrollment of workers not eligible for the employer's plan, or all workers, if the employer does not offer a plan.	c. Similar provisions appear to be intended, but the legislation seems to apply these requirements only to employers that agree to "participate" in the Connector.
6. State-Authorized Pool	**6. "Commonwealth Health Insurance Connector"**
a. Contracts with private health plan(s) to provide coverage for people who do not have access to employer-sponsored coverage.	a. Same
b. Bills worker's employers, or the individuals themselves if they have no employer; bills the state for subsidy amounts due; handles enrollment functions; and transmits premium payments to participating health plan(s).	b. Similar, if not identical

About the Authors

This issue brief was written by Ed Neuschler and Rick Curtis of the Institute for Health Policy Solutions, who also developed the specifications for the illustrative individual mandate in California. The estimation model was developed and the quantitative estimates of health care spending by payer were produced by Susan Marquis, Ph.D., of RAND, except for the estimated revenue from a Massachusetts-style $295 per-worker fee.

Endnotes

1. As enacted, the mandate applies only to persons 18 and older. But state officials indicate that the intent is to include children, and that this will be clarified.

2. This summary is drawn from the "Health Care Access and Affordability Conference Committee Report," dated April 3, 2006, and accessed April 6, 2006, from **www.mass.gov/legis/summary.pdf**. In the interest of brevity, the short summary given here omits many details.

3. The Poverty Guidelines issued by the U.S. Department of Health and Human Services, colloquially referred to as the "Federal Poverty Level," set the "poverty level" in 2006 at $9,800 for one person, $13,200 for a couple, $16,600 for a family of three, and $20,000 for a family of four. Accessed April 19, 2006 from **aspe.hhs.gov/poverty/06poverty.shtml**.

4. The Massachusetts legislation specifies that people are ineligible for subsidies if they are eligible for employer contributions of 20 percent or more of the cost of family coverage or 33 percent or more of the cost of individual coverage. But the Connector Board is also authorized to waive this limitation and provide subsidies if the low-income worker's employer will re-direct its normal contribution toward coverage through the Connector. How this waiver authority might be used and the extent to which employers will be willing to so re-direct contributions remains to be seen.

5. Section 6 of Chapter 118H of the Massachusetts Code, as added by section 45 of H 4850, provides that people below the FPL shall receive coverage that includes at least: (1) inpatient services; (2) outpatient services and preventative care by participating providers; (3) prescription drugs as provided under the MassHealth formulary; (4) medically necessary inpatient and outpatient mental health services and substance abuse services; and (5) medically necessary dental services, including preventative and restorative procedures. The same section also provides that people below the FPL "shall only be responsible for a copayment toward the purchase of each pharmaceutical product and for use of emergency room services in acute care hospitals for nonemergency conditions equal to that required of enrollees in the MassHealth program," which may be waived in cases of substantial financial or medical hardship. No other premium, deductible, or other cost sharing shall apply to enrollees below the FPL.

6. The $125 million "General Fund" figure appears in an April 3, 2006, slide presentation on the "Health Care Reform Conference Committee Bill" to the Joint Caucus for House Member. Accessed April 6, 2006, from **www.mass.gov/legis/presentation.pdf**.

7. This nominal "Fair Share Contribution" was to be based on the costs the state incurs to provide free care to workers whose employers do not provide insurance, but it could not exceed $295 per full-time-equivalent worker per year. In addition, a "Free Rider surcharge" is imposed on employers whose employees' use of free care exceeds specified thresholds.

8. Steve LeBlanc, "Romney signs health bill; vetoes key provision," Associated Press, April 12, 2006. Accessed from **www.boston.com/news/local/massachusetts/articles/2006/04/12/romney_signs_health_bill_vetoes_key_provision/**, April 12, 2006.

9. Whether or not to limit subsidies based on immigration status is an important policy issue. For purposes of illustration, the estimates presented here include the cost of subsidies for all California residents, without regard to immigration status. Though not presented

in this issue brief, the estimated cost of subsidies associated with people who do not qualify for federal matching funds due to immigration status can be separately identified. But, due to data limitations, the database does not separate undocumented immigrants from those who entered legally but have not been in the county long enough to qualify for federal funding.

10. In California, 65.3 percent of all uninsured people and 42.8 percent of all residents under age 65 have incomes below 250 percent of FPL. In Massachusetts, 60.6 percent of all uninsured people and 35.8 percent of the nonelderly population have incomes below 300 percent of FPL. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2005. Income and health insurance estimates pertain to 2004 and were generated by the authors using the Current Population Survey's online Table Creator at **www.census.gov/hhes/www/cpstc/cps_table_creator.html**.

11. Note that low-income persons eligible for group coverage with an employer contribution would be required to participate in that coverage in order to be eligible for subsidies. This requirement reduces state subsidy costs. In Massachusetts, the Connector Board may, by waiver, allow low-income people with an employer contribution to enroll in the Connector and receive subsidies if their employer agrees to pay its usual contribution to the Connector. If this practice were to become widespread in Massachusetts, which is very uncertain, its effect on state costs would be analogous to the direct premium assistance toward employer coverage that is proposed here for the California model.

12. U.S. Census Bureau, American Community Survey Profile, 2003.

13. Ibid.

14. This relatively conservative estimate is based on a review of varying California and national estimates of the proportion of current employer premiums that are caused by provider cost-shift associated with care for the uninsured.

15. In reviewing estimates, it is important to keep in mind that this database includes only the civilian non-institutionalized population under age 65. Therefore, for example, the baseline estimate does not include all Medi-Cal spending. Spending on the elderly and on people in long-term institutions is not included. Spending on Medicare and on military-related health care such as CHAMPUS is also excluded. Health care spending on federal civilian employees is included.

16. Under this plan, all workers' premium contributions would be sheltered from FICA (Social Security and Medicare) taxes, as well as from income taxes. Thus, new tax-sheltered contributions by previously uninsured workers would reduce the FICA taxes their employers owe, in addition to reducing the workers' own taxes. Employers that previously did not arrange section 125 plans for their workers would also save on FICA taxes by doing so. Thus, FICA savings would reduce the apparent increase in employer contributions. For the lower-bound cost-estimate, the savings would be about $0.6 billion, enough to reduce the apparent increase in employer outlays from 8.8 percent to 7.8 percent.

17. Note, however, that if employers were to respond by reducing their contribution rates to offset some or all of the increase in their total costs, much of the resulting cost-shift would be borne by higher-income non-subsidized workers, rather than by the state.

18. Because, as Massachusetts apparently did, these estimates assume that employers do not change their current contribution policies for health coverage, even the "upper-bound" estimate may be low, given that California's income distribution and employer-group wage profiles differ significantly from those in Massachusetts. In our forthcoming analysis of alternatives which include a similar coverage construct, we also estimate how much state costs would increase if employers reduced their contribution rates to keep their total costs from increasing.

19. If low-income workers were required to bear much greater costs for coverage because they were eligible for their employer's plan, they would have a very strong incentive to switch jobs to a position without health benefits, and without the wage offset accompanying employer contributions to health coverage. And employers with a number of low-income workers would face compelling incentives to drop their plan altogether. Even if, like Massachusetts, subsidies were denied for six months after dropping employer coverage, such employers could benefit their workers by dropping coverage and increasing wages by the amount of their former contribution. The workers would be no worse off in the short run, and their low-income workers would gain substantially in the longer run as they become eligible for state-subsidized coverage.

20. Section 3(b) of Chapter 118H of the Massachusetts Code, as added by section 45 of H 4850, It is unclear, however, whether this waiver authority applies to all employer or only to those with 50 or fewer workers. Only businesses with 50 or fewer workers may join the Connector as "participating institutions."

21. Some observers argue that states should not worry about how state coverage initiatives might worsen erosion of employer coverage, since it is happening already. They note that the percentage of nonelderly Californians with employer coverage fell from just over 60 percent in 2000 to 55.6 percent in 2004 (according to figures from the Census Bureau's Current Population Survey). But relatively dramatic fluctuations in the employer-coverage rate have happened before. For example, CPS data indicate that the proportion of nonelderly Californians with employer coverage fell sharply from 61 percent in 1987 to 53.2 percent in 1993, then jumped from 56.8 percent in 1998 to over 60 percent in 2000. As these numbers suggest, our current coverage system is relatively volatile, long-term trends are hard to discern, and any erosion of employer coverage to date has been relatively gradual. In our view, a policy-induced precipitous decline in employer contributions would be unwise.

22. Author's analysis of data from the U.S. Agency for Healthcare Quality and Research's Medical Expenditure Panel Survey—Insurance Component, 2003, a survey of employer-provided health benefits. Tabular data may be access through **www.meps.ahrq.gov/MEPSDATA/ic/2003/Index203.htm.** (Hereafter cited as MEPS-IC, 2003.)

23. MEPS-IC, 2003.

24. Currently, about 1.8 million Californians work for firms that do not offer coverage. Of these, about 0.8 million work for firms with fewer than 10 employees. (MEPS-IC, 2003.) For purposes of illustration, we assume that part-time workers work, on average, half as much as a full-time worker. The Massachusetts fee (if the Governor's veto is overridden) would apply to employers with 11 or more full-time-equivalent employees. But available data sources categorize employers as "under 10 employees," rather than "10 employees and fewer." As mentioned in an earlier note, even non-offering employers would realize savings in FICA taxes as a result of setting up section 125 plans to allow their workers to pay premium contributions with pre-tax dollars. Depending on the precise arrangement for payroll deductions, these savings in FICA taxes would offset at least a portion, and in some cases all, of the $295 annual fee.

The California HealthCare Foundation's program area on Health Insurance works to serve the public by increasing access to insurance for those who don't have coverage and helping the market work better for those who do. For more information on the work of the Health Insurance program area, contact us at insurance@chcf.org.