California HealthCare Foundation

Covering California's Uninsured: Three Practical Options

Introduction

Policymakers in California are faced with a compelling need to find sources of health coverage for the state's growing ranks of uninsured—a population whose numbers now exceed 6 million. Interest in such a solution has been intensified by Massachusetts' recent enactment of "near-universal" coverage for its residents.

To help guide the design of a practical system capable of providing health benefits for virtually all Californians, the California HealthCare Foundation funded a project that developed and analyzed a number of alternative coverage models. All require individuals to participate, with varying levels of requirements placed on employers and the state.

This summary identifies the essential components of these alternatives and how they would affect employers, individuals, and the state budget. Each of these alternatives is designed to make use of the federal tax benefits available for health insurance purchased through employers, thus reducing individual and state costs. Each also includes sliding-scale subsidies and a coverage venue for individuals to assure that health insurance is accessible and affordable for all.

Cost estimates are provided for three specific approaches that were developed, analyzed, and refined in consultation with numerous experts. A detailed presentation of the models outlined here is contained in the full report, available on the CHCF Web site at http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=125690.

Overview

The approaches outlined here are predicated on two elements that also form the core of the Massachusetts plan:

- All would make participation in health insurance mandatory for all individuals and families in the state; and
- For people whose employers do not offer coverage, a health insurance "Exchange" assures a convenient way for individuals to have access to their choice of health plans, and for employers to tax shelter and administer their premium payments. (See sidebar on page 2.)

In addition:

- To assure that such coverage is affordable for every resident, regardless of income, all the models incorporate premium assistance for low-income Californians, directing it towards either their employers' health plan or the Exchange.

The three alternatives vary in two primary respects:

- Whether and what financial contribution is required from employers; and
- The proportion of workers who receive coverage through employer-sponsored plans rather than the Exchange.

EXECUTIVE SUMMARY

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Comparison of Model Design

A side-by-side comparison of the models can be found in a matrix table on the following page. (The common elements described above are not repeated.)

The three coverage alternatives fall into the following categories:

1. Basic Individual-Mandate Model

This model makes the fewest changes in the health care financing system. People are required to have health insurance; cost estimates assume that most would meet this requirement by participating in their employers' current health benefit plan. Employers are not required to contribute, but they must at least shelter from taxes workers' premium payments made through payroll deductions. Premium subsidies are available for all low-income Californians. And a new "Exchange" provides an access mechanism for people whose employers do not offer them coverage.

2. "Pay-or-Play Plus" (Employer Contribution Floor plus Part-Time Worker Fee)

This coverage model combines the individual mandate and subsidies for low-income people with a fee levied upon employers of part-time and short-term workers, plus a contribution floor, both in the form of a payroll fee equal to 5 percent of wages. Most employers who already offer health insurance to their permanent full-time workers would be expected to avoid the payroll fee by contributing the equivalent amount or more toward regular group coverage; so most people would still get coverage through their employer, as they do now. All part-time and short-term workers, as well as others without employer coverage, would purchase coverage through the Exchange. The employer payroll fee would help to offset state subsidy costs for lower-income workers. Employers with just one employee or an annual payroll below $75,000 would be exempt.

3. All-Consumer Choice Exchange (ACE) Model

The all-consumer choice exchange (ACE) replaces today's employer-by-employer coverage system with an all-consumer "Exchange" or "choice pool" that enables workers and their families to choose among competing health plans.

Under this approach, health insurance coverage would be primarily funded by a payroll fee paid by both employers and workers. Structuring the fee as a percentage of wages would make coverage relatively more affordable for low-wage workers and businesses that employ mostly low-wage workers. The 80/20 split in employer/worker share of costs mirrors the average share in the current health benefit market. As in the

The Health Insurance Exchange

Coverage for people not eligible for employer-group coverage would be made available through a health insurance exchange authorized by state legislation, referred to in this summary as the "Exchange." Competing health plans and insurers would be offered through the Exchange on a guaranteed-issue basis; carriers would not be allowed to consider an individual's health status in determining premium rates.

The Exchange would:

- Offer workers a choice of health plans on an family-by-family basis;
- Work with employers to facilitate workers' signing up for health insurance at work;
- Collect workers' enrollment information and tax-sheltered payroll deductions from employers;
- Receive subsidy payments from the state on behalf of low-income workers and families;
- Distribute enrollment information and premium payments to the health plan in which each worker and family enrolled; and
- Serve as the exclusive source of premium subsidies for individuals not eligible for Medi-Cal, Healthy Families, or employer coverage.

Using an Exchange would help to assure affordable access through broad risk spreading and administrative efficiencies, particularly since multiple public and private financing sources would be involved.

Table 1: Matrix of Model Design

Scenario Design Element	Basic Individual Mandate	Pay-or-Play Plus	All-Consumer Choice Exchange ("ACE") "High-Value" Option
Employer contribution level required	None. Current contribution levels assumed.	5.0% of Social Security wages* as required payment for part-time workers; floor for full-time workers.	10.5% of Social Security wages.*
Exempt employers	None	Firms with one employee or annual payroll below $75,000.	
Families with employer coverage pay:	Contribution required under employer plan, minus premium assistance if low-income.		No employer coverage. All workers pay 2.6% of Social Security wages* for Exchange coverage.
Low-income families covered through Exchange pay:	After-tax contribution as a percent of family income: sliding scale from 0.0% (households below 100% FPL) to 7.5% (201% to 250% FPL).		Families that include a full-time worker pay 2.6% of Social Security wages.* Others pay 0.0% to 7.5% of income.
Higher income families covered through Exchange pay:	Full premium		Families that include a full-time worker pay 2.6% of Social Security wages.* Others pay full premium less any payroll fees.
Benefits for people with employer coverage	Determined by employer plan (No supplementation for low-income people except those who qualify for Medi-Cal or Healthy Families.)		Eliminates employer coverage in favor of an Exchange in which health plans compete to attract consumers. Full-time workers and dependents can receive average of current employer-plan benefits ("mainstream" package) or pay more for richer benefits or broader networks.
Benefits for people eligible for Medi-Cal or Healthy Families	Medi-Cal or Healthy Families benefits, directly or as supplement to employer coverage. (Other low-income kids receive Healthy Families benefits.)		Medi-Cal or Healthy Families benefits, directly or as supplement to "mainstream" package.
Benefits for other adults under 250% FPL in Exchange	Healthy Families "Adult" package† for those with incomes at or below 200% FPL; primary and preventive care package plus $2,000-deductible plan for adults over 200% to 250% FPL.		Healthy Families "Adult" package.†
Mandated minimum benefits package for higher income people.	$5,000-deductible plan		For full-time workers and dependents, "mainstream package." For others, $5,000-deductible plan.

Note: FPL (Federal Poverty Level) for a family of three is $16,600 in 2006.

* For 2006, wages up to $94,200.

† Adults with family incomes below 250% FPL (and not eligible for Medi-Cal) who enroll through the Exchange would receive the benefit package that would have been available to parents under the proposed-but-never-implemented expansion of the Healthy Families program. This package provides comprehensive coverage with no deductible and only minimal patient cost-sharing at the point of service.

pay-or-play-plus model, employers with only one worker or an annual payroll less than $75,000 are exempt.

The full report presents estimates for two variants of the ACE model. One would set the fees to fund current average employer coverage at average group premium prices in California (less an expected 3 percent savings expected from universal coverage). That model would sharply increase employer costs in California and may not be a realistic option. A second, the "high-value" model described in this summary, would set the fees to fund coverage that costs 15 percent less (an assumed savings that derives from tighter provider network plans or higher cost-sharing). Both variants allow individuals to choose more expensive plans as long as they are willing to pay the associated higher premiums.

Sources of Coverage

Table 2 shows the source of coverage for 31.2 million Californians under the three main coverage approaches, compared to the current system.

Under the basic individual-mandate model, the Exchange would enroll 4.1 million Californians, almost four times as many as are now covered in the individual market (1.1 million), but only about one-fifth as many as those with employer-group coverage. The estimated employer-coverage growth (from 19.2 to 22.6 million) reflects enrollment of workers and dependents who currently decline an employer's offer of coverage and are either uninsured or enrolled in Medi-Cal or Healthy Families. The pay-or-play-plus model would see 1.3 million fewer Californians in employer coverage than the individual mandate, due to the fact that all part-time and temporary workers and their dependents would be covered through the Exchange or Medi-Cal/Healthy Families. In the ACE model, all Californians not enrolled in Medi-Cal or Healthy Families would receive coverage through the Exchange.

Table 2: Nonelderly Population by Source of Coverage under Three Approaches to Universal Coverage in California, 2006 (in millions)

Coverage Model	Current System	Basic Individual Mandate	Pay-or-Play Plus	All-Consumer Choice Exchange (ACE)
Source of Coverage				
Uninsured	6.4	-0-	-0-	-0-
Direct Medi-Cal/ Healthy Families (only)	4.5	4.5	5.0	4.2
Employer-Group Coverage	19.2	22.6	21.3	-0-
Exchange Coverage	1.1*	4.1	4.9	27.0
TOTAL	**31.2**	**31.2**	**31.2**	**31.2**

Notes: Figures are numbers of civilian, non-institutionalized California residents under age 65. Details may not add to totals due to rounding.

* Under "Current System," the entry for "Exchange Coverage" is an estimate of people who currently have individual (non-group) coverage.

Cost Estimates by Payment Source

Table 3 summarizes the estimated cost of each of these models and shows how costs would be affected for employers, the state government, and Californians compared to estimated current health care spending in 2006 for the civilian population not on Medicare and not in long-term care institutions.

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

Table 3: Summary of Cost Estimates: Current Spending and Change in Spending by Source, California, 2006 (in billions of dollars)

Coverage Model / Category of Spending*	Current Spending (2006)	Increase or (Decrease) in Spending under...		
		Basic Individual Mandate	Pay-or-Play Plus	All-Consumer Choice Exchange (ACE) "High-Value" Option
Payments by employers (net of tax savings)	$57.9	$4.5	$6.8	$0.5
Contribution to premiums paid by individuals and employers from tax savings on worker contributions	4.4	3.9	3.0	2.6‡
Premium payments and out-of-pocket spending by individuals (net of tax savings)	28.4	(6.8)	(10.8)	(6.3)‡
Premiums paid by public programs (including direct public coverage)	15.9	7.2	5.6	0.6
TOTAL Premiums and Out-of-Pocket Costs*	**106.6**	**8.7**	**4.3**	**(2.5)**
Net Cost to State (including tax revenue loss)	9.2 [16.9]†	6.1	3.5	1.5

Note: Details may not add to totals due to rounding.

* Spending estimates are for the civilian, non-institutionalized population under age 65 and exclude payments by Medicare, CHAMPUS, and the military, as well as payments for long-term care. Estimates also do not include payments to health care providers other than those for the treatment of individual patients, such as state supplemental payments to "disproportionate-share hospitals."

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

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

Comparative Analysis

The alternative coverage approaches specified here involve a number of policy and economic trade-offs.

The basic individual mandate model would not require employer contributions and thus would not threaten the viability of businesses or employment rolls in California. But the cost to the state would be relatively high, and could increase substantially over time if employers respond to the state's incentives by dropping coverage of workers and families earning modest wages, a phenomenon known as "crowd-out."

Given the high subsidy costs associated with a basic individual mandate approach, the state would need to find offsetting revenue sources. These might include approaches that capture the savings that result from near-universal coverage, such as some reallocation of public spending on services for the uninsured, or assessing a fee on providers proportional to the aggregate cost of treating uninsured patients. Another potential source of revenue is a fee on employers that do not offer health benefits. Massachusetts' revenue sources include all of these ingredients, although its fees on employers that do not offer coverage would generate relatively inconsequential revenues.

By establishing minimum employer contribution payments, the pay-or-play plus model would both provide revenues to offset state subsidy costs and define a floor beneath which employers could not shift costs to the state. The basic concept is that a "floor" would be set at a level that would not increase contribution costs for most employers that now offer coverage for full-time workers. If it is set as a proportion of wages (such as the 5 percent of payroll estimated here), the cost to the low-wage firms that typically do not offer health benefits would be substantially less than the cost of providing traditional group coverage.

Adding a required employer fee for all part-time and part-year workers, as is the case with the pay-or-play-plus model, would serve several related purposes. It should help avoid perverse incentives to convert full-time permanent positions to part-time, temporary, or contract worker arrangements. Further, the approach would provide continuity of coverage, plan enrollment, and associated provider care for a population otherwise denied such access and stability. And it would generate premium revenues by consolidating proportionate contributions from multiple or sequential employers of a given worker. Because most families with no full-time permanently employed workers have low incomes, these revenues would offset substantial state costs associated with subsidies for this population.

The employer requirements under pay-or-play-plus could engender strong opposition from those firms that would be required to begin contributing; indeed, they could affect the viability of some businesses, such as those faced with direct competition from foreign firms that do not bear health insurance costs. An offsetting consideration is that a number of other firms employing many California workers clearly face stiff global competition, and already pay much more for their workers' health benefits costs than the minimums estimated here. These businesses and their workers would also stand to gain from the elimination of cost-shifts for uncompensated care consumed by the uninsured employees of firms that now contribute nothing. While a number of employers that now offer benefits to part-time workers would realize a savings, others would be required to pay for the first time towards coverage of such workers.

The all-consumer choice exchange (ACE) model would constitute the most sweeping change from the current system. Because all Californians (other than Medi-Cal and Healthy Families beneficiaries and federal employees) would be covered through the Exchange, it could result in significant improvements in consumers' ability to choose among competing health plans and maintain continuity of coverage, health plan

enrollment, and provider care. State subsidy costs would be sharply lower than those under the other coverage models because, by design, employer and worker fees are set at the percent of payroll that fully pays for coverage of all full-time permanent workers and their families. And the basic design of ACE is structured to substantially improve market incentives for cost discipline, as virtually all Californians who choose more expensive plans would pay the difference directly.

The "high-value" ACE approach would involve relatively low aggregate payment requirements for employers, as well as for the state and for workers, and would have the greatest potential to achieve health care cost discipline. However, it would involve substantial cost increases for a number of individual employers that, for example, pay higher-than-average wages or enjoy lower-than-average premiums. (For example, more than 20 percent of employers who now offer health benefits would see their total costs more than double.) And although most individuals would have reduced out-of-pocket costs, how many would opt for more expensive plans—and how much they would be willing to pay—cannot be accurately predicted. Some could be upset over the prospect of having to pay more in order to obtain the broad networks (or cost-sharing levels) associated with their current benefit plans. These factors, plus the sweeping change associated with this model, suggest that its adoption would be more controversial than the other approaches examined here.

Conclusion

Both policymakers and the electorate have long believed that all Californians should have access to essential medical services. Each of the coverage models described and estimated here (and detailed in the full report) would assign individual, employer, and government responsibilities that, unlike the current health insurance system, are consistent with that belief. While there are difficult judgments and trade-offs involved, it is hoped that this analysis ultimately assists policymakers, stakeholders, and the public in the design and adoption of such a system.

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