Covering California's Uninsured: Three Practical Options

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We also received input from others when we presented preliminary findings about several of these coverage models at an April 27, 2006, briefing that was organized by the California HealthCare Foundation in the State Capitol in Sacramento, was attended by a large number of legislative aides and representatives of consumer, provider, union, and employer interests, and generated considerable discussion and feedback.

About the Authors

Rick Curtis of the Institute for Health Policy Solutions (IHPS) served as project director, identified alternative approaches for analysis in consultation with experts based in California, provided substantive guidance for the project as a whole and this report in particular, and drafted some portions of this report.

Ed Neuschler of IHPS was the principal writer of the report and also worked with the RAND Corporation to identify the public budget and other implications of the alternatives coverage models

About the Foundation

The California HealthCare Foundation, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care.

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I. Introduction and Scope of Project

Policymakers in California, as in other states, continue to wrestle with the question of how to extend health insurance to people who are without it—who number more than 6 million in California.

The reasons for policymakers to address this difficult issue are compelling. Many uninsured people delay or forgo needed medical services, often resulting in more severe illness and sometimes death. As the uninsured population has grown, charity care providers as well as their state and local funding sources are increasingly hard-pressed. Mainstream providers' ability to cross-subsidize uncompensated care has diminished as covered employer groups and their health plans understandably seek to avoid cost-shifts for the care of uninsured workers. And some businesses bearing the highest costs per active worker, such as the domestic auto industry, are rapidly losing market share to foreign firms with dramatically lower health-benefit costs.

A wide variety of proposals are being put forward and discussed by advocates and policymakers, both in California and elsewhere. This interest has been further intensified by Massachusetts' recent enactment of "near-universal" coverage involving individual mandates. Our preceding report analyzed the costs of a similar coverage framework in California.[1]

This report seeks to inform the development of a workable coverage construct to bring virtually all Californians into health coverage. It describes and provides cost estimates for three approaches we developed, analyzed, and refined over the past year with input from other experts.

One element needed to achieve this goal is a requirement that individuals participate in coverage. A related state responsibility is to ensure that everyone has affordable and convenient access to coverage.

Voluntary expansions cannot bring significant numbers of uninsured workers and families into coverage without large subsidies that allow modest-income uninsured people to pay much less than many other modest-income workers who already participate in comparable coverage. Such contribution differentials encourage shifts from private-employer to state-financed coverage, which in turn cause unaffordable further increases in state costs per previously uninsured person covered. Despite many voluntary coverage initiatives across the states, the uninsured population has continued to grow.

Mandates focusing on employer group coverage, including most "pay-or-play" proposals, are subject to legal challenges under the federal Employee Retirement Income Security Act of 1974 (ERISA), as in the recent Maryland case.[2] They also leave many workers and families uninsured, including the self-employed, the unemployed, part-time, seasonal, and contract workers; nor do they afford coverage for some full-time workers who hold sequential part-year jobs. California's Health Insurance Act of 2003, or SB 2, (narrowly defeated as Proposition 72 in a November 2004 referendum) mandated coverage for full-time workers in firms with 50 or more workers, as well as dependents in firms over 200, but we found it would have covered only an estimated 26.4 percent of the uninsured.[3] And that estimate did not take into account the powerful incentives created to reduce the number of full-time permanent jobs. Our SB 2 analysis also found that the purchasing pool it created would not have been a viable coverage construct because of adverse selection and a related lack of low-income subsidies. However, the insights

and database our team developed for that in-depth analysis proved to be important building blocks toward the development and analysis of the coverage models discussed in this report.

This project developed and analyzed alternative models that could extend health coverage to all Californians through mandated participation of individuals and, under several alternatives, through varying financial roles for employers. Each alternative includes sliding-scale subsidies and a coverage venue for individuals to ensure that health insurance is accessible and affordable for all.

This report identifies critical components of these alternatives and how they would affect employers, individuals, and the state budget. Each of these alternatives is designed to parlay the federal tax benefits available for health insurance purchased through employers, thus reducing individual and state-subsidy costs. By exploring such effects, the project aims to inform policymakers in their development of proposals and help them avoid unaffordable or unworkable designs.

An important purpose of the analysis is to estimate the respective costs under each model to the state, the federal government, individuals, and employers, including estimates of the tax effects that, by design, would reduce net costs to individuals and the state. (Although the role of employer contributions is generally recognized, a lesser-known determinant of the costs to Californians is how a given coverage approach affects the substantial federal tax subsidies available for employment-based coverage.) More specifically, for each alternative, we estimate:

- Changes in the number of Californians covered, and in sources of coverage.
- State budget impact (including changes in Medi-Cal, Healthy Families, and other state subsidy expenditures, and changes in tax revenue).
- Changes in individuals' and employers' contribution costs and cost distributions.
- Changes in tax subsidies for workers' contributions, which reduce payers' net costs.
- Changes in federal funds coming into California, including both Medicaid and State Children's Health Insurance Program (SCHIP) program funds, as well as federal tax subsidies for health insurance.

II. Alternative Approaches and Their Components

To achieve the goal of coverage of all Californians, each of the alternative approaches we developed and analyzed for this project assigns responsibilities to government, employers, and individuals. All include a requirement that individuals and families have health insurance, as well as income-based subsidies to make buying coverage affordable for all low-income people. And all were designed from the outset to require all employers to tax-shelter their workers' premium contributions (including workers not enrolled in employer coverage).[4] Building on our earlier work to harness tax subsidies available for worker contributions,[5] we incorporated this feature to reduce both subsidy costs for the state and after-tax premium costs for workers not eligible for subsidies. An individual mandate could be far more fair and palatable if these workers are concurrently given convenient, tax-advantaged access to affordable coverage.

Another critical element for achieving virtually universal coverage is a means of ensuring that everyone has affordable and convenient access to coverage. In all alternatives examined here, a health insurance "Exchange" provides both an access mechanism offering a choice of plans for people whose employers do not offer them coverage and a convenient vehicle for employers to convey tax-sheltered contributions on behalf of these workers. (Individual access guarantees are made possible by the requirement that *all* individuals participate, including those who are currently low-risk and uninsured.)

The alternatives vary primarily in whether and what financial contributions they require of employers and in how many workers have coverage through employer-sponsored plans versus the Exchange. Where the alternatives impose financial contributions on employers, they have been designed to minimize exposure to potential challenges under federal ERISA provisions, taking into account the recent U.S. District Court ruling with respect to Maryland.[6]

We chose the alternatives after consultation with experts knowledgeable about the history and current status of proposals to expand health insurance coverage in California. And we designed each alternative scenario to be internally coherent and workable in roles, responsibilities, and financial incentives. We elected *not* to focus on approaches limited to children because others have explored those approaches extensively.

The alternative mandatory coverage models analyzed in this report include:

- An individual mandate with no required contribution by employers.
- An individual mandate with a "pay-or-play-plus" requirement on employers, including a modest employer-contribution floor for full-time permanent workers and a required employer fee for other workers and their dependents.
- An All-Consumer Choice Exchange (ACE) funded by payroll fees on all employers and workers.

These models, and how they differ from each other, are summarized in Table 1 and are presented and discussed more fully in the following chapters. First, however, we briefly lay out those design features that are common to all the alternative models. To facilitate even-handed

Table 1. Summary of Important Design Features of Coverage Models

Scenario Design Element	Basic Individual Mandate	Pay-or-Play Plus	All-Consumer Choice Exchange (ACE)
Employer contribution level required	None; current contribution levels assumed	5.0% of Social Security wages = required payment for part-time workers; floor for full-time workers	Four-fifths of "full payroll fee" based on Social Security wages (estimated range: 10.5%–12.1%)
Exempt employers	None	Firms with one employee or an annual payroll below $75,000	
Families with employer coverage pay:	Contribution required under employer plan, less premium assistance if low-income		No employer coverage; *all* workers pay 1/5 of "full payroll fee" (estimated range: 2.6%–3.0% of Social Security wages) for Exchange coverage
Low-income families covered through Exchange pay:	After-tax contribution as a percentage of family income = sliding scale from 0.0% (below 100% federal poverty level [FPL]) to 7.5% (201%–250% FPL) See Table 2 for details		If full-time worker is in family, payroll fee is as described above; others pay 0.0% to 7.5% of income
Income limit for subsidies	250% FPL		250% FPL (No additional subsidy where a full-time worker is in family)
Higher income families covered through Exchange pay:	Full premium		If a full-time worker is in family, payroll fee is as described above; others pay full premium less any payroll fees paid
Benefits for people with employer coverage	Whatever employer plan offers (No supplementation for low-income people except for those who qualify for Medi-Cal or Healthy Families for children)		No employer coverage; Through Exchange, full-time workers and dependents can get current average employer-plan benefits ("mainstream" package) or pay more for richer benefits or broader networks
Benefits for people eligible for Medi-Cal	Medi-Cal (direct or as supplement to employer coverage)		Medi-Cal (direct or as supplement to "mainstream" package)
Benefits for other low-income children	Healthy Families (direct or as supplement to employer coverage)		Healthy Families (direct or as supplement to "mainstream" package)
Benefits for other adults under 200% FPL in Exchange	Healthy Families Adult package		

Scenario Design Element	Basic Individual Mandate	Pay-or-Play Plus	All-Consumer Choice Exchange (ACE)
Benefits for other adults 200%–250% FPL in Exchange	Primary and preventive care package plus $2,000-deductible plan	Healthy Families Adult package	
Benefits for high-income people in Exchange	$5,000-deductible plan satisfies mandate (Estimates assume people retain current individual plan, if richer benefits)		For full-time workers and dependents, "mainstream package"; others choose (and pay for) that or $5,000-deductible plan.

comparison of the costs of the alternative approaches, we used the same policy specifications for some elements of all of the coverage models. Differences were specified where important to achieve a realistic and internally consistent set of assumptions.

Note, however, that the costs of any or all of these coverage approaches could be altered through changes in the benefit plans, contribution schedules, premium assistance toward employer coverage, or assumptions regarding provider payment arrangements and rates for participating plans serving low-income people.

All of the coverage models analyzed here include the following elements.

Features Common to All Coverage Models

Public Subsidies to Ensure Coverage Is Affordable For Low-Income People

For purposes of these estimates, we define "low-income" as having family income below 250 percent of the federal poverty level (FPL), the eligibility level currently in use for the Healthy Families program. People eligible for the Medi-Cal or Healthy Families programs under current rules remain eligible for those programs. People with family incomes below 100 percent of FPL are not required to contribute toward the premium cost of their coverage.[7] People with family incomes between 100 percent and 250 percent of FPL are required to contribute a percentage of their income on a sliding scale, as shown in Table 2.[8]

Requiring families between 200 percent and 250 percent of FPL to pay 7.5 percent of income toward their health coverage may seem excessive to some readers. But many low-income workers currently pay about that much to enroll in their employer's plan. For example, the average annual worker contribution for private-employment-based family coverage in California in 2005 was $2,883.[9] For a family of three at 200percent of FPL, this amount represented 9.0 percent of income; for a family of four, it was 7.4 percent of income. (The tax savings that results from use of a Section 125 plan would reduce these percentages by about 1.5 points.) Using the database developed for this project, RAND estimated that 25 percent of California families in which any family member is enrolled in employment-based coverage pay more than 5 percent of family income toward their premiums.

Table 2. After-Tax-Savings Contributions Expected from Low-Income Workers and Families as a Percentage of Family Income

Family Income Relative to Poverty Level	"After-Tax-Savings" Contribution as a Percentage of Income
100% or less	0%
101%–125%	1.5%
126%–150%	3.0%
151%–175%	4.5%
176%–200%	6.0%
201%–225%	7.5%
226%–250%	7.5%
More than 250%	No subsidy[10]

Because the goal is assumed to be universal coverage, sliding-scale public subsidies are made available for *everyone* below this income level, regardless of their age, family structure, or previous insurance status. When health insurance coverage is mandatory, it seems unfair to require people in otherwise identical situations to pay substantially more for their coverage based solely on their being eligible for or having participated in their employer's plan before the mandate became effective. Doing so would probably also be self-defeating. When comparable non-employment-based coverage is offered on a heavily subsidized basis for low-income workers, not helping such workers pay for employer coverage would create powerful incentives for them to switch to jobs with no health benefits and for employers to create such jobs.

As a condition of qualifying for subsidies, low-income people with access to employer group coverage would be required enroll in that coverage.[11] They would then receive a subsidy ("premium assistance") payable toward their share of the premium for that coverage. The subsidy would equal the same percentage of the worker's premium as it would have if the worker had enrolled through the Exchange.[12] As a result, the worker would almost always pay less out-of-pocket toward the premium for employer coverage than for coverage through the Exchange.[13] (Though premium assistance of this kind requires considerable administrative effort, these provisions are intended to reduce state costs by deterring "crowd-out" (explained below) while ensuring affordable coverage for all low-income people.[14] And, although the gross premium-assistance costs involved are substantial, these measures generate significant savings for the Medi-Cal and Healthy Families programs in the mandatory-coverage environment.)

Our estimates separately identify the subsidy costs associated with immigrants whose status precludes them from being eligible for federal matching funds under current law.[15]

Employer Tax Sheltering for All Worker Contributions (Even Where There Is No Employer Contribution and No Traditional Employer Coverage)

Whether or not employers are required to contribute toward coverage under a particular alternative model, all alternatives analyzed require that *all* employers must: (a) allow workers to

pay their share of health insurance premiums by payroll deduction, (b) establish a Section 125 plan to allow workers to shelter their health insurance payroll deductions from taxation,[16] and (c) cooperate with the Exchange (discussed next) in enrollment activities and by transmitting workers' premium contributions to the Exchange (for workers who are not enrolled in any group coverage offered by the employer).[17]

These requirements harness significant tax savings to reduce individuals' net costs and, for low-income people, state subsidy costs. Moreover, payroll deduction is the most efficient, reliable, and easy way to make and obtain health insurance contributions from individuals.[18]

Efficient Access Mechanism: Health Insurance Exchange

Coverage for people not eligible for employer-group coverage would be made available through a health insurance exchange authorized by state legislation. (For brevity, we will refer to this entity simply as the "Exchange.") The Exchange would offer workers a choice of health plans on a family-by-family basis. It would work with employers to facilitate workers' signing up for health insurance at work, collect workers' enrollment information and payroll deductions from employers, receive subsidy payments from the state on behalf of low-income workers and families, and distribute enrollment information and premium payments to the health plan in which each worker and family enrolled. It would also serve as the exclusive source of premium subsidies for individuals not eligible for Medi-Cal, Healthy Families, or employer coverage.

Using an Exchange will help to ensure affordable access through broad risk-spreading and administrative efficiencies, particularly because multiple public and private financing sources are involved. It also greatly simplifies tax-sheltering of workers' health insurance contributions by giving employers that do not sponsor their own health plan a single entity to deal with on behalf of their workers who choose different plans.[19]

People not eligible for Medi-Cal, Healthy Families, or employer coverage would be required to purchase coverage through the Exchange if they wish to qualify for public subsidies. If not eligible for subsidies, people who do not have an "employer" (e.g., the unemployed, retirees) could purchase coverage either through the Exchange or in the regular individual insurance market, which would be subject to the same access and premium-rating rules as the Exchange. For ease of presentation, however, our estimates do not make the latter distinction.

Note that, under federal law, people without an employer cannot make use of Section 125 plans. If they are self-employed, however, they can subtract their health insurance premiums from income for income-tax purposes (but not for Social Security and Medicare taxes). People with no employer and no self-employment income cannot tax-shelter their health insurance premium payments.

Health plans and insurers would be required to offer coverage through the Exchange and in the individual market (if applicable) on a guaranteed-issue basis, and the only factors they could use in varying premium rates would be family composition, geography, and possibly age on a limited basis. (Although applying this kind of adjusted community rating in the present individual market would cause an adverse-selection price spiral as growing numbers of low-risk individuals dropped coverage as their rates rose, this would not occur under an individual mandate.) We assume that health plans that enrolled a disproportionate share of high-risk individuals would be appropriately reimbursed by the Exchange using mechanisms such as risk adjustment and reinsurance, but we do not specify which approach or approaches would be used.

The Exchange might or might not be given a broader "purchasing" role than described here. But estimating the premium discount that might be obtained by such a purchaser is, at best, speculative. Therefore, issues related to the purchasing role of the Exchange—although they raise extremely important policy questions—do not affect our estimates and are not specified further here. Our estimates assume only the basic "billing and enrollment intermediary" role already described.

Benefits: What Coverage Meets the Mandate?

Non-low-income people. For purposes of these estimates, the mandate is assumed to require Californians to carry, at a minimum, $5,000-deductible coverage to protect themselves from catastrophic out-of-pocket costs if they experienced a major illness or an accident not covered by casualty insurance. This assumption reflects the view that the rationale for mandating health insurance coverage is that people who are not insured impose costs on everyone else when they use health care services they cannot afford to pay for. The requirement would protect higher income people against personal bankruptcy and would reduce uncompensated care and the associated shifting of costs to Californians who do have coverage.

As a practical matter, the "catastrophic coverage" package affects very few people in our estimates because we assume that everyone who currently has coverage keeps what they have unless it does not meet the mandate requirement and because coverage needs are different for low-income people who often cannot afford even routine preventive and primary care. (We discuss coverage for them next.) Thus, the "mandate" benefit package affects only people who are currently uninsured and do not qualify for public subsidies and perhaps a very few people who currently purchase individual coverage.[20]

Medi-Cal and Healthy Families. Benefits under the Medi-Cal and Healthy Families programs are assumed to remain unchanged, and people eligible for those programs under current rules would receive those benefits. Eligible people without access to employer coverage would receive Medi-Cal/Healthy Families benefits directly, as they do now. People eligible for these programs who have access to employer coverage would be required to enroll in that coverage and would receive state-provided supplemental coverage to ensure that they can access the full range of Medi-Cal or Healthy Families benefits (as applicable).[21] Though considerable administrative effort is required, these provisions produce significant savings for Medi-Cal and Healthy Families in a mandatory-coverage environment.

Other low-income children. Low-income children not eligible for Medi-Cal would receive the current Healthy Families benefit package even if they are not actually eligible for the Healthy Families program (presumably because they have employer-group coverage). These benefits would be provided either directly or as a state-provided supplement to employer coverage.

Low-income adults not eligible for Medi-Cal. Adults enrolled in employer-group coverage would receive whatever benefits that coverage offers. Unless they are eligible for Medi-Cal, low-income adults enrolled in employer-group coverage would not receive any supplemental benefits.

Under most alternatives analyzed, adults with family incomes below 250 percent of FPL (and not eligible for Medi-Cal) who enroll through the Exchange would receive the benefit package that would have been available to parents under the proposed-but-never-implemented expansion of the Healthy Families program. This package provides comprehensive coverage with no

deductible and only minimal patient cost-sharing at the point of service. We refer to it as the Healthy Families Adult benefit package.

If provided at rates typical in the commercial insurance market, we estimate this policy would cost about $4,900 per year for a single adult. For purposes of estimation, however, we assume that for this low-income population, the vast majority of which would otherwise be uninsured, the Exchange would be able to offer adult health plans with premiums comparable to those currently enjoyed by the Healthy Families program for children, adjusted for the normal cost differences between children and adults. Therefore, our estimates assume the premium for this policy would be $2,710 per year per adult.

The Healthy Families Adult coverage provided to low-income adults through the Exchange would cost about as much as Healthy Families coverage for children currently costs, after adjusting for the standard actuarial cost difference between children and adults.

Under the Basic Individual Mandate model—both without and with a contribution floor for employers—adults with family incomes below 200 percent of FPL who enroll through the Exchange would receive Healthy Families Adult coverage, but those between 200 percent and 250 percent of FPL would not. Instead, they would receive more limited coverage combining a package of preventive, primary, and routine care with a $2,000-deductible traditional policy.[22] This more limited benefit package would entail substantial financial exposure for modest-income people who have a chronic health condition or experience a major acute illness. However, it would provide important financial access to primary and preventive care, as well as catastrophic protection, for the currently uninsured. It would reduce state subsidy costs and could be viewed as a transition between comprehensive coverage for low-income populations and the high-deductible, catastrophic coverage that satisfies the mandate requirement for higher income people (i.e., those above 250 percent of FPL).

For purposes of estimation, we also assumed that the Exchange would be able to offer lower cost plans for this product also. However, we assumed a more modest differential relative to commercial rates, leading to an assumed premium for this policy of $2,430 per year per adult.

For estimation purposes, we assume that low-income people who are enrolled in employer group coverage in the "baseline" would remain enrolled in that coverage under any "scenario" and that they would take advantage of the premium assistance made available to them toward that coverage.[23] With respect to low-income people who are uninsured in the baseline but have access to employer group coverage, however, we approximate the cost-effectiveness test for premium assistance by assuming that they would choose whichever coverage—employer group or Exchange—gives them the lowest out-of-pocket cost for premiums (taking the available subsidy into consideration).[24]

(Note that the ACE alternative assumes that traditional employer-group coverage will be completely replaced by coverage through the Exchange, and so "premium assistance" toward employer coverage is not applicable under that coverage model.)

Common Assumptions

Savings from Universal Coverage

Under the present coverage system, private insurance premium rates are higher than they would be under a universal coverage system because providers have to somehow recover the costs of

providing care to people who cannot pay for it. They do this by "cost shifting"—negotiating payment rates from health plans that are higher than the costs of providing care to the health plans' enrollees alone. Health plans pass these costs on to buyers in the form of higher premiums. The need for cost-shifting virtually disappears under a near-universal coverage system.

The current provider "cost-shift" for care of the uninsured is probably in the range of 5 to 6 percent of private health plan premiums.[25] However, health plans would have to negotiate lower provider payment rates in order to "recover" these excess costs and be able to lower their premiums. Therefore, it seemed to us unreasonable to assume that the entire amount of uncompensated care for the uninsured would be passed through as reductions in provider fees and health plan premiums, unless the state adopted policies to help ensure that the uncompensated care savings are fully captured. The development and estimation of such policies (such as evolving policies in Maine[26]) was beyond the scope of this analysis. For purposes of the estimates presented here, we assumed that about half of the savings would be passed through, resulting in a reduction of 3 percent in private market premium rates.

Federal Matching

To estimate the costs to the state of California, we had to make assumptions about what expenditures for premium subsidies (for Exchange coverage) and premium assistance (for employer coverage) would and would not be matched by the federal government under Medicaid and SCHIP. Because of the associated Medicaid "budget neutrality" requirement, we determined that we would *not* assume that the state would receive any further demonstration waivers under Section 1115. As a result, we assume that federal matching funds would *not* be available for childless adults who are not eligible under current Medi-Cal rules. With respect to parents and children, we assume that:

- Federal matching under Medicaid would be available for *all* subsidies paid to parents because the federal Medicaid statute effectively allows states to set their Medicaid eligibility standard for family groups at whatever income level the state chooses.
- Federal matching at the higher SCHIP match rate would be limited to California's current SCHIP allotment. However, we also assume that the state would be able to obtain federal matching at the Medicaid rate for *all* children under the income standard, even those with employer coverage.[27]
- For non-citizens, federal matching would be available *only* for people who have been legal residents of the United States for five years (as under current law).

Important Technical Notes about These Estimates

The following chapters describe the characteristics of each mandatory coverage model and provide estimates of their costs. It is important to understand several technical aspects of these estimates.

- First, in all cases, our estimates apply only to civilians under age 65 not on Medicare or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and not in long-term institutions. Our estimates also do not include payments for long-term care or payments to health care providers that are not payment for the care of specific patients, such as (for example) state supplemental payments to Disproportionate Share Hospitals (so-called DSH payments).

- Second, our estimate of current state spending includes only state tax effects and state spending on non-elderly, non-institutionalized people enrolled in the Medi-Cal and Healthy Families programs. State spending, even under Medi-Cal, that is not associated with specific patients is not included in the base amount, nor is local spending on programs for the uninsured. Both of these could be sources of funds to offset new state costs for premium subsidies.
- Third, the estimates presented here show the tax savings *only* on the worker's contribution, i.e., the portion of the premium that is deducted from the worker's paycheck or paid directly by an individual to an insurer and that can be excluded from taxable income when a Section 125 plan is in place. Much larger tax savings result from the fact that the employer's contribution toward health coverage—which economists consider part of total worker compensation—is excluded from workers' taxable income. In the current system, we estimate that this exclusion eliminates about $22.5 billion in tax liability for Californians—about $19.1 billion in federal income and payroll taxes and $3.4 billion in state income and payroll taxes. But changes in the tax treatment of employer contributions toward health coverage are not considered in this report; therefore, we elected not to focus on the tax savings associated with the current tax treatment of employer contributions.

  For the same reason, we show employer contributions net of *only* the payroll tax savings that result when the *worker's* contribution is made through a Section 125 plan.[28]

III. Basic Individual-Mandate Model

Features and Assumptions

Overview

The basic individual-mandate model requires that all individuals in the state have health insurance coverage. Although we do not specify an enforcement mechanism, for estimation purposes, we assume this mandate is fully effective. The model also establishes the Exchange described earlier and public subsidies for low-income people to ensure that everyone has ready access to coverage they can afford.

Employers are not required to offer or contribute toward coverage for their workers. Whether or not they do so, however, they must allow their workers to pay health insurance premiums by tax-sheltered payroll deduction (by establishing a Section 125 plan); and, for workers not covered by the employer's plan (if any), the employer must transmit the worker's premium contributions to the Exchange.

Benefits Offered

We assume that, to meet the mandate, people who now have employer coverage keep it, and people who previously declined an employer's offer of coverage would accept the offer.[29] The Exchange described above makes coverage available to people who do not have access to employer coverage.

We assume that employers that offer coverage continue to offer the same benefit packages they do now so that most people would retain the same coverage they have now. Non-subsidized people who previously purchased individual coverage that exceeds the mandate requirement are assumed to retain that coverage. Non-subsidized people who previously were uninsured are assumed to purchase $5,000-deductible coverage through the Exchange.

People eligible for Medi-Cal or Healthy Families would get the benefits available under those programs, either directly or as a supplement to employer coverage. Adults with family incomes below 200 percent of FPL who enroll through the Exchange would receive Healthy Families Adult coverage. Those between 200 percent and 250 percent of FPL would receive the more limited coverage described earlier, which combines a package of preventive, primary, and routine care with a $2,000-deductible traditional policy.

Low-income adults would receive either premium assistance toward employer coverage or subsidized coverage through the Exchange, according to the subsidy schedule described briefly earlier.

Relationship to Earlier Estimates

This coverage model largely mirrors the "Massachusetts-style" specifications that we estimated earlier.[30] But we made a few changes here to reduce the very high state costs we estimated at that time for California, which has a much higher proportion of low-income and uninsured people than Massachusetts has. Most important, we increased the sliding-scale contributions required from subsidized people: The contribution ceiling under the schedule used for our earlier

estimates was 6 percent of income for people with incomes between 225 percent and 250 percent of FPL, rather than the 7.5 percent used here, because a 6 percent maximum was more consistent with the illustrative materials circulated by Massachusetts. Our "Massachusetts-style" specifications also included comprehensive coverage for subsidized people with incomes between 200 percent and 250 percent of FPL, rather than the more limited benefit package we adopted for the present estimates. We also made technical changes in how we calculated the tax savings associated with the use of Section 125 plans. Finally, it is worth noting that the Massachusetts approach generally does not include premium assistance toward employer coverage for low-income workers (other than those eligible for Medicaid[31]), which is included in the coverage models analyzed here for reasons that have been discussed. In our previous work, we estimated costs for California both with and without such premium assistance.[32]

Alternative Assumptions about Employer Behavior

Even though the basic individual mandate model does not require employers to contribute toward health coverage for their workers, its implementation could lead to increased contribution costs for employers. This is so because some workers and dependents currently decline their employer's offer of coverage and remain uninsured or enroll in public coverage. Our estimates assume that these people would now accept the employer's offer as the least expensive way to comply with the individual mandate. Thus, if currently offering employers maintain their current contribution and plan-eligibility policies, implementation of an individual mandate would cause their total health plan contributions to increase.

It is impossible to predict exactly how employers would respond to this projected increase in their health care costs, the extent of which would vary considerably across employers. Therefore, we decided to do two estimates using two different simple assumptions about how employers would respond. The first estimate assumes that employers would make no changes in their current contribution or plan-eligibility policies. We call this estimate the "lower state-cost estimate" because it produces the lower estimate of costs to the state (and the higher estimate of spending by employers). This assumption is not unreasonable; the current labor market incentives that motivate employers to contribute toward health benefits would still pertain. In fact, workers facing an individual mandate—at least those not eligible for subsidies—would probably put even more pressure on their employers to offer and contribute toward coverage than they do at present.

The second estimate assumes that any employer faced with increased enrollment and, therefore, aggregate contribution costs would adjust its contribution policies—i.e., reduce the share of the premium it pays—in an effort to avoid increased costs. Because employer contributions are lower under this assumption, worker contribution costs are higher, which in turn leads to higher state costs for premium assistance for low-income workers. Therefore, we refer to this estimate as our "higher state-cost estimate." Individual employer responses would probably vary, of course, depending on how many of their workers and dependents currently do not participate. In the estimate presented here, the aggregate effect is that employers hold their total premium contributions at their current total dollar level after taking into account the expected overall 3 percent reduction in premiums that results from universal coverage. (As will be seen, employers as a whole experience some after-tax savings even under this "no increase" assumption because the universal use of Section 125 tax sheltering for workers' contributions reduces employers' Federal Insurance Contributions Act (FICA) tax liability, even for non-offering employers.)

(We discuss later the risk that employers with mostly subsidy-eligible workers might decide to stop offering coverage entirely. But we did not attempt to estimate the possible cost implications because there was not an adequate analytic or research base to do so, particularly in such a dramatically different environment.)

Estimates

Using these assumptions, our lower state-cost estimates are shown in Table 3, and our higher state-cost estimates are shown in Table 4.

Lower state-cost estimate. Under the lower state-cost estimate, i.e., if employers maintain their current contribution policies:

- Total health care spending for the affected portion of the health care system (civilians under age 65 not on Medicare or CHAMPUS and not in long-term institutions) would increase by $8.7 billion or about 8.2 percent, primarily because of increased access and use by the previously uninsured.
- Employers as a whole would pay $4.5 billion more, an increase of about 7.8 percent.
- Individuals and families would pay $6.8 billion less, a decrease of almost 24 percent. All of these savings would accrue to low-income people, who as a group would spend 50 percent less than before; higher income people as a group would pay about 1 percent more.
    - Most of this savings—$5.0 billion—would come from reduced out-of-pocket costs for low-income people at the time of service; high-income people would save about $0.3 billion in out-of-pocket costs. (See Table 5, Section B.)
    - Pre-tax premium payments by individuals and families would increase for high-income people, but these would be largely offset by a substantial increase in tax savings (because of the tax sheltering of worker contributions).
    - Low-income people would also experience reduced premiums because of tax savings and subsidy payment. In the aggregate, people would spend less, after taxes and subsidies, on premium payments also.

Table 3. Change in Health Care Spending by Source under a Basic Individual Mandate, Lower State-Cost Estimate (in Billions of Dollars)

Category of Spending *	Current Spending	Spending under this Alternative	Change from Current Spending	Change from Current Spending (Percentage)
Premiums paid by employers (net of tax savings)	57.9	62.4	4.5	7.8%
Premium payments and out-of-pocket spending by individuals (net of tax savings)	28.4	21.6	-6.8	-23.9%
Below 250% FPL	*13.9*	*6.9*	*-6.9*	*-50.1%*
Above 250% FPL	*14.5*	*14.7*	*0.1*	*1.0%*
Contribution to premiums paid by individuals and employers from tax savings on worker contributions	4.4	8.3	3.9	89.3%
Premiums paid by public programs (including direct public coverage)	15.9	23.1	7.2	44.9%
Total premiums and out-of-pocket costs (excluding Medicare, CHAMPUS, long-term care, etc.) *	**106.6**	**115.4**	**8.7**	**8.2%**
Net cost to state (including tax revenue loss)	**9.2 [16.9]** †	**15.3**	**6.1**	**65.9% [36.0%]** †
Amount of net state costs going for subsidies for immigrants not eligible for federal matching funds	1.4	1.7	0.3	18.9%

Figures are in billions of dollars in 2006. Details may not add to totals because of rounding.

* Spending estimates are for the civilian, non-institutionalized population under age 65 and exclude payments by Medicare, CHAMPUS, and the military, as well as payments for long-term care. Estimates also do not include payments to health care providers that are not payment for the care of specific patients, such as state supplemental payments to Disproportionate Share Hospitals.

† Because our estimates exclude long-term care and people over age 64, much Medi-Cal and other state health care spending is excluded from our estimates. To put net state cost increases into proper perspective, the figures in brackets show the estimated state share of *total* spending on Medi-Cal and Healthy Families for calendar 2006 [$16.2 billion], plus the state revenue loss associated with tax-sheltering through Section 125 plans [$0.7 billion].

Table 4. Change in Health Care Spending by Source under a Basic Individual Mandate, Higher State-Cost Estimate (in Billions of Dollars)

Category of Spending *	Current Spending	Spending under This Alternative	Change from Current Spending	Change from Current Spending (Percentage)
Premiums paid by employers (net of tax savings)	57.9	56.9	-1.0	-1.7%
Premium payments and out-of-pocket spending by individuals (net of tax savings)	28.4	24.8	-3.6	-12.7%
Below 250% FPL	*13.9*	*8.0*	*-5.9*	*-42.5%*
Above 250% FPL	*14.5*	*16.8*	*2.3*	*15.7%*
Contribution to premiums paid by individuals and employers from tax savings on worker contributions	4.4	10.2	5.8	132.4%
Premiums paid by public programs (including direct public coverage)	15.9	23.5	7.6	47.5%
Total premiums and out-of-pocket costs (excluding Medicare, CHAMPUS, long-term care, etc.)*	**106.6**	**115.4**	**8.7**	**8.2%**
Net cost to state (including tax revenue loss)	**9.2 [16.9] †**	**16.0**	**6.8**	**73.4% [40.1%] †**
Amount of net state costs going for subsidies for immigrants not eligible for federal matching funds	1.4	1.7	0.3	18.9%

Figures are in billions of dollars in 2006. Details may not add to totals because of rounding.

* Spending estimates are for the civilian, non-institutionalized population under age 65 and exclude payments by Medicare, CHAMPUS, and the military, as well as payments for long-term care. Estimates also do not include payments to health care providers that are not payment for the care of specific patients, such as state supplemental payments to Disproportionate Share Hospitals.

† Because our estimates exclude long-term care and people over age 64, much Medi-Cal and other state health care spending is excluded from our estimates. To put net state cost increases into proper perspective, the figures in brackets show the estimated state share of *total* spending on Medi-Cal and Healthy Families for calendar 2006 [$16.2 billion], plus the state revenue loss associated with tax-sheltering through Section 125 plans [$0.7 billion].

- Under this estimate, about one-quarter of the total public subsidy amount—$5.5 billion out of $23.1 billion (not shown)—goes to subsidize enrollment of low-income workers and dependents in employer coverage. But this premium assistance, combined with the requirement to enroll in available employer coverage, reduces spending for direct coverage under Medi-Cal by about $4.0 billion.
- The net cost increase to the state, taking into account both the state's share of premium subsidy costs and the reduction in state tax revenue caused by the tax sheltering of

worker contributions, would be about $6.1 billion, an increase of 66 percent over the current level of $9.2 billion.[33] (Note, however, that our estimate of current state spending includes *only* state tax effects and state spending on the Medi-Cal and Healthy Families programs for the non-elderly, non-institutionalized population. In particular, spending on long-term care is *not* included. Including *all* Medi-Cal spending would increase the base to $16.9 billion and reduce the percentage increase to about 36 percent. Some other state and local spending on programs for the uninsured also is *not* included in the base amount and could be a source of funds to offset new state costs for premium subsidies.)

Higher state-cost estimate. As noted, our higher state-cost estimate assumes that employers seek to avoid any increase in their total outlays for health insurance by reducing the share they pay of premiums across all workers. (See Table 4.) We assume, for purposes of illustration, that employers adjust their contribution shares so that their total contribution amount remains the same as it was before implementation of the mandate, given their increased enrollment (if any) and the expected 3 percent savings in total premiums caused by universal coverage.

Though their contributions toward premiums remain unchanged in the aggregate, employers still experience a savings of about $1.0 billion in their after-tax contributions because the universal use of Section 125 tax-sheltering for workers' contributions reduces their employers' FICA tax liability by that additional amount, relative to current levels.[34] Under these assumptions:

- The state's net costs would increase by $6.8 billion, or 73.4 percent, over current spending (a 40 percent increase over the adjusted base including *all* Medi-Cal spending). This amount is about $0.7 billion more than the state's net cost under the lower state-cost estimate. This increase is the result of higher premium assistance payments for low-income people enrolled in employer coverage.
- The impact of the employer reductions would fall primarily on non-low-income people with group coverage through their employers.
- Overall, people would pay $3.6 billion less than under the current system. But this amount is $3.2 billion more than under the lower state-cost estimate. (See Table 5, Section A.)
    - People's out-of-pocket spending at the time of service is the same under both estimates. (See Table 5, Section B.)
    - But, under the lower state-cost estimate, people would pay $1.5 billion *less* in premiums (after tax savings) than they do at present. (See Table 5, Section C.) Low-income people would pay $1.9 billion less, and higher income people would pay $0.4 billion more.

Table 5. Change in Health Care Spending by Individuals under Two Different Estimates of a Basic Individual Mandate (in Billions of Dollars)

Category of Spending *	Current Spending	Change from Current Spending		Difference Between the Two Estimates
		Under the Lower-State-Cost Estimate	Under the Higher-State-Cost Estimate	
A. Total premium payments and out-of-pocket spending by individuals (net of tax savings)	28.4	-6.8	-3.6	3.2
Below 250% FPL	*13.9*	*-6.9*	*-5.9*	*1.0*
Above 250% FPL	*14.5*	*0.1*	*2.3*	*2.2*
B. Out-of-pocket spending by individuals	13.3	-5.3	-5.3	0
Below 250% FPL	*7.4*	*-5.0*	*-5.0*	*0*
Above 250% FPL	*5.9*	*-0.3*	*-0.3*	*0*
C. Premium payments by individuals (net of tax savings)	15.2	-1.5	1.7	3.2
Below 250% FPL	*6.5*	*-1.9*	*-0.9*	*1.0*
Above 250% FPL	*8.6*	*0.4*	*2.6*	*2.2*
D. Tax savings to individuals from paying premiums through a Section 125 plan	3.6	3.2	4.8	1.6
Below 250% FPL	*1.1*	*1.9*	*2.4*	*0.5*
Above 250% FPL	*2.5*	*1.3*	*2.4*	*1.1*

Figures are in billions of dollars in 2006. Details may not add to totals because of rounding.

* Spending estimates are for the civilian, non-institutionalized population under age 65 and exclude payments by Medicare, CHAMPUS, and the military, as well as payments for long-term care.

- Under the higher state-cost estimate, low-income people would pay $0.9 billion less in premiums (after tax savings) than under the current system, and high-income people would pay $2.6 billion more, for a net result of $1.7 billion *more* in premium payments (after tax savings) by individuals and families than under the current system. (See Table 5, Section C.)
- The tax savings reduce the net impact on people by about 33 percent. Before tax savings, people pay $4.8 billion more in premiums under the higher state-cost estimate than they do under the lower state-cost estimate (not shown). But the additional $1.6 billion in tax savings reduces the after-tax difference to $3.2 billion.[35] (See Table 4, Section D.) The percentage reduction caused by the tax savings is essentially the same for both low-income and high-income people.

Discussion

General Observations

Although it incorporates important reforms, the basic individual-mandate model would make fewer changes in the health care financing system than the other mandatory-coverage approaches analyzed in this report would. In particular, it would place very few additional requirements on employers and would leave decisions about whether and how much to contribute solely up to the discretion of each employer. Employers would be required only to tax-shelter their workers' premium payments and to coordinate with the Exchange on behalf of workers not eligible for the employer plan (if any).

Although employers would not be required to contribute, use of employer coverage would be encouraged. Premium subsidies would be available for *all* low-income people, including those required to contribute toward coverage in their employer's plan. Those eligible for employer coverage would not be eligible for assistance for other coverage because that would require substantially higher subsidies to offset the lack of employer contributions. To encourage employer contributions, premium assistance would reduce their low-income workers' premium share below what they would have to pay for coverage through the Exchange.

Perhaps surprisingly, net personal costs across all individuals would decrease under the basic individual mandate (as well as under the other coverage models yet to be discussed). This result largely reflects a reduction in out-of-pocket spending by previously uninsured low-income people who would benefit from the subsidized coverage under each of these approaches. In addition, many low-income individuals who already had coverage would receive premium assistance under the specifications used here. Further, some high-income individuals would realize newfound tax savings that would reduce their net cost of coverage.

For the state, an approach with no employer contribution mandates or benefit plan requirements has some important advantages. It avoids legal challenges based on the federal pre-emption of state regulation of employer benefit plans (under ERISA). It also avoids the possibility that jobs might be lost to other states or countries if firms were to move, shrink, or go out of business because of excessive state-mandated employer costs. Further, a state coverage approach that relies on individual mandates seems less likely than other universal coverage constructs to invite relocation from other states by a large number of people with high-cost medical conditions.

On the other hand, mandating only individual and not employer participation leads to substantial net state subsidy costs for low-income people. Even under the optimistic assumption that employers would continue to contribute toward coverage on the same basis as they do now, the net cost to the state would be about $6.1 billion. (This assumption might be optimistic because employers' aggregate contribution costs would increase by $4.5 billion as workers and dependents who had previously declined coverage would now enroll. And any reduction in employers' premium share would increase state costs for premium assistance.)

But, more important, not requiring employer participation potentially exposes the state to large cost increases caused by a reduction in employer coverage over time, a phenomenon often called "crowd-out."

The Risk of Employer "Crowd-Out" under an Individual-Mandate Model

The broad availability of state subsidies for low-income workers and dependents, combined with the Exchange structure that would make comparable coverage readily accessible to everyone, creates the risk that, over time, a growing number of employers might decide to drop coverage they now offer. This could be the case especially for employers with a large number of low-wage workers (e.g., those earning less than $10 per hour) likely to qualify for subsidies in the absence of an employer contribution.

Consider the example of firms that now pay for health benefits but have mostly low-wage workers. If firms could instead arrange heavily subsidized coverage for their low-income workers at no cost to the firm, they could use the resulting cost advantage to offer either higher wages to their workers or lower prices to their customers, or both. Their higher income workers could also readily access coverage through the Exchange and could be given higher wages in lieu of the employer's former premium contribution. Because the entire premium payment would still be fully tax sheltered (through the Section 125 plan), the workers would not be made worse off by this substitution of wages for benefits.

Given the scale and visibility of measures needed to achieve coverage of all, employers would be well aware that, in the absence of employer coverage, their low-income workers would be eligible for subsidized coverage, possibly at a *lower* cost than if there were an employer contribution.

If any significant number of employers were to react as suggested here, state subsidy costs could be considerably higher than even under our higher state-cost estimate ($6.8 billion), which did *not* assume that any employers would cease contributing entirely. (Despite the importance of this issue, we did not attempt to estimate the extent to which crowd-out might occur under the individual mandate model because there was not an adequate analytic or research base to do so, particularly in such a dramatically different environment.)[36]

Provisions Aimed at Preventing Crowd-Out

Existing voluntary programs in a number of states have tried to avoid crowd-out through policies that deny access to state-subsidized coverage where an applicant was eligible for coverage during a "look-back" period of, e.g., six months. Massachusetts adopted such an approach in its recent individual-mandate legislation. But, as discussed in the issue brief on the "Massachusetts-style" approach,[37] California has a much higher proportion of workers with employer coverage who are low income and a higher proportion who are in firms with a high percentage of low-wage workers. Thus, a sizable number of employers and workers could have strong incentives to find ways to work around such "firewalls" and shift to state-subsidized coverage. Even if this proved difficult, their workers and customers could shift to new or existing competitors that do not offer coverage.

To reduce the incentive for employers to stop contributing, we developed (and our estimates reflect) a premium assistance structure designed to reduce the risk of employers dropping coverage or reducing their contributions. First, that structure ensures that low-income workers benefit from their employers' contributions. That is, workers with employer coverage always pay *less* than they would have to pay for subsidized coverage through the Exchange, and any increase in the employer's contribution reduces the net amount the worker has to pay, after premium assistance. (Conversely, any reduction in the employer's contribution increases the

worker's net payment.) Although this approach increases the initial cost of premium assistance, we believe it would cost much less over time than the cost to the state of replacing employer contributions.

Second, under this premium assistance structure, a subsidized worker would make the same standard contribution through payroll deduction as would other workers who did not receive premium assistance, so the employer would not be aware of which workers were eligible for how much premium assistance. Nor would the employer know how much the worker would have to pay for coverage through the Exchange, if the employer were to drop coverage. Premium assistance payments would be made directly to workers by the state (perhaps through the Exchange or perhaps through some other entity or agency). This is the way most states administer premium assistance now, both to relieve employers of an administrative burden that would otherwise make them resistant to premium assistance and to alleviate workers' concerns about confidentiality of family income. While paying premium assistance directly to families is administratively cumbersome for the state, it also means higher tax subsidies, which can lower state subsidy costs.

However, the only way to ensure that employers will contribute toward the cost of their worker's health coverage is to require that they do so. The other coverage models examined here impose varying degrees of financial responsibility on employer, beginning with a modest "floor" on employer contributions.

IV. Pay-or-Play-Plus Model

Features and Assumptions

This coverage model is a hybrid that combines the individual mandate and subsidies for low-income people with a requirement that employers pay a fee to the state. The fee would be waived with respect to full-time workers if employers "played" by contributing that much or more to their own employer plan. However, employers would have to pay the fee for all part-time and short-term workers. The estimates here set this fee at 5 percent of Social Security wages, which is substantially below our estimates of current employer contributions in California. Basing the assessment on a percentage of wages would help the Exchange to avoid adverse selection based on health status that could arise if the assessment were a per-capita amount.[38]

For Permanent, Full-Time Workers

For their permanent full-time workers, employers would either pay the assessment or contribute at least that much toward their regular group coverage. If they did not offer group coverage, their workers and dependents would buy coverage through the Exchange or be covered directly by Medi-Cal or Healthy Families, if applicable.

In our estimates, all currently offering employers are assumed to avoid the assessment by continuing to contribute the assessment amount or more toward their regular group coverage for their permanent full-time workers. (For most offering employers, this will not require any increase in their current contributions.) By doing so, they would ensure that their health benefit contributions benefit their own workers, i.e., reduce their own workers' costs for health insurance, rather than helping to pay the state's cost of subsidies for low-income people generally. As a result, most workers and their dependents would continue to get coverage through their employers. We further assume that offering employers would not reduce their current contribution levels because so doing would require at least their non-low-income workers to pay more for coverage they are now required to have. The current labor market incentives that motivate employers to contribute toward health benefits would still pertain.

If contributions made by an offering employer toward regular group coverage for its permanent, full-time workers fell short of the required floor, the employer would have to pay the difference to the state. The estimation model assumes that currently offering employers would increase their contributions for their workers up to 100 percent of the premium, if necessary to avoid paying the assessment, because doing so would directly benefit their workers, whereas paying the assessment would not. Only if this increase was insufficient to bring the employer's total contribution amount up to the required floor would an offering employer pay any assessment with respect to its permanent full-time workers.[39]

For Part-Time and Short-Term Workers

Many uninsured workers would not be covered under typical pay-or-play proposals, especially if they are designed to minimize the risk of a successful legal challenge under the federal Employee Retirement Income Security Act (ERISA).[40] In particular, those who do not work full-time or are not permanent employees (including "contract workers") are often omitted. The approach taken here is intended to ensure that some "fair share" employer contribution is made toward coverage costs for all workers.[41] By requiring *all* employers to pay a percentage-of-wage

assessment for their part-time and short-term workers (including, potentially, contract workers), the approach allows the state to combine proportional contributions from multiple part-time or sequential part-year employers toward a stable source of coverage for these workers, through the Exchange. It also avoids creating powerful incentives for employers to shift workers to part-time employment in order to avoid mandatory contributions, as has happened in Hawaii.[42] (Hawaii's employer mandate applies only to employees who work 20 or more hours per week.)

Under this approach, the state would define what number of hours worked per week (or per month) constitutes full-time employment and how long a worker must work for a particular employer to be considered a permanent employee. For full-time permanent workers, employer contributions toward their regular group coverage could be applied to reduce the employer's liability to the state. For all other workers (part-time, short-term), they could not. Applying a uniform distinction based on hours worked and length of employment in this way is the only approach we could identify that achieves the desired objective without being highly vulnerable to pre-emption under ERISA.[43]

For estimation purposes, we assumed that workers would be considered permanent once they had worked for a particular employer for three months and would be considered full-time if they usually worked 30 or more hours per week. (However, available data did not allow us to estimate the effects of including contract workers.) Employer payments toward regular group coverage for workers who are not full-time or not permanent under these definitions, though not prohibited, would *not* reduce the employer's percent-of-wages liability for that subgroup of workers. For estimation purposes, we assumed that employers would no longer offer or contribute toward regular group coverage to their part-time or short-term workers.

Exempt Employers

The pay-or-play requirement would *not* apply to businesses with fewer than two employees or with an aggregate Social Security payroll of less than $75,000 per year. The requirement also would not apply to federal government agencies.

Setting the Payroll Assessment Rate

The payroll assessment would be a specified percentage of total Social Security wages paid. Our concept was that the employer assessment should pay *half* the cost of covering people who are full-time workers or dependents of workers (at non-exempt employers), if *all* such workers and dependents enrolled through the Exchange. To determine this amount, we calculated the total dollar amount necessary to fund coverage of all full-time workers and their dependents with the Healthy Families-type plans that two-thirds of people actually enrolled through the Exchange would receive. We then divided by the aggregate Social Security wages paid to all full-time workers (at both offering and non-offering employers). Premiums were found to represent just over 10 percent of Social Security payroll, and so we rounded the employer assessment to 5.0 percent of payroll. This rate is substantially below our estimates of current employer contributions in California, which total 11.2 percent of Social Security wages (or 9.5 percent of total wages) among non-federal employers that now offer coverage.[44]

Thus, non-offering employers would pay 5 percent of total Social Security wages paid. Offering employers would be required to contribute the equivalent of *at least* this amount toward regular group coverage for their full-time permanent workers. As discussed above, offering employers would also be required to pay the payroll assessment with respect to *all* of their new (short-term)

and part-time workers, even if they offered direct coverage to all or some of these workers. (The estimation model assumes that they would cease offering direct coverage to these workers.)

Benefits Offered

Employers that offer coverage are assumed to continue to offer the same benefit packages they do now so that most people would retain the same coverage they have now. People who have access to employer group coverage are assumed to enroll in it, even if they had not done so before the mandate.[45]

People eligible for Medi-Cal or Healthy Families would get the benefits available under those programs, either directly or as a supplement to employer coverage. Adults with family incomes below 250 percent of FPL who enrolled through the Exchange would receive Healthy Families Adult coverage.

Non-subsidized people (i.e., those above 250 percent of FPL) who do not have access to employer group coverage and who previously purchased individual coverage that exceeds the mandate requirement are assumed to retain that coverage. Non-subsidized people who previously were uninsured and do not have access to employer group coverage are assumed to purchase $5,000-deductible coverage through the Exchange.[46]

Individual Contributions and Subsidies

People with employer coverage and not eligible for subsidies (i.e., above 250 percent of FPL) pay whatever their employer charges them for coverage. They benefit from tax-sheltering their contributions through their employer's Section 125 plan.

Low-income people (i.e., below 250 percent of FPL) who are enrolled in employer coverage would receive premium assistance toward their share of the premium for the employer plan, as described earlier. Low-income people who are enrolled through the Exchange would be required to contribute according to the standard schedule described earlier.

Non-subsidized people (i.e., above 250 percent of FPL) who buy coverage through the Exchange would pay the applicable premium for the coverage they select. They would not receive any credit toward the premium from the payroll assessments paid by their employer (if any).

Estimates

Estimates of spending by source under the pay-or-play-plus model are presented in Table 6.

Employer premium contributions toward regular group coverage would increase by $1.9 billion or 3.3 percent over current (pre-mandate) levels. However, because of the assumed shift of part-time workers from regular group coverage to the Exchange, this aggregate increase would not be as large as under the basic individual mandate (lower state-cost estimate: $4.5 billion).

The 5-percent-of-payroll assessment would raise a substantial amount of revenue from employers: $4.9 billion. It is significant that only about $1.5 billion of this amount would come from employers that do *not* offer regular group coverage. The remainder, about $3.4 billion, would come from employers that *do* offer coverage to their full-time workers. About $0.6 billion represents the failure of some of these employers to pay at least 5 percent of Social Security wages toward health coverage for their full-time workers. (Such employers presumably

either have a very high-wage workforce or currently offer coverage only to a portion of their full-time workforce.) The other $2.8 billion represents payment by offering employers for their part-time and short-term workers. (Thus, eliminating the assessment on part-time and short-term workers at offering employers would reduce revenue from the assessment from $4.9 billion to $2.1 billion and would convert the pay-or-play-plus model into a more traditional pay-or-play construct with a modest employer contribution floor.)

Taking regular premium contributions and payroll assessments together, the amount paid by *offering* employers would increase by about $5.3 billion, or about 9.2 percent, compared to their current spending (not shown). And *non-offering* employers would pay $1.5 billion, for a total employer-payment increase of $6.8 billion (11.8 percent).

Table 6. Change in Health Care Spending by Source under the Pay-or-Play-Plus Model (in Billions of Dollars)

Category of Spending *	Current Spending	Spending under This Alternative	Change from Current Spending	Change from Current Spending (Percentage)
Premiums paid by employers (net of tax savings)	57.9	59.8	1.9	3.3%
Payroll-fee payments by employers (both offering and non-offering)	0	4.9	4.9	8.5%
Premium payments and out-of-pocket spending by individuals (net of tax savings)	28.4	17.6	-10.8	-38.0%
Below 250% FPL	*13.9*	*3.1*	*-10.8*	*-78.0%*
Above 250% FPL	*14.5*	*14.5*	*0*	*0.1%*
Contribution to premiums paid by individuals and employers from tax savings on worker contributions	4.4	7.4	3.0	68.2%
Premiums paid by public programs (including direct public coverage)	15.9	21.6	5.6	35.4%
Total premiums and out-of-pocket costs (excluding Medicare, CHAMPUS, long-term care, etc.) *	**106.6**	**111.2**	**4.6**	**4.3%**
Net cost to state (including tax revenue loss)	**9.2 [16.9] †**	**12.7**	**3.5**	**38.1% [20.8%] †**
Amount of net state costs going for subsidies for immigrants not eligible for federal matching funds	*1.4*	*1.8*	*0.4*	*23.8%*

Figures are in billions of dollars in 2006. Details may not add to totals because of rounding.

* Spending estimates are for the civilian, non-institutionalized population under age 65 and exclude payments by Medicare, CHAMPUS, and the military, as well as payments for long-term care. Estimates also do not include payments to health care providers that are not payment for the care of specific patients, such as state supplemental payments to Disproportionate Share Hospitals.

† Because our estimates exclude long-term care and people over age 64, much Medi-Cal and other state health care spending is excluded from our estimates. To put net state cost increases into proper perspective, the figures in brackets show the estimated state share of *total* spending on Medi-Cal and Healthy Families for calendar 2006 [$16.2 billion], plus the state revenue loss associated with tax-sheltering through Section 125 plans [$0.7 billion].

In this coverage model, the payroll assessments paid by an employer would be considered state revenue. That is, they would *not* be applied toward purchasing coverage through the Exchange specifically for that employer's workers. Instead, those assessments would provide revenue to help the state pay subsidies for coverage of low-income people. Because of this new revenue source, the increase in net state cost under this alternative (after deducting the new revenues)

would be more modest than under the basic individual mandate. The state would spend $3.5 billion more than at present.

People would also spend much less under the pay-or-play-plus coverage model than they do at present ($10.8 billion less) and less than under any of the other alternatives we analyzed. (All of these savings accrue to low-income people; net spending by higher income people is essentially unchanged.) This result bears some explanation. As under the basic individual mandate, much of the savings for people under the pay-or-play-plus model would come from lower out-of-pocket costs at the time of service ($5.3 billion under the basic individual mandate, $5.0 billion under the pay-or-play-plus model, not shown.) But under the pay-or-play-plus model, people's after-tax premium contributions would be $5.8 billion lower than under the present system (not shown). The corresponding after-tax premium savings under the basic individual mandate (lower state-cost estimate) would total only $1.5 billion. The reason for this difference is that, under the pay-or-play-plus model, fewer workers and dependents are enrolled in employer group coverage (part-timers, new workers) and more are enrolled in the Exchange and in direct Medi-Cal and Healthy Families, compared to the basic individual mandate. For different reasons, per-capita premiums are lower in the Exchange and in the public programs than for employer coverage.[47]

Discussion

The pay-or-play-plus coverage model constitutes a hybrid that combines an individual mandate, an employer-pay minimum for their full-time permanent workers, and a payroll-based fee for all part-time workers. (It shares the last feature with the ACE coverage model, discussed next.) The floor payment level for employers is designed to be below the current market norm for employer contributions and to avoid driving up the cost of most employers' contributions for their full-time workers. It should not reduce current market incentives, which cause most employers to contribute substantially more than this floor amount for workers. As with the individual mandate model, increased demand from workers (who are newly mandated to have coverage) might actually cause some employers to increase their contributions.

This model would offset state subsidy costs and reduce the uncompetitive differential costs that offering employers now bear by requiring financial contributions from employers that do not offer coverage to their workers. It will further require all employers of part-time workers to make payments on their behalf. Because it is based on a percentage of payroll, employers with mostly low-wage workforces would be required to pay proportionately less. And because low-wage firms would generally find the fee to be less expensive than buying group coverage directly, regardless of the health status of their workforce (low-risk, normal, or high-risk), the Exchange should not experience the adverse health-selection effects it would suffer if the fee were assessed on a per-capita basis.

The most significant change under this model is for temporary and part-time workers and families. These are the workers who are most likely to be uninsured in the current largely employer-based coverage system and who would also continue to be uninsured under conventional pay-or-play proposals. Some alternative structure is needed to better meet their needs. Under the estimated approach, all employers would pay an assessment on the wages of these workers that would offset the state's costs for the subsidies most of them would need. This assessment would lessen incentives to convert full-time to part-time (or contract) positions (to avoid contribution requirements) and allow the Exchange to pool proportionate contributions

from multiple or sequential employers while providing a stable and efficient coverage venue for these workers. But it would require payments for some workers that few employers now pay for. While their proportionate costs for this are relatively modest, it seems likely that many employers would oppose this measure.

V. All-Consumer Choice Exchange (ACE) Model

Features and Assumptions

Overview

The All-Consumer Choice Exchange (ACE) replaces the current employer-by-employer coverage system with an all-consumer "Exchange" or "choice pool" that facilitates worker and family choice among competing health plans. Instead of having coverage through their employers, people would choose their health plan through the Exchange.

Under this approach, health insurance coverage would be funded primarily by a mandatory payroll-based fee paid by both employers and workers. Because employer and worker contributions to an employer-sponsored plan would *not* count as an offset to the fee, we assume that virtually all employers—except for federal agencies—would get out of the business of providing coverage, although they would not be required to do so.[48] Structuring the fee as a percentage of wages would make coverage relatively more affordable for low-wage workers and for businesses that employ mostly low-wage workers, though it could also increase costs for higher-wage firms. (To limit the latter effect, the payroll fee would be based on Social Security wages, which exclude earnings that exceed $94,200 in 2006.)

Nature of the Exchange

All health insurance coverage would be offered through the Exchange; however, the Exchange could take a wide variety of forms. Although these estimates assume the Exchange would structure and facilitate competition among carriers, the extent of its purchasing role could vary considerably. The basic elements described earlier would apply. But in this instance, there would be no reason to have a separate "individual market" because everyone would be selecting their coverage as an individual rather than as a member of an employer group.

Benefits Offered

The benefits offered through the exchange could be set at any level desired. We refer to the benefits financed by the payroll fee as the "mainstream benefit package." (And, whatever "mainstream benefit" level is set, people could be permitted to buy additional coverage if they wished.) For purposes of illustration, our estimates assume that the "mainstream benefit package" offered would be equal, in actuarial value, to the average coverage offered by California employers today. One plan with that actuarial value would have a $250 annual deductible, a $10 co-payment for physician office visits and prescription drugs, an 80/20 co-insurance rate on all other services, a $3,000 annual limit on out-of-pocket cost-sharing, and a $1 million benefit maximum.

Financing

The payroll fee would be a specified percentage of total Social Security wages paid. The fee would be set at a level sufficient to fully fund the mainstream benefit package for all full-time workers and their dependents. That is, the percentage rate would be determined by calculating the total dollar amount necessary to fund coverage of all full-time workers and their dependents with the mainstream benefit package then dividing by aggregate Social Security wages paid to all

full-time workers by non-exempt employers. In our estimates, the full payroll fee rate varies from 13.1 percent to 15.1 percent of aggregate Social Security payroll, depending on which employers are exempt and what assumptions are made about premium levels under the ACE structure. (We estimated the costs of the ACE model under two different premium assumptions, which are discussed below.)

These estimates assume employers would pay 80 percent of the total payroll fee, which is the approximate percentage for current employer coverage (aggregated across all covered workers and all family tiers). (The fee could be split between employers and workers as desired, but other splits would result in greater reallocation of costs among employers and workers who now finance coverage. Or, rather than prescribe fixed shares, a floor could be set for the employer's share. Doing so could reduce the number of currently offering employers forced to pay much more than they do now, but public subsidies might then be required for more low-income workers.)

Employers would pay their share of the fee based on their aggregate payroll for all workers, regardless of employees' length of employment or hours worked per week. (To avoid perverse incentives against hiring regular workers, contract workers could be included also, although we could not model this.)

Workers would pay 20 percent of the total payroll fee on all Social Security wages earned. People without a full-time worker in the family might have to pay an additional amount for their coverage; this is discussed further below.

In our estimates, the payroll fee is based on Social Security wages (i.e., wages up to $94,200 for each worker in 2006[49]), rather than on all wages without limit. This limitation is intended to avoid requiring high-wage businesses to pay much, much more than they do now to provide health coverage for their own workers. But doing so also raises the percentage rate required by almost 2 percentage points. (It therefore makes the percentage rate appear to be quite high compared to "health costs as a percent of payroll" comparisons readers may be used to seeing, which are invariably based on total payroll.)

Exempt Employers

In our estimates, the payroll-fee requirement does *not* apply to businesses with fewer than two employees or with an aggregate Social Security payroll of less than $75,000 per year, or to their employees. It also would not apply to federal government agencies and their workers. Additional employers could, of course, be exempted if desired.

The individual mandate would still apply to workers at exempt employers, and those workers would have to buy coverage through the Exchange, as described in the next section.

Health Plans, Benefits, and Premium Contributions by Employment Status and Income

• **Employees who work full-time** for non-exempt employers, regardless of income, could obtain the mainstream benefit package for themselves and their dependents at no additional cost beyond their payroll fees. If they chose a higher cost plan or greater benefits, they would have to pay the additional premium themselves. But the additional premium could be tax-sheltered. (See also further discussion under "Alternative Premium Assumptions," below.)

• **People who are not employed full time** (30 hours or more per week) themselves, or are self-employed without other employees, and are not the dependent of a full-time worker would have to pay for their coverage on a sliding-scale basis. People below the poverty level would pay no premiums. People with family income between 100 percent and 250 percent of FPL would pay an increasing percentage of their income. (For comparability of estimates, we used the same contribution schedule used for all alternatives analyzed in this report, as described earlier.) People with higher incomes would pay the full premium for the plan they chose.[50]

All people who work for non-exempt employers would have to pay their share of the payroll fee, even if they work only part-time. For those less-than-full-timers who are required to pay more to obtain coverage through the Exchange, the payroll fees on their wages paid by *both* them and their employers would be credited against the premium or sliding-scale contribution they owe.

• **Children below 250 percent of FPL** would be guaranteed access to the Healthy Families benefit package (or the Medi-Cal package, if they qualify). If their parent is a full-time worker, they would get the mainstream package plus supplemental coverage. If not, they would be enrolled directly in Healthy Families.

• **Adults below 250 percent of FPL** would be guaranteed access to the Healthy Families' Adult benefit package discussed earlier (or the Medi-Cal package, if they qualify under current eligibility rules). If they are full-time workers (or dependents of one), they would be enrolled in a plan offering the mainstream package and would get supplemental coverage in addition. If not full-time workers, they would be enrolled directly in a Healthy Families Adult or Medi-Cal plan.

• **People above 250 percent of FPL** who are self-employed without other employees or do not work full time (and are not dependents of a full-time worker) would choose what they want to pay for. But they would be required to have a plan that at least satisfies the individual mandate requirement. Our estimates assume these people would choose the mainstream package if they previously had employer coverage or individual coverage with a lower deductible. If not, they are assumed to choose the $5,000-deductible plan.

Alternative Premium Assumptions for Mainstream Plan Contribution

We estimated spending by payer under the ACE model under two different assumptions about the cost of the mainstream benefit package.

The first variant assumes only the standard 3 percent savings from universal coverage that is assumed under all the coverage models. Further, it assumes no additional administrative efficiencies due to use of the Exchange. (For brevity, we refer to this variant as being based on "average current market prices.") Under this variant, the estimated premium for coverage of an adult under the mainstream package would be $4,075 per adult per year, and the full payroll assessment rate would be 15.1 percent of Social Security wages. (Thus, the employer's 80-percent share would be 12.1 percent of Social Security payroll, and the worker's 20-percent share would be 3.0 percent of Social Security wages.)

The second variant is called the "high-value plan" approach. Under it, the expected premium cost used to set the payroll fee would be the premium charged by "high-value" health plans for the mainstream benefit package. These are plans that can offer the mainstream package most efficiently while meeting access and quality standards.

In determining this cost under the high-value plan approach, the Exchange is assumed to bring about administrative efficiencies that reduce administrative overhead costs from the current group market average—15 percent of medical claims—down to 10 percent of medical claims. Considerable efficiencies could be achieved through administrative streamlining, including collection of a payroll-based fee rather than variable premium payments from employers.

Our estimates also assume that basing a payroll fee on cost of high-value plans would mean that the premium on which the fee is based would be 10 percent lower than if the premium were based on the current average in the employer market (after taking into account the 3 percent universal-coverage savings under all alternatives). This assumption is consistent with observations that, in California, commercial plan options with tight networks generally offer premium savings of about 10 percent.[51] (The Exchange could also offer broader network plans with higher cost sharing at no additional premium, although we did not estimate the effects of such plans on people's out-of-pocket service costs.)

Under these assumptions, our estimated premium for the mainstream package is $3,495 per adult per year, and the full payroll assessment rate would be 13.1 percent of Social Security wages. (Thus, the employer's 80-percent share would be 10.5 percent of Social Security payroll, and the worker's 20-percent share would be 2.6 percent of Social Security wages.)

Under either variant, people could choose plans that were more expensive—either because they offered more comprehensive benefits or because they had looser or more expensive provider networks, but they would have to pay the additional premium cost themselves. (No estimates of these potential additional premium payments are provided.[52]) Presumably, this would happen more often under the high-value plan approach.

Estimates

With these assumptions, our estimates of premium payments by source under the ACE high-value-plan model are shown in Table 7, and estimates using average current-market prices are shown in Table 8.

Perhaps surprisingly, the net cost to the state differs only slightly between the two variants. The state's additional net cost is $1.5 billion under the high-value-plan model and $1.7 billion if average current-market prices are assumed. This result is obtained because the cost of coverage for low-income people who are directly enrolled in Medi-Cal or Healthy Families (i.e., there is no full-time worker in their family) is assumed to be the same under both variants, as is the cost of supplemental coverage for Medi-Cal eligibles and low-income children who are enrolled in the mainstream benefits package. The small difference in net state cost results because, under the high-value-plan option, a slightly larger amount of total employer payroll contributions is not needed to fund mainstream coverage for full-time workers. These "excess" employer contributions would be applied to reduce state subsidy costs.

Under the high-value-plan model, total employer contributions would increase by only $0.5 billion, or about 0.9 percent over current levels. Of course, employers that do not currently contribute toward coverage would pay more, as would employers with high-wage workforces while other employers would pay less. On the other hand, if we assume average current-market prices, total employer contributions would increase by $9.7 billion, or about 17 percent.

Assuming everyone selected the high-value plan, people would save more relative to current spending under that option—$6.3 billion compared to $4.4 billion under average current-market prices. The difference here is entirely a difference in premium payments; people's savings in out-of-pocket service costs would be $6.0 billion under both variants (not shown). Of course, under the high-value-plan option, it is very likely that a significant number of people would choose to pay more for plans other than the high-value plan. We did not estimate the likely additional premium cost to individuals.[53]

Discussion

The ACE coverage model would require employers to pay assessments toward coverage through the Exchange and thus would avoid the risk of reductions in system-wide employer contributions. The ACE high-value-plan option seems particularly attractive because of its relatively modest additional costs both for the state and for employers, although there would be very substantial redistribution of spending across employers. It is designed in such a way that those employers that now spend the most on coverage relative to wages could realize substantial savings, and overall employer contributions would not be increased. The net cost increase to the state could be as low as $1.1 billion (i.e., $0.4 billion less than the $1.5 billion shown in Table 7) if the state obtained a waiver to retain current federal program matching funds toward coverage of an expanded low-income population with coverage. Further, this model would establish a coverage structure with substantial promise both to dramatically improve the ability of workers to choose and retain a stable coverage source and to increase workers' incentives to be highly cost-conscious in their choice of plans.

Table 7. Change in Health Care Spending by Source under All-Consumer Choice Exchange (ACE) Model Using the High-Value-Plan Assumptions (in Billions of Dollars)

Category of Spending *	Current Spending	Spending under This Alternative	Change from Current Spending	Change from Current Spending (Percentage)
Payments by employers (net of tax savings) (Current = premiums; alternative = payroll fees)	57.9	58.4	0.5	0.9%
Premium payments and out-of-pocket spending by individuals (net of tax savings)	28.4	22.1 ‡	-6.3 ‡	-22.3%
Below 250% FPL	*13.9*	*6.7*	*-7.2*	*-52.0%*
Above 250% FPL	*14.5*	*15.4 ‡*	*0.9 ‡*	*6.0%*
Contribution to premiums paid by individuals and employers from tax savings on worker contributions	4.4	7.0 ‡	2.6 ‡	60.1%
Premiums paid by public programs (including direct public coverage)	15.9	16.6	0.6	4.0%
Total premiums and out-of-pocket costs (excluding Medicare, CHAMPUS, long-term care, etc.) *	**106.6**	**104.1 ‡**	**-2.5 ‡**	**-2.4%**
Net cost to state (including tax revenue loss)	**9.2 [16.9] †**	**10.7**	**1.5**	**16.2% [8.8%] †**
Amount of net state costs going for subsidies for immigrants not eligible for federal matching funds	1.4	2.5	1.0	69.4%

Figures are in billions of dollars in 2006. Details may not add to totals due to rounding.

* Spending estimates are for the civilian, non-institutionalized population under age 65 and exclude payments by Medicare, CHAMPUS, and the military, as well as payments for long-term care. Estimates also do not include payments to health care providers that are not payment for the care of specific patients, such as state supplemental payments to Disproportionate Share Hospitals.

† Because our estimates exclude long-term care and people over age 64, much Medi-Cal and other state health care spending is excluded from our estimates. To put net state cost increases into proper perspective, the figures in brackets show the estimated state share of *total* spending on Medi-Cal and Healthy Families for calendar 2006 [$16.2 billion], plus the state revenue loss associated with tax-sheltering through Section 125 plans [$0.7 billion].

‡ People would probably choose to spend an unknown additional amount on premiums for plans other than the high-value plan. But, if so, their tax savings would also increase.

Table 8. Change in Health Care Spending by Source under All-Consumer Choice Exchange (ACE) Model, Using Average Current Market Prices (in Billions of Dollars)

Category of Spending *	Current Spending	Spending under This Alternative	Change from Current Spending	Change from Current Spending (Percentage)
Payments by employers (net of tax savings) (Current = premiums; alternative = payroll fees)	57.9	67.5	9.7	16.7%
Premium payments and out-of-pocket spending by individuals (net of tax savings)	28.4	24.0 ‡	-4.4 ‡	-15.5%
Below 250% FPL	*13.9*	*7.0*	*-6.9*	*-49.5%*
Above 250% FPL	*14.5*	*17.0 ‡*	*2.5 ‡*	*16.8%*
Contribution to premiums paid by individuals and employers from tax savings on worker contributions	4.4	8.0 ‡	3.7	84.0%
Premiums paid by public programs (including direct public coverage)	15.9	16.6	0.7	4.1%
Total premiums and out-of-pocket costs (excluding Medicare, CHAMPUS, long-term care, etc.)*	**106.6**	**116.2 ‡**	**9.6 ‡**	**9.0%**
Net cost to state (including tax revenue loss)	**9.2 [16.9] †**	**10.9**	**1.7**	**18.5% [10.1%] †**
Amount of net state costs going for subsidies for immigrants not eligible for federal matching funds	1.4	2.4	1.0	68.9%

Figures are in billions of dollars in 2006. Details may not add to totals because of rounding.

* Spending estimates are for the civilian, non-institutionalized population under age 65 and exclude payments by Medicare, CHAMPUS, and the military, as well as payments for long-term care. Estimates also do not include payments to health care providers that are not payment for the care of specific patients, such as state supplemental payments to Disproportionate Share Hospitals.

† Because our estimates exclude long-term care and people over age 64, much Medi-Cal and other state health care spending is excluded from our estimates. To put net state cost increases into proper perspective, the figures in brackets show the estimated state share of *total* spending on Medi-Cal and Healthy Families for calendar 2006 [$16.2 billion], plus the state revenue loss associated with tax-sheltering through Section 125 plans [$0.7 billion].

‡ People would probably choose to spend an unknown additional amount on premiums for plans with more generous benefits. But, if so, their tax savings would also increase.

However, the percentage-of-wage financing structure we estimated would require many employers to pay much more than they now do. In addition to employers that do not currently offer coverage at all, employers that now cover a lower-than-average proportion of their workers, as well as employers with higher-wage but relatively young workforces would pay much more.

(Where desired, such effects could be lessened in a number of ways, most of which would increase costs to individuals or to government. These include adjustments to the payroll assessment scheme, exempting very small employers from the assessments, etc.)

The ACE high-value model also assumes that the payroll fees would fund access to coverage through high-value "tight-network" plans where provider costs are 10 percent less than the average in the current California employer market. (Broader networks with higher cost-sharing could also be offered, but we did not estimate their effects on out-of-pocket costs.) Such plans would be more acceptable to the degree that workers had choice among competing plans such that most workers were likely to have access to a high-value plan network that included their physicians.

Workers would be free to select and pay for more expensive plans and to bargain with employers to increase their wages to pay for such coverage. But some Californians who now enjoy richer employer benefit plans with broader provider networks than assumed for the ACE high-value plans might well strongly oppose such major changes, especially if they would need to pay more out of pocket to obtain comparable coverage.

The basic structure of the high-value ACE model would make excessive increases in the cost of health insurance very visible to all participants in the system. Unless health care efficiency gains and healthy behaviors offset the expanding use of new, often more expensive technologies and treatments, the payroll fee originally established will soon become insufficient to fund the original "mainstream" benefit package. Then the decision maker designated in the authorizing legislation—whether that be the Exchange, the legislature, the public through the referendum process, or some combination—will face a difficult and very public dilemma: Raise the payroll fee rate or reduce benefits, or increase patient deductibles and co-insurance for the baseline plans financed by the basic payroll fees. At the individual level, workers and families would have significant incentives to make more cost-conscious choices of health plans and services.

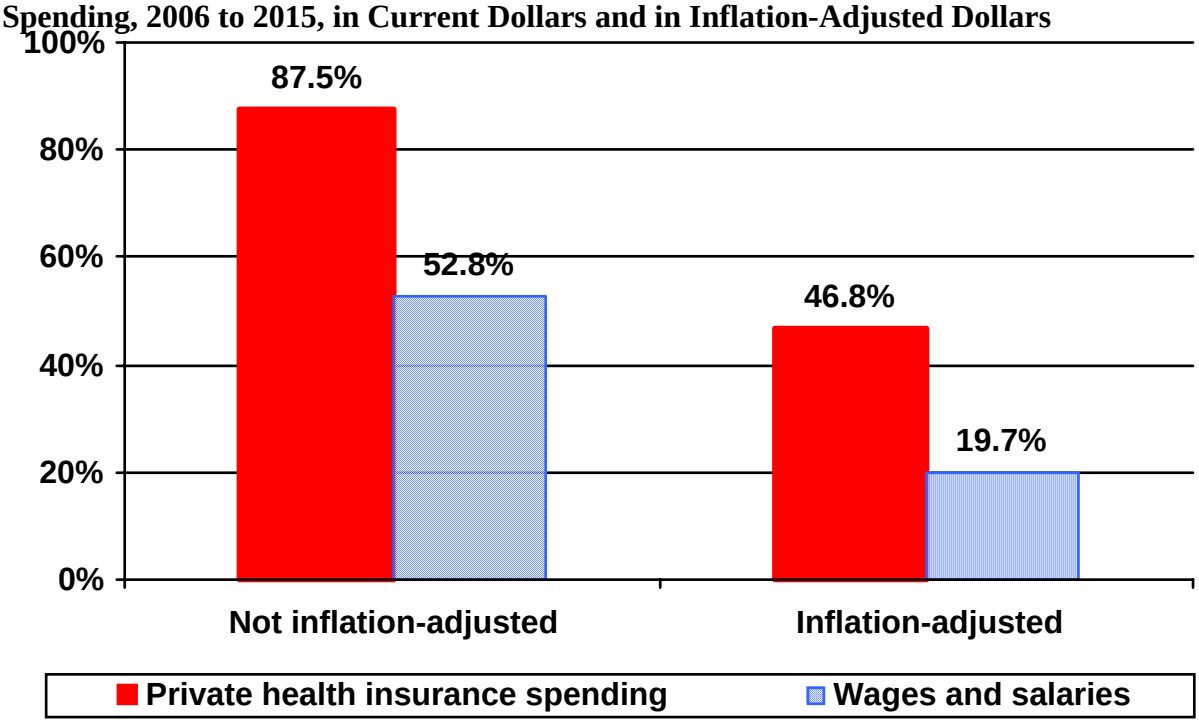
Such express trade-offs could be too uncomfortable for policymakers and the electorate to embrace. Thus, despite rising concerns over health care costs, a more incremental albeit more expensive, alternative might be more feasible.

VI. Health Care Cost Trends

It is well known that health care costs continue to increase at rates well in excess of general inflation, the growth in personal income, or the growth of state revenues. From 2006 to 2015, private health insurance spending nationwide is projected to rise by 87.5 percent or, when adjusted for general inflation, by 46.8 percent.[54] That is, if nothing is done to slow the growth of health care use and prices, by 2015 private health insurance will cost almost 50 percent more than it does now—*in 2006 dollars.*

Can California afford such increases in the cost of coverage on an ongoing basis? Wages and salaries are both the major component of personal income for the non-elderly and a useful indicator of government's ability to raise revenue. If the growth of wages and salaries were to keep pace with the growth of health care costs, then we might say that the affordability of health care was not changing, at least to a rough approximation. Unfortunately, the projected growth of wages and salaries over the same nine-year period is only 52.8 percent (again, nationwide), or 19.7 percent after discounting for general inflation.[55] This means that, between 2006 and 2015, in real terms private health insurance spending is projected to grow at a rate roughly 2.4 times the growth rate of wages and salaries.[56] (See Figure 1.)

Figure 1. Percentage Growth in Wages and Salaries Compared to Growth in Health Spending, 2006 to 2015, in Current Dollars and in Inflation-Adjusted Dollars



In 2006, we estimate that premiums for employment-based health insurance (employer and worker shares combined) totaled $70.6 billion in California. Assuming nothing else changes and the national growth rate applies, by 2015 California employers and workers would be paying

$132.5 billion for coverage, or $103.7 billion in 2006 dollars. And that amount does not include public spending for the Medi-Cal and Healthy Families programs or for private insurance not purchased through employers.

If the cost of health care continues to rise so much more rapidly than wages and salaries, coverage will become less affordable for most workers. Among the possible responses under the current system are:

- More workers may decline coverage because of their share of rising costs.
- Employers may reduce the benefit packages they offer.
- Employers may drop coverage or reduce their premium contributions rather than reduce wages.
- Health care delivery could become more efficient.

Only the last of these possibilities would not leave people worse off. But continuing escalation in health care costs suggests that current market directions and constructs will not be effective in creating such changes.

All of the alternative mandatory-coverage approaches estimated in this project would, to the extent that they were sustainable, both preclude people from becoming uninsured and ensure that modest- and low-income people could afford coverage. We have no research basis for estimating different growth rates for health care spending under the different alternatives we analyzed. But unless the disproportionate increases in health care costs are curtailed, a growing number of people with higher incomes will not be able to afford coverage without subsidies, and government's ability to finance adequate subsidies for even the initial low-income population will falter.

VII. Summary Observations

As discussed in the introduction, a requirement that individuals participate in coverage is one essential ingredient of any approach to bring all (or virtually all) of the uninsured into coverage. In addition to low-income subsidies, tax sheltering of worker contributions, and a health insurance Exchange for those not eligible for employer coverage, the alternative coverage approaches presented here add varying employer responsibilities.

This concluding section presents side-by-side comparisons of the alternative coverage models. It summarizes where Californians would be covered and estimated changes in costs by payer, which differ substantially under these alternative models. The section then discusses broader observations regarding the alternative coverage models, and concludes with brief observations regarding health care costs and coverage.

Comparing Sources of Coverage across Models

Table 9 shows the source of coverage for 31.2 million Californians under the three main coverage approaches, compared to the current system. Coverage sources for the 16.6 million low-income state residents (under 250 percent of FPL) are also shown. Under the basic individual-mandate model, the Exchange would enroll 4.1 million people, almost four times as many as are now covered in the individual market (1.1 million), but only about one-fifth as many as those with employer-group coverage. Estimated employer-coverage growth (from 19.2 to 22.6 million) reflects enrollment of workers and dependents who currently decline an employer's offer of coverage and are uninsured or on Medi-Cal or Healthy Families. The pay-or-play-plus model would see 1.3 million fewer people in employer coverage (21.3 million) as all part-time and temporary workers and their dependents would be covered through the Exchange or directly through Medi-Cal or Healthy Families. Finally, under the ACE model, 27.0 million workers and dependents would be covered through the Exchange, with 4.2 million enrolled directly in the Medi-Cal and Healthy Families programs. (Only a relatively few federal workers and their dependents would remain outside the Exchange.)

Comparing Estimated Costs by Payer across Coverage Models

Table 10 summarizes cost estimates for each of the models presented earlier and shows how costs would be affected for employers, government, and Californians compared to estimated current health care spending in 2006 for the civilian population not on Medicare and not in long-term institutions.

Under all of the alternatives, low-income people (those below 250 percent of the federal poverty level or FPL) as a group would pay much less than they do now. Most of this savings would come from premium subsidies and lower out-of-pocket costs for the previously uninsured, but general use of Section 125 tax-sheltering would also lead to savings in "after-tax" premiums for low-income people as well. Although previously uninsured higher income people would pay more for premiums, they too would benefit from tax-sheltering of premium payments. Spending by higher income people as a group could increase significantly under the ACE coverage models and only marginally, if at all, under the others.

Not surprisingly, approaches with higher employer payments generally would have lower net state costs. Net state costs would be lowest under the high-value option All-Consumer Choice Exchange (ACE), and aggregate employer payments under this alternative would increase only minimally: less than 1 percent. Under this variant, the required level of employer contributions would be keyed to the cost of tighter network (or higher cost-sharing) plans, and individuals would pay the extra costs themselves if they chose more expensive plans. Conversely, state costs are highest under the basic individual mandate approach, which involves no requirement for employer contributions.

(Recall that, to facilitate even-handed comparison of the costs of the alternative structures, the same policy specifications were used for some elements of all of the coverage models. Thus, the costs of any or all of the major coverage approaches could be altered through changes in the benefit plans, contribution schedules, premium assistance toward employer coverage, or assumptions regarding provider payment arrangements and rates for participating plans serving low-income people. Also, as discussed below, longer-term costs might be reduced through

Table 9. Non-Elderly Population by Source of Coverage under Three Approaches to Universal Coverage in California, 2006 (in Millions)

Coverage Model Source of Coverage	Current System *	Basic Individual Mandate	Pay-or-Play Plus	All-Consumer Choice Exchange †
Uninsured	6.4	0	0	0
Direct Medi-Cal/Healthy Families only	4.5	4.5	5.0	4.2
Employer-group coverage (EGC)†	19.2	22.6	21.3	0
Exchange coverage *	1.1	4.1	4.9	27.0
Total people	**31.2**	**31.2**	**31.2**	**31.2**
People below 250% FPL				
Uninsured *	4.6 *	0	0	0
Direct Medi-Cal/Healthy Families only	4.5	4.5	5.0	4.2
People with both EGC or Exchange and Medi-Cal/Healthy Families supplemental coverage ‡	1.3	5.0	4.5	5.4
Others with EGC	5.8	4.0	3.7	0
Others with Exchange coverage *	0.4 *	3.1	3.4	7.0
Total below 250% FPL	**16.6**	**16.6**	**16.6**	**16.6**

Figures are numbers of civilian, non-institutionalized California residents under age 65 in millions. Details may not add to totals because of rounding.

* Under Current System, the entries for Exchange coverage and Others with Exchange coverage are estimates of people who currently have individual (non-group) coverage. Among the low-income population under Current System, the separation of people without employer coverage or public coverage into uninsured and people with individual coverage (Others with Exchange coverage) is a rough estimate not directly obtained from our estimation model.

† Under the ACE model, only a very few federal employees and dependents still have traditional employer group coverage, and they are not shown separately in this table. Everyone else is covered through the Exchange.

‡ The entry for People with both EGC or Exchange and Medi-Cal/Healthy Families supplemental coverage indicates children eligible for the Medi-Cal or Healthy Families programs and adults eligible for Medi-Cal who get their primary coverage from an employer (under the current system, the basic individual mandate, or pay-or-play plus) or through the Exchange as *full-time permanent* workers or dependents thereof (under ACE). These people would also receive supplemental coverage to ensure that they continue to receive the full range of Medi-Cal or Healthy Families benefits, as applicable.

Table 10. Summary of Cost Estimates: Current Spending and Change in Spending by Source for Three Approaches to Universal Coverage in California, 2006 (in Billions of Dollars)

Coverage Model / Category of Spending *	Current Spending (2006)	Increase or Decrease in Spending under …			
		Basic Individual Mandate	Pay-or-Play Plus	All-Consumer Choice Exchange (Current Average Price)	All-Consumer Choice Exchange (High-Value Option)
Payments by employers (net of tax savings)	57.9	4.5	6.8	9.7	0.5
Contribution to premiums paid by individuals and employers from tax savings on worker contributions	4.4	3.9	3.0	3.7 ‡	2.6 ‡
Premium payments and out-of-pocket spending by individuals (net of tax savings)	28.4	-6.8	-10.8	-4.4 ‡	-6.3 ‡
Below 250% FPL	*13.9*	*-6.9*	*-10.8*	*-6.9*	*-7.2*
Above 250% FPL	*14.5*	*0.1*	*0.0*	*2.5 ‡*	*0.9 ‡*
Premiums paid by public programs (including direct public coverage)	15.9	7.2	5.6	0.7	0.6
Total premiums and out-of-pocket costs *	**106.6**	**8.7**	**4.3**	**9.6**	**-2.5**
Net cost to state (including tax revenue loss)	**9.2 [16.9] †**	**6.1**	**3.5**	**1.7**	**1.5**
Amount of net state costs going for subsidies for immigrants not eligible for federal matching funds	*1.4*	*0.3*	*0.4*	*1.0*	*1.0*

Figures are in billions of dollars in 2006. Details may not add to totals because of rounding.

* Spending estimates are for the civilian, non-institutionalized population under age 65 and exclude payments by Medicare, CHAMPUS, and the military, as well as payments for long-term care. Estimates also do not include payments to health care providers that are not payment for the care of specific patients, such as state supplemental payments to Disproportionate Share Hospitals.

† Because our estimates exclude long-term care and people over age 64, much Medi-Cal and other state health care spending is excluded from our estimates. To put net state cost increases into proper perspective, the figure in brackets shows the estimated state share of total spending on Medi-Cal and Healthy Families for calendar 2006 [$16.2 billion], plus the state revenue loss associated with tax-sheltering through Section 125 plans [$0.7 billion].

‡ Under the ACE model, people might choose to buy more expensive coverage than that on which these estimates are based. If so, they would pay more, but their tax savings would also increase.

incentives and benefit plan provisions that encourage healthy behaviors aimed at reducing the incidence of chronic conditions, such as those that result from smoking or avoidable obesity. Further, channeling low-income subsidies and associated population enrollment through the

Exchange, as suggested here, would enable the state to encourage development of more cost-effective health care organizations for that population, which could then also be made available in the broader market.)

One potential source of funds to offset new state costs for premium subsidies would be a transfer of funds from state programs that now pay for charity care for the uninsured, which should be greatly reduced under any of these coverage options. As discussed in our earlier policy brief estimating the costs of a Massachusetts-style plan in California,[57] Massachusetts is reallocating such funds to pay for premium subsidy costs under its individual mandate program.

The associated funding levels are much lower per uninsured person in California than in Massachusetts, which, for example, already had a dedicated inpatient hospital surcharge to fund its uncompensated care pool. But they might be sufficient to offset most or all new state costs for some variation on the pay-or-play plus or ACE alternatives. To bring in further revenues to pay low-income subsidy costs, California might also consider establishing a surcharge on provider payments. To the extent that the surcharge approximated current uncompensated care costs for the uninsured, surcharge costs should be offset by the reduction of such uncompensated costs and associated cost shifts to private payers. This would, in effect, capture uncompensated care cost reductions due to mandated coverage of the uninsured and use those savings to fund low-income subsidies.

Comparative Observations

How the alternative models compare on several areas of policy concern is discussed in this section and summarized in Table 11.

Basic individual mandate. For a state, a basic individual mandate approach with no employer contribution mandates or benefit plan requirements has some important advantages. It avoids legal challenges under the federal ERISA pre-emption of state regulation of employer benefit plans. It also avoids the possibility that jobs might be lost to other states or countries if firms move, down-size or go out of business because of disproportionate state-mandated employer costs.

Perhaps surprisingly, net costs for individuals (in the aggregate) are estimated to go down under the basic individual mandate model (as well as under the other models). This result in part reflects the tax savings that some individuals would realize, as well as premium subsidies for low-income people and a large reduction in out-of-pocket spending by previously uninsured people under each of these approaches.

But mandating only individual and not employer participation means substantially higher net state subsidy costs than under the alternative models that do have employer-financing requirements. It also potentially exposes the state to large shifts in costs from employers over time. Given the scale and visibility of these access and subsidized-coverage measures, employers would be well aware that, in the absence of employer coverage, their low-income workers would be eligible for subsidized coverage, possibly at a *lower* cost than if there were an employer contribution. About one in five Californians with employer coverage have incomes under 250 percent of FPL,[58] mirroring the national ratio.

Table 11. Relative Impact of Alternative Coverage Models

Scenario Policy Consideration	Basic Individual Mandate	Pay-or-Play Plus	All-Consumer Choice Exchange (ACE) High-Value Option
Net state subsidy cost	High	Moderate	Low
Risk of increasing state costs over time because of crowd-out	High	Modest	None
Risk of being overturned by ERISA challenge	None	Designed to minimize risk	
Risk of job loss	Virtually none	Difficult to predict; depends on employer characteristics and competitive environment	
Cost-discipline potential	Modest	Modest to moderate	High
Employer financial support for coverage of part-time workers	No change	Modest	Moderate
Impact on aggregate out-of-pocket costs for families below 250% FPL	Significant savings	Significant savings	Significant savings
Impact on aggregate out-of-pocket costs for families above 250% FPL	Minimal cost	Minimal cost	Modest cost
Impact on non-offering employers	None	5% of payroll	10.5% of payroll
Impact on offering employers with differing characteristics:			
—High median wage (most workers typically are covered)	Minimal cost	Minimal cost	Minimal to high cost, depending on other factors
—Low median wage, few currently ineligible workers	Minimal cost	Modest savings to minimal cost	Significant savings
—Low median wage, many currently ineligible workers	Minimal cost	Moderate cost	High cost

Note: This table uses this following approximate scale of impact: None | Minimal | Modest | Moderate | Significant | High.

To reduce the incentive for employers to stop contributing, our estimates reflect premium assistance policies designed so that low-income workers (as well as the state) benefit from their employers' contributions. That is, the higher the employer contribution, the lower the amount the worker would pay for coverage. Although this would not fully compensate for workers' wage reductions that economists find on average offset employer contribution costs, it should reduce incentives to drop employer coverage.

Employer-contribution floor. Adding a percent-of-payroll employer contribution floor to the individual mandate would preclude crowd-out of an employer's entire contribution. Though it

would also generate revenue toward state subsidies for low-wage groups, a 5 -percent payroll fee would by design cost significantly less than the premium costs for these workers.

Pay-or-pay plus. The pay-or-play-plus model constitutes a hybrid that combines an individual mandate, an employer-pay minimum for their full-time permanent workers, and a payroll-based employer fee for all part-time workers.

The percent of payroll "pay" fee is designed to achieve both a relatively affordable "pay" option for low-wage groups and thus a viable population-risk profile for the Exchange. Regardless of the health status of their workforce (i.e., low-risk or high-risk), low-wage firms would generally find the fee to be less expensive than buying group coverage directly. Thus, the Exchange should not suffer the adverse health-selection effects it would experience if the fee were set at a per-capita amount.[59]

The percent-of-payroll employer fee on all part-time and temporary workers' wages would mean that an individual employer's contribution is proportionate to the share of time a worker is employed there. Employer mandates (as in Hawaii) or pay-or-play requirements (as in California's SB 2) can create strong perverse incentives for part-time, temporary, or contract jobs in lieu of full-time permanent positions. This not only has serious shortcomings for workers and families where they are forced to hold multiple jobs, it often would adversely affect employers who might save considerable health care costs but suffer from a less dedicated and efficient workforce. The approach here is intended to help avoid such perverse outcomes. Further, some alternative structure is needed to meet the needs of working families without a full-time worker better than does the current largely employer-by-employer coverage system. This approach allows the Exchange to obtain and pool such funds across multiple part-time or short-term jobs toward the costs of coverage for those workers who do not have permanent full-time jobs.

All-Consumer Choice Exchange. The ACE model would replace the current employer-by-employer coverage system and thus would be the most controversial approach analyzed here. All workers and families would obtain coverage through the Exchange, although they would enroll and make payments through their employer. This model is designed to dramatically improve the ability of workers to choose and retain a stable coverage source and their associated health care providers. Because individuals would pay the cost difference for more expensive plans, this approach would increase workers' incentives to be highly cost-conscious in their choice of plans. And because workers' as well as employers' fees are set as a percentage of wages that "self-finances" coverage of all full-time workers and their families, the need for state subsidies is much lower than under the other models.

Although the "high-value" variant would allow coverage of all Californians without increasing aggregate employer spending, it would entail substantial cost increases for some individual employers. In addition to employers that do not currently offer coverage at all, employers that now cover a lower-than-average proportion of their workers, have low-cost benefit plans or contribution policies, and employers with higher-wage but relatively low-risk workforces would often experience substantial cost increases. Employers with obverse characteristics, and those who pay more for coverage of workers' dependents, would often realize substantial savings.

And though this construct would probably reduce system-wide costs, because many workers would probably choose more cost-effective plans, many may balk at the prospect of having to pay more to retain the broader access or richer benefits many workers now enjoy.

Equity and Crowd-Out

An individual mandate alone raises difficult, interrelated issues regarding equity and potential crowd-out of employer contributions. These issues are also raised, but to a lesser degree, under the employer contribution floor and pay-or-play-plus alternatives. These issues are eliminated by the ACE model.

Making premium assistance (or subsidized coverage) available only to low-income workers who are not eligible for employer coverage penalizes low-income workers who already pay for their coverage both directly through worker contributions and indirectly through the wage reductions associated with employer contributions. It also creates substantial incentives for these workers and their employers to shift to state-subsidized coverage over time. A complete shift by these workers could "level the playing field" regarding employers' compensation costs for modest-income workers and may therefore be seen as an acceptable outcome per se. But it would dramatically increase state subsidy costs.

In the shorter run, some low-income working families with access to employer coverage would have to pay worker contributions that are disproportionate to their incomes and that could require sacrifices in food, shelter, transportation, and other necessities. For example, a family of four at 150 percent of FPL, or $30,000 income, could be faced with a 50 percent worker-contribution requirement of $5,500 or more for family coverage—almost 20 percent of their income.[60]

As we discussed in our analysis of Massachusetts-style coverage, a substantially higher share of Californians with employer coverage have incomes below 250 percent of FPL than in Massachusetts, and thus California needs to be more concerned about this matter. We believe that the premium assistance approach we included and described herein could substantially ease this problem. Moreover, the short-term costs of such a policy could be offset by the savings in Medi-Cal and Healthy Families that would result from using the employer contributions available for these populations. (Under both the basic individual mandate and pay-or-play-plus models, the reduction in direct public coverage costs offsets about three-quarters of the cost of premium assistance for employer coverage.) More important, it should reduce the longer-term shift of costs from employer to the state. Similar results might be achieved with narrower, lower-cost premium assistance policies that are targeted to address those with the most significant cost problem.

Alternatively, as in some other states, California might consider lower-cost, more limited benefit plans for subsidized coverage through the Exchange. This could both significantly lower state subsidy costs in the short run and greatly reduce incentives for shifts from more comprehensive employer-based coverage. However, to achieve these ends, such coverage would probably need to be substantially limited (e.g., by imposing a low maximum on total benefit payments), which would neither protect participants against catastrophic costs nor significantly reduce existing cost-shifts for uncompensated care provided to the uninsured.

Health Care Costs

As these estimates reflect, bringing the uninsured into coverage would increase their access and use and, thus, health care costs. But it could also help to improve systemic incentives for health-care cost discipline. It would dramatically reduce the need for hidden cross subsidies, which obscure cost accountability and which provide a rationale for expansions of high-priced services that can be a source of such cross subsidies. However, this alone will not adequately curtail the

disproportionate increases in health care costs relative to workers' earnings and to total economic output.

Unless complementary strategies are adopted to reduce health care costs, a growing number of people with higher incomes will not be able to afford coverage without subsidies, and government's ability to finance subsidies adequate to afford financial access to care for those in need will falter. Reducing health care costs will take some combination of: more efficient health care providers, service arrangements, and administrative systems; new technologies that focus on efficiency improvements; more cost-conscious consumers; and healthier behaviors that reduce the growing incidence of avoidable chronic conditions. We believe that whatever approach to coverage of the uninsured is adopted, complementary measures to achieve these ends can and should be included in the final policy package.

The subsidized coverage plans to be offered by the Exchange under any of these alternative models could incorporate features with promise to reduce health care costs over time. These might include development of lower-cost alternative delivery settings and systems also facilitated by appropriate state regulatory changes. And those plans and their providers could be encouraged to use the cost-reducing technologies the state and private payers might more broadly encourage. The scale of estimated Exchange enrollment should be large enough to ensure economies of scale for providers and plans that invest in such changes. Incentives might be incorporated that help induce healthier behaviors that reduce the incidence of preventable chronic conditions. Because the Exchange structure should allow people to retain the plan of their choice over time, health plans would be much more likely to realize the longer-term savings from such measures. These positive incentives would be greatest under an ACE model, where all workers would be able to retain their choice of plans and providers even as their employer, job status, and income changes over time.

Conclusion

Although coverage of the uninsured will require some new spending on this population, our existing system of hidden cross subsidies and hidden costs has caused health care cost escalation that diverts an increasing share of our economy to health care and compromises our ability to compete in an increasingly global economy.

Trying to sustain this system will become more and more difficult, until a crisis point is reached. We hope that crisis will not lead Californians to give up their belief that everyone should have access to essential medical services when they are in need. Each of the alternative coverage approaches specified here would assign individual, employer, and government responsibilities that, unlike the current health insurance system, are consistent with that belief.

Endnotes

[1] Ed Neuschler and Rick Curtis. *Massachusetts-Style Coverage Expansion: What Would It Cost in California?* Issue Brief, California HealthCare Foundation, April 2006.

[2] In July 2006, the U.S. District Court for the District of Maryland invalidated a Maryland state law that would have required very large for-profit employers (those with 10,000 or more employees) to pay at least 8 percent of wages toward health insurance for their workers or pay the difference into the state's Fair Share Health Care Fund, which would help to fund the state's Medicaid program (*Retail Industry Leaders Association v. Fielder).* (A lower 6 percent threshold was established for non-profit employers.) Although three businesses employ more than 10,000 workers in Maryland, only Wal-Mart was not spending the required amount on health care. The court held that the law was primarily intended to mandate that firm to cover its workers, rather than to raise revenue. The judge noted, however, that his opinion might differ in the case of "comprehensive" legislation like that in Massachusetts. For this and other reasons discussed in note 6 below, we do not believe the Maryland ruling precludes properly constructed "pay-or-play" laws.

[3] Institute for Health Policy Solutions, *Challenges and Alternatives for Employer Pay-or-Play Program Design: An Implementation and Alternative Scenario Analysis of California's Health Insurance Act of 2003 (SB 2)*, prepared for the California HealthCare Foundation and the California Managed Risk Medical Insurance Board, March 2005, (http://www.ihps.org/pubs/2005_SB2.shtml) or (http://www.chcf.org/topics/healthinsurance/coverageexpansion/index.cfm?itemID=109984) July 6, 2006. Hereinafter referred to as our "SB 2 Report."

[4] In general, these requirements would not place an onerous burden on employers and do not appear to violate the federal Employee Retirement Income Security Act of 1974 (ERISA). See note 17 for more details.

[5] Rick Curtis, Rafe Forland, Ed Neuschler, and Lynn Taylor. *Covering Uninsured Small-Firm Workers and Dependents Through a Work-Based, Multiple-Financing Model: The "Working for Health" Concept*, A Report for the Bay Area County Consortium and the California HealthCare Foundation, Institute for Health Policy Solutions, December 2003.

[6] All the coverage models presented here have been designed to avoid state regulation of employee benefit plans, which is pre-empted by ERISA. In particular, we believe that ERISA does not pre-empt a properly constructed "pay-or-play" law that imposes a fee on employers to help finance a public program or subsidize low-wage workers' premiums. Despite the unfavorable ruling with respect to Maryland's "Wal-Mart bill" (see note 2), the Maryland statute is so different from the models analyzed in this report that we believe the pay-or-play approaches specified here, which apply broadly to employers as part of a comprehensive state health care access program and which set "pay" fees that (a) are less than what most employers currently contribute and (b) are expressly designed to help finance low-income subsidies and care, would overcome a challenge under ERISA's pre-emption clause. Further, a challenge to a local ordinance requiring minimum employer contribution levels is pending in a federal district court in New York, and the Maryland case is likely to be appealed.

[7] There is one exception: Under one of the alternatives analyzed (the ACE model), all workers are required to pay a fee assessed as a percentage of their wages, regardless of their family income.

[8] To take advantage of the available tax subsidies—and thereby reduce the other public funds required to make subsidy payments—the required percent-of-income contribution is calculated net of the available tax subsidies discussed in the next section. That is, to determine what percentage of income the worker is "contributing toward health coverage," the worker's actual dollar contribution (payroll deduction) is reduced by the amount of tax savings the worker realizes by sheltering that contribution through a Section 125 account, before dividing by the worker's (family) income.

[9] California HealthCare Foundation and Center for Studying Health Systems Change. *California Employer Health Benefits Survey, 2005.* (http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=117114)

[10] Above 250% FPL, people would be required to purchase only the $5,000-deductible plan, which is considerably less expensive than more comprehensive coverage. In addition, those with employers would receive tax savings from sheltering their premium contributions through their employer's Section 125 plan.

[11] This requirement would apply when enrollment in group coverage with premium assistance is cost-effective for the state compared to direct enrollment in public coverage. There is also one exception. The ACE alternative assumes that traditional employer-group coverage will be completely replaced by coverage through the Exchange.

Notes (cont'd)

[12] In the Exchange, the subsidy amount is the full premium for the family's coverage less the low-income family's income-based sliding-scale contribution.

[13] There could be a few instances in which the worker's share of the premium for employer coverage would exceed the total premium for coverage through the Exchange. In these situations, the worker would pay more for employer coverage than for Exchange coverage. The state would never pay a larger dollar subsidy toward employer coverage than it would have toward Exchange coverage for the same family. In such situations, workers could be given the option of declining employer coverage and enrolling through the Exchange. In our estimates, this option was extended to previously uninsured low-income people but not to those who were already enrolled in employer coverage.

[14] Not providing subsidies for low-income workers who cannot otherwise afford employment-based coverage would be unfair in a mandatory-coverage environment and would probably also be self-defeating. When comparable coverage is offered on a subsidized basis through the Exchange, not subsidizing employer coverage would create powerful incentives for low-income people to switch to jobs with no health benefits and for employers to create such jobs. To further discourage such "crowd-out" of employer coverage, we designed the premium assistance structure so that low-income workers would almost always pay less out-of-pocket toward the premium for employer coverage—because of the employer's contributions—than for coverage through the Exchange with no such contributions. The subsidy would equal the same percentage of the worker's premium as it would have if the worker had enrolled through the Exchange. In the Exchange, the subsidy amount is the full premium for the family's coverage less the low-income family's income-based sliding-scale contribution. Thus, in most cases where employer coverage is available, both the state and the worker will pay less than if the worker were enrolled through the Exchange.

[15] These include both undocumented immigrants and immigrants here legally who have not been in the United States long enough to qualify for federal funds.

[16] Section 125 of the Internal Revenue Code authorizes employers to establish plans under which workers' contributions toward health insurance premiums reduce their incomes for federal income and FICA (Social Security and Medicare) tax purposes. This allows what is sometimes referred to as paying premium contributions with "pre-tax" dollars rather than "after-tax" dollars. All but one or two states with state income taxes follow the federal rules in this area.

[17] In general, these requirements would not place an onerous burden on employers. One option under Section 125 is a "premium-only plan," which simply shelters worker contributions for health coverage and which requires minimal employer effort or costs. Moreover, use of such plans reduces the employer's FICA taxes along with the worker's income and FICA taxes. We consulted with ERISA expert Patricia Butler, J.D., about whether state implementation of such requirements could be blocked if there were a legal challenge under the federal Employee Retirement Income Security Act (ERISA). After researching the issues, Butler believes a state could overcome a legal challenge to these requirements under ERISA. Among other considerations, the U.S. Department of Labor has issued an advisory opinion clarifying that Section 125 plans are *not* "ERISA plans." Further, Massachusetts enacted such a requirement subsequent to our development of this approach and Butler's analysis. Employer organizations in Massachusetts are said to generally support this approach. (Even if a straightforward requirement were struck down, the state could take the alternative approach of conditioning deductibility of employer health insurance contributions *for state tax purposes* on adherence to the proposed requirements.)

[18] We assume that people with incomes below 125% FPL would *not* participate in Section 125 tax-sheltering plans because, for many of them, doing so would actually increase their tax liability by reducing their earned income tax credit. Because individual circumstances vary, this would not be true for everyone under 125% FPL, but using a uniform level for this purpose simplified our analysis.

[19] There are three alternatives to using an Exchange to arrange coverage for workers who are not eligible for employer-sponsored coverage, but they all have notable drawbacks. First, workers could buy coverage in the individual insurance market and pay for it directly, not by payroll deduction. But, except for self-employed people, this approach would forgo the significant tax benefits available by using a Section 125 plan in conjunction with payroll deduction. And overhead costs are particularly high in the individual market. Second, the employer could permit workers to pay premiums by payroll deduction to a single health plan chosen by the employer. But if the employer makes no contribution toward the premium, why should the employer get to choose the health plan? Third, the employer could offer to collect premiums by payroll deduction and transmit them to any health plan

Notes (cont'd)

chosen by the worker. But many employers would be unwilling to take on the administrative burden of paying multiple health plans on a monthly basis.

[20] In our estimates, however, everyone who currently purchases individual coverage is assumed to have coverage that meets the mandate, and therefore they retain their current coverage rather than purchasing the "mandate" package.

[21] This requirement would apply when enrollment in group coverage with premium assistance is cost-effective for the state compared to direct enrollment in public coverage. There is also one exception. The ACE alternative assumes that traditional employer-group coverage will be completely replaced by coverage through the Exchange.

[22] The cost of this combination was estimated assuming that the primary-preventive package would provide first-dollar coverage with a $10 co-payment for office visits (and 80%/20% co-insurance for other services) but that total benefit payments under this portion of the plan would be limited to $850 per person per year. However, other arrangements for providing the primary-preventive portion of the package, less like traditional insurance, could potentially be developed for the same price. (For example, the Exchange might negotiate with provider groups to provide preventive, primary, and perhaps some other relatively routine services to this population at a fixed per-capita rate.)

[23] The fact that they enrolled in employer coverage even in the absence of subsidies suggests that they considered it "affordable" and thus further suggests that the arrangement will be cost-effective for the state.

[24] Because of the way the premium assistance schedule is constructed, this method generally results in the lowest costs for the state as well as for the family. Ideally, both the family's preference and the state's cost-effectiveness determination would consider total out-of-pocket costs, including premium share and cost-sharing at the point of service. But project resources did not permit that level of behavioral modeling.

[25] A report prepared by Families USA, *Paying a Premium: The Added Cost of Care for the Uninsured* (June 2005), estimates the "markup on private health insurance premiums due to health care for the uninsured" to be 10.6 percent in California in 2005. However, the denominator that report uses for "total premiums for private, employer-sponsored health insurance" ($38.9 billion) is too low. Correcting the total premium figure (details available upon request) would reduce the Families USA estimate to a range of 6.0–6.6 percent. A direct comparison of "indirect costs for the uninsured" to total premiums for employment-based and private individual coverage in our own database produces a figure of 4.8 percent, but some of those indirect costs are actually covered by government programs, not passed on to private payers, as the Families USA report also finds.

[26] Maine's Dirigo program was to be funded by "savings offset payments" from health insurance carriers. But calculating the savings has been controversial and alternatives are now being sought. See, e.g., "Dirigo panel weighs future. Participation, funding at issue." *Bangor Daily News*, August 10, 2006.

[27] This would probably require raising the income level separating Medi-Cal from Healthy Families eligibility to the level that just uses up the SCHIP allotment for children above that level but below 250% FPL. Obtaining federal matching for premium assistance toward employer coverage for children over the revised Medi-Cal income level could be problematic.

[28] Employers could be seen as realizing additional tax savings from their contributions toward workers' health coverage, e.g., savings in business taxes. However, we assume that, if contributions toward employee benefits were not considered deductible business expenses for business-tax purposes, employers would shift such payments to wages and salaries, which would presumably remain deductible.

[29] As noted above, our estimates assume that previously uninsured low-income people with access to employer coverage would opt instead to join the Exchange if doing so would lower their after-subsidy premium payments.

[30] Neuschler and Curtis, *Massachusetts-Style Coverage Expansion*.

[31] Massachusetts provides premium assistance in lieu of direct coverage for low-income parents and children eligible for "MassHealth," Massachusetts' Medicaid program, when it is cost-effective to do so. In addition, Massachusetts provides premium assistance to low-income workers, whether or not they have children, if their small employers participate in the Insurance Partnership program. As part of its recent legislation, eligibility for premium assistance through the Insurance Partnership was increased to 300% FPL. To participate, small employers must contribute at least half of the total premium.

[32] Our previous "Massachusetts-style" estimates showed expected additional state costs of $9.4 billion *with* premium assistance toward employer coverage and $6.8 billion *without* premium assistance—assuming that no "crowd-out"

Notes (cont'd)

of employer coverage resulted. See Neuschler and Curtis, *Massachusetts-Style Coverage Expansion*. As we observed there, however, California's substantial number of low-wage workers who now have employer coverage, and their employers, would have huge incentives to shift to state-financed coverage. Therefore, we believe, and stated in our Massachusetts report, that the $6.8 billion "lower-bound estimate" is "almost certainly much less than could realistically be expected." Here (see tables 2 and 3) our estimates of additional state costs under the basic individual mandate range from $6.1 billion to $6.8 billion *with* premium assistance, or $2.6 billion to $3.3 billion *less* than our earlier estimates.

[33] Of this amount, about $8.5 billion represents the state's share of current spending under the Medi-Cal and Healthy Families programs for the population on which our estimates are based (i.e., people under age 65 and not in long-term care institutions). The current state revenue loss caused by tax-sheltering workers' premium contributions is about $0.7 billion.

[34] About one-third of the additional FICA savings (relative to current levels) accrues to employers that make no contribution to coverage but that must now allow their workers to pay premium contributions to the Exchange by payroll deduction through a tax-sheltered Section 125 plan.

[35] The additional tax savings under the higher state-cost estimate ($5.8 billion, from Table 4) total $1.9 billion more than the additional tax savings under the lower-bound estimate ($3.9 billion, from Table 3), but these amounts include the savings in FICA taxes that accrue to businesses ($1.0 billion under the higher state-cost estimate and $0.7 billion under the lower state-cost estimate). Table 4 presents *only* the tax savings that accrue to individuals.

[36] A widespread retreat of low-wage employers from providing health benefits could create a more level playing field for such employers and their workers, which by itself is not necessarily a bad result. But our point here is that, if "crowd-out" became widespread, it would substantially increase individual and public subsidy costs.

[37] Neuschler and Curtis, *Massachusetts-Style Coverage Expansion.*

[38] Our SB 2 Report (cited earlier) found that the pay-or-play pool would suffer unsustainable adverse selection if health rating were permitted in the regular employer group market but not used by the pool.

[39] In practice, employers might well also provide richer benefits rather than pay the assessment, but we were not able to incorporate this possibility into our estimation model.

[40] For a detailed discussion of ERISA pre-emption issues presented by state pay-or-play-type access programs, see Patricia Butler, *ERISA Implications for SB 2: Full Report*, March 2004, California HealthCare Foundation. (http://www.chcf.org/topics/healthinsurance/coverageexpansion/index.cfm?itemID=110245) See also notes 2 and 6 regarding the recent court decision with respect to Maryland's Fair Share Health Care Act.

[41] It would still be at least theoretically possible for an employer to meet the contribution "floor" for permanent, full-time workers without actually offering regular group coverage to every such worker. But because of ERISA, there seems to be no way that a state could mandate employer contributions for every single worker using a pay-or-play construct alone.

[42] Sang-Hyop Lee, Gerard Russo, Lawrence H. Nitz, and Abdul Jabbar. *The Effect of Mandatory Employer-Sponsored Insurance (ESI) on Health Insurance Coverage and Labor Force Utilization in Hawaii: Evidence from the Current Population Survey (CPS) 1994-2004*, Working Paper No. 05-12, University of Hawaii at Manoa, July 6, 2005.

[43] For example, requiring employers to extend eligibility for their group coverage to part-time workers, or requiring employers to pay the payroll fee for whichever workers are not eligible for or, perhaps, do not participate in, the employer's regular group coverage, would run afoul of ERISA, which forbids state laws that "refer to" ERISA plans. For a detailed discussion of ERISA pre-emption issues presented by state pay-or-play-type access programs, see Patricia Butler, *ERISA Implications for SB 2: Full Report*, March 2004, California HealthCare Foundation (http://www.chcf.org/topics/healthinsurance/coverageexpansion/index.cfm?itemID=110245)

[44] These estimates were produced by dividing total employer contributions toward health coverage by total wages paid by employers that offer health coverage. The payroll percentage contributed by a "typical employer" might be better estimated by averaging contributions as a percentage of payroll across private employers (i.e., counting each employer that offers coverage as "one," regardless of the employer's total payroll). Using this approach, the estimated averages are even higher: 13.8 percent of Social Security wages and 13.4 percent of total wages.

Notes (cont'd)

[45] There is an exception to this rule for low-income people who were previously uninsured but have access to employer coverage. In the estimation model, they choose the coverage—employer group or Exchange—that is least expensive for them, after taking subsidies into account.

[46] Under this coverage model, some non-subsidized people who enroll through the Exchange previously had employer coverage but lost it because of the assumed change in employer-plan eligibility provisions for part-timers. At present, the model assumes they buy the high-deductible coverage.

[47] As discussed earlier, subsidized coverage in the Exchange (the Healthy Families Adult benefit package) and in the traditional public programs is available at per-capita rates that are considerably below current commercial rates. Non-subsidized people in the Exchange, including many part-time workers who under the basic individual mandate would have had employer coverage, are assumed to buy high-deductible coverage, which costs considerably less than employer coverage. This effect is reflected in a $0.3 billion increase in out-of-pocket service costs under the pay-or-play-plus model compared to the basic individual mandate.

[48] We believe this approach would survive a challenge under ERISA because it does not require employers to make any changes to their health plans and in fact can and should be framed in a way that makes no reference whatsoever to employer health plans.

[49] The limit on wages subject to Social Security taxes increases each year according to the estimated growth in average wages.

[50] Although part-time workers *could* have been included in the population fully funded by the payroll fee, doing so would have required a significant increase in the assessment rate.

[51] Based on personal communications with California health plan executives and purchasers.

[52] Estimating the effects of allowing worker choice among different benefit packages, or among different carriers offering the same benefit package, would require a behavioral-choice model that is beyond the scope of this project.

[53] Incorporating the choice model necessary to make such estimates was beyond the scope of this project.

[54] The projections for health spending are those published by the U.S. Centers for Medicare and Medicaid Services for the nation as a whole and include increases caused by population growth. The inflation-adjusted number is deflated by the projected growth in the Consumer Price Index over the same period.

[55] The wage and salary projections are published by the Congressional Budget Office for the nation as a whole and include increases caused by growth in the labor force. Again, the inflation-adjusted number is deflated by the Consumer Price Index.

[56] Dividing 46.8% by 19.7% yields 2.38.

[57] Neuschler and Curtis, *Massachusetts-Style Coverage Expansion*.

[58] Based on three-year CPS data collected 2003–2005, 22.2 percent of non-elderly Californians with employer coverage have incomes under 250% FPL, which mirrors the national percentage of 22.3 percent. U.S. Census Bureau, *Current Population Survey, Annual Social and Economic Supplement,* 2003 through 2005 (three-year average for 2002 through 2004). Authors' tabulations using the CPS online table creator (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).

[59] In general, only employers with higher-risk workforces that cost as much or more than such a fee would choose to pay the fee, thus causing an adverse-selection "death spiral," as we estimated would have occurred under SB 2.

[60] Premiums for employment-based family coverage in California averaged $10,301 in 2005. California HealthCare Foundation and Center for Studying Health Systems Change, *California Employer Health Benefits Survey, 2005.* (http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=117114). It seems reasonable to assume the family premium will exceed $11,000 in 2006.