Challenges and Alternatives for Employer Pay-or-Play Program Design:

An Implementation and Alternative Scenario Analysis of California's "Health insurance Act of 2003" (SB 2)

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

Project Team Led by the
INSTITUTE FOR HEALTH POLICY SOLUTIONS

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Drs. Kanika Kapur and M. Susan Marquis of the RAND Corporation developed the data base and estimation model, conducted the quantitative simulation analysis on the implications of SB 2 and alternative scenarios, and drafted Supplements A, H and I describing the simulation process and results. In addition, Dr. Kapur authored Supplement E, Risk Adjustment Methods and Their Relevance to "Pay-or-Play." Stephanie Teleki and Cheryl Damberg of the RAND Corporation authored Supplement F on quality measurement and monitoring.

Pat Butler, J.D., Dr. P.H., prepared Supplement D on ERISA implications and drafted the legal considerations section of the main text. The authors wish to recognize the considerable contributions from other members of the project team, including Bob DiPrete, consulting senior fellow at IHPS, who was project lead and principal author of the report on stakeholder interviews (Supplement G) and provided valuable suggestions on earlier drafts; Jim Mays of the Actuarial Research Corporation, whose insightful input was invaluable to conduct of this analysis; and Tom Davies, who provided substantive guidance and assistance regarding large-employer purchasers in California. In addition, discussion presented here reflects the insightful observations of the many policy analysts, program managers, employers and health insurance experts interviewed for this project.

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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)

1. Introduction and Background

1.1. Project Overview

In Spring 2004, the California HealthCare Foundation (CHCF) selected the Institute for Health Policy Solutions (IHPS), in collaboration with the RAND Corporation, to conduct an in-depth implementation study and analysis of California's landmark "pay-or-play" legislation: *The Health Insurance Act of 2003* (SB 2).[1] This report presents the findings of that research.

SB 2 would have phased in a requirement that employers with 50 or more employees in California either provide health coverage for their workers or pay the state a fee to provide them coverage. Under this "pay or play" requirement, employers would either: (a) "pay" a fee to the state so that their workers and, for employers with 200 or more workers, dependents could be covered through a State Health Purchasing Program (SHPP)—or "purchasing pool"—established under the Act, or (b) "play" by directly providing health coverage for specified workers and dependents.

SB 2 required the SHPP pool, to be developed and run by California's Managed Risk Medical Insurance Board (MRMIB), to rely exclusively on the fees collected from employers that elect to "pay," rather than "play," and to contract with licensed health plans to provide coverage. A key challenge for successful implementation of such a coverage approach is determining how various program-policy dimensions might be structured so that a pool designed to be self-sufficient can be viable. A primary task of this study was to identify the extent to which a state-administered purchasing pool, as envisioned in SB 2, would be fiscally sound and what program policies might be necessary to support the pool's long term viability. The project was specifically designed to highlight issues for consideration by MRMIB, should it be called upon to implement such a program, and to identify and assess alternative policy scenarios that might make the SHPP pool more viable.

[1] Chapter 673, Statutes of 2003.

1.2. Why Analyze SB 2?

In November 2004, the voters narrowly overturned SB 2 in a referendum initiative (Proposition 72). Despite this reversal, the passage of legislation intended to expand employment-based coverage provides a unique opportunity to assess and to evaluate the implementation issues and challenges presented by a "pay-or-play" program.

This report is intended to assist decision makers in the design of manageable, effective and sustainable coverage expansions for workers and their families. This study is most obviously pertinent to pay-or-play approaches similar to SB 2, whether considered in California or in other states, but can also inform a range of other approaches involving one or more of the design features of SB 2:

- Employer-financed coverage (and related ERISA issues);
- Health insurance purchasing pools;
- Premium subsidies for low-income workers and dependents; and
- Individual coverage mandates.

Although SB 2 requires employers to make substantial contributions to coverage, the purchasing pool established to cover the workers and dependents of "pay" employers would be essentially an optional source of coverage for those employers. Therefore, the factors that affect whether the pool would be viable, and the extent to which adverse selection might be a problem, are largely the same, whether or not there are employer mandates such as those required by SB 2.

SB 2 incorporates two additional noteworthy features: (a) individual mandates for workers; and (b) premium subsidies to cover employee contribution costs for low-income parents and children eligible for the state's existing Medi-Cal (Medicaid) or Healthy Families (SCHIP) programs. This report's analysis of alternative program designs or "scenarios" includes the impact of extending such subsidies to other low-income workers and dependents. The budget factors and dynamics analyzed here parallel those that would be involved if the state were to coordinate with employment-based coverage, whether in the context of voluntary expansions, individual mandates and/or alternative employer requirements or incentives.

As these examples suggest, SB 2 affords a heuristic model for considering future reforms. In particular, the SB 2 framework specifies many of the key factors and dynamics that would be involved in virtually any major state coverage expansion intending to maintain or expand employer-financed health insurance as an element of the system. Many stakeholders and policy makers (including a number who are opposed to employer mandates like those in SB 2) believe that coordinating with employer-financed (employment-based) insurance is the only way to make health coverage for the uninsured affordable and, therefore, feasible for the state. We hope that this analysis of SB 2 will help them design effective policies toward that end.

1.3. Study Methodology

The initial CHCF project design focused heavily on the implementation challenges that would face the Managed Risk Medical Insurance Board (MRMIB), were they called upon to implement

SB 2 as passed by the legislature. The study methodology included the following major components:

- Interviews with key stakeholders and informants, to obtain their views and insights about the most important barriers to implementation;
- Development of basic descriptive information about the existing market for health insurance in employer groups that would be affected by SB 2 and about the employers, workers and dependents in the SB 2 universe (i.e., subject to the provisions of SB 2);
- Development of alternative "scenarios" to describe different policy approaches to implementing SB 2;
- Quantitative analysis of the alternative scenarios, using a simulation model developed by RAND; and
- Qualitative analysis of other key policy design issues that could not be examined using the simulation model.

Early in the project, IHPS conducted interviews of about thirty key stakeholders and experts to help identify key challenges and barriers to successfully implementing SB 2. Those interviewed represented the perspectives of those who would have been directly and indirectly impacted by SB 2 (stakeholders), as well as those who were party to the drafting of the bill or would have been responsible for some aspect of its implementation (key informants). We asked the interviewees to look beyond the political and legal challenges facing SB 2 and to discuss the barriers to implementation relating to policy and procedures rather than to politics and the law. Details on the interviews and the interview findings are included in Supplement G, "Stakeholder and Key Informant Interviews."

Another early task was RAND's development of basic descriptive information about the current coverage patterns of private-sector employers, workers and dependents in California and how they would be affected by SB 2. Some of this information appears on the CHCF website as "SB 2: Effects on Employers and Employees."[2] Because no single existing database provided all of the necessary information on California businesses, their employees and dependents, RAND relied on multiple data sources to create a synthetic database that describes employers and their employees in California in 2003.[3] (How the synthetic database was constructed is described in detail in Supplement H, "Scenario Simulation Model: Data Sources and Database Construction.")

Among the primary tasks of this project were to determine whether the State Health Purchasing Program (SHPP) or purchasing pool (the "pay" option) contemplated in SB 2 could be designed

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[2] <http://www.chcf.org/topics/healthinsurance/sb2/index.cfm?itemID=106121>. The larger descriptive report, "Implementing the Health Insurance Act of 2003: The Health Insurance Market Context and Demographic Profile," was submitted in August 2004.

[3] The sources used in developing the synthetic database included: the Employment Development Department (EDD) in California; the 2002 and 2003 surveys of private employers in California conducted by the Kaiser Family Foundation and the Health Research and Educational Trust (KFF/HRET); the 1997 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey; the 2001 panel of the Survey of Income and Program Participation (SIPP); and the 1997 Medical Expenditure Panel Survey.

to be viable financially, and to identify program design elements that might support a viable pool. SB 2 would have required MRMIB to "administer the program in a manner that assures that the fees and enrollee contributions collected pursuant to this part are sufficient to fund the program, including administrative costs."[4] That is, the SHPP pool was intended to be entirely self-sufficient.

However, in health insurance markets, and in health insurance purchasing programs, self-sufficiency is easier to prescribe than to attain, due to the potential for adverse selection in a product or a program leading to a classic "death spiral," where only the high-risk, high-cost subscribers remain in the program.

To understand how alternative program designs would affect the SHPP pool's financial viability, size, composition and cost, we developed alternative "scenarios" to describe a range of policy approaches to implementing SB 2. Our intent was to illustrate the major alternative approaches available to MRMIB. Because it was known from the outset that SB 2 might not survive the November referendum, and because it was questionable whether the SHPP pool could be self-supporting under the bill as enacted by the legislature, we developed and considered both scenarios that complied with SB 2 and several that differed from the SB 2 construct.

To analyze the effects of the alternative scenarios, RAND then developed a behavioral simulation model that is described in detail in Supplement I, "Scenario Simulation Model: Methodology." (The model uses as input the synthetic database of employers and workers just mentioned.)

The project also analyzed other policy design issues that could not be examined using the quantitative simulation model, such as offering workers a choice of health plans, dependent coverage options for medium-sized employers, possible cost containment strategies given the likely size of the pool under alternative scenarios, administrative issues and legal considerations. These analyses are based on the project researchers' knowledge of purchasing pools.

Because SB 2 was rejected by the voters, this report focuses less than was originally intended on specific administrative implementation recommendations for MRMIB and more on policy design features important for developing manageable, effective and sustainable coverage expansions for workers and their families.

1.4. Organization of This Report

In the next section, we lay out the basic features of SB 2 that the reader needs to know in order to understand the analysis in this report.

In section 2, we present the results of our quantitative analysis. After some basic preliminary results, we describe the alternative policy scenarios that we analyzed and then discuss the results of our analysis. Topics addressed include the financial viability of the pool, its size, the amount of "outside" or subsidy funds that would be needed to support the pool (as envisioned under some of the scenarios), and state budget implications. We then summarize the key conclusions

[4] Section 2130.4 in Chapter 3, Part 8.7, Division 2 of the California Labor Code, as proposed to be added by section 2 of SB 2.

from out quantitative analysis, and reference very briefly how our estimates vary if the pool offered a different benefit level, as well as how the characteristics of the pool's enrolled population would vary under different scenarios. (Greater detail about these last topics is presented in Supplement A, "Complete Results of Scenario Simulation Modeling.")

In section 3, we discuss other key design considerations that fall outside the scope of the quantitative analysis. These issues include: the pool's market role and its ability to exert purchasing power and to use various cost containment strategies, offering worker choice of health plans, dependent coverage, administrative considerations, premium assistance and legal consideration.

Our key conclusions are presented in section 4.

1.5. Key Features of SB 2: California's Health Insurance Act of 2003

In this section, we present only those basic features of SB 2 that the reader needs to know about in order to understand the analysis in this report. More comprehensive summaries of SB 2 are available elsewhere.[5]

Key features of SB 2 included:

1.5.1. Basic Employer, Worker and Dependent Participation Requirements

a. "Large" employers—those with 200 or more employees in California—were to either pay the applicable fee for eligible workers and dependents, or directly cover them with a qualified benefit plan. (Would have been effective January 1, 2006.)

b. "Medium" employers—those with 50 or more employees in California—were to pay the applicable fee for eligible workers, or directly cover them with a qualified benefit plan. (Would have been effective January 1, 2007.)

- *Although included in the SB 2 definition of "medium" employers, businesses with 20 to 49 employees in California would not have been subject to the mandate unless the legislature were to enact a tax credit equal to 20 percent of the net cost to such employers of the fee payable for participating in the SHPP pool. Therefore, our analysis assumed that such businesses would not be subject to SB 2.*

c. "Small" employers—those with 2 to 19 employees in California—would be not subject to the SB 2 requirements.

d. These employer "pay-or-play" requirements were to apply for workers who worked at least 100 hours per month for any individual employer and had worked for that employer for at least three months. Eligible dependents were to include spouses, domestic partners, and

[5] Extensive background information about SB 2 is available on the California HealthCare Foundation's website at <http://www.chcf.org/topics/healthinsurance/sb2/index.cfm.>

minor children[6] of covered workers but did not include dependents covered by another employer.

- Note that SB 2 would have effectively imposed an "individual mandate" for the specified workers. Workers could not avoid paying their share of the fee or premium, at least for coverage of themselves.
- The "mandate" was less clear with respect to dependents. It appeared that workers could avoid covering their dependents by simply not reporting them to the employer. According to interviews with knowledgeable stakeholders, the drafters did not intend to force workers to identify and cover their dependents.
- Note also that the *employer* decided whether to provide coverage directly or pay the SHPP fee. If an employer offered qualified coverage, that employer's workers could not receive coverage through the SHPP pool.

1.5.2. Employer and Worker Contribution Requirements and Associated Benefit Standards

a. Employers opting to "pay" into the SHPP pool would have been required to pay at least 80% of the SHPP fee for coverage of their workers, or workers and dependents, as applicable depending on employer size.

b. Employers could avoid paying the SHPP fee by opting to provide coverage directly. (Technically, they would qualify for a "credit" against the fee.) Taft-Hartley plans and other collectively bargained plans would have been exempt from the following requirements and qualify for the credit automatically.[7] To qualify, other employers would have been required to:

- Offer coverage that at least met the benefit standards applicable to HMOs or insured plans under California law.
- Pay at least 80% of the premium for at least one qualifying plan offered to their workers (or workers and dependents, as applicable depending on employer size).

c. Employers could require workers to pay no more than 20% of the premium or SHPP fee, except that:

- "Low-wage" workers could not be required to pay more than 5 percent of their wages. (Employers must make up any difference and therefore may have to pay more than 80% of the premium or SHPP fee for these workers.)
- "Low-wage" meant earning *wages* that were less than 200% of the federal poverty level (FPL). (The FPL standard for one person was used with respect to worker-only

[6] Children 18 years of age and over who were "dependent" on an enrollee (as specified by MRMIB) could also be covered.

[7] Multiple employer welfare arrangements (MEWAs) that were established before January 1, 2004, would also have been exempt from the benefit standard, provided they did not change their benefits thereafter.

coverage, and the FPL standard for three people was used when dependents were also covered.[8])

d. *Note that employers that wanted to avoid paying the SHPP fee would only need to offer one plan that met the benefit standards and toward which the employer paid 80% (and limited low-wage workers' contributions to 5 percent of wages).* Employers could offer other options for which they paid less than 80% of the premium. For example, 80% of premium for a high-deductible plan—which would be permissible under SB 2—would often cost the employer less in dollar terms than a lower percentage contribution to their current plan. As a result, SB 2 would have had a less extensive effect on employer contribution levels than some observers might have expected.

1.5.3. Public Program Subsidies for Some Low-Income Workers

a. SB 2 also provided for refunding the worker's share of fee or premium contributions made on behalf of workers or dependents who applied and were found eligible for the Medi-Cal or Healthy Families programs under current eligibility rules. The refunds for worker contributions, called "premium assistance," were to be available whether the worker participated in the SHPP pool or in employer-provided coverage.

b. SB 2 thus made public subsidies toward employer coverage available for eligible children under 250% of poverty and very low-income parents (but not for others such as low-income childless workers).[9]

1.5.4. Pool Revenues, Fee Structures and Insured Health Plans

a. The employer and worker fees were to be the sole source of revenue to pay both medical and administrative costs for the SHPP pool.

b. The Managed Risk Medical Insurance Board (MRMIB) was to administer the SHPP pool and was given latitude to determine what factors would be used to determine the fee for any given employer.

c. The SHPP was to contract only with insured plans to provide pool coverage.

d. Once medium employers became subject to the pay-or-play mandate (January 1, 2007), state rules governing offering, marketing, and selling health insurance in the small-employer market were to become applicable to the medium-employer market, with one adjustment. Health care service plans (HMOs) and health insurers would be permitted to apply a risk adjustment factor of no more than 115 percent and no less than 85 percent of the standard employee risk rate, which is based on age, geographic region, and family composition. (In the small-employer market, the permissible range is 90 percent to 110 percent.)

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[8] Thus, in 2004, the "low-wage" threshold was $18,620 for a single worker and $31,340 for a worker covering dependents.

[9] We discuss details of the interaction between employer coverage and public coverage under SB 2 in greater detail in section 2.6.1 beginning on page 26.

2. Summary of Quantitative Analysis Results

2.1. How Many of the Uninsured Would SB 2 Have Reached?

As part of the background for this project, we developed market- and demographic-profile information to describe and understand the employers and employees that would have been affected by SB 2, including analyzing current coverage patterns.[10] One of the primary drivers for expansion proposals that build on employer-sponsored coverage is the high number of uninsured persons who are workers or the dependents of workers. We estimate that about two-thirds of California's uninsured are in working families. But how many of these working uninsured eventually would be covered depends on the specific design of the pay-or-play mandate.[11] This section focuses on the extent to which SB 2 would have expanded coverage to the uninsured.

The drafters of SB 2 omitted employers with fewer than 20 employees in California from the coverage requirements entirely. Presumably, this decision reflected concern that paying for health insurance would be too burdensome for such small employers. Similarly, employers with 20-49 employees would not have been subject to SB 2 unless the legislature subsequently enacted a tax credit covering 20 percent of the net cost to such employers from complying with SB 2. Only employers with 50 or more employees would have been required to contribute toward coverage for their workers, and only employers with 200 or more employees would have been required to contribute toward coverage for their workers' dependents.

Because medium firms would not have been required to cover dependents, and because firms with fewer than 50 workers would not have been required to cover anyone, SB 2 would only have covered 26.4 percent of California's uninsured. If the requirements had applied to smaller businesses, a larger share of the uninsured could have been covered, as shown in Exhibit 1.

Exhibit 1: Percent of California's Uninsured Population That Would Gain Coverage Under A Mandate on Employers with Various Numbers of Employees

If the pay-or-play mandate applied to:	Percent of uninsured who would gain coverage
Workers in businesses of 50+ employees, dependents in businesses of 200+ employees (SB 2 as enacted):	26.4
Workers and dependents in businesses of 50+ employees	34.5
Workers and dependents in businesses of 20+ employees	40.5
Workers and dependents in businesses of 10+ employees	45.7
Workers and dependents in businesses of 2+ employees	58.2

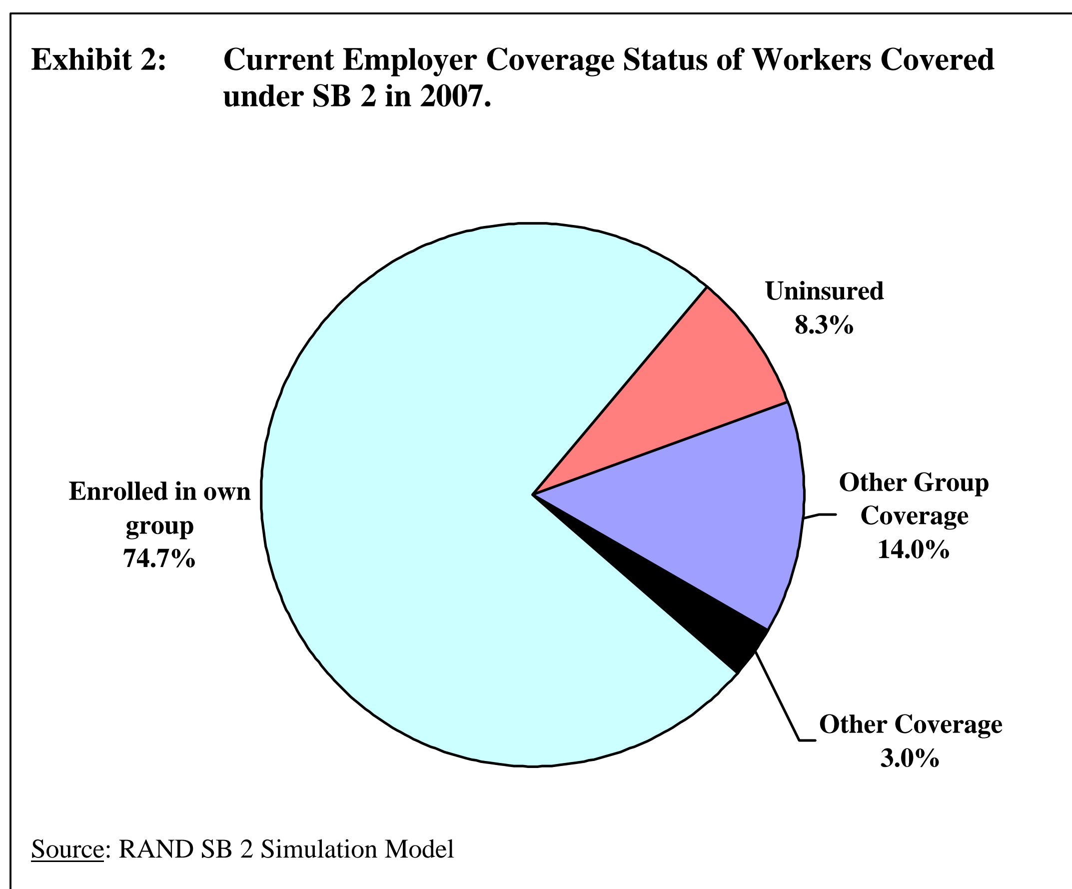
Source: RAND SB 2 Simulation Model

[10] A snapshot of the anticipated effects of SB 2 on employers, employees and coverage, developed for this project, can be found at <http://www.chcf.org/topics/healthinsurance/sb2/.>

[11] The one-third (33.7 percent) of California's uninsured who are in families that have no working members simply cannot be reached through employment-based coverage. (The self-employed are also excluded here.)

Further, because almost all California businesses with 50 or more employees already provide health benefits (to at least some of their workers), the increase in coverage under SB 2 would have come mostly from requiring employers that already offered coverage to cover more of their workers rather than from requiring employers to begin offering coverage for the first time. We estimate that, of workers subject to SB 2 requirements in 2007 (after full implementation), *only one percent work for employers that do not now offer coverage*. Three-quarters (74.7 percent) already have their own employer's coverage, and the remaining 24.3 percent work for an employer that offers coverage but are not enrolled, either because they chose not to enroll or because they are ineligible under their employer's current coverage rules. (Not shown.) Among SB 2-covered workers who are not now covered through their own employer, only about one-third—8.3 percent of all SB2-covered workers—are uninsured. See Exhibit 2.

Exhibit 2: Current Employer Coverage Status of Workers Covered under SB 2 in 2007.



Source: RAND SB 2 Simulation Model

Nevertheless, the low offer rate among small employers, particularly among small employers with a majority of low-wage workers, suggests that paying for coverage would be particularly burdensome for such employers unless outside subsidies were available. But such subsidies could be very expensive for the state. Analysis of broader pay-or-play constructs that would be more successful in increasing participation from small employers was beyond the scope of this project.

2.2. Descriptions of the Alternative Scenarios

To understand how alternative program designs would affect the SHPP pool's financial viability, size, composition and cost, we developed several "scenarios" to describe a range of policy approaches to implementing SB 2. Our intent was to illustrate the major alternative approaches available to MRMIB. Because it was known from the outset that SB 2 might not survive the November referendum, and because it was questionable whether the SHPP pool could be self-supporting under the bill as enacted by the legislature, we developed and considered both scenarios that complied with SB 2 and several that differed from SB 2 in certain respects. The scenarios are described below and are summarized in Exhibit 3.

2.2.1. Primary Design Variables

We hypothesized that the design variables likely to have the greatest impact on the SHPP pool's financial viability were the level(s) of benefits offered and the structure of the fee(s) charged to employers. The scenarios used for the simulation varied by the benefit design and by the method and factors used to set employer fees. In addition, we included one scenario where subsidies were provided to low-income participants in the pool and two where "outside funding"—i.e., funding from sources other than SHPP-participating employers and workers—was available to the pool.

<u>Benefit Level</u>

The scenarios included two different benefit plan designs as follows:

- A "lean" plan with an actuarial value equal to the 10th percentile of plans currently offered by California employers. In current terms, a plan at this level would typically have a $1,000 deductible, 20 percent coinsurance and a $5,000 out-of-pocket limit.
- A "mainstream" plan with an actuarial value equal to the 75th percentile of plans currently offered by California employers. A typical such plan would have a $100 deductible, 20 percent coinsurance, and $1,250 out-of-pocket limit.

<u>Methods and Factors for Setting the Fee</u>

Risk selection would be a key factor in the financial viability and sustainability of the SHPP. The fee structure established by MRMIB would have a dramatic impact on the type of employers choosing to enroll their employees in the SHPP pool and on the risk selection that occurred in the program. If healthy, low-cost employer groups could buy coverage less expensively in the outside market, then the SHPP pool would attract too many high-cost groups (a condition known as "adverse selection"), and its fees would not be sufficient to cover its costs.

One way to keep the SHPP fee low for healthy, low-cost groups would be to adjust the fee to match the risk (expected costs) of each employer group.[12] SB 2 gave MRMIB the latitude to set

[12] SB 2 appeared to expect that the SHPP pool would be able to offer low-cost coverage to all participants by negotiating with health plans and adopting other cost-containment strategies. We were unable to incorporate these ideas directly into the quantitative simulation model. Instead, we discuss them separately in sections 3.1 and 3.2 beginning on page 36, and in Supplement C.

the fee using factors it deemed to be appropriate, and the scenarios consider factors typically used in the private insurance market—geography, age and health status.

At the same time, it is important to recognize that establishing the SHPP fee(s) based on multiple and/or complex factors could present significant policy and operational challenges. For example, using health risk or health status in setting the fee could be an effective strategy to manage risk selection, but would also make the program more complex to administer and increase both the pool's and participating employers' administrative costs. We discuss these concerns in section 3.4.2 on page 48.

In addition to per-capita fees with and without adjustment factors, we also considered setting fees as a percentage of payroll or wages, as pay-or-play proposals in other states have done.[13]

Subsidies

Given the challenge of designing the program to be self-sufficient while keeping administrative costs reasonable, we also considered three alternative scenarios that went beyond SB 2 by providing broader subsidies towards coverage in the pool. One such scenario would make subsidized coverage available only for low-income workers whose employers participated in the SHPP pool. This subsidy approach could help the SHPP pool's viability by making it attractive to employers with many low-risk, subsidy-eligible workers. By doing so, it could make the SB 2 pool viable without the need to adjust each employer's fee for the health status of its workers.

In addition, we tested two other approaches that would rely on "outside funding"—i.e., funding from sources other than SHPP-participating employers and workers—to help support the SHPP pool. One approach would provide lower SHPP fees for low-wage employer groups. The other would simply offset losses due to the high-risk profile a pool with flat rates would likely experience; we examined two variants of this approach.

2.2.2. Scenarios That Comply with SB 2

Using the primary design variables just described, we developed and analyzed six alternative design "scenarios" for the SHPP pool. Three comply with SB 2, and three incorporate elements not included in SB 2. But, unless otherwise specified, all scenarios incorporate the "key features" of SB 2 described in section 1.5 above, such as "premium assistance" for workers and dependents enrolled in the Medi-Cal and Healthy Families programs.

Because benefit level was found during our analysis to be less significant than originally hypothesized, we do not use it as a primary means of distinguishing among scenarios for purposes of this presentation. We do use it, however, to distinguish two "subscenarios" under several of the primary scenarios.

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[13] For example, under the Massachusetts Health Security Act of 1988 (subsequently repealed), employers that opted not to provide health insurance directly would have been required to pay a 12 percent tax on the first $14,000 of annual wages per worker. Thomas Oliver, *State Employer Health Insurance Mandates: A Brief History,* California HealthCare Foundation, March 2004.
<http://www.chcf.org/topics/healthinsurance/sb2/index.cfm?itemID=105814>.

Exhibit 3: Schematic Outline of Alternative Scenarios

	Scenario Name	Fee Structure	Benefit Level	Additional Funding or Subsidies (i.e., beyond Medi-Cal/Healthy Families eligibles)
A1	SB 2 with Flat Community Rating	Per capita, adjusted for geography only	A1: "Mainstream"	None
A2			A2: "Lean"	
B1	SB 2 with Age Rating	Per capita, adjusted for geography and age	B1: "Mainstream"	None
B2			B2: "Lean"	
C1	SB 2 with Health Rating	Per capita, adjusted for geography, age and health status.	C1: "Mainstream"	None
C2			C2: "Lean"	
D	Subsidies and Healthy-Families-type Plans for All Low-Income People	Per capita, adjusted for geography and age.	"Lean" for non-low-income PLUS Healthy-Families-type plans available only to low-income workers and dependents.	Subsidies for all low-income workers and dependents who enroll in Healthy-Families-type plans through the pool.
E	Percent of Payroll	Percent of payroll/ wages, plus family-income sliding scale for dependents.	"Lean"	Outside funds cover shortfall caused by fee structure.
F1	High-Risk Employer Pool: 100% of Market Average, No Age Adjustment, Mainstream Benefits	Per capita, equal to expected market-wide average cost, adjusted for geography only	"Mainstream"	Outside funds cover excess cost. Could be all-employer assessment.
F2	High-Risk Employer Pool: 125% of Market Average, with Age Adjustment, Lean Benefits	Per capita, equal to 125% of expected market-wide average cost, adjusted for geography and age	"Lean"	Outside funds cover excess cost. Could be all-employer assessment.

Scenario A: "SB 2 with Flat Community Rating"

Description: The SHPP pool would charge a flat per-capita fee that varied only by geographic location. No outside funding or additional subsidies would be available (beyond the premium assistance available for Medi-Cal and Healthy Families enrollees under SB 2).

- Under Subscenario A1, the "mainstream" benefit package would be offered.
- Under Subscenario A2, the "lean" benefit package would be offered.

Rationale: A flat per-capita fee would be simplest to administer and also seems to have been the intent of some of SB 2 supporters. We allow the fee to vary by geographic location to account for the varying costs of health services in different regions and communities. Varying premiums by geographic location is common in the private health insurance market.

Scenario B: "SB 2 with Age Rating"

Description: The SHPP pool would charge a per-capita fee that varied by geographic location and the age of the workers in the employer group. No outside funding or additional subsidies would be available (beyond the premium assistance available for Medi-Cal and Healthy Families enrollees under SB 2).

- Under Subscenario B1, the "mainstream" benefit package would be offered.
- Under Subscenario B2, the "lean" benefit package would be offered.

Rationale: Age is a key predictor of health risk and potential health service utilization differences across groups of people. Age rating—varying the SHPP fee according to the average age[14] of each employer's workers—would, therefore, be one strategy to manage risk selection in the pool by better matching the fee charged to the health care costs expected for a given employer group. Because employers often already know and thus could easily report their workers' ages, age rating would also be relatively easy to administer. Age rating is widely used by private health plans, especially where the actual claims experience of an employer group cannot legally be used to set premiums, as in the small-employer market.

Scenario C: "SB 2 with Health Rating"

Description: The SHPP pool would charge a per-capita fee that varied by geographic location and by both the age and health status of the workers in an employer group. No outside funding or additional subsidies would be available (beyond the premium assistance available for Medi-Cal and Healthy Families enrollees under SB 2).

- Under Subscenario C1, the "mainstream" benefit package would be offered.
- Under Subscenario C2, the "lean" benefit package would be offered.

Rationale: Allowing the SHPP pool to charge different rates for employer groups depending on the health risk and health status of their workers would be the most direct way to match the fee charged to the health care costs expected for a given employer group, and thus to avoid the risk that the pool's fees would not be sufficient to cover its costs. This scenario would comply with SB 2[15] but would also raise significant policy, operational and legal issues, which we discuss in section 3.4.2 beginning on page 48.)

[14] An employer group's "average age" would be calculated by actuaries to reflect expected health care costs and, therefore, would likely not be the straightforward mathematical average of the workers' ages.

[15] Section 2140.5 in Chapter 3, Part 8.7, Division 2 of the California Labor Code, as proposed to be added by section 2 of SB 2, provides in part: "The fee to be paid by each employer shall be based on the number of potential enrollees, and if applicable, dependents, using the employer's own workforce on a date specified by the board as the basis for the allocation and such other factors as the board may determine in order to provide coverage that meets the standards of this part." (Emphasis supplied.) Objections might also be raised on the grounds that federal law prohibits employer plans ("group health plans") from charging enrollees premiums that vary with the individual's health status. [Section 702(b) of the Employee Retirement Income Security Act of 1974, as added by section 101 of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).] However, the SHPP pool would not be a "group health plan" under ERISA and therefore would not technically be subject to the federal non-discrimination-on-health-status requirement.

2.2.3. Scenarios That Go Beyond SB 2

Scenario D: "Subsidies and Healthy-Families-Type Plans for All Low-Income Workers"

Description: As in Scenario B, the SHPP pool would charge a per-capita fee that varied by geographic location and the age of the worker. As under all scenarios, workers and dependents who applied and were found eligible for Medi-Cal or Healthy Families would receive a refund for their share of the fee and would be enrolled directly in the applicable program, as under SB 2.

In addition, however, all other low-income workers and dependents (i.e., those with family incomes below 200 percent of the federal poverty level (FPL)) whose employers elected the SHPP pool would be permitted to apply to enroll in plan(s) similar to existing Healthy Families plans. These Healthy-Families-type plan(s) would provide benefits comparable to those provided under the Healthy Families program at rates comparable to those paid by the Healthy Families program.[16] (We discuss later questions and issues regarding the feasibility of expanding Healthy-Families-type plans to a larger population.) Eligible workers and dependents who elected this option would pay a fee that varied with family income[17] and would also benefit from lower cost-sharing provisions, similar to those under the Healthy Families program.

Workers and dependents above 200% FPL (250% FPL in the case of Healthy Families-eligible children) would be enrolled in regular SHPP-pool coverage, which in this scenario would be the "lean" benefit plan. The pool's fee would be based upon that plan.

Because of the additional subsidies for low-income workers and dependents, this scenario would go beyond what SB 2 would have authorized.

Rationale: Making the subsidy available to low-income workers only through the SHPP pool would be an alternative strategy to attract enough groups that have low-risk workers to make the pool financially stable even without health adjustments to the fee. By offering the subsidy in the pool, and not in the private market, this approach would give the pool an advantage over the private market in attracting these low-income groups, and thus avoid the need for MRMIB to administer a complex program that set rates based on health status.

Also, making subsidies available to all low-income workers and dependents would help to mitigate an inequity that would otherwise persist under SB 2. Currently, children qualify for Healthy Families only if they are uninsured and have not recently dropped employer coverage.[18] Thus, low-income children who obtained either employer coverage or SHPP coverage under SB 2 would qualify for premium assistance as a Healthy Families child only if they were

[16] Although these special plans would not necessarily be offered by the same carriers that participate in the Healthy Families program, we will refer to them in the remainder of this discussion as "Healthy Families-type plans," because benefits, patient cost sharing and provider payment rates would be very similar, if not identical, to those under the Healthy Families program. For simulation purposes, plan capitation rates for adults were based on rates that had been negotiated for coverage of parents under the planned expansion of Healthy Families.

[17] Adults would be charged between $5 (under 133% FPL) and $35 per month per person (over 175% FPL), based on family income. Coverage for children would be charged at Healthy Families rates. The difference between these amounts and the regular worker contribution (20 percent of the fee, limited to 5 percent of wages for many of these enrollees) would be refunded to the family in the form of premium assistance.

[18] There is no similar requirement under Medi-Cal.

receiving or had applied for Healthy Families before they had employer coverage. Otherwise, they would be insured, and could no longer qualify for Healthy Families and the associated premium assistance, despite their low income.[19] This current inequity could be more salient in the SB 2 mandatory-coverage environment where otherwise similar working parents participating in the same employer plan would be treated differently.

Scenario D would make premium subsidies available to low-income children (and their parents) in the SHPP pool who did not meet the "uninsured" test to qualify for Healthy Families. Any employer wishing to address this inequity among its low-income workers could opt to join the pool. But Scenario D would provide only a partial solution for the equity problem, because it would not provide assistance to low-income children with direct employer coverage who were not on Healthy Families prior to obtaining employer coverage. (As we discuss later, we estimate that the pool could provide this assistance at no cost to the state, while providing such subsidies outside the SHPP pool would be expensive.)

Scenario E: "Percent of Payroll"

Description: For worker-only coverage, the SHPP pool would charge employers a fee calculated as a percentage of their total payroll. The percentage would range from 10 percent to 14 percent and increase with the average wage of the employer's workforce. The worker's fee would be a percentage of their own wages, ranging from 2.5 percent to 3.5 percent, and would increase as the worker's wage level increased.[20] Large employers and their workers who covered dependents would pay a multiple of the basic fee. The multiple would be two if the worker enrolled in two-party coverage and three if the worker enrolled in family (three-or-more-party) coverage. (The fee structure is described in more detail in Supplement A.)

Under this scenario, the SHPP pool offers only the "lean" benefit plan.

Rationale: A percent-of-payroll contribution approach has been used in earlier pay-or-play proposals in other states.[21] It appears to be a simple way to avoid putting an unsupportable financial burden on low-wage workers and their employers and to attract a normal distribution of risks into the SHPP pool without using health rating. Therefore, it seemed an important option to examine.

Outside funding would be required under this scenario, however, because essentially every SHPP-participating employer group would pay less than the expected cost of their coverage. (Any employer whose expected cost of coverage was less than their payroll-based fee would be

[19] SB 2, section 1(n) declares the legislature's intent "to preserve benefits available to the recipients of these programs, including dental, vision, and mental health benefits." But the legislation did not specifically address the question of how eligibility for coverage under SB 2 would affect children's eligibility for Healthy Families coverage.

[20] These percentages may seem high, but they produce fees much lower than low-wage employers would have to pay under a per-capita fee structure. The percentages were chosen after preliminary analysis indicated that lower contribution rates would produce a large pool and require a very large subsidy cost. The level chosen yields an estimated pool size roughly comparable to the previous scenario.

[21] As, for example, in Massachusetts. See Thomas Oliver, *State Employer Health Insurance Mandates: A Brief History,* California HealthCare Foundation, March 2004. <http://www.chcf.org/topics/healthinsurance/sb2/index.cfm?itemID=105814>.

able to obtain less expensive coverage in the traditional insurance market, or by self-insuring.) Therefore, this scenario would go beyond what SB 2 would have authorized.

Scenario F: "High-Risk Employer Pool"

Two variants of this scenario were developed. Like the high-risk pool MRMIB operates for individuals, both would use outside funding to offset pool losses (costs in excess of fees charged to participating employers). The source of this outside funding might be state general revenue, or it might be an assessment, charge or tax on all employers subject to the pay-or-play mandate, whether they enrolled in the SHPP pool or provided coverage directly. Such a charge might be implemented either as a separate fee or by making the SB 2 credit for "playing" employers less than the SHPP fee by the desired amount.

Subscenario F1: "100% of Average, No Age Adjustment, Mainstream Benefits"

Description: The SHPP pool would charge a flat per-capita fee that varied by geographic location only, as in Scenario A. The fee would be set equal to expected market-wide average costs, i.e., the expected average cost for all workers in the SB 2 universe. The "mainstream" benefit package would be offered.

Rationale: Subscenario F1 is intended to illustrate much additional funding would be required to make the SHPP pool financially viable if it operated as some SB 2 supporters appear to have expected and desired.

Subscenario F2: "125% of Average, With Age Adjustment, Lean Benefits"

Description: The SHPP pool would charge a per-capita fee that varied by both geographic location and the age of the workers in the employer group (i.e., "age rating"), as in Scenario B. The fee would be set at 125 percent of expected market-wide average costs. The "lean" benefit package would be offered.

Rationale: Subscenario F2 is intended to illustrate much additional funding would be required to make the SHPP pool financially viable in the absence of health rating, if it operated as the employer-group analog of an individual high-risk pool. That is, the pool would set a ceiling on how much extra a high-risk employer group could be charged, relative to the outside market; and the pool would expect to enroll only high-risk groups.

Other key design issues

Other aspects of program design would also be of great interest to policy makers and necessary for potential program implementation. Perhaps the most important among these are:

- Should the SHPP pool make dependent coverage available to medium employer groups and, if so, under what conditions?
- Should the pool offer workers a choice of different benefit levels and/or a choice among carriers offering the same standardized plan?

Policy decisions on these design variables could affect the attractiveness and, therefore, the financial viability of the SHPP pool. Due to resource limitations, our behavioral model does not estimate how workers' decisions about dependent coverage would vary in response to different employer contribution levels or how their preferences would vary if the pool offered a choice of benefit levels. (The behavioral model is discussed briefly in the next section and in greater detail in Supplement I.) In addition, there is no research basis for quantifying the effects on employer "pay-or-play" decisions of whether the pool offered a choice of competing carriers. Therefore, these important variables could not be included in the quantitative modeling. Policy and administrative considerations regarding making dependent coverage available to medium employer groups and offering a choice of benefit levels and/or carriers are discussed in section 3, along with other important design consideration that were not amenable to quantitative modeling.

2.2.4. Overview of Simulation Model

Simulating the effects of SB 2 requires comprehensive information on businesses in California as well as on their employees and dependents. Because no single existing database provided such information, RAND created a synthetic database that describes employers and their employees in California in 2003 based on a number of sources including: data from the Employment Development Department (EDD) in California; the 2002 and 2003 surveys of private employers in California conducted by the Kaiser Family Foundation and the Health Research and Educational Trust (KFF/HRET); the 1997 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey; the 2001 panel of the Survey of Income and Program Participation (SIPP); and the 1997 Medical Expenditure Panel Survey.

The resultant database includes information about each business and unit of government, the health insurance plans it offers, and worker enrollment decisions, as well as demographic and socio-economic information about each employer's workers, including self-reported health status and expected health spending.[22] The database characterizes each insurance plan that each employer currently offers by the share of medical expenses that the plan would cover—which we refer to as the "the actuarial value" of the plan.[23] How the synthetic database was constructed is described in detail in Supplement H, "Scenario Simulation Model: Data Resources and Database Construction."

To analyze the effects of the alternative SB 2-implementation scenarios described above, RAND then developed a behavioral simulation model that is described in detail in Supplement I, "Scenario Simulation Model: Methodology." The model assumes that employers' insurance decisions are based on the preferences of their workers, so it starts by determining worker preferences for the employer-offered plan and the SHPP plan. If the majority of workers within a firm prefer the employer-offered plan(s), the employer is assumed to offer health insurance

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[22] The database includes information about employers with fewer than 50 employees and about people who work for those small firms. But it does not yet "link" specific small-firm workers with specific small firms, as it does for businesses with 50 or more employees and their workers.

[23] Insurance typically covers large medical bills more generously than small medical bills. Therefore, we calculated the actuarial value of the plan benefits according to spending levels based on the quartiles of the distribution of spending in the entire population. That is, we have four actuarial values, one for each quartile, to characterize each plan offered.

directly. Alternatively, if the majority of workers prefer the SHPP plan, the employer pays the fee to join the SHPP pool. Worker preferences depend on whether the net value to the worker from choosing the SHPP plan exceeds the net value to the worker from choosing the plan(s) offered by the employer. The net value of any plan is the value of the health services the worker and his/her family expect to receive, less the cost to the worker of the plan—including direct out-of-pocket premium payments, the expected out-of-pocket costs of services, and the effect on wages—and less the risk or financial uncertainty that the family remains exposed to, given the plan choice.[24]

The model does have some limitations. Those most likely to be of interest to policy analysts and program designers include:

- Because the model focuses on financial considerations in choosing a plan (and plans are represented in the model by their "actuarial value"), it cannot simulate worker choice among actuarially equivalent benefit plans offered by different carriers.[25]
- Because health savings accounts (HSAs) are new (and there is limited experience with their predecessors, medical savings accounts), there has been no research about how individuals value the savings-account-plus-catastrophic-insurance construct vis-à-vis more traditional insurance plans. Therefore, we did not use the simulation model to analyze how offering an HSA plus a high-deductible plan might affect the financial viability of the SHPP pool.[26]
- As already noted, the model does not currently allow alternative medium-employer dependent-coverage contribution levels to alter family decisions about covering dependents or about who would cover dependents in two-worker families. However, such responses are likely and could affect the preferences of families for the SHPP pool.

In general, it is worth noting that the model was built primarily to analyze implementation of SB 2 as passed by the legislature. After the referendum failed to uphold SB 2, not enough project resources remained to make significant changes to the model, as might have been desired, for example, to analyze alternative pay-or-play constructs. In particular:

- The model was built to estimate effects of approaches that reflect the 80% contribution requirement under SB 2, so it could not at present estimate the effects of alternative scenarios with different employer contribution percentages.
- The model assumes that employers with fewer than 50 workers do not change their current coverage and contribution decisions, even though SB 2 could create incentives for them to do so.[27]

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[24] The last component arises because a family still has some uncertainty about what out-of-pocket health care expenditures will be once they have chosen an insurance plan, due to uncertainty about what their health care needs will be. Risk-averse individuals will attach some value to eliminating that risk or uncertainty, and we deduct this from the net value of the plan.

[25] We recognize that non-financial considerations—such as freedom of choice of provider—may also factor into worker's plan-choice decisions. To incorporate this, we assume that the value of the health services received in an HMO are worth 90 percent of the value of the same services received in other types of plans.

[26] The possible role of HSAs is discussed theoretically in Supplement C, however.

[27] SB 2 would have required large employers to cover their workers' spouses, except where a working spouse was covered by his/her own employer. But SB 2 neither required small firms to offer coverage nor required small-firm

2.3. Financial Viability of the SHPP Pool under Alternative Scenarios

The primary focus of the simulation analysis is to determine under what scenarios—combinations of design parameters—the SHPP pool would be financially viable or sustainable. To determine this for scenarios A through D, we used the following procedure:

- We initially set the SHPP fee for single coverage under the assumption that workers entering the SHPP pool were of average risk, using the adjustment factors applicable to each scenario. The fees for two-party and family coverage were set at two and three times the fee for single coverage, respectively.
- We simulated worker/employer choices given these fee levels and then recalculated the "premium" (fee) necessary to cover the pool's expected payout based on workers in businesses that chose to participate in the pool.
- We iterated in this way until premiums for the SHPP pool changed by less than 0.5 percent—indicating a stable solution—or until the pool failed to attract at least 1 percent of employers—indicating the pool is not financially sustainable.[28]

(The pool is not financially sustainable when it is impossible to set the SHPP fee high enough to cover the expected costs of employer groups that choose to enroll in the pool at that fee. This result indicates a classic "death spiral" due to adverse selection—a disproportionate share of high-risk enrollees going into the pool.)

Using this procedure, we found that the SHPP pool would not be financially viable under Scenario A, "Flat Community Rating," or under Scenario B, "Age Rating," using either benefit level. Our analysis indicates that, in the absence of broader subsidies, the SHPP pool would only be sustainable if the group's total fee, including both the employer and employee contributions, were adjusted for health status as well as for geographic location and age of worker. Rating only on the basis of geography, or geography and age, in setting the fee would make the SHPP pool attractive to higher-than-average risks. Groups that would find the pool the more attractive option at a total fee based on the average costs of all eligible workers and dependents have expected costs (or age-adjusted expected costs) that are about 25 percent higher than this overall average. But raising the total fee would make the pool unattractive to the healthiest of these groups, thus producing a fee spiral that would ultimately lead to the collapse of the pool (as illustrated whimsically in Exhibit 4).

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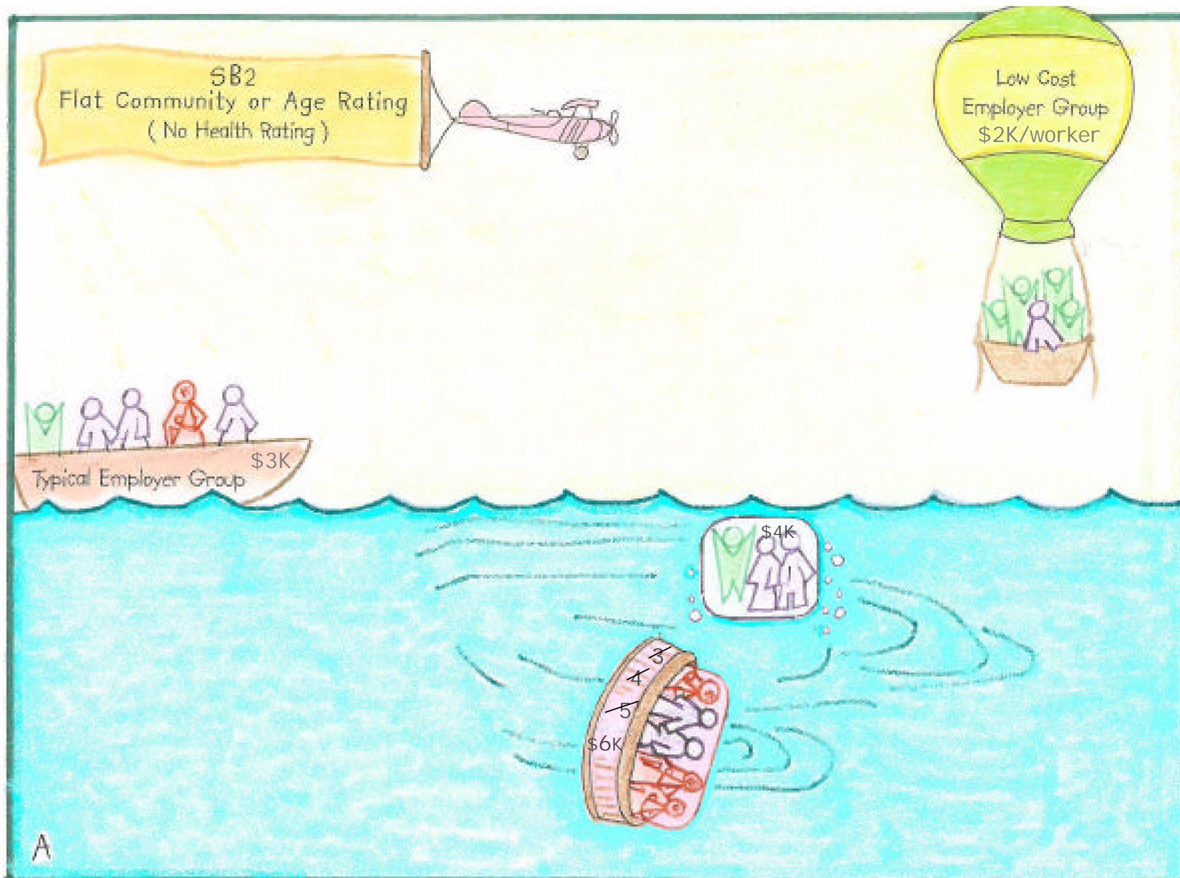
workers to participate in any coverage offered them. Thus, where small-firm workers were married to large-firm workers, there would be an incentive to find ways to shift the costs to the large employer. Unless SB 2 were changed, large employers could not adopt policies to avoid this, though many now have such policies. About 12.9 percent of workers currently covered through employers with fewer than 50 employees—about 500,000 people—have an SB 2-eligible spouse who works for a large employer. And about 9.7 percent of people currently covered as dependents through small employers have an SB 2-eligible worker in a large firm—about 250,000 people.

[28] We do not necessarily attribute a time dimension to this decision. Insurers will have better foresight about who will actually choose the plan than the simulators.

Exhibit 4: The Fate of the Pool Under Scenarios A and B Illustrated



Without health rating, the SB 2 pool would not be sustainable. Even if it was launched, it would sink into an adverse selection "Death Spiral."

<u>We did find stable solutions for Scenario C, "Health Rating," and Scenario D, "Subsidies and Healthy-Families-Type Plans for All Low-Income Workers</u>." Analyzing Scenario E, "Percent of Payroll," and Scenario F, "High-Risk Employer Pool," did not require use of the iterative procedure, because those scenarios postulate the existence of external subsidies sufficient to cover SHPP pool costs that exceed the fees it collects. The analysis of these scenarios sought instead to determine the size of the pool and of the external subsidies needed. Scenario F, in particular, is intended to illustrate how much additional funding would be required to make the SHPP pool financially viable in the absence of health rating.

Because they did not produce a financially viable SHPP pool, Scenarios A and B are not discussed further. In the following sections, we compare Scenarios C, D, E and F on a number of dimensions. The first results we present assume that, as under SB 2, medium employers electing the pool would <u>not</u> be permitted to contribute toward coverage of their workers'

dependents (the worker must pay the full dependent cost) and that the "lean" benefit package would be offered.[29] Later, we examine the effects of offering the "mainstream" benefit package.

2.4. Size of the SHPP Pool under Alternative Scenarios

The number of businesses and workers participating in the SHPP pool would vary under alternative scenarios, as summarized in Exhibit 5.

The scenario using health rating without additional subsidies or outside funding (C: "SB 2 with Health Rating") would produce a relatively small SHPP pool, covering 6.9 percent of businesses and only 2.8 percent of SB 2-eligible workers. Participating businesses would be overwhelmingly (92.5%) "medium" in size. The pool would attract 6.2 percent of businesses that previously offered coverage, and 24.0 percent of businesses that did not offer coverage.

Subsidizing coverage for low-income workers in the pool (Scenario D: "Subsidies and Healthy-Families-Type Plans for All Low-Income Workers") would make it attractive to more businesses and workers. About 26 percent of businesses would elect the SHPP pool when low-income workers received substantial premium subsidies to enroll in Healthy-Families-type plans through the pool.[30] This would be about four times as many businesses as would enroll in the absence of a subsidy program. Moreover, as intended, making the pool attractive to low-income workers would bring in a risk mix that would lead to a sustainable pool even when employer payments were adjusted for only geography and age and not health status. That is, we would not have a pool in which bad risks raised costs to the point that good risks flee the pool as unaffordable.

Setting the contributions on the basis of payroll and worker wages (Scenario E: "Percent of payroll") would also attract a greater number of businesses and workers to the SHPP pool than would the non-subsidized "SB 2 with health rating" approach (Scenario C).[31] In the "percent-of-payroll" approach, about 14 percent of businesses and 13 percent of workers would elect the pool.

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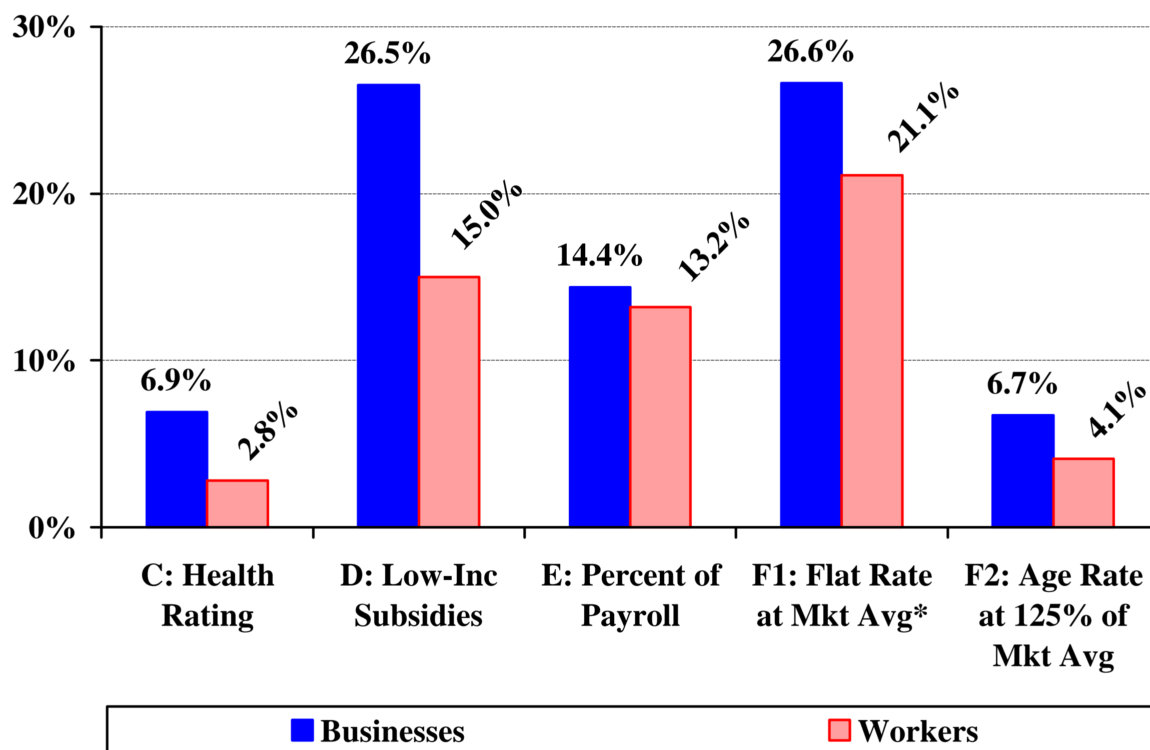
[29] We assumed that medium employers that now offer coverage directly and contribute to dependent coverage would continue to do so, at their current rates.

[30] Our results assume that 90 percent of eligible families with children in the pool would enroll in the Healthy-Families-type plans, 80 percent of childless workers (singles or couples) with incomes below 150% of poverty would do so, and 50 percent of childless workers with incomes between 150 and 200% of poverty would enroll. See Supplement I for more details.

[31] Recall that SB 2 would provide subsidies in the form of worker-contribution refunds for people who applied and were found eligible for the Medi-Cal or Healthy Families programs under current rules. The basic SB 2 design also would limit worker contributions to 5 percent of wages for workers with wages less than 200% of poverty.

Exhibit 5: Percent of Businesses and Workers Participating in the SHPP Pool under Alternative Scenarios



"Businesses" include private businesses and all governmental units—local, state, and federal. However, we treat all state government workers as employees in one business, and all federal workers as employees in one business. (Although the federal government would not be subject to SB 2's requirements, federal workers are included in our counts of workers; they would continue to be covered by FEHBP.)

* Under Scenario F1, the "mainstream" benefit package is offered. Under all other scenarios shown here, the "lean benefit package is offered.

Source: RAND SB 2 Simulation Model

Finally, if outside funds were available to cover the SHPP pool losses (Scenario F), the size of the pool would vary depending on the benefits offered and where the fee was set relative to average market-wide expected costs. The pool would remain small—6.7 percent of businesses and 4.1 percent of workers—if the pool offered lean benefits and its fee was set at 125 percent of the age-adjusted expected market-wide average cost per worker (Scenario F2). The pool would become quite large—26.6 percent of businesses and 21.1 percent of workers—if the pool offered mainstream benefits and its fee was set at 100 percent of the expected market-wide average cost per worker, without age adjustment (Scenario F1). However, the external funding required to sustain the pool in the latter case would be very large, as discussed in the next section.

2.5. "Outside" or Subsidy Funds Required under Alternative Scenarios (Other Than for Current Public Program Eligibles)

As noted earlier, the fees the SHPP imposed would be sufficient to sustain the pool under Scenario C, "SB 2 with Health Rating," but it is critical to assess whether and how much additional funding would be required under the other scenarios. Here we examine the outside or subsidy funds required under each of the alternative scenarios for workers and dependents enrolled in the SHPP pool who were not eligible for the Medi-Cal or Healthy Families programs under current law. (We discuss how SB 2 affects state Medi-Cal and Healthy Families expenditures more comprehensively in the next section. Generally, SB 2 would create savings for the state with respect to public-program eligibles.) Our analysis is summarized in Exhibit 6. Scenario C, "SB 2 with health rating," is not included here because it would not require outside funds or provide broader subsidies.)

Exhibit 6: "Outside" or Subsidy Funds Required under Alternative Scenarios (Other Than for Current Public Program Eligibles)

(dollar amounts in millions)	**Scenarios [a]→**		**F: "High-Risk Employer Pool"**	
	D: "Subsidies for All Low-Income Workers"	**E: "Percent of payroll"**	**F1: 100% of Average, No Age Adjustment, Mainstream Benefits [b]**	**F2: 125% of Average, with Age Adjustment, Lean Benefits [b]**
Cost of "Healthy-Families-type" coverage for low-income enrollees	$2,214.1	n/a	n/a	n/a
Less sliding-scale family contributions [c]	279.2	n/a	n/a	n/a
Less fees available from pool	2,381.3	n/a	n/a	n/a
Additional Funding Required [d]	**$ (446.4)**	**$1,359.8**	**$5,287.0**	**$ 38.5**

a. Scenario C, "SB 2 with Health Rating," is not included because it would not require outside funds or provide subsidies except to workers and dependents eligible for Medi-Cal or Healthy Families.

b. Our estimates for Scenarios F1 and F2 did not separately identify costs for Medi-Cal/Healthy Families eligibles. Therefore, these estimates are not strictly comparable with our estimates for Scenarios D and E. Nevertheless, they illustrate the broad order of magnitude of costs that might be expected.

c. In Scenario D, low-income workers and dependents would make contributions on a sliding scale that would be less than the regular 20 percent-of-the-fee or 5 percent-of-wages contribution required under SB 2.

d. In Scenario D, although the (employer) fees payable with respect to low-income enrollees would be more than sufficient to fund "Healthy-Families-type" coverage for all low-income enrollees in the SHPP pool, we assume that any fees in excess of the amount needed would be retained by the SHPP and would not be available for other state purposes. This is in part to prevent the SHPP fee from being considered a tax under California law. (See discussion of legal considerations in section 3.6.2, beginning on page 59.)

Source: RAND SB 2 Simulation Model

As can be seen in Exhibit 6, providing subsidies to all low-income workers and dependents who were willing to enroll in Healthy-Families-type plans through the pool (Scenario D) would require no additional funds. In fact, there would be savings because the fees that employers paid to the pool would be more than sufficient to cover the costs of Healthy-Families-type coverage for those workers. (Most of the workers' share of the fee—the part that exceeds their sliding-scale requirement—would be refunded to them in this scenario.)

This result depends critically on the assumption that Healthy-Families-type coverage for low-income adults could be obtained at premium rates equivalent to those projected under the proposed expansion of the Healthy Families program to include parents. However, we do not know the extent to which health plans could provide coverage to more adults at those rates. Where Healthy Families plans have negotiated significant discounts off providers' normal reimbursement rates, plans might not be able to convince their providers to accept low payment rates for a significantly larger population, at least if practice and facility capacities are nearly fully utilized already. However, the fact that the new plans would be open only to low-income workers and dependents, many of whom would otherwise be uninsured, should make such expansions more feasible. The terms agreed to for the planned Healthy Families expansion to parents suggest that this scenario could well be viable.

But the diversity of the health plans involved makes it even harder to assess the feasibility of these savings. Plans that operate their own delivery systems and already limit the number of Healthy Families children they are willing to cover, because they believe they incur losses on that population, probably would not be willing to accept more than a few low-income adult enrollees. Plans that use primarily public and community health centers and other "safety-net" providers might have capacity limits or, on the other hand, might simply rejoice that they could now get paid for patients they already take care of without payment. But if such plans and providers were the only Healthy-Families-type option available, fewer workers might choose to enroll in them—especially workers at the upper end of the "low-income" eligibility range.

An in-depth analysis of these important issues is beyond the scope of this project. We should also note, however, that we considered developing a scenario in which the SHPP pool would offer Healthy-Families-type plans to all participants, regardless of income. While this might be possible in some counties,[32] we concluded that, overall, it would not be realistic to assume that the SHPP pool could negotiate premiums comparable to Healthy Families capitation rates for a much larger population that would include many non-low-income people. Simply put, if any plans were able to offer such rates and enroll a large number of employer groups, they would likely already be doing so.[33]

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[32] In some counties—generally outside the major metropolitan areas of the state—some commercial plans cover Healthy Families children through their commercial networks and pay providers their commercial rates.

[33] That is, if a number of Healthy-Families-type plans could offer such rates on a large scale and be attractive to many workers and families, they would offer themselves to employers directly, i.e., not through the SHPP pool. In this event, Scenario D would no longer be self-financing, for the following reason: If in fact those plans could offer "Healthy Families" coverage outside the SHPP pool for less than the employer's share of the SHPP fee, as our analysis assumes would be the case inside the pool, then businesses could make both themselves and their workers better off by buying the non-SHPP Healthy-Families-type coverage and agreeing to pay the entire premium. In this event, the SHPP pool would attract essentially no enrollment unless it dropped the non-Healthy-Families "lean" plan and based its fee on the Healthy-Families-type plans. And, if the SHPP fee were so reduced, there would be no

Scenario E, the percent-of-payroll approach, would require over $1.3 billion in additional funding beyond employer and worker fees. (By way of comparison, in 2003-2004, California spent $9.9 billion from its general fund on Medi-Cal.) As noted earlier, outside funding would be required under this scenario because essentially every SHPP-participating employer group would pay less than the expected cost of their coverage. Any employer whose expected cost of coverage was less than their payroll-based fee would be able to obtain less expensive coverage in the traditional insurance market, or by self-insuring.

Scenario F was specifically designed to maintain SHPP pool fees at any desired level by using other funds to cover losses the pool incurred at that fee level. The two key questions are: how much additional funding would be required, and where would it come from? Subscenarios F1 and F2 illustrate the possible range of additional funding required.

Under Subscenario F1, "mainstream" benefits would be provided at a community-rated fee equal to the market-wide average cost for workers in the SB 2 universe. This appears to be the kind of pool some key SB 2 supporters envisioned. It would require $5.3 billion in funding beyond the fees paid by SHPP participants. If this amount were raised by assessing <u>all</u> employers subject to the SB 2 mandate (whether or not they participated in the SHPP pool), the charge would be $598 per worker per year, or about $50 per worker per month.[34]

Under Subscenario F2, "lean" benefits would be provided at an age-rated fee equal to 125 percent of the market-wide average cost for workers in the SB 2 universe. This approach would be similar to a traditional "high-risk pool" for individuals that seeks to limit how much more than average cost a "high-risk" individual can be charged. (MRMIB operates such a pool.) It would require only $38.5 million in funding beyond the fees paid by SHPP participants. If this amount were raised by assessing all employers subject to the SB 2 mandate (whether or not they participated in the SHPP pool), the charge would be less than $5 per worker per year. The pool would be small and the amount of outside funding required would be very low because employer groups with 50 or more workers incorporate people with a range of health care costs and are therefore much less likely than individuals or very small employers are to have costs that deviate very far from average.

2.6. Public Program Spending Estimates and State Budget Implications

Although under SB 2 the SHPP pool was intended to be self-supporting and "off budget," SB 2 nevertheless would have important implications for the state's budget because many working families eligible for the Medi-Cal (Medicaid) or Healthy Families (SCHIP) programs would be affected by the SB 2 coverage mandate. In general, having employer coverage available to these families would reduce state spending; but in some cases larger enrollment could increase spending. In this section, we discuss the reasons for varying cost implications and estimate the potential impact on the state's budget.

"excess" employer contributions to provide the premium subsidies for low-income workers. External funds would be needed.

[34] Because this charge could not be imposed on the federal government, federal workers were excluded in making this per-worker calculation.

2.6.1. Interaction With Public Coverage

SB 2 specified that workers or dependents who applied and were found eligible for the Medi-Cal or Healthy Families programs would receive prompt refunds of their contributions toward either SHPP-pool or direct employer coverage, less any premium payments required under the applicable public program. Beyond these "premium assistance" payments, the treatment of Medi-Cal and Healthy Families enrollees would differ, depending on whether their employer provided coverage directly or paid the SHPP pool fee.

Medi-Cal and Healthy Families eligibles[35] whose employers chose to pay the SHPP fee were to be enrolled directly in those programs rather than in the coverage provided through the SHPP pool. So they would receive full public coverage, and their share of the SHPP fee would be refunded to them. In addition, SB 2 directed the SHPP pool to pay the state's share of the cost of providing coverage to enrollees eligible under these federally matched programs.

Thus, for SB 2-covered workers and dependents already enrolled in Medi-Cal or Healthy Families whose employers chose to pay the SHPP fee, the state would save money, because it would not have to use general revenue for this purpose. (We assume for the moment that the federal government would allow this use of SHPP fees, although that is not a certainty.[36]) Even if more people with SHPP-fee-paying employers chose to apply for Medi-Cal and Healthy Families (and we assume most would, in order to get reimbursed for their share of the SHPP fee), the state would not have to appropriate additional funds out of general revenue.[37]

Medi-Cal and Healthy Families eligibles whose employers chose to provide coverage directly would be required to enroll in their employer's plan, unless doing so would not be "cost-effective" for the state (as defined shortly). The state would then pay the worker's premium cost to enroll in the employer's plan and would also provide a "wraparound" benefit that would cover any gap between the employer-based coverage and the benefits provided by Medi-Cal or Healthy Families (as applicable), such as copayments that exceed those permitted under those programs.

In this situation, the state's payments for premium assistance and wraparound benefits would be direct public program expenditures, and the state's share of their cost would have to be appropriated from revenues available to the state, <u>not</u> from SHPP pool fees. The "cost-effectiveness" requirement means that the expected cost of providing premium assistance plus wraparound coverage must be less than the expected cost of direct enrollment in public coverage. If it was not, premium assistance would <u>not</u> be provided, and the worker or dependent would

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[35] SB 2 made clear that the decision to apply for Medi-Cal or Healthy Families would be entirely optional for each individual or family. To save space, however, we will use the shorthand term "eligibles" in place of the lengthier "those who choose to applied and were found eligible."

[36] See discussion in section 2.6.2 on page 27 and note 42.

[37] SB 2 said simply that MRMIB "shall provide the state share of financial participation for the cost of Medi-Cal [and Healthy Families] coverage provided through the program." The payment would not be limited to the employer's share of the SHPP fee, but the worker's share would not be available, since it would be refunded to the worker. And, since the state's share of Medi-Cal is 50 percent and of Healthy Families is 35 percent, it seems highly likely that the employer's share of the fee would be more than sufficient to cover the state's share of the cost of public coverage.

simply be enrolled in the public program.[38] Therefore, the state should spend less whenever it provided premium assistance than it would spend on direct public coverage.

For current Medi-Cal or Healthy Families recipients who became enrolled in employer coverage due to SB 2, the state would thus save money. But these savings would be offset by new costs for workers who previously did not enroll themselves or their dependents in Medi-Cal or Healthy Families but now would decide to apply in order to obtain a premium-contribution refund, as they would be entitled to under SB 2. (Pre-SB 2, premium assistance is not available under Healthy Families, and is available only in very limited circumstances under Medi-Cal.)

This same interaction with existing public coverage programs is assumed in every scenario included in this report. In addition, as described earlier, Scenario D would provide premium-assistance-type subsidies to low-income workers and dependents who were not eligible for Medi-Cal or Healthy Families, and Scenarios E and F would require outside funding that would not be directed to specific individuals. Our estimates for the additional expenditures associated with these additional subsidies, however, are presented in Exhibit 6 on page 23 and are not repeated or included here. Here we present estimates under Scenarios C, D and E of the likely state-budget impact of changes in state spending on Medi-Cal and Healthy Families enrollees in the SB 2 universe. These cost estimates include expected spending on premium assistance and wraparound coverage for people with direct employer coverage and on direct public coverage where premium assistance is not cost-effective. But they do not include any offset for the administrative costs of operating a premium assistance system. Such costs could vary greatly, depending on the approach taken to implementing the program.

2.6.2. Changes in State Medi-Cal and Healthy Families Spending under Alternative Scenarios

Under all three scenarios, the number of Medi-Cal/Healthy-Families-participating families in the SB 2 universe would grow by an estimated 55 or 56 percent, from 540,000 pre-SB 2 to between 836,000 and 842,000 (not shown).[39] Despite this significant increase in enrollment, we estimate (see Exhibit 7) that total program spending for these workers and dependents would be lower under Scenario C, "SB 2 with Health Rating" ($1,009.3 million) than under current law (about $1.406.3 million).

The reduction would occur because, outside the SHPP pool, we estimate that paying premium subsidies plus wraparound costs would range from about 55 percent to about 70 percent less expensive, per capita, than enrolling people directly in Medi-Cal or Healthy Families, and

[38] SB 2 did not address the potential dilemma raised by the cost-effectiveness requirement—the state could refuse to pay premium assistance, but under SB 2 the worker could not refuse to pay their share of the premium for the employer's plan. Presumably, its drafters expected that premium assistance would always be cost-effective given that SB 2 limited the worker's share to 20 percent of the premium or, for most people eligible for Medi-Cal or Healthy Families, 5 percent of wages. But SB 2 did not require medium employers to contribute anything toward coverage of dependents and, as we noted earlier, only required employers to offer one plan that met its requirements.

[39] We assumed that all current Medi-Cal/Healthy Families enrollees would remain enrolled and that 90 percent of those eligible but not enrolled pre-SB 2 would now choose to enroll.

Exhibit 7: Changes in State Medi-Cal and Healthy Families Spending in 2003 under Alternative Scenarios (excluding administrative costs of premium assistance)

Scenarios→ (dollar amounts in millions)	**C: "SB2 with Health Rating"**	**D: "Subsidies for All Low-Income Workers"** [a]	**E: "Percent of payroll"**
Current (pre-SB2) Medi-Cal/Healthy Families spending on workers and dependents in the SB2 universe	**$1,406.3**	**$1,406.3**	**$1,406.3**
State share of current spending	664.6	664.6	664.6
Post-SB 2 Medi-Cal/Healthy Families Spending: Premium assistance payments (outside SHPP pool only [b])	447.4	441.7	423.3
Cost of wraparound coverage (outside SHPP pool only)	317.3	240.8	242.6
Medi-Cal/Healthy Families costs for direct enrollment [c]	306.9	839.9	799.3
(Less) applicable family contributions	(62.3)	(84.3)	(60.6)
Post-SB 2 Medi-Cal/Healthy Families Spending Total	**1,009.3**	**1,438.1**	**1,404.6**
State share of New Spending (preliminary)	467.5	685.7	664.3
Preliminary State Budget Cost (Savings)	**$ (197.1)**	**$ 21.1**	**$ (0.3)**
(Less) payments from SHPP pool	(30.1)[d]	(276.6)	(255.3)
Post-SB 2 State Budget Cost (Savings)	**$ (227.2)**	**$ (255.5)**	**$ (255.6)**
Memo: "Excess" SHPP employer fees [e]	n/a	577.1	389.7

a. This analysis of Scenario D focuses only on public costs for people who qualify for Medi-Cal and Healthy Families under current (pre-SB 2) eligibility rules. As discussed earlier, the subsidies for other low-income workers and dependents in the SHPP pool (essentially, partial refunds of their contributions) could be financed entirely within the pool, if our assumptions about relative premium levels (between "Healthy-Families-type" plans and "lean" commercial coverage) are correct. (See discussion in section 2.5 beginning on page 23.)

b. In the SHPP pool, worker-contribution refunds would be paid from pool funds and, therefore, would be not considered public (i.e., on-budget) spending.

c. Medi-Cal/Healthy Families costs for direct enrollment include both costs for eligible workers and dependents in the SHPP pool, who would be enrolled directly in Medi-Cal or Healthy Families, as applicable, and for eligible workers and dependents with direct employer coverage that is found to be not cost-effective for premium assistance.

d. The simulation model did not produce a figure for employer SHPP fees under Scenarios C. To illustrate the likely impact, we assume (conservatively) that the amount would be at least as large as the "state share" of public program costs for Medi-Cal eligibles enrolling through the SHPP pool. Because the pool has very few large employers under Scenario C, we assume (again conservatively) that no employer SHPP fees would be available toward coverage of children under Healthy Families.

e. "'Excess' SHPP employer fees" represent the portion of SHPP employer fees received by the pool on behalf of Medi-Cal and Healthy Families eligibles that would not be needed to reimburse those programs for covering those eligibles and would, therefore, be retained by the pool.

Source: RAND SB 2 Simulation Model

because under Scenario C the vast majority of Medi-Cal and Healthy-Families eligibles work for businesses that would provide coverage directly, not through the SHPP pool.[40]

Under Scenario E, "Percent of Payroll," total spending on Medi-Cal and Healthy Families eligibles in the SB2 universe would be essentially unchanged at $1,404.6 million, and under Scenario D, it would increase only slightly—by about 2 percent—to $1,438.1 million. Here the savings due to premium assistance would entirely, or almost entirely, offset any cost increase due to greater enrollment in these public programs.

If the federal government agreed that SHPP fee revenues could be considered "state funds" for this purpose, then regular state budget costs would be as shown in the next-to-last line of Exhibit 7 [labeled "Post-SB 2 State Budget Cost (Savings)"]. State savings would be quite significant, exceeding $200 million per year under all three scenarios. In effect, funding of coverage for Medi-Cal and Healthy Families recipients eligible for employer coverage under SB 2 would be partially shifted from the public to the employers of low-income workers.

In addition, because the SHPP fees available from the employers of Medi-Cal and Healthy Families eligibles would greatly exceed the state share of public program costs for these families under Scenarios D and E, the SHPP pool would retain significant funds that could be used to reduce pool fees across the board, or stabilize fees over time, or for similar purposes.[41] (See the last line of Exhibit 7.)

Whether the federal government would accept the argument that SHPP fees are "state revenues" rather than "premium payments" is uncertain.[42] If it did not, then employer SHPP fees could be applied to reduce total public program outlays before federal and state shares were calculated. Under Scenarios D ("Low-Income Subsidies") and E ("Percent of Payroll"), this alternative approach would achieve the same state public program savings as under the approach specified in SB 2. The same state budget savings would result because, in these scenarios, employer SHPP fees paid on behalf of Medi-Cal and Healthy Families eligibles would be sufficient to offset the <u>entire</u> cost of covering them through the public programs.[43] The difference between the two approaches is that, under the second alternative, the SHPP pool would transfer a larger

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[40] Under Scenario C, the SHPP pool would be very small, and only about 4 percent of SB 2-covered Medi-Cal and Healthy Families eligibles would be in it. Inside the pool, there would be no change in total public program spending, because Medi-Cal and Healthy Families eligibles would be enrolled directly in those programs. But the financing arrangements would change.

[41] The simulation model did not produce a figure for employer SHPP fees under Scenario C1 or C2.

[42] Federal policy interpretations to date have held that employer and employee premium contributions must be treated as reducing total public (state plus federal) outlays for health coverage; they cannot be counted toward the state share of total outlays. However, these interpretations have been made with respect to voluntary premium contributions by some employers, rather than fee contributions required across a broad range of employers. To allow SHPP fees to be used as "state match," the state would presumably assert that under SB 2 SHPP fees were not premiums and would note that Medi-Cal and Healthy Families eligibles who enter through the SHPP pool were not receiving employer coverage and that the employer would pay the same fee whether their workers were enrolled in public coverage or SHPP coverage. Whether the federal Centers for Medicare and Medicaid Services would accept this position is uncertain, especially given the pains SB 2's drafters took to assure that SHPP fees would not be considered "taxes" under state law.

[43] Although formal estimates were not made, it seems likely that this would not be true under Scenario C, particularly for the Healthy Families program.

amount to the state programs and, therefore, a smaller amount would be left over that the pool could use for other purposes (e.g., for fee stabilization or reduction).[44]

2.6.3. Net Cost (Savings) to the State

In the interest of clarity, we have discussed separately the impact of alternative SB 2 scenarios on state Medi-Cal/Healthy Families costs and the other funding (if any) needed to sustain the pool under each scenario. Here we combine the two estimates to summarize each scenario's net cost to the state's budget. We do not assume that federal matching funds would be available for any populations other than people who meet current Medi-Cal or Healthy Families eligibility standards. (Scenario D's subsidies for other low-income workers would be paid from SHPP fee revenues.) Our estimates are summarized in Exhibit 8.

Exhibit 8: Net Effect of Alternative SB 2 Scenarios on Non-SHPP State Spending

(dollar amounts in millions) **Scenarios ↓**	**Effect on State Share of Medi-Cal/ Healthy Families** [from Exhibit 7]	**Additional Funds Needed** [from Exhibit 6]	**Net Effect on Non-SHPP State Spending**
C: "SB 2 with Health Rating"	**$227.2 Savings**	**No additional subsidies or "outside" funds.**	**$227.2 Savings**
D: "Subsidies and Healthy-Families-Type Plans for All Low-Income Workers"	**$255.5 Savings**	**SHPP fees would be more than sufficient to fund additional subsidies within pool.**[a]	**$255.5 Savings**
E: "Percent of payroll"	**$255.6 Savings**	**$ 1,359.8**	**$1,104.2 Cost**
F: "High-Risk Employer Pool" … **F1: 100% of Average, No Age Adjustment, Mainstream Benefits**	**Not calculated.**	**$ 5,287.0**	**Probable Cost of $5,000 or more.**
F2: 125% of Average, with Age Adjustment, Lean Benefits	**Not calculated. Small pool size suggests savings similar to Scenario C.**	**$ 38.5**	**Savings of $180+ possible**

a. In Scenario D, although the (employer) fees payable with respect to low-income enrollees would be more than sufficient to fund "Healthy-Families-type" coverage for all low-income enrollees in the SHPP pool, we assume that any fees in excess of the amount needed would be retained by the SHPP and would not be available for other state purposes. This is in part to prevent the SHPP fee from being considered a tax under California law. (See discussion of legal considerations in section 3.6.2, beginning on page 59.)

Source: RAND SB 2 Simulation Model

[44] We estimate that, under Scenario D, the pool would retain $259.9 million rather than the $577.1 million shown in Exhibit 7 and that, under Scenario E, it would retain $134.4 million rather than $389.7 million.

2.7. Key Conclusions for Pool Structure from the Quantitative Analysis

The scenarios we analyzed did not include many other conceivable policy designs. Nevertheless, we believe our analysis effectively identified the key design elements likely to affect the financial viability of the SHPP pool. Our key findings are:

a. The pool would suffer adverse selection and could not be self-sustaining if it used either flat community rating [Scenario A] or age rating [Scenario B].

b. Even in the absence of additional subsidies, however, the SHPP pool would be stable and self-supporting if it used the health status of each employer's workers in addition to workers' age and geographic location in establishing the fee for that employer group. [Scenario C] (But health rating could compromise the viability of the pool in other ways that we discuss in section 3.4.2 on page 48.)

c. If substantial subsidies were provided toward the worker's share of the fee for <u>all</u> low-income workers and dependents (under 200% FPL) who enrolled in the SHPP pool, and <u>not</u> for people who had direct employer coverage (unless they were otherwise eligible for Medi-Cal or Healthy Families), then the SHPP pool would remain stable and self-supporting without the need for health rating, as illustrated in Exhibit 9. (Fees would be adjusted for each group's geographic location and average worker age.) [Scenario D]

- Further, if Healthy-Families-type coverage could be purchased for low-income adults at rates (relative to the commercial market) proportionate to those Healthy Families currently negotiates for children, and if the SHPP fee were based on the "lean" benefit package made available to non-low-income pool enrollees, then the cost of subsidies for low-income workers and dependents could be financed within the SHPP pool, without additional funds. [Scenario D]
- Note that this scenario would also subsidize coverage for low-income children in the pool who could not qualify for regular Healthy Families coverage because they were not uninsured. Thus, it would mitigate an inequity that would otherwise persist under SB 2.

d. Setting the pool fee as a percentage of payroll would be another way to make the pool attractive to low-income groups that would bring to the pool a number of lower risk workers. But our analysis shows that, if the SHPP fee were based on a graduated percent of payroll, the pool could not be self-financing. Even if a significant percentage of payroll (12.5% to 17.5%) was contributed for single coverage, the outside subsidies required would be substantial—in excess of $1 billion. [Scenario E]

e. Some key SB 2 supporters appear to have envisioned a pool that would provide "mainstream" benefits at a community-rated fee equal to the market-wide average cost for workers in the SB 2 universe. Our analysis shows that this approach would require $5 billion or more in funding beyond the fees paid by SHPP participants, or almost $600 per SB 2-covered worker per year. [Scenario F1]

Exhibit 9: The Pool with Subsidies and Healthy-Families-Type Plans for All Low-Income Workers (Scenario D)

The pool could survive without health rating <u>if</u> it offered subsidies and Healthy-Families-like plans for low-income workers (at no state cost <u>if</u> adult rates proportional to Healthy Families kids rates can be obtained)

f. If neither health rating nor $5 million in subsidies were acceptable, the SHPP fee could be held at 125 percent of age-adjusted average cost for the "lean" benefit package across the SB 2 universe with only a modest external subsidy of less than $40 million. These external funds could come from a number of possible sources. If they were raised by imposing a per-worker "fee" on all employers subject to SB 2, whether or not they participated in the SHPP pool, the fee would total less than $5 per worker per year. [Scenario F2]

2.8. Additional Comparisons of Alternative Scenarios from the Quantitative Simulation

2.8.1. SHPP Pool Composition and Characteristics under Alternative Scenarios

Supplement A presents additional results of the simulation analyses, which highlight how the composition of the SHPP pool would differ under the alternative scenarios. (Scenario F is not included in these more detailed analyses.) Among the findings are:

- Scenario C, "SB 2 with Health Rating" would attract businesses with the youngest, least expensive workers. Scenario E, "Percent of Payroll," would attract the oldest and most expensive. (See Figures A-31 and A-32 in Supplement A.)
- The average annual employer contribution per worker would range from $2,445 under Scenario C to $3,064 (in 2003 dollars) under Scenario D, "Low-Income Subsidies." (See Figure A-25 in Supplement A.)[45]
- The SHPP pool would be most likely to attract low-wage businesses and low-income workers under Scenario E, "Percent of Payroll." (See Figures A-28, A-29 and A-30 in Supplement A.)
- Businesses that already offer insurance would be most likely to switch to the SHPP pool under Scenario D, "Low-Income Subsidies" (under which 26.3% of such businesses would choose SHPP) and least likely under Scenario C, "SB 2 with Health Rating" (under which 6.2% would choose it). (See Figure A-26 in Supplement A.)
- Although large employers would be a distinct minority of SHPP participants under all scenarios, their share of total employer participation in the pool would be greatest under Scenario E, "Percent of Payroll" (21.7%). (See Figure A-27 in Supplement A.)

2.8.2. Different Benefit Levels under Scenario C, "SB 2 with Health Rating"

The analyses presented thus far have assumed that the pool would offer the "lean" benefit package described earlier. In this section, we examine differences in the composition of the SHPP pool under different choices about the level of benefits offered. These differences are examined only in the context of Scenario C, "SB 2 with Health Rating," which is the only SB 2-compliant scenario under which the pool would be financially viable.[46]

We note, first, that the SHPP pool would be financially viable when health rating was used, regardless of the level of benefits offered. (Without health rating, the pool would not be self-supporting using either level of benefits.)

In the context of health rating (Scenario C), our simulations indicate that offering a "mainstream" benefit package rather than a "lean" one would not have a significant effect on the number of businesses or people selecting the pool. (See Exhibit 10.)

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[45] Note that this figure <u>includes</u> large-employer contributions made toward coverage of dependents.

[46] Scenario F1, presented earlier, is based on the "mainstream" level of benefits, but only limited analyses were conducted on that scenario, due to its very high cost.

Exhibit 10: Number of Businesses and Workers Participating in the SHPP Pool under Alternative Benefit Levels (in Scenario C, "SB 2 with Health Rating")

	Subscenario→	**C1**	**C2**
SB 2 Universe [000s]	**Benefit Level→**	**Lean**	**Mainstream**
34.7	**Businesses** [000s] [a]	**2.4**	**2.5**
9,071.0	**Workers** [000s] [a]	**254.9**	**258.1**
8,657.7	**Dependents** [000s] [b]	**211.7**	**219.0**
17,728.7	**Workers + Dependents**	**466.6**	**477.1**

a. "Businesses" include private businesses and all governmental units—local, state, and federal. However, we treat all state government workers as employees in one business, and all federal workers as employees in one business. (Although the federal government would not be subject to the requirements of SB 2, federal workers are generally included in our counts of workers; they continue to be covered by FEHBP, outside the SHPP pool.)

b. "Dependents" include all dependents of SB 2-eligible workers in businesses of 200 or more workers, and dependents of workers in businesses of 50-199 who are currently covered by the worker's group policy. These latter dependents would be not SB 2-eligible, but they are included in our simulation analyses because we assume that the worker continues to cover them irrespective of the employer's choice to offer coverage or elect the pool.

Source: RAND SB 2 Simulation Model

Supplement A provides additional detailed results describing how the composition of the SHPP pool would differ under different choices about the level of benefits offered (the "subscenarios" of Scenario C). Worth noting here are the following:

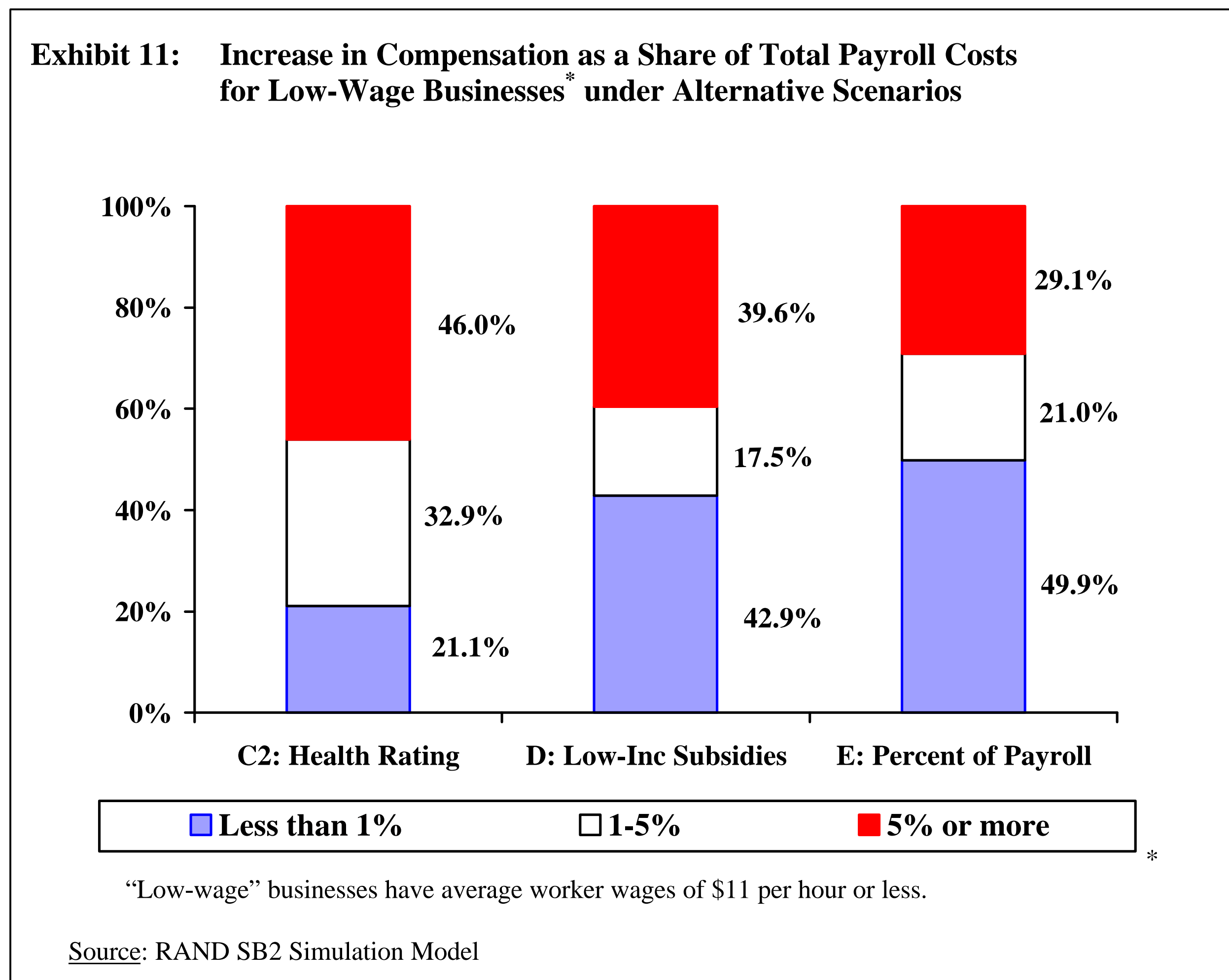
- Offering "mainstream" rather than "lean" benefits would increase the average annual employer contribution per worker (in the SHPP pool) by about one-third (from $2,445 to $3,243). (See Figure A-17 in Supplement A.)
- When it offered "lean" benefits, the pool would attract relatively more businesses that did not previously offer coverage.[47] (See Figure A-18 in Supplement A.)
- Average worker age and average worker risk for businesses in the SHPP pool would vary only slightly across the two benefit levels within Scenario C, under which the pool would use both age- and health-rating in determining its fees. Both measures are substantially (10% - 14%) lower for the pool than the average across all workers in the SB 2 universe. (See Figures A-21 and A-22 in Supplement A.)

[47] Workers in non-offering businesses presumably are more likely than other workers to prefer cash wages to compensation in the form of insurance. (Perhaps more of them are young and childless.) Hence, if required to take some part of compensation in insurance, they may be more likely to prefer a low-cost lean plan over a more generous plan.

2.8.3. Cost Burden of SB 2 Under Alternative Scenarios

The increase in worker compensation stemming from the increase in employer insurance contributions would fall most heavily on low-wage businesses—defined here as businesses paying average wages of less than $11 per hour.[48] Exhibit 11 shows the expected distribution of increased cost from required employer contributions, relative to current total payroll costs, for low-wage businesses under three alternative scenarios. (Note that some of the businesses shown in the "less than 1%" category would experience a cost reduction, rather than an increase.[49])

Exhibit 11: Increase in Compensation as a Share of Total Payroll Costs for Low-Wage Businesses* under Alternative Scenarios



* "Low-wage" businesses have average worker wages of $11 per hour or less.

Source: RAND SB2 Simulation Model

Under Scenario C, "SB2 with Health Rating," the required increase in employer contributions would be equivalent to 5 percent or more of total payroll costs for almost half (46%) of the low-wage businesses subject to SB2. (Only about 25 percent of all businesses would experience

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[48] Because minimum-wage requirements would constrain low-wage businesses from directly reducing wage rates, these businesses would be the ones most likely to seek to reduce their burden by reducing their workforce, increasing part-time employment, or increasing overtime.

[49] In some cases, this reduction might be due in part to a shifting of coverage source for spouses in two-worker families.

a 5-percent-or-more increase under this scenario. See Figure A-10 in Supplement A.) The other two scenarios, both of which would involve subsidies, would reduce the additional burden on low-wage businesses relative to the basic "pay-or-play" mandate.

Under Scenarios D and E, substantially more low-wage businesses would choose the pool, where the subsidies would be available. Under Scenario E, "Percent of Payroll," about 62 percent of low-wage businesses would opt for the SHPP pool, where their total contribution for insurance would be limited by the pool contribution design.[50] As a result, this scenario would impose the smallest new-cost burden on low-wage businesses.

Scenario D, "Low-Income Subsidies" would not directly subsidize the employer contribution but would offer low-income workers the opportunity to enroll in Healthy-Families-type plans and would subsidize the workers' share of the fee for those who did so. Thus, many low-income workers would likely prefer pool coverage to direct employer coverage. But low-wage businesses could also benefit in two ways if they chose to participate in the SHPP pool. First, the availability of comprehensive, low-cost-sharing coverage for low-income workers—at no additional employer cost—under this scenario might make it more feasible for low-wage businesses to accept the pool's lean benefit package for their non-subsidized workers. And that lean package might be less costly than the package of benefits currently offered by employers who offer. Second, under this scenario the employer contribution would be adjusted for geography and age, but not for health status. Participating in the pool would thus permit some higher risk employer groups to avoid health or experience rating and therefore, potentially, pay less than in the outside market.[51]

3. Other Key Design Considerations

3.1. Market Role and SHPP Pool's Ability To Exert Purchasing Power and To Use Various Cost Containment Strategies

Some SB 2 supporters desire and expect the SHPP pool to play a major role in shaping the health insurance market in California. They expect the pool to be large enough to command favorable rates from health plans and, by providing a desirable alternative, to force improvements in the outside market as well. Other stakeholders (typically not sponsors) see the SHPP pool as a sort of residual mechanism for insuring employees "left over" after most employers—including nearly all who currently offer health insurance—decide to "play" rather than "pay" into the pool.

In general, a purchasing pool cannot use "market clout" to negotiate lower prices or other concessions from health plans unless the pool is large, and no pool can become large unless there

[50] Because Scenario E would require employers in the pool to contribute at least 10 percent of payroll, the high percentage of employers with increased costs of less than 5 percent of total payroll costs may seem strange. Recall, however, that the SHPP pool would cover less than 15 percent of businesses under this scenario and that the vast majority of businesses subject to SB 2 already offer coverage. Even the pool would be comprised mostly of employers that previously offered coverage directly. For these employers, the additional cost would be much less than the pool's required employer contribution.

[51] The fact that the pool would be viable under this scenario means that, overall, the low-income subsidies would allow the pool to attract enough lower risk groups to offset the additional costs of any higher risk groups.

is some compelling reason for people to obtain and retain health insurance through the pool rather than directly from health plans. Voluntary pools are not automatically large groups.

Strong group "cohesion" is also important for gaining and maintaining "market clout." "Cohesion" is the force that makes members of a group tend to remain members of that group. Employer-offered health plans have strong cohesion and, therefore, stability because few employees are willing to forego the employer's contribution toward health insurance and buy coverage independently. Thus, insurers know that, if they want to enroll members of an employer group, they need to contract with the employer; they cannot try to sell coverage to each of the workers individually.

Similarly, when government programs like Healthy Families offer coverage by contracting with health plans, they present a large group that the health plans cannot reach outside these programs, because recipients cannot use their large public subsidy to buy coverage elsewhere.

On the other hand, a purchasing pool, such as the SHPP pool established by SB 2, would be made up of many individual employers; and those employers would be free to buy coverage either through the pool or directly from a health plan.[52] Further, they can change their decision at any time.[53] They go where they can get the best deal. Thus, the pool would not be an inherently strong, cohesive group. Health plans would know this and would have strong incentives to exploit it.

To be in a strong negotiating position with health plans, a pool has to be able to offer them a large and cohesive population—that is, a population they cannot access in any other way.

As discussed earlier (in section 2.3 beginning on page 19), if it must survive only on the fees it charges to participating businesses, the SHPP pool will be forced to use health rating to avoid an adverse-selection-induced death spiral. Under this scenario (C: "SB 2 with Health Rating), we estimate that the SHPP pool would remain small relative to the total SB 2 universe. It would cover about 470,000 total lives—about 2.6 percent of SB 2-eligible workers and dependents. As such, it would be less than half the size of CalPERS (about 1,200,000 lives), not as large as the Healthy Families Program (about 700,000 lives), about the same size as the Pacific Business Group on Health's purchasing alliance (about 400,000 lives), and about three times the size of the PBGH's PacAdvantage small-employer pool (about 150,000 lives).

More to the point, under this scenario the SHPP pool's "participating" employers would readily go elsewhere if they could obtain less expensive coverage by doing so. In this, it would be similar to PacAdvantage, which is not able to obtain or offer lower prices than the health plans offer small employers directly. (PacAdvantage actually has some degree of cohesion because it

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[52] We recognize that, in the SB 2 paradigm, employers choosing to pay the SHPP fee would not actually be "buying coverage." But, since the employer would decide whether to offer coverage directly or send its workers to the SHPP pool, the same dynamic is at work.

[53] A priori, one might expect that employers would be limited to an annual choice. Under SB 2, however, employers that provided coverage directly would qualify for a credit against the fee they would otherwise owe for SHPP coverage. We see nothing in the statutory language that would preclude employers from deciding at any time to begin offering direct coverage. As a practical matter, the limiting factor would likely be how often the SHPP fee was collected.

gives small employers an administratively easy way to offer workers a choice of competing plans—something that is very difficult for a small employer to do on its own.[54] But the large employers in the SB 2 universe can, and many do, offer and administer a choice of health plans on their own. They do not need a pool to do it for them.) Further, research indicates that small-employer choice pools generally did not realize savings relative to the outside market.[55]

Because SB 2 would not permit the SHPP to self-insure—unlike CalPERS, for example—it could only purchase coverage through health plans or insurers. And health plans would be unlikely to offer the pool better rates than they offer to employers directly. Because the health plans presumably would not control the health underwriting and rating process, they would likely see the pool as an unknown population, initially presenting a high risk of adverse selection. In addition, most health plans have little desire to shift private employer contracts to a government pool, or to help create a very large purchaser with more bargaining clout out of separate employer groups. In general, they can better control the risk profile of their own enrollment and related premiums, avoid losses and position themselves to realize higher margins by dealing directly with employers, particularly if the health plan is already well-established in the employer market. Further, health plan officials indicate they are particularly worried about a state government pool becoming very large. They point to current state budget circumstances and Medi-Cal cutbacks and express fear that if the pool was large and "caught cold, it could give a health plan a fatal case of pneumonia."[56] Therefore, health plans could not be expected to cooperate voluntarily in helping the SHPP pool become large.

Under Scenarios D and E (described in section 2.2.3 beginning on page 14), significant subsidies would be available for low-income (Scenario D) or low-wage (Scenario E) workers only through the SHPP pool, and not in the outside market. Making these subsidies available only through the pool is intended to help the pool attract enough low-risk workers to make the pool financially stable even without health adjustments to the fee. The subsidies would also give the pool greater cohesion and, therefore, greater leverage in negotiating with health plans. Under both of these scenarios, the RAND simulation model predicts a SHPP pool considerably larger than CalPERS, covering about 2.7 million workers and dependents under Scenario D and about 2.4 million under Scenario E. In this situation, the pool could employ the kinds of negotiating and contracting strategies used by very large groups such as General Motors, CalPERS, and the large-employer purchasing alliance at the Pacific Business Group on Health. Supplement C to this report, "Cost Management Strategies and Examples for the Pool," profiles the purchasing approaches used by these and other large purchasers. It is also worth noting that MRMIB itself has obtained remarkably good value from health plans participating in Healthy Families, as reflected in our estimate for Scenario D and discussed in more detail in Supplement C.

In the absence of such additional subsidies, the competitive dynamics of the health insurance market would force the SHPP pool to use health rating in order to survive. State insurance

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[54] CalChoice is a competing choice pool for small employers that somewhat diminishes this source of cohesion for PacAdvantage.

[55] Stephen H. Long and M. Susan Marquis, "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs* 20:1 (January/February 2001).

[56] Approximate quote from a health plan representative participating in an expert roundtable convened by the project team in Sacramento, CA, on December 20, 2004.

rules—after being expanded by SB 2 to include the medium-employer market—would allow carriers to vary medium-employer-group rates by ±15 percent from their standard rate due to health status, claims experience, or any other group characteristic not specifically permitted by the rules. (The standard rates would be based on allowable group characteristics such as worker age.) In the 51-to-199-employee market, this degree of permissible variation should be sufficient to encompass most of the expected difference in cost between groups. And insurers face no rating restrictions with respect to large employers. (Any regulatory limits would be futile in any event, since large employers could avoid them by self-insuring their health benefits.)

In this environment, if the SHPP pool were to establish fees that did not take health risk into account, insurers would offer more favorable rates to the healthier groups, leaving the SHPP pool with the less healthy, more expensive groups (other factors, such as worker age, being equal). As a result, the RAND simulation shows that, without health rating, it would not be possible to set a fee that would make the SHPP pool self-sustaining.

3.2. Offering Worker Choice of Health Plans

Two type of choice are of interest: choice of benefit level and choice of health plan in the sense of competing carriers or provider networks. There is no research basis for quantifying the effects on employer "pay-or-play" decisions of whether the pool offers a choice of competing health plans. Neither type of choice was included in the quantitative analysis, so we deal with the issue qualitatively here. We discuss choice of competing health plans first.

3.2.1. Choice of Competing Health Plans

Most sponsors/stakeholders assume that the SHPP pool would offer workers a choice of competing health plans. This assumption is based in part on MRMIB's experience in operating programs with individual choice of plan, including the Health Insurance Plan of California (HIPC, now PacAdvantage) for small employers and the Healthy Families program for children.

Negotiating reasonable premium levels for the SHPP pool with at least two plans—at least in the metropolitan areas of the state—seems a reasonable possibility, given the likelihood that Kaiser Permanente would participate and the fact that employers that offer Kaiser often offer other plans as well.

But the SHPP pool could contract with and offer competing health plans only if multiple health plans would be willing to contract at reasonable rates. This might not be the case if, as just discussed:

- Most health plans would see the pool simply as a competitor to their direct employer-contracting business and, therefore, would not want to participate because doing so could put the pool in a stronger position to compete against the health plan's own business; or
- Health plans generally would not want to make the pool bigger or more attractive, because they would not want it to have purchasing clout.

Further, even if multiple health plans would be willing to contract with the pool, MRMIB might be able to obtain lower premium prices, and thus lower employer "fees," if it contracted with

only one health plan (or one plan in each geographic area). This might be the case if, for example:

- Health plans' risk selection concerns were high enough that no health plan was willing to assume them at a reasonable price unless they were assured of getting all enrollment in the pool, and therefore assured of getting all low-risk enrollment; or
- Contracting with only one health plan (or only one in a geographic area) would allow MRMIB to exercise some of the cost-containment strategies discussed in Supplement C.

On the other hand, the availability of competing plans could serve as an important source of cost discipline. If workers had to pay the extra costs for enrolling in more expensive plans out of their own pockets, and health plans knew this, the plans would be more likely to offer the lowest price they deemed possible, so as to attract enrollment from their competitors. Thus, offering worker choice of competing health plans would be highly desirable from a cost-containment point of view.

In addition to being desirable for cost containment, having the worker directly pay the additional cost of a more expensive choice might be the only feasible way to administer worker choice of health plan in the SB 2 context. If the employer had to pay any part of the additional cost, the total employer fee would vary with the composition of worker choices, and could not be known in advance, when the employer was deciding whether to "pay" or "play."[57] In addition, employers might consider it too significant an administrative burden for a "paying" firm to withhold differential amounts for workers based upon their health plan choices.

Another advantage of offering worker choice of carriers would be that, once workers of a given employer were enrolled in different competing health plans offered by the SHPP pool, that employer group would be somewhat less likely to leave the pool. To make leaving profitable, the employer would have to obtain either lower prices from most of the plans that had sizable employee enrollment from that employer, or at least appreciably lower prices from one plan. That is, the employer group would be less likely to leave the pool simply because one plan offered it a slightly lower price. And, unless the employer were to offer similar plan choices, leaving the pool would likely dissatisfy workers who would be forced to change plans and providers. Apparently for such reasons, MRMIB found that the HIPC experienced unusually high retention rates among the small employer groups who enrolled. This fact could give the pool more cohesion over time, putting it more in the position of a large employer group like CalPERS. That is, health plans would be somewhat more likely to view the pool as a unique source of enrollment rather than as a competitor for their own direct employer contracting enrollment.

In sum, offering a choice of competing health plans through the SHPP pool would be highly desirable <u>unless</u> MRMIB desired to pursue an alternative cost-containment strategy that required contracting with a single health plan. (See Supplement C.) But whether multiple health plans would be willing to contract with the pool cannot be predicted at this time.

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[57] Employer choice of health plan could be administered easily but would not have the same cost-containment effects.

If there was worker choice of competing plans, the SHPP pool would need to assure accurate and timely enrollment and payment to the health plan of the worker's choice. See the discussion in section 3.4.1 beginning on page 45. Also, a risk-adjustment instrument and mechanism would likely be required, such as those currently used by PacAdvantage. (See Supplement E.)

3.2.2. Choice of Benefit Levels or Designs

Many large employers already offer their workers a choice of different health-coverage benefit levels or designs.[58] The SHPP pool should consider offering a choice of benefit levels or designs, because it could make the pool more attractive to employers whose workers do not all value health insurance equally. Because our quantitative simulation did not address the potential effects of allowing a choice of benefit levels, we examine relevant issues qualitatively in this section. (Approaches to offer richer benefit plans only to low-income workers are addressed separately under Scenario D, "Low-Income Subsidies".)

Two considerations are primary: how a choice of benefit levels or designs could be administered, and the potential for adverse selection.

If the choice of benefit level or design was made by the employer for the entire employee group, relatively little additional complexity would be added to the fee determination and employer-choice process. The SHPP pool would simply establish a different fee for each benefit level or design—a process that, once automated, could produce two, three or four fee levels for different benefit designs as readily as one—and the employer would choose which level or design it wanted its workers to receive. And, if the fees for all benefit levels or designs were health-rated, the pool should be able to avoid any adverse selection resulting from higher-risk employer groups choosing more generous benefits.

But having employers choose one benefit level or design for their workers would not address the different health insurance preferences of individual workers—a principal reason for offering different benefit levels.

Allowing individual workers to choose the benefit level they prefer would raise many more administrative problems and issues.

Under one approach, the employer could be required to pay 80 percent of the fee for the benefit level each worker selected. Basing the employer's fee on each worker's choice of benefit design would create greatly increase administrative complexity for the pool administrator, for the agency that collected the fees from employers, and for employers. It would also greatly complicate the employer's initial pay-or-play decision, because the employer could not estimate its total fee under the "pay" option without knowing which benefit level each of its workers would choose.[59]

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[58] See, for example, Chart 21 in *California Employer Health Benefits Survey: 2004* from the California HealthCare Foundation and the Health Research and Educational Trust. See also "Implementing the Health Insurance Act of 2003: The Health Insurance Market Context and Demographic Profile," an earlier report under this project, submitted to the California HealthCare Foundation in August 2004.

[59] This additional complexity could make the program more vulnerable to a successful ERISA challenge. (ERISA issues affecting pay-or-play proposals are discussed in section 3.6.1 on page 57.)

A second approach would be more realistic.[60] The SHPP fee—and the employer's contribution—would be based on a single benefit package. If workers wanted to purchase a more expensive benefit package, they would have to pay the entire additional cost themselves. But how to collect this additional charge would be problematic.

The SHPP pool could collect the additional charge by providing employers with an itemized bill showing the employer's contribution and the worker's contribution for each enrolled worker, so that the employer could make the appropriate payroll deduction for each worker. This would require that the pool collect and record each workers' benefit decision upon enrollment and would greatly increase administrative complexity. (For example, the process of reconciling periodic fee payments would be much more complex.) It would also create substantial administrative complexity for employers who presumably decided to "pay the fee," rather than provide direct coverage, at least partly in order to avoid such complexities. The possibility that requiring employers to make payroll deductions for worker-chosen voluntary benefit upgrades could make the program more vulnerable to a successful ERISA challenge would also need to be evaluated. We do not recommend this approach.

Alternatively, the pool might collect the charge for an enriched benefit package directly from the individual employees, not through their employer. Doing so would avoid any ERISA issues, but would necessitate an entirely separate billing and collection system for the pool and appreciably increase administrative costs. Hence, this approach also seems to be unrealistic.

The SHPP pool could avoid the considerable additional administrative costs either of the other approaches would entail by leaving benefit-upgrade choice, enrollment and premium collection up to the participating health plan chosen by the worker. Health plans could be permitted to offer benefit upgrades to SHPP workers and would bill workers directly,[61] or through their employer. Employers could voluntarily offer payroll deduction as a way for workers to pay their benefit-upgrade bills, but would not be required to do so. In any event, major health plans in California already have systems to bill and collect premium payments from individuals.

Even if the plans administered any benefit upgrades offered, the pool would still have to establish program rules governing these upgrades in order to minimize adverse selection against some plans due to risk skimming by other plans. To ensure a "level playing field," these rules could specify the benefit level or levels and perhaps require that all participating carriers offer them. In addition, it would likely be necessary to put in place a risk-adjustment mechanism to adjust pool payments to plans based on the risk profile of their enrollees. (Supplement E presents an assessment of available instruments for this purpose.) In the absence of uniform program standards, it is likely that no available risk-adjustment instrument could adequately compensate for the adverse selection that would likely occur.

Charging the employee the full cost of any benefit upgrade would be essentially a "defined contribution" approach. Such an approach would remove the incentive for employees to "over-insure" because they would face the entire cost of purchasing the upgrade. On the other hand,

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[60] And perhaps more consistent with SB 2 in that the 80% contribution requirement would apply to only one plan.

[61] A similar role is played by health care plans in California in the administration of Cal-COBRA (California's COBRA law for employers with 2-19 employees).

under some scenarios, it could leave low-income workers with coverage that did not give them financial access to needed and appropriate care. As mentioned earlier, a design such as Scenario D, which includes low-income worker options for Healthy-Families-style coverage, could alleviate these concerns.

3.3. Dependent Coverage

Under SB 2, medium employers would be not required to contribute toward coverage of dependents. Medium employers that chose to provide coverage directly could offer dependent coverage or not offer it and, if they offered it, could contribute any amount they choose, or nothing at all (unless they were insured and their carrier refused to offer dependent coverage without some level of employer contribution).

The SHPP pool could not require participating medium employers to contribute toward dependent coverage. But offering dependent coverage to medium employer groups on a voluntary basis could make the pool more attractive to such groups. Under what conditions would doing so improve, rather than compromise, the financial viability of the pool?

As noted earlier, due to project resource limitations, our behavioral model does not allow workers' decisions about dependent coverage to vary in response to different employer contribution levels. (See Supplement I.) Therefore, we cannot provide a quantitative analysis of how alternative employer contribution levels (as a condition of obtaining dependent coverage through the SHPP pool) would affect the pool's financial viability, if workers' decisions to enroll dependents are sensitive to the marginal cost of doing so. Instead, we offer guidance based on observation of how the health insurance market functions.

Insurance works by spreading risk across a pool of people. To remain solvent and viable, an insurer must collect enough of a surplus from some people in its pool—the less costly low users—to offset its losses for the more expensive high users in the pool. The trick is to obtain participation from enough low users. This can be difficult, because people who doubt they will use health insurance coverage very much value it less and are willing to pay less for it.[62] If the premium price becomes too high, they will simply drop coverage.

In typical employer coverage, the employer pays a large share of the premium. This reduces the price to the individual worker so that most workers, even those who are low-risk, sign up for the employer's plan. (The perception that workers who don't enroll in the employer's plan are "giving up" a substantial employer contribution may also help increase enrollment.)

In the individual market, on the other hand, where the individual pays the entire premium out of their own pocket, insurers use a wide variety of underwriting and rating techniques (within what state insurance law allows) to match the premium they charge to the expected risk of each purchaser and to avoid insuring people they expect will cost more than the premiums they pay. (For this reason, California and other states have high-risk pools that offer insurance to people

[62] Of course, most people are risk averse and are willing to pay something to have insurance in place in case they need it. But people in poorer health know they need health insurance and will use it, so they value it more and are willing to pay more for coverage.

denied coverage by health plans.[63] These pools use other funds to offset the losses they incur in excess of the premiums they collect.)

These basic dynamics of health insurance suggest a few guidelines for SHPP consideration of dependent coverage at medium employers:

a. Workers at SHPP-participating medium employers should not be permitted to enroll their dependents in the pool on a worker-pay-all basis (i.e., with no employer contribution toward the dependents' coverage).

   - Doing so could make the pool vulnerable to adverse selection (i.e., the risk that only workers who knew their dependents were in need of care would be willing to pay the full fee necessary to cover them), unless each dependent was subject to health underwriting and charged a fee based on their health status. But such a process would be inconsistent with generally held policy goals for the SHPP pool, and would also be extremely complex and resource-intensive for the pool to implement and administer.[64]
   - Theoretically, the health plans serving the SHPP pool (rather than the pool itself) could offer dependent coverage to medium-employer workers in the SHPP pool on a worker-pay-all, health-underwritten basis. The plan could bill each worker directly for dependent coverage, not through the SHPP pool, as we suggest elsewhere for "upgraded" benefit plans. As a practical matter, however, this would be essentially individual coverage for dependents, with all of the administrative and underwriting overhead that individual coverage typically entails. It would not be likely to offer better value to workers than the regular individual market.

b. Medium employers participating in the SHPP pool could be permitted to offer their workers dependent coverage if the employer agreed to pay at least a specified percentage of the cost of coverage that includes dependents.

   - Our preliminary recommendation would be to require a minimum fee equal to at least half the cost of any coverage that included dependents, for medium employers in the SHPP pool that wanted to offer their workers access to dependent coverage. Requiring employers to pay at least half the cost of worker-only coverage is common in the commercial marketplace at present and is generally seen as workable. Therefore, it seems a reasonable requirement to establish for voluntary dependent coverage.
   - But, as a practical matter, SHPP would need to set a minimum contribution level that its participating health plan(s) would agree with.

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[63] By federal and state law, health plans cannot refuse to insure employer groups or individual workers in those groups who are otherwise eligible for the coverage. In most states (including California), however, health plans serving the individual market are free to accept or reject any applicant for coverage.

[64] Federal law prohibits employer plans ("group health plans") from charging enrollees premiums that vary with the individual's health status. [Section 702(b) of the Employee Retirement Income Security Act of 1974, as added by section 101 of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).] However, the SHPP pool would not be a "group health plan" under ERISA and therefore would not technically be subject to the federal non-discrimination-on-health-status requirement.

3.4. Administrative Implications and Issues

This report was originally intended to include specific recommendations to MRMIB regarding administrative implementation of SB 2. After SB 2 was rejected by the voters, however, the project was revised to put more emphasis on policy design features important for developing manageable, effective and sustainable coverage expansions for workers and their families. Therefore, this section presents only a basic overview of the kinds of administrative systems needed to implement pay-or-play approaches like SB 2. But because our simulation analysis found that the "pay" pool could only be self-supporting if it charged fees based on health status, this section also discusses in some detail the administrative difficulties that would be involved in implementing health-rated fees.

3.4.1. Overview of Administrative Systems Required to Implement Pay-or-Play Approaches Like SB 2

The operation of a pay-or-play coverage approach would require the state, employers, or some other entity to perform several important administrative functions.[65] (In this section, we refer generically to "the administrator," which could be a state agency or a contractor or a combination thereof.) Depending upon the policy approach adopted, the complexity of the administrative tasks required would vary. The basic functions the administrator would need to perform are summarized briefly below.

a. Determination of employers that must comply with the pay-or-play mandate.

If the pay-or-play approach did not apply equally to all employers—for instance, SB 2 would have applied to firms with 50 or more employees[66]—the administrator would need to develop a mechanism to determine which employers were required to comply with the statute. Moreover, this mechanism would need to monitor employers over time to determine whether they would have to begin to or no longer needed to comply with the requirements. (For instance, a business's status under SB 2 could change as its number of employees changed.) The primary activities needed to perform this task include:

- Development and maintenance of an employer database. (Note that existing state databases might not be adequate for this purpose.)
- Notification of employers with regard to compliance.
- Following-up with employers that have not complied.

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[65] Note that this section does not discuss administrative implementation activities with which a state would have to be engaged if it enacted a pay-or-play statute. Such implementation activities might include designing the basic structure of the pay alternative coverage mechanism, i.e., the pool; designing more specific rules of participation; designing the benefit plan or plans to be offered by the pool; contracting with health plans, and if necessary, some form of administrative vendor; and designing the structure of the fee and how it would be collected.

[66] Although SB 2 technically applied to employers with 20 or more employees, businesses with 20 to 49 employees in California would not have been subject to the mandate unless the legislature enacted a tax credit equal to 20 percent of the net cost to such employers of the fee payable for participating in the SHPP pool. Hence, we refer to SB 2 as applying only to firms with 50 or more employees.

b. Development and ongoing operation of the pay "alternative" or "pool."

This function includes activities necessary to provide the alternative mechanism through which workers of "paying" employers obtain coverage. Under SB 2, that mechanism would be the State Health Purchasing Program (SHPP) or pool. The state could perform the following range of administrative functions directly or contract them out. (Note that key administrative activities include assessing and collecting the fee from paying employers. Given the importance of those activities, they are discussed later in this section.)

- Determine that a paying employer is a bona fide firm subject to the pay-or-play statute.
- Determine that all workers and dependents eligible for coverage through the pool enroll.
- Enroll eligible employers and their workers (and dependents, if applicable). This task includes the full range of enrollment-processing activities associated with health insurance coverage. In addition to initial enrollment, addition and deletion of workers and dependents would have to be handled on an ongoing basis.
- Transfer employee and dependent enrollment data to health plan(s)[67] on a regular (monthly) basis, preferably electronically.
- Disenroll employers that choose to leave the pool and provide coverage directly.
- Provide customer service to employers and workers.

c. Coordination with public programs.

The specific activities under this function would depend on the relationship between pool coverage and public coverage specified in the statute. SB 2, for example, specified that workers and dependents of "paying" employers who were found eligible for Medi-Cal or Healthy Families (Medicaid or SCHIP) were to be enrolled in those programs rather than in pool coverage. It also provided that the pool was to pay the state's cost for the public coverage provided to these workers and that the worker's share of the pool's fee was to be refunded to the worker. (See more detailed explanation in section 3.5 beginning on page 52.)

To implement these requirements, three major administrative systems would be required:

- a system or interface to share eligibility and enrollment information between the pool administrator and the public programs' administrative entity(ies);
- a financial system to transfer funds; and
- a refund-payment system.

If pool coverage remained primary for public-program eligibles, then the discussion of administrative requirements for premium assistance in section 3.5 would also apply. In such situations, it would be helpful to the public programs if the pool administrator kept them apprised of the employment status of such individuals.

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[67] Or claims administrator, if the pool were to self-insure, which the SHPP pool under SB 2 was not authorized to do.

d. Collection of the appropriate fee from "paying" employers.

In a normal pay-or-play construct, this function should constitute the bulk of administrative activities. However, the range and complexity of the required activities would depend upon the specific design of the pay-or-play system and the administrative capabilities of employers and the state. The more important tasks under this function include:

- Determine the appropriate (composite[68]) fee to be paid by each employer.
- Notify the employer of the fee due.
- Collect the fee on a periodic, pre-determined basis.
- Transfer fees to the appropriate entities.

Note that, if the state adopted a simple or straightforward fee structure—such as a set amount per worker, a percentage of wage, etc.—this task would be much simpler (and the state may be more secure from an ERISA challenge—see section 3.6.1 beginning on page 57).[69] However, while a simple fee structure would be easier to administer, our analysis shows that, in the absence of outside subsidies, the pool would not be financially sustainable due to adverse selection. (See section 2.3 beginning on page 19.)

To protect the pool under an SB 2 construct, the fee charged to each employer group would need to reflect not only its geographic location and workers' ages, but also its workers' health status. Obtaining such data, however, would be more complicated and create a greater administrative burden for the administrator and for paying employers. Pertinent existing state databases might not even contain information on worker age. For example, California's Employment Development Department (EDD) does not collect age or birth date information.[70] And neither the state nor employers typically collect information on individual worker health status. [We discuss the special problems of implementing a health-rated fee, including the possibility of using overall group claims experience to set the pool fee, in the next subsection, 3.4.2. We discussed earlier (see section 3.2 beginning on page 39) the additional complexities that would be introduced if workers could choose between different health plans or benefit designs.]

In the SB 2 context, these observations mean that the existing system for collecting unemployment insurance (UI) taxes would need considerable modification and augmentation in order to collect SHPP fees (as SB 2 specifically directed), even if the pool used only age-rating. If SHPP fees were health-rated, an extensive new data collection and fee-quoting system would

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[68] "Composite" means that, although the characteristics of each employer's workers, such as age, might be used to determine the fee, the same fee would be charged with respect to all workers in the same employer group. (Of course, different fees could be charged for workers who covered dependents and workers who did not.)

[69] Note that the State might not even readily have employee wage information, thus making the assessment for a "simply structured" fee more complicated as well. For instance, in California the Employment Development Department (EDD) collects wage-rate information when a worker first joins a business, but afterwards only collects total wages paid to a worker. If the fee was a flat percentage of wages paid, for both employer and worker, knowing total wages would be sufficient. But under Scenario E, the applicable percentage varies depending on the employer's average wage paid and each individual worker's wage rate.

[70] In an interview, California's EDD indicated that the only state agency that has birth date information statewide is the Department of Motor Vehicles (DMV). They expressed grave doubts about their ability to tie into the DMV's administrative systems to obtain such information.

have to be developed, which would not logically be housed at the Employment Development Department.

e. Verification that "play" employers have complied with state statute.

Verification might be undertaken only at the outset—when an employer announces its intention to "play"—or on a regular periodic basis (e.g., yearly) for all "playing" employers. Such activities could include:

- Determining that a playing employer is a bona fide firm subject to the pay-or-play statute.
- Verifying that the structure and terms of the firm's coverage are in compliance with the provisions of the pay-or-play statute. These provisions could include: eligibility criteria, benefit plan, employer contribution, adequate provider access, etc.
- If applicable, verifying employer coordination with state public programs.
- If applicable, assessing and collecting a state "reinsurance" fee (such as might be imposed on all employers to help support the "pay" pool, as suggested under Scenario F discussed in section 2.2.3 on page 16.)

In other states or outside the SB 2 context, the specific activities that would need to be performed would depend upon the nature of the pay-or-play policy enacted, the nature of the state's health insurance market and employer-sponsored coverage in general, the existing authority of the state's regulatory bodies, and the resources the state has at its disposal.

f. Auditing and enforcement of the pay-or-play statute.

The state might want to oversee actively the continued operation of its pay-or-play statute. A simple way to do this would be to develop and maintain a complaint tracking and response system. Complaints from workers and/or their dependents of both paying and playing employers could form the principal means for monitoring the statute. In addition, the state might want to audit actively specific employers—either at random and/or if they fail specific tests—as a means of ensuring better compliance among both paying and playing firms.

3.4.2. The Special Problems of Implementing Health Rating

As discussed in section 2.3 on page 19, for the SHPP pool to be viable, it would either need to subsidize coverage for low-income workers or establish fees that were commensurate with the risk presented by each employer group ("health rating"). But health rating would present both legal and practical problems. The legal issues arise from the general expectation under a "pay-or-play" construct like SB 2 that all employers subject to the requirements would be told up front what the applicable fee would be, and each employer could then choose to "pay" the fee or, instead, "play" and provide employer-sponsored coverage directly. But, if the pool fee were health-rated, considerable information would have to be obtained from each (interested) employer, and that information would have to be analyzed, before the employer's fee could be determined. This process would be time-consuming and expensive, and could strengthen an ERISA challenge, as discussed in section 3.6.1 on page 57. Here we identify several approaches

the SHPP could adopt to implement health rating in its fee structure and discuss their advantages and limitations.

There are basically two ways to assess the health risk (expected cost) of an employer group: (1) obtain data about the group's prior claims experience, or (2) obtain health-status information about each member of the group. Both approaches are used by health plans in the commercial market (where insurance regulations permit). Both would be difficult, time-consuming and expensive for the SHPP pool to implement, and could also raise difficult confidentiality issues.

a. Obtain Claims Data from Employers: This approach should permit the most accurate prediction of expected costs for each employer group. However, it suffers from a number of important limitations.

- First, because the data pertain to an ERISA health plan, the state could not compel employers to submit it. Employers (in their role as a plan fiduciary) would have to submit the data voluntarily.
- Second, this approach would be time-consuming. The data would have to be requested from employers in a specified format, and once received, would likely have to be actuarially adjusted to reflect differences in covered services, cost-sharing, and provider reimbursement between the employer's plan and the pool's benefit plan.
- Third, the approach would probably require an enormous administrative effort and significant resources on the part of the pool, and would not be timely nor administratively simple for employers.
- Finally, some (perhaps many) firms would not be able to provide valid claims data, because they are too small for the data to be actuarially reliable, are not able to obtain it from their health plans because the plans do not collect it or are unwilling to provide it, or have no experience to provide because the firms did not offer coverage previously.

The last difficulty might be partially overcome by using claims experience to set the fee only at renewal.[71] When groups initially entered the pool, age rating would be applied, but not health status.

- But this approach would do nothing to protect against adverse selection in the pool's critical first year, when fees from new applicant groups would constitute 100 percent of the pool's revenue. Knowing this, pool-participating health plan(s) would likely demand higher initial premiums to protect themselves against the unknown level of risk, thus putting the pool at a competitive disadvantage and perhaps making it a "non-starter." Nor would this approach protect against adverse selection by new applicant groups in subsequent years.
- Alternatively, if the pool were self-insured (which would not be permitted under SB 2), implementing this approach would require that the pool have sufficient reserves to weather any discrepancy between fees and costs for each employer's first year of

[71] Note that if multiple health plans were offered, obtaining worker claims data from different plans and then aggregating them into an overall risk profile for a firm would not necessarily be an insignificant administrative task, assuming the health plans could provide such data.

participation. Generating such reserves would require either higher fees or outside funds, i.e., from a source other than pool-participating employer groups.

b. Obtain Health Questionnaires from Workers: Alternatively, health status information could be obtained by collecting health questionnaires from employees. Workers often have the best knowledge of their health status and often are very truthful when answering questions about specific health conditions. But this approach, too, has significant disadvantages.

- Substantial administrative effort would be required to collect, record, possibly analyze, and then aggregate worker responses into an overall adjustment for each firm. Though this effort would fall mostly on the pool administrator, employers would have to distribute and then collect and submit the questionnaires.
- Much administrative effort would be spent on underwriting businesses that ultimately decide to "play," rather than "pay." (And this effort would be particularly overwhelming if it were found necessary—to defend against an ERISA challenge—to collect health information and promulgate fees for all employers subject to the pay-or-play mandate. See section 3.6.1.)
- Delays would be likely as employers would have to wait for stragglers to complete their questionnaires.
- Although our quantitative analysis assumed that the pool would not have to be as effective at health rating as private health plans are in order to survive, a crude questionnaire, while simple to complete, might not permit the pool to assess prospective health costs accurately.[72]

c. Obtain Claims Experience and/or Health Status Questionnaires: Of course, it would be possible to give employers the option of submitting either claims data or worker health status questionnaires. This would overcome some of the limitations of each approach individually, but would still involve very significant administrative effort on behalf of employers and the pool.

d. Assign the Highest Fee and Adjust Downward for Employers that Provide Data: One way to reduce the volume of health underwriting, and the associated administrative workload, would be to establish a maximum fee for the highest health-risk category and make that fee the formal "pay" fee for employer-notification purposes. Employers interested in the "pay" option would then be given the option of paying the maximum fee or submitting data (claims data or health questionnaires) that the pool would then analyze, and if appropriate, reduce the employer's fee accordingly.

- By establishing a formal "pay" fee, this approach makes it easier to defend against an ERISA challenge without the necessity of collecting claims data or health questionnaire from every employer group subject to SB 2.

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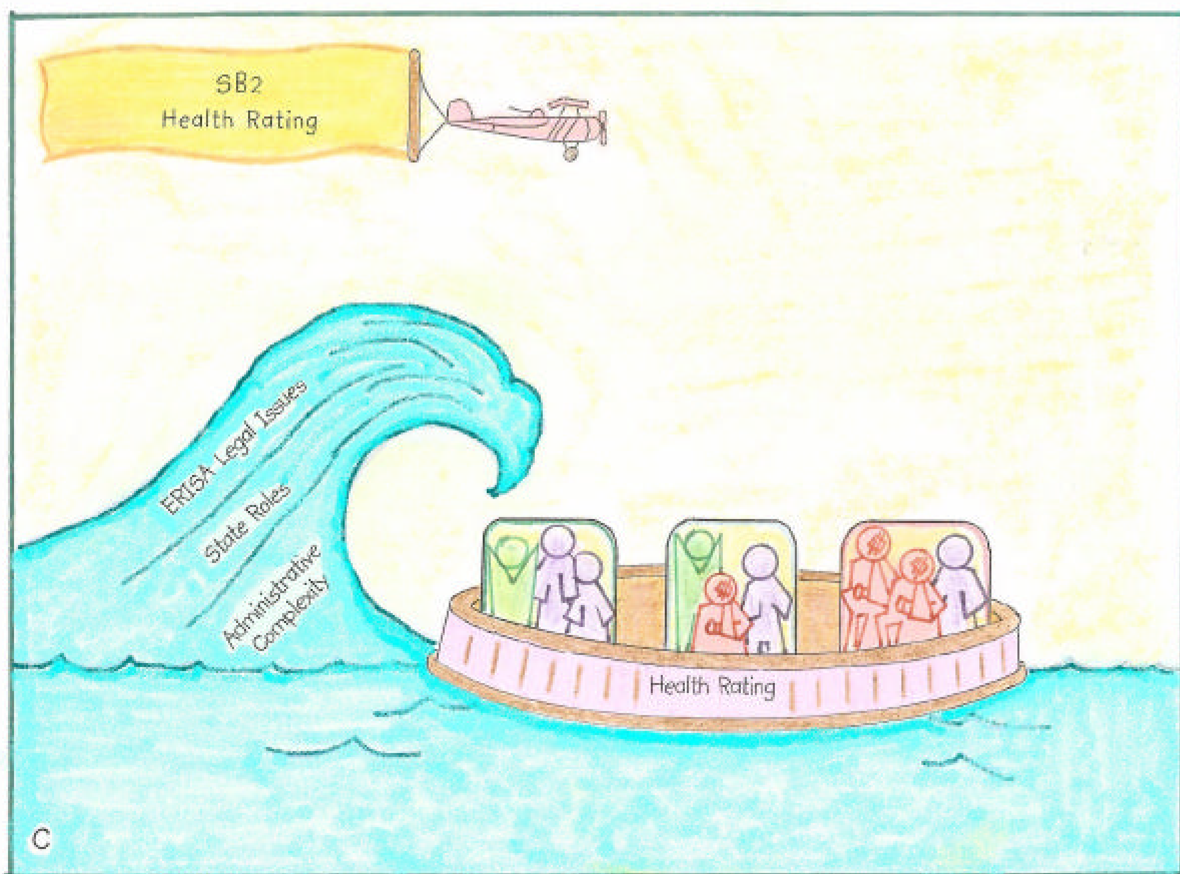
[72] The simulation model grouped workers into only three health-status classes based on a simple "self-assessment" of health status. But, while people may be relatively accurate in responding to a general health self-assessment question in a research survey, it would be unrealistic to expect such a simple self-assessment—as opposed to questions about the presence or absence of specific conditions—to be completely accurate where money is at stake.

- We could not estimate the results of such a policy because there was no basis on which to predict how employers would react to such an approach, much less how those reactions might vary with employer characteristics. But the sense of the project team was that most average- and lower-risk employer groups would be put off by a high initial fee quote, and only high-risk groups would bother to apply for pool coverage or provide the requested information in hopes of obtaining a lower fee. Thus, this approach might make the pool attractive primarily to businesses whose current or projected costs are greater than the maximum fee—a textbook case of adverse selection. As the simulation analysis of Scenarios A (flat community rating) and B (age rating) suggests, the pool might not be able to set the fee high enough to prevent this dynamic from taking hold.

For all of these reasons, it would be extremely difficult for the "pay" pool to implement health rating effectively. The challenges it would face are illustrated in Exhibit 12.

Exhibit 12: The Pool Would Face Challenges Under Scenario C with Health Rating



<u>With</u> health rating, the SB 2 Pool could be financially viable.
But health rating would raise other perils.

3.5. Premium Assistance

"Premium Assistance" means helping low-income working families to pay the employee contribution necessary to enroll (or remain enrolled) in employer-sponsored coverage that is available to them.[73] It may also involve paying for services that are not covered by the employer's plan but are covered by a public program the family is eligible for.

In addition to its employer pay-or-play provisions, SB 2 would have required both the Medi-Cal and Healthy Families programs to implement premium assistance programs for their enrollees who had access to employer-based coverage. These programs were to include mandatory enrollment in available employer coverage (when "cost-effective"), prompt reimbursement for the worker's share of the premium cost (less any premium owed for public coverage), and "a wraparound benefit that covers any gap between the employer-based coverage and the benefits" provided under Medi-Cal or Healthy Families, as applicable.[74]

The premium assistance requirement was not limited to Medi-Cal and Healthy Families enrollees who worked for employers subject to the pay-or-play requirements under SB 2.[75] But it was intended, at least in part, to protect workers (or dependents) who were eligible for public coverage from having to pay out of their own pockets for (newly mandatory) coverage under SB 2.

Most state Medicaid programs (like Medi-Cal at present) have small premium assistance programs limited to known high-cost cases. Experience in the relatively few states that have broader premium assistance programs indicates that they are difficult and expensive to administer, although they do save money for states that have eligibility standards higher than the poverty level for parents and that invest the resources necessary to make the programs work.[76]

In this section, we focus primarily on premium assistance for employer-provided coverage. We discuss first the tasks that must be undertaken under a traditional approach to premium assistance and then suggest some alternative approaches that might become viable in a "mandatory-coverage" environment such as that created by SB 2 or by other possible initiatives such as "individual mandates." Because SB 2 was not enacted, we focus on policy structures that could help to simplify premium assistance administration, rather than on detailed implementation advice.

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[73] Premium assistance is also called "Health Insurance Premium Payment" or "HIPP" (usually under Medicaid) or "premium support." California's Healthy Families statute uses the term "purchasing credits."

[74] Sections 5 and 9 of SB 2.

[75] However, since the relevant provisions were included in SB 2, they were subject to the November referendum and therefore are not in effect.

[76] See Ed Neuschler and Rick Curtis, *Premium Assistance: What Works? What Doesn't?* Washington, D.C.: Institute for Health Policy Solutions, April 2003. Available at <http://www.ihps.org.> See also the "premium assistance toolbox" developed by the National Academy for State Health Policy at <http://www.patoolbox.org.>

3.5.1. "Traditional" Premium Assistance Tasks

Where employers provide coverage directly, the tasks that must be undertaken to implement a premium assistance program include:

a. Identifying which public-program applicants have employment-based health insurance.

- The partially mandatory environment under SB 2 would have simplified this task, because many more employed applicants would have access to employer coverage and some applicants would apply specifically in order to obtain premium assistance.

b. Obtaining enough information about the specific employer coverage to evaluate whether providing premium assistance would be "cost-effective" for the state (i.e., cost less than providing public coverage directly, all things considered).

- Under SB 2, the employer were to offer one plan that met certain standards and toward which the employer contributed 80%. But we expect many employers would also continue to offer, and enroll most of their employees in, their "old" plan at their old contribution percentage. This plan often would be better value for premium assistance recipients, because the employer contribution to this plan would be higher in dollar terms and the benefits better. But the state would have to obtain this information from the employer, just as they would in the absence of SB 2.
- Thus, each employer would have to be contacted to determine what plans were available to the worker and, for each plan, what deductibles, coinsurance and/or copayments applied, how much the worker had to pay toward the premium, and possibly, what services are covered.[77] Under ERISA, employer plans are not required to provide this information to anyone other than a plan beneficiary. Therefore, each employer's cooperation would be strictly voluntary unless the state had the worker sign a form designating the state as his/her agent for this purpose.[78]

c. Evaluating the employer coverage. Developing a system (probably automated) to accept details about the applicant and their employer plan(s) and make a cost-effectiveness determination.

- The state may wish to impose some minimum standards (perhaps cost-sharing limits) that an employer plan must meet to qualify for premium assistance. Whether or not this is done, a cost-effectiveness determination must be made with respect to every employer plan.
- If the worker's share is never more than 20% of the premium (or, in the case of low-wage workers, 5% of wages, whichever is less), it might be expected that premium assistance would virtually always be cost-effective. But, as noted above, employers were only required to offer one plan that comported with these contribution limits, and that plan might be a high-deductible plan. Also, "medium" employers could offer coverage for dependents with no minimum contribution requirement.

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[77] If the coverage offered was through a state-licensed health plan, precise details of services covered might not be required.

[78] Pennsylvania uses this approach.

d. Paying premium refunds to eligible families on a prompt and regular basis. Given the volume of premium assistance expected under SB 2, an automated system would be required and use of electronic funds transfer would be highly recommended. Particularly difficult issues include:

- Making the premium refund "coincide" with each worker's payroll deduction date (as required by SB 2 for Medi-Cal recipients). One reason this requirement would be especially difficult to implement under SB 2 is that SB 2 also sought to keep employers—who would handle regular payroll deduction for the worker's contribution that would then have to be refunded—from knowing any information affecting their workers' eligibility for Medi-Cal or Healthy Families.[79]
- Verifying that workers remain enrolled in the same employer's plan and that their payroll deduction amount has not changed. (Low-income workers tend to change jobs frequently, though perhaps less so where health benefits are offered.)

e. Developing a system to pay for services covered by Medi-Cal or Healthy Families but not covered by the employer's plan and to pay cost-sharing charges under the employer's plan that exceed those allowable under the applicable public program.

- Where a fee-for-service (FFS) claims payment system is available (as, e.g., under Medi-Cal), these objectives can be accomplished by giving the premium assistance recipient a (properly annotated) program ID card.
- But the limited number of Medi-Cal FFS providers and the standard Medi-Cal approach to third-party liability[80] are important drawbacks that could limit the effectiveness of this approach in truly guaranteeing financial access for premium assistance recipients who are using employer-plan provider networks.

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[79] Section 2160.4 in Chapter 6, Part 8.7, Division 2 of the California Labor Code, as proposed to be added by section 2 of SB 2. The specific prohibition was: "An employer shall not request or otherwise seek to obtain information concerning income or other eligibility requirements for public health benefit programs regarding an employee, dependent or other family member of an employee …" Similarly, section 2190(a) in Chapter 8 would have prohibited the board (MRMIB) from "requir[ing] the employer to obtain from the potential enrollee information about the family income or other eligibility requirements for Medi-Cal, Healthy Families, or other public programs other than that information about the enrollee's employment status otherwise known to the employer consistent with existing state and federal law and regulation."

[80] Under Medicaid third-party liability / coordination-of-benefits procedures in many states, Medicaid subtracts the amount paid by the private health plan from the amount that Medicaid would pay if it were the primary insurer, and pays only the difference, if any, to the provider. Because Medicaid usually pays providers less than private health plans pay, using this procedure would mean that the provider would rarely recover any portion of the copayment owed by the recipient under the employer plan. While this outcome is fine for the recipient, it could lead to provider dissatisfaction with the employer health plan, which in turn would reduce employer and health plan cooperation with the premium assistance program. In addition, Medicaid rules prohibiting providers from billing Medicaid patients more than Medicaid allows apply only to providers who participate in Medicaid. Many providers in private health plan networks do not participate in Medicaid, so premium assistance recipients would have no protection on out-of-pocket costs when using those providers. To circumvent these problems, Rhode Island expanded its Medicaid FFS system to handle "copayment-only" claims and launched a major effort to enroll additional providers as "copayment-only" providers, who did not have to agree to take regular Medicaid patients. This effort is one of the reasons why Rhode Island's premium assistance program, RIteShare, is one of the most effective in the nation.

- Thus, to be most helpful to premium assistance recipients, Medi-Cal's FFS claims payment system would likely need to be upgraded to accept co-payment-only billings from otherwise-non-enrolled providers (i.e., providers participating in the employer plan who do not participate in Medi-Cal).
- Where no FFS claims payment system is available (as, e.g., under Healthy Families), a contract with another entity to provide this service would likely be the most efficient way to meet the wraparound requirement under SB 2. A contract with the Medi-Cal claims processor would be one possibility.

Although Medi-Cal and Healthy Families are separate programs in California, it would be efficient for both to contract with a common administrative entity or entities to handle premium assistance tasks for both programs.

3.5.2. Possible Alternative Approaches

In California's SB 2 universe, about 540,000 families have members currently receiving coverage from Medi-Cal or Healthy Families. Another 330,000 or so families have members who meet the eligibility criteria for those programs but do not now participate. Almost 35,000 businesses would be covered (although some of them might not have any low-income workers or dependents potentially eligible for public coverage). Many of these businesses offer multiple health plans. Thus, implementation of SB 2, or of any proposal that effectively requires people to make use of available employer coverage, could create very substantial demand for premium assistance. Given the complex, difficult and costly administrative requirements, the likely volume could simply overwhelm a "traditional" approach to premium assistance. An alternative approach would be highly desirable.

SB 2 would have simplified one aspect of premium assistance for one subset of the potentially eligible population—those in the SHPP pool. It would have eliminated the need to provide wraparound coverage by directing that workers and dependents in the SHPP pool who were found eligible for Medi-Cal or Healthy Families were to be enrolled directly in those programs. (Providing wraparound coverage could also be avoided if the pool itself offered upgraded plans, as under Scenario D.) But it would still require a payment system to refund the worker's share of the SHPP fee to many separate workers, as just discussed in section 3.5.1 on page 54 above.

If concerns about employers knowing which of their workers were receiving public subsidies could be overcome,[81] an alternative system involving "list billing" of SHPP-participating employers could be developed. Under such a system, employers would know upfront the correct (i.e., post-subsidy) amount to deduct from each worker's paycheck, and no system for paying refunds would be needed. Changes in worker status would also be taken care of automatically, as part of the regular fee-payment reconciliation system. As noted in section 3.2.2 on page 41 above, a list-billing system would be complex for both the pool and for employers and would require additional administrative resources. Employers might be somewhat more willing to implement list billing when doing so would provide a direct financial benefit to some of their workers. But they might also be reluctant to assist directly in a subsidy system that some

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[81] Such concerns were embodied in SB 2, see note 79 above. In this regard, however, note that employers already have access to tax withholding information that can give strong clues about a worker's broader financial situation.

workers might see as inequitable—because some workers (e.g., those with previously uninsured children) would receive subsidies, while others in like circumstance (e.g., those who previously paid for dependent coverage for their children) would not. These considerations would have to be weighed against the costs of developing and operating a separate system to pay refunds directly to families.

Unfortunately, even if privacy concerns could be allayed, it would be difficult to put in place an analogous approach for employers that provide coverage directly. To make it work, employers would have to voluntarily agree to accept premium subsidy payments from the public programs and reduce individual worker's health insurance payroll deduction amounts accordingly. (If the state tried to require employers to do so, it would likely be challenged under ERISA.) Periodic reconciliation would also be necessary.

One possible alternative approach would use the state's payroll and income tax withholding system. Premium assistance recipients would be given a "voucher" to present to their employer. The amount of the voucher would equal the worker's premium subsidy. The voucher would direct the employer to advance that sum of money to the worker on each pay day by reducing the amount of state tax that would otherwise be withheld from the worker's pay. (The employer would continue making payroll deductions for health insurance in the usual manner.) If little or no tax was being withheld from the worker's pay (due to low income), and the voucher therefore made the state tax withholding a negative amount, money would be added to the worker's paycheck. The employer would recoup any funds so advanced by deducting the total amount of all vouchers submitted by all employees of that employer from the employer's periodic tax payments (and employee withholding transmissions) to the state.[82] The state tax agency would bill the public program(s) for the amount of the vouchers submitted.

This approach would require new systems in the state's tax agency. Record-keeping and other administrative requirements under this approach would not be insubstantial. It would not prevent workers from dropping their employer coverage, but under a mandatory system like SB 2 (or an individual mandate), that should not be a major concern. And, by linking payment to the employment-based tax withholding system, subsidy payment would automatically stop if the worker left that employer. To implement such a system, privacy concerns would have to be allayed. One consideration in this regard is that employers already have access to tax withholding information that can give strong clues about a worker's broader financial situation.

3.5.3. Potential Insurance Market Changes to Help with Premium Assistance

Because the vast majority of California firms offer at least one insured plan, the state could use insurance rules to improve access, continuity and administrative efficiency under premium assistance.[83]

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[82] This mechanism is analogous to the way "advance payment" of the federal earned income tax credit works today. The total "advance payments" made to all employees by a given employer are netted out against all federal tax payments (both FICA taxes and employee income taxes withheld) transmitted by that employer.

[83] Although state law cannot affect self-insured employer plans, we estimate that almost 95 percent of covered California workers have access to at least one insured plan. According to the *California Employer Health Benefits Survey: 2004* from the California HealthCare Foundation and the Health Research and Educational Trust, 31% of covered California employees are enrolled in partly or entirely self-insured plans. But five out of six California

For example, to improve the cost-effectiveness of premium assistance for small families, the state could require standard coverage tiers under all group plans to include a separate tier for "worker plus one child."[84] To greatly simplify the process of "benchmark comparisons" and cost-effectiveness analysis, the state might require carriers to submit information comparing all their group benefit plans to state premium-assistance benchmark plans.

Although SB 2 required that Medi-Cal and Healthy Families provide supplemental coverage for premium assistance recipients, advocates expressed concern over the differences between employer plans and public programs in provider networks and payment policies and over the discontinuities in care and access that would result. These concerns might be addressed if group carriers were required to offer upgraded plans to public eligibles (only) to avoid the need for separate wraparound coverage. As long as the state paid plans for these upgrades (which it would use and pay for only where cost-effective for the state), employers should not be affected.

Successful design and implementation of such rules could greatly reduce the administrative cost and burden of premium assistance for employers and the state, and facilitate cost-effective coverage of low-income families.

Several of these approaches would not make sense in the current environment, where the numbers of individual that might obtain premium assistance in a given employer plan or carrier would be quite small and thus not worth the effort and resources necessary to develop new systems. But such approaches could well justify their start-up costs under a substantial coverage expansion that, like SB 2, mandated enrollment in cost-effective employer coverage as a condition of receiving public assistance.

3.6. Legal Considerations in Designing Pay-or-Play Constructs

In addition to the policy issues discussed in this report, "pay-or-play" constructs like that in SB 2 raise several legal issues. Foremost is the potential that ERISA, the federal pension and benefits law, may preempt any state's law with an impact on private employer-sponsored plans. These types of proposals also face state constitutional issues peculiar to California.

3.6.1. ERISA

Pay-or-Play Laws. SB 2 was subject to challenge under the federal Employee Retirement Income Security Act because ERISA preempts state laws that "relate to" employee benefits programs (like employer-sponsored health coverage). As discussed more fully in Supplement D, courts have interpreted ERISA's preemption language to invalidate state laws that either refer to employer-sponsored benefit plans or attempt to dictate plan benefits, structure, or administration. For example, ERISA would preempt a state law mandating that employers offer coverage or defining the type of coverage employers must provide if they offer coverage voluntarily. SB 2 raised ERISA preemption concerns because, to qualify for a waiver of the fee, an employer plan

workers (83%) who are enrolled in self-insured plans also have access to an insured plan offered by their employer (from a special tabulation of the same survey). Thus, 94.7% are either enrolled in an insured plan (69%) or have access to one (31% * 83% = 25.7%).

[84] Consideration might also be given to a separate tier for "worker plus spouse and one child."

would have to include certain benefits and premium sharing features,[85] which arguably could interfere with plan benefits and structure so as to cause preemption. SB 2 contained an alternative fee-waiver provision that might have been less vulnerable to preemption.[86]

Based on Supreme Court cases interpreting ERISA's preemption clause, it seems likely that a carefully drafted pay-or-play law could survive an ERISA challenge. Least vulnerable to preemption are laws that:

- do not require employers to offer coverage to workers;
- assess *employers* but avoid directly referring to employer-sponsored *plans;*
- create a public program that at least partially is funded by employer contributions while remaining neutral regarding whether an employer pays into the pool or covers its workers; and
- do not impose conditions on what type of employer plan qualifies for the credit.

A law that credits an employer's actual costs of coverage (up to the limit of the fee) might be more defensible than SB 2, which waives the fee entirely but only if the coverage meets benefits and premium sharing standards. Allowing a partial credit makes it easier for a state law to avoid referring to employer-sponsored plans, while requiring an employer with benefits costing less than the fee to pay a partial fee. This approach might discourage employers from purchasing inadequate benefits (and could allow employees with insufficient benefits to obtain supplemental coverage from the public pool). But the sliding-scale credit could be cumbersome to administer and does not assure that workplace coverage is adequate, which was a major concern of SB 2's drafters.

<u>Health-Rated Assessments</u>. In Scenario C, the employer fee would vary according to worker age, health status, and geographic location. ERISA's preemption provisions should not interfere with a state pool assessment merely because it varies by these factors. But the process of obtaining employee health status information may raise preemption concerns. As a practical matter, employee health risk information may not be available until an employer applies to participate in the pool, in which case the fee would not be determined until after the application is processed. In this case, the public program could be argued to be a thinly disguised mandate that employers provide coverage, with the public pool as one optional vehicle to fulfill the mandate. (That is, the employer would have an option to apply for a fee determination from the pool and could opt to use the pool or any other source of coverage.) Such a design feature could therefore make the arrangement somewhat more vulnerable to an ERISA preemption challenge

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[85] At least one plan offered by every SB 2-covered employer would have to include all benefits mandated by California's Knox-Keene and Insurance laws, and the employer would have to pay at least 80 percent of the premium for that plan.

[86] If a court declared the original fee-waiver requirements under SB 2 invalid, the fee could be waived if employer coverage was deductible against business income and cost at least as much as the lower of the cost of coverage under Healthy Families or 150 percent of the cost of Medi-Cal for adults with incomes up to the federal poverty line. This alternate basis for the credit might have survived an ERISA challenge because it did not directly attempt to define benefits or premium-sharing arrangements. On the other hand, employer-sponsored coverage costs still needed to exceed a threshold, and a court might hold that even this requirement impermissibly interferes with the design and administration of employer-sponsored health coverage.

than a more straightforward "pay" fee that is predetermined for any given employer and that the employer must pay unless they reduce or obviate it by providing coverage directly.

On the other hand, it might be possible for the state to counter this potential challenge by requiring *all* employers (presumably, those with more than a specified number of workers) to provide the information needed by the state to determine what their health-rated fee would be. Every employer would then know its fee and would be free to pay it or seek to reduce or eliminate it by providing coverage directly. No doubt this approach would be very burdensome for employers that already provide coverage and plan to continue to do so. It would therefore be costly, system-wide, and politically difficult; but it would seem to address the potential ERISA challenge.

Fees Exceeding Costs of Pool Coverage. Under Scenario D, low-income workers ineligible for Medi-Cal or Healthy Families could receive premium subsidies to enroll into Healthy-Families-type plans whose per-capita costs are estimated to be less than the employer fee. Because the fee would be set to cover average employee costs and employees could enroll in the "lean" commercial plan without a subsidy, ERISA should not pose a problem for a public program that collects employer fees exceeding the costs to cover some enrollees (for which the state is able to negotiate lower provider payments or achieve other efficiencies).

Excess Risk Assessment. Scenario F would assess all employers (both those paying the fee and those covering workers) a small per-capita charge to cover the excess risk the pool would experience if it attracts a sicker-than-average population. Although courts have held that states cannot tax private sector-employer *plans* to fund high-risk pools for people unable to obtain insurance in the individual market, ERISA should not preempt a state assessment on *employers* to defray higher risks experienced by the public pool.[87]

3.6.2. Constitutional Considerations in California

Education Funding Guarantees. Proposition 98, a 1988 initiative amended in 1990 by Proposition 111, added a state constitutional requirement for minimum levels of state and local funding for K-12 schools and community colleges.[88] These provisions require education to be funded at different levels depending on the state's economy. When tax revenues are growing strongly, guaranteed funding must equal at least the proportion of the state budget spent on education in 1988, adjusted for changes in per-capita income and school enrollment. In normal revenue-generating years, education must be funded at the previous fiscal year's level. If tax revenues grow more slowly than personal income, education can be cut, but only in the same proportion as other state spending. These constitutional provisions limit the state's ability to fund new programs, such as subsidies for lower income employees participating in a state coverage program described in Scenario D (to the extent funds beyond SHPP fees are needed to fund the subsidies) or outside funding required for the percent-of-payroll approach in Scenario E.

[87] Such a law should avoid referring to employer plans but should be imposed on employers directly.

[88] Article 16, section 8. In addition, Constitution Article 12B provides an overall state budget spending cap, but it has not constrained the state budget since its inflation factor was redefined to reflect personal income growth.

"Fees" vs. "Taxes." California Constitution Article 13A, section 3, requires the state legislature to enact a tax increase by no less than a two-thirds majority vote in both houses.

Employer Assessment. SB 2 (enacted by only majority votes in each house) characterized the employer payment to the SHPP pool as a "fee" in an attempt to escape this constitutional supermajority requirement. Because there have been few court cases involving Article 13A, it is not clear whether the employer payment would qualify as a fee rather than a tax. The only California Supreme Court case to interpret this constitutional provision is *Sinclair Paint v. Board of Equalization*,[89] which held that a fee imposed on paint manufacturers to mitigate lead paint injury by funding a lead poisoning treatment program was a regulatory fee, not a tax subject to supermajority vote. Drawing from lower court decisions interpreting local laws under a parallel state constitutional provision, the Court noted that fees would not be considered to be taxes not only if they regulate the payer but also if they fund permits or privileges (such as land development approval) or fund government benefits. If the employer assessment under SB 2 had been challenged as a tax, its supporters may have been able to argue that it either regulated employer conduct like that in *Sinclair* [90]or funded services benefiting employers or employees.

Employer Fees Exceeding Pool Cost. It might be argued that two assessments analyzed in this report constitute taxes rather than fees: 1) the employer fee in Scenario D that exceeds the pool's cost to cover lower income workers enrolling in Healthy-Families-type plans or 2) an employer assessment that might be used under Scenario F to cover excess risks experienced by the SHPP pool. To constitute a fee, the employer assessment must benefit the employer or employee and not exceed the value of that benefit. It may be possible to argue that a fee exceeding the costs to cover certain lower income workers benefits both the employee who chooses to enroll in it (rather than the leaner benefits plan) and the employer that has chosen to participate in a public pool, whose overall purpose is to spread risk. The same logic may support an argument that an employer excess-risk payment benefits all employers—those that participate in the SHPP plan benefit from a more stable pool and those that do not participate benefit from the existence of the pool in which they may wish to participate in the future.[91]

4. Conclusion: Key Lessons for Crafting Pay-or-Play Programs

A "pay-or-play" employer coverage expansion can work only if there is a viable coverage vehicle for the workers of "pay" employers. SB 2 would have established a pool to be operated by MRMIB for this population. We find it unlikely that a sustainable pool could be developed under SB 2 as enacted. But alternative pool constructs (scenarios) could achieve a sustainable pool and reduce the financial burden for low-income groups. And our estimates indicate that this could be achieved without increasing total state budget outlays.

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[89] 15 Cal. 3d 866, 64 Cal. Rptr. 2d 447, 937 P. 2d 1350 (1997).

[90] Arguing that the assessment was a regulatory fee might have made SB 2 more difficult to defend against an ERISA preemption challenge. For a more detailed discussion of Article 13A implications for SB 2, see *Insurance Markets: California Constitutional Barriers to Implementation of SB 2*, March 2004, California HealthCare Foundation, www.chcf.org.

[91] In a case involving landfill fees, a California Court of Appeals held that the assessment was not a tax, even though the assessed property owners did not use the landfill and did not perceive that the fee benefited them, *Kern County Farm Bureau v. County of Kern*, 23 Cal. Rptr. 2d 910 (1993).

4.1. SB 2 Pool Challenges and Implications

SB 2 specified that "pay" employers' (and their workers') fees would be the sole revenue source to cover all costs of the pool. However, self-sufficiency would be difficult to attain for such a voluntary health insurance pool.

The SB 2 pool would not be an inherently strong, cohesive group. An employer could opt not to pay the pool "fee" by obtaining direct coverage at a cost based on its own group health profile and experience. Since the pool would not be a unique source of contributions or subsidies for any populations, there would be no inherent advantage for any set of employers with "normal" risk profiles to obtain coverage through the pool rather than directly in the market.

Given the pool's exposure to adverse selection, and given health plans' ability and preference to contract with employers directly, group health plans would be highly unlikely to agree to lower premiums for pool enrollment. But under SB 2 the pool could only contract with insured health plans and would not have the authority or financial wherewithal to self-insure. In these and other ways, the SB 2 pool would not be in the same negotiating position as is a very large private employer or CalPERS.

Our simulation analysis found that the SB 2 pool would not be viable without health rating. (And we estimate that it would require $5 billion dollars to offset the losses of an SB 2 pool offering flat community rates equal to the average SB 2 employer plan's costs). However, the pool could be financially viable and self-sufficient if it used health as well as age and geographic adjustments to its fees. (SB 2 gave MRMIB the flexibility to adopt rating factors it determined were needed to operate a sustainable pool.)

But health rating would be administratively complex, burdensome and legally problematic. It would raise nettlesome confidentiality and state program role issues. Unless the state were to obtain current health or claims experience information for all SB 2 employee groups, the state could not prospectively notify employers of what their "pay" fee would be. If employers instead had to apply for a fee quote, it could substantially increase the state's vulnerability to a successful ERISA challenge.

All things considered, it would be extremely difficult for the state to successfully implement health rating for the pool. We therefore conclude that it is unlikely that the state could implement and sustain a viable pool under SB 2 as enacted.

4.2. SB 2 Low-Income Population Assistance and Implications

For the majority of low-income workers and dependents not already eligible for Medi-Cal or Healthy Families, employer and worker contributions would be the sole funding source under SB 2. Medi-Cal and Healthy Families recipients eligible for employer coverage under SB 2 would be shifted from public to employer-financed coverage.[92] And low-wage workers' share of

[92] Outside the pool, public program eligibles would enroll in their employer's coverage and receive premium assistance and wraparound coverage from the public program. In the pool, public program eligibles would still receive coverage directly from the public program, but their employer's SHPP fees would be used to pay the state's cost for that coverage.

premium would be limited to 5% of wages, with their employers required to increase their contribution above 80% as needed. These provisions reflect a broader strategy by SB 2 sponsors to avoid state budget costs.

But such approaches would have other implications for low-income populations. Our impact analysis of SB 2 finds that employers with a majority of low-wage workers would bear a disproportionately high cost burden relative to their total payroll costs. In a number of cases, such employers might respond to this burden by reducing their workforce or adopting other cost cutting measures that would negatively affect low-income workers and their families.

For those parents and children enrolled in employer coverage who were eligible for Medi-Cal or Healthy Families, SB 2 would provide premium assistance for the worker's share of costs, as well as supplemental public coverage. (For the estimated 4 percent of such eligibles for whom the employer would choose to "pay" the fee for the pool under Scenario C2, eligible applicants would receive premium assistance and direct enrollment into the public program.)

We estimate that about $200 million net state savings annually (plus associated federal matching fund savings) would result, despite an increase in enrollment, because employer-financed coverage would substitute for publicly financed coverage.[93] This would dramatically lower state costs even after premium assistance and supplemental coverage costs were taken into account. We note that, on a state budget-neutral basis, such savings could alternatively be used to assist other low-income workers and dependents beyond those already eligible for Medi-Cal and Healthy Families. And our analysis of alternative scenarios indicates that, if such subsidies were made available through the pool, they could help to achieve a viable and sustainable pool.

Our budget estimates for SB 2 also point to a more general conclusion—that California could utilize employer-financed coverage to leverage limited state funds to cover many more low-income workers and dependents.

But our savings estimates for SB 2 assume that public-program eligibles with access to employer coverage would receive premium assistance toward that coverage and would not receive direct public coverage, while SB 2 would not create an environment conducive to streamlined administration of premium assistance. Without related changes, premium assistance would be very burdensome for the state and for employers, especially given the extremely large number of recipients involved. It is unlikely that expectations and requirements for premium assistance under SB 2 could be realized unless it could be simplified. Without major streamlining, many low-income families could go without premium assistance and wraparound coverage, and/or public program costs could be dramatically higher than otherwise expected. New approaches might include using the state tax withholding system to administer premium refunds.

Further, because the vast majority of California firms offering health benefits contract with at least one insured plan, California is in a unique position to use insurance rules to make premium assistance much less burdensome. Insurance rules could be used to greatly streamline the process of collecting and assessing employer plan information by requiring provision of such information by licensed health plans. Wraparound coverage could be streamlined and continuity

[93] Note that this estimate does not include any offset for the administrative costs of operating a premium assistance system. Such costs could vary greatly, depending on the approach taken to implementing the program.

of providers and care for recipients could be improved if appropriate supplemental coverage were available through the group health plans providing the primary coverage. Such seamless supplemental coverage could also avoid the substantial costs and burden to health plans, providers and recipients associated with coordination of benefits and provider payments among multiple coverage sources.

Realistically, we conclude that any major coverage expansion intending to use premium assistance for a very large number of people should incorporate new structures that are more appropriate to the goals and scale involved, that serve the needs of low-income workers and their dependents, and that avoid creating unnecessary and costly new state administrative roles and associated staff requirements.

4.3. Using Low-Income Assistance to Make the Pool Viable

We also conclude that making subsidies for low-income employee groups available exclusively through the pool could obviate the need to adjust employer group fees for the health status of workers. Depending on specific design features, the subsidies would attract enough employers with many low-risk and low-income workers to make this possible. (Such subsidy approaches could also be adapted to reach uninsured small employer groups, where many uninsured workers are employed.)

One such approach would be to set the fee as a percentage of payroll on a sliding-scale basis (Scenario E). Doing so would attract employers with many low-wage workers and allow their health coverage costs to be more proportionate to their wages. We did find that this approach would allow the pool to be viable without health rating. But it would require very substantial external funding to offset the shortfall in fee revenues for the pool, and these funding requirements would outstrip any expected state savings on Medi-Cal and Healthy Families.

Another approach (Scenario D) would provide premium assistance to all low-income workers and dependents in the pool (under 200% FPL), and enroll them in a more comprehensive Healthy-Families-type plan. The pool's standard offering (upon which fees would be based) would be a lean (higher cost-sharing) plan. We found that the pool would be viable without health rating under these provisions, and that no external funds would be required. That is, the pool's "pay" employer fees for a lean commercial plan, plus net sliding-scale contributions from low-income workers, would more than cover the cost for the Healthy-Families-type health plans these workers would be enrolled in.

This scenario assumes that premiums proportionate to those for Healthy Families plans could be extended to low-income workers under 200% of poverty (as was previously planned for parents in the same income range). Because the plans would be asked to serve only a low-income population at these rates, it seems feasible that enough of them would willing be and able to do so.

On the other hand, somewhat higher health plan premiums could well be needed. But this or similar approaches could still be implemented on a state budget-neutral basis. The significant Healthy Families and Medi-Cal savings from the use of employer-financed coverage could be used to fund low-income worker subsidies. Workable variations could be designed involving

some combination of altered benefit plans or eligibility and subsidy schedules that in turn might alter the size of the pool.

These dimensions are significantly inter-related. And, because health plan premium negotiations cannot be accurately predicted, we would strongly recommend that, if there were any subsequent proposal similar to SB 2, MRMIB should be granted flexibility to design and alter such policies to achieve a viable pool while staying within state budget constraints.

In conclusion, our analysis provides strong evidence to support consideration of a low-income worker subsidy approach in any subsequent efforts to expand employer-financed coverage. If carefully adapted to the relevant variables at hand, it could achieve a viable pool while extending needed financial assistance to low-income groups and avoiding the perils of health rating for the pool. It could also give the pool membership cohesion and a healthy risk mix and, therefore, substantially improve its ability to negotiate lower rates with health plans.