A Proposal To Cover The Uninsured In California

A reform proposal that acknowledges and respects the unique political and cultural environment of this large state.

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ABSTRACT: The lack of health coverage for millions of Californians is a major societal problem. In the absence of federal action, we propose a state-based approach that leverages existing systems to create near-universal coverage within two years. We describe several subsidized benefit options for low-income uninsured Californians, emphasizing preventive and primary care, and we propose catastrophic coverage, at a minimum, for higher-income uninsured Californians. Proposed financing mechanisms include a health care sales tax and an "in-lieu" payroll tax. [*Health Affairs* 26, no. 1 (2007): w80–w91 (published online 12 December 2006; 10.1377/hlthaff.26.1.w80)]

COMPARED WITH MASSACHUSETTS AND OTHER STATES, California faces daunting challenges in initiating universal health coverage. The state contains 10 percent of all uninsured Americans, many low-income uninsured people, and fewer employed uninsured people; thus, its options for a state-level solution might be more relevant to many states than solutions proposed in Massachusetts and Vermont, which have lower uninsurance rates.[1]

Despite the greater dimensions of the problem in California, we believe that a state-based solution is possible. Broad national reform—our preferred long-term solution—seems unlikely in the near future. We describe a state-based approach that, like Massachusetts' new law, requires employers, individuals, and government to participate. This proposal could be implemented within two years and would provide near-universal coverage to the more than five million Californians who lack health insurance.[2] It addresses two issues that have largely been ignored by other state-based initiatives: (1) affordable and appropriate benefit designs for different population segments; and (2) sustainable revenue sources. In addition, it specifically addresses several basic requirements for a system of near-universal coverage, including mechanisms to encourage or mandate individuals to take up coverage and employers to offer coverage; an infrastructure to handle the business

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functions of public or private plans; provider reimbursement policies; cost control and resource efficiency features, including the support and promotion of efforts to develop an electronic personal health record (PHR); and a framework for encouraging primary and preventive care.

In devising this proposal, we were guided by the following principles and goals aimed at ensuring maximum fairness, feasibility, and value to the tax-paying residents of California: (1) Increase enrollment in current public programs among those who are eligible; (2) provide affordable and guaranteed basic health coverage for low-income uninsured people who are ineligible for other coverage; (3) provide affordable, guaranteed coverage to higher-income uninsured people who have chosen not to purchase coverage or who are medically uninsurable; (4) directly support, strengthen, and expand the safety net of public and private health care providers; (5) use broad-based, dedicated, dependable, and equitable funding for financial subsidies; (6) provide incentives for every person to obtain and for all employers to offer coverage; (7) avoid major disruption in the existing employer-based and individual markets; (8) maximize California's use of available federal Medicaid funding; (9) limit aggregate program costs; and (10) support and integrate efforts to create a PHR database.

We hope that this proposal, although modeled specifically to meet California's needs, might serve as a prototype for other states where higher-than-average rates of uninsurance, higher levels of poverty, and fewer resources for uncompensated care render Massachusetts-type solutions unrealistic.[3]

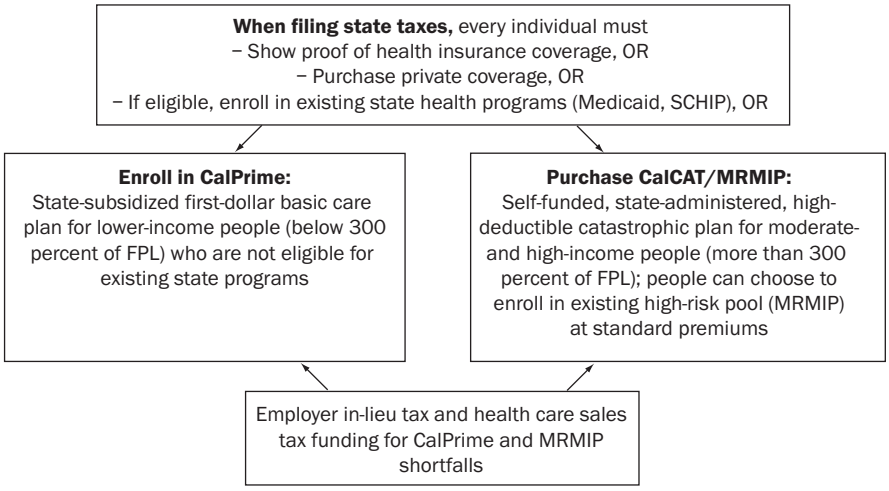
The Proposal

Our proposal leverages existing state-based programs; creates new programs; and identifies dependable, self-sustaining revenue streams to provide subsidized health coverage for the low-income uninsured (Exhibit 1). It further defines minimum health coverage for all California tax filers. Low-income legal residents who are uninsured and who do not file taxes could also voluntarily elect subsidized health coverage. Individuals and their dependents below a defined income threshold would, if eligible, receive subsidized health coverage under existing public health care programs or enroll in a new state-administered basic plan (CalPrime), featuring coverage for ambulatory care services. Uninsured people exceeding the income threshold would be obligated to either purchase private coverage, enroll in public programs if eligible, enroll in California's high-risk pool, or be automatically enrolled in a new state-run catastrophic care plan (CalCAT).

■ **Individual health coverage obligation.** When filing state income tax, all Californians would certify a defined minimum level of health coverage for themselves and their dependents. This obligation would be expected to cover many more people than a voluntary program with premium subsidies for low-income people.

To achieve near universal coverage, state income tax filing was chosen as the primary enrollment and enforcement mechanism because it reaches a large num-

EXHIBIT 1
Elements Of The Proposal To Cover The Uninsured In California



SOURCE: Authors' analysis.
NOTES: CalPrime is the proposed state-administered basic health plan. CalCAT is the proposed state-run catastrophic plan. MRMIP is the existing Managed Risk Medical Insurance Program. See text for plan details. FPL is federal poverty level.

ber of California residents efficiently. Voluntary enrollment for subsidized coverage is available at the point of service for low-income legal residents who do not file. The income tax collection process also provides an efficient mechanism to collect premiums from moderate- or high-income uninsured people.

■ **Low-income people.** For uninsured state tax filers with family incomes under 300 percent of the federal poverty level (FPL), we emphasize coverage of primary care services to improve access for them and their dependants. Their coverage obligation could be met through Medicaid or the State Children's Health Insurance Program (SCHIP). Everyone who is eligible for these programs would be encouraged to enroll. If not eligible for Medicaid or SCHIP, low-income people and their dependants would be eligible for a new, guaranteed-issue, state-administered program called CalPrime.

We modeled four benefit options and three reimbursement alternatives for CalPrime, ranging from a basic $2,000 primary care allowance alone to full, comprehensive coverage. The four plans create a spectrum of choices for California policymakers; descriptions include the cost implications of each choice. We recommend that the state select one of the options presented as the basic CalPrime plan. Except for the most basic benefit option—the $2,000 primary care allowance alone—coverage under CalPrime would include the following components.

Basic benefit. A $2,000 annual basic benefit for outpatient care, prescription drugs, and emergency care should provide 100 percent of basic annual care for more than 80 percent of CalPrime enrollees. Per visit copayments and selected prescription drug copayments would be minimal ($10) under the basic benefit.

A deductible that follows the basic benefit level. After the deductible is met, all services would be covered. We modeled three deductible options: $10,000, $2,000, and zero. The deductible is included in the benefit package primarily to make the program affordable for taxpayers and to encourage using preventive services rather than emergency services or hospitalizations. Plan C, with the $2,000 deductible, has several advantages, including the fact that it covers 100 percent of the costs for all care needed by 80 percent of enrollees, encourages appropriate use of preventive and primary care, prevents bankruptcies, and greatly limits the cost shift to private payers.

Comprehensive umbrella coverage. This coverage would pay for all care once the deductible is satisfied. Minimal copayments and cost sharing could be added selectively to encourage wise use of resources.

These options reflect our belief that incentives for low-income patients are better aligned by promoting up-front primary care coverage followed by out-of-pocket expense, rather than an up-front deductible followed by full coverage. These front-loaded benefit plans create direct financial incentives for CalPrime enrollees to seek proactive care such as cholesterol-lowering drugs or asthma-control medications. In contrast, most commercial "consumer-directed" benefit plans feature large front-end deductibles that discourage the use of primary care and pay in full only for catastrophic cases.

CalPrime premiums would be fully subsidized for uninsured people with incomes below 200 percent of FPL. Premiums for those with family incomes at 200–300 percent of FPL would be subsidized on a sliding scale, to 50 percent at 300 percent of FPL.

Under our proposal, low-income people would receive health coverage based on their CalPrime delivery system choices, assuming both fee-for-service and prepaid plan options. We recommend allowing community clinics and safety-net hospitals to be both fee-for-service and prepaid participants in CalPrime, to strengthen and encourage growth in this invaluable portion of our health care infrastructure. Community clinics, properly supported, could expect revenue growth. As prepaid participants in CalPrime, they would be able to implement appropriate care management and preventive programs for their enrolled populations and compete with other participants based on their ability to provide more visits per patient.

■ **Moderate- to upper-income people.** For uninsured people with incomes exceeding 300 percent of FPL, we propose mandating, at a minimum, an affordable catastrophic option. Their obligation to be insured could be met by any of the following.

Private coverage. First is private health coverage that meets or exceeds a minimum level of coverage, purchased directly by individuals or indirectly by employers prior to state tax filing. (Evidence of insurance status would be indicated in a special section of the California personal income tax form. All carriers and payers

would provide a "proof of coverage" document similar to those used for automobile insurance.)

Public coverage. Next is enrollment in public programs for those eligible to participate in Medicare, Medicaid, SCHIP, or another publicly sponsored health coverage program. CalCAT, a new state-run, high-deductible, catastrophic coverage plan, would automatically cover people who do not show evidence of insurance status. At enrollment, these people would pay additional taxes equal to the estimated annual average cost of the plan. The proposed CalCAT benefit is a guaranteed-issue, $10,000 deductible plan administered by the Department of Health Services. It might provide sufficient coverage for some higher-income Californians. For those just above 300 percent of FPL, this coverage is intended as a stopgap measure: relatively affordable, immediately available protection from catastrophic costs. We anticipate that over time, CalCAT enrollees will benefit from new, innovative, and affordable plans in the private marketplace as insurers recognize the inherent opportunities of this population.

The Managed Risk Medical Insurance Program (MRMIP), the current state plan for the medically uninsurable, would cover medically uninsurable people who choose to buy a more complete set of benefits than CalCAT offers at standard MRMIP premiums on a guaranteed-issue basis. MRMIP is a good safety-net program but has been historically underfunded, with limited enrollment. Under this proposal, MRMIP would be fully funded by a broad revenue base. Funding for MRMIP is included in the cost and revenue estimates below.

■ **Expected enrollment.** Implementation of the proposal would extend health coverage to an estimated 85 percent of uninsured Californians (about 4.7 million).[4] Among those with incomes at or below 300 percent of FPL, about 730,000 state tax filers eligible for but not enrolled in Medicaid or SCHIP would be encouraged to enroll in those programs. An estimated 2.9 million people who are ineligible for other coverage would receive subsidized CalPrime coverage or would be newly covered by employers instituting coverage. An additional 500,000 low-income people who now have individual coverage would also be eligible for CalPrime.

Of California's 1.1 million uninsured people with incomes above 300 percent of FPL, 62 percent (about 682,000) would be expected to purchase private coverage in the individual market or through their employer; 34 percent (about 374,000) would be expected to purchase the state-administered, high-deductible plan; and the remaining 4 percent (44,000) would be expected to purchase the MRMIP plan.[5]

■ **Information technology to improve quality.** This proposal, which would add nearly five million Californians to the insured population and provide broader access, underscores the need for better health information technology (IT). We believe that promoting consistency and quality of care should be a crucial component of any proposal for near-universal coverage. When each patient's full medical record is in a protected, confidential electronic database, individual care can be based on the best

possible clinical information. Near-universal coverage presents opportunities for CalPrime, CalCAT, Medicaid, and all private carriers in California to collaborate in efforts to establish a PHR database, based on records supplied by medical groups and other organized delivery systems in California, through their existing clinical information systems, or by health plans' claims systems. With such a database, as patients change providers, their personal health information and history would be accessible to themselves and their designated providers.

Assumptions Used In Deriving Cost Estimates

We developed our estimates using the Lewin Group's Health Benefits Simulation Model (HBSM), a model of the U.S. health care system designed to provide estimates of state-level health reform initiatives. We adapted it to represent California's health care system, based on extensive analysis of California-specific population and health spending data from public sources and the Office of Statewide Health Planning and Development (OSHPD). The HBSM was used to estimate the impact of our proposal on coverage and costs, using premium estimates developed by Kaiser Foundation Health Plan actuaries.[6]

Premium estimates provided for health care costs, plus a 10 percent administrative allowance. Health care cost estimates incorporated assumptions about the likely use of covered services, using the "allowed charge" for each unit, net of beneficiaries' cost-sharing obligations. Utilization estimates were developed for each covered service (such as physician office visits) based on industry-standard data for large-group coverage, adjusted to represent the demographic characteristics of the uninsured population. Estimates are intended to capture health care utilization levels in a mature group, which might not be consistent with resource use at program inception. Although initial use rates might reflect some pent-up demand, long-range rates should roughly mirror levels observed for large groups.

Unit-cost estimates were developed under three fee-level scenarios: Medicare; Medicare plus 20 percent; and competitive commercial fee levels, assuming discounts (relative to billed charges) achieved by an average commercial insurer. The assumed ratio of competitive commercial fees to Medicare fees is not constant by service category; generally, differences between the two are smaller for physician services than for hospital services. Allowed charges for prescription drugs were assumed to be the same under all scenarios. Because differences in fee schedules among scenarios could determine whether the primary care cap or the catastrophic deductible is met or exceeded, the ratio of premiums from one scenario to the next will not be identical to respective fee schedule ratios.

The HBSM population data are based on the 2003 California Health Interview Survey (CHIS) and the Medical Expenditure Panel Survey (MEPS), which provided detailed information on sources of coverage, health spending, and income. Using these data and program eligibility rules, we identified those eligible for but not currently enrolled in Medicaid and SCHIP. In addition, we identified unin-

sured people eligible for the high-risk pool, based on reported serious chronic medical conditions.

The Lewin Group analyzed tax-filing data from the March 2003 Current Population Survey (CPS), which indicate that about 77 percent of tax filers with one or more uninsured members file a tax return and includes low-income working people who file although they are not required to, presumably to obtain refunds.

Employer data were based on the Henry J. Kaiser Family Foundation's annual survey of employers, comprising insuring and noninsuring firms, statistically matched to workers in the population data to form a database of "synthetic firms" with socioeconomic characteristics and health spending information for each worker in each firm, including covered workers, ineligible workers, and eligible workers who have declined coverage.

We also simulated employers' response to the in-lieu tax, imposed under this proposal on noninsuring firms or those offering coverage that fails to meet a minimum threshold amount of health care sales taxes. We conceptualized the in-lieu tax to capture the cost of not providing coverage in a way that effectively lowers the relative cost to the employers who provide coverage at levels sufficient to avoid the in-lieu tax. The HBSM simulated employer take-up using a multivariate model of the effect of changes in premiums on the likelihood of offering coverage. Although take-up varied with firm characteristics, it was generally consistent with price elasticity of −0.87 for firms with two to nine employees, dropping to about −0.35 for firms with ten to fifty workers and lower as firm size increased.

In modeling, we considered the issue of "crowd-out," a situation where public funding leads to a reduction in existing private coverage. Theoretically, some employers might drop coverage if their workers become eligible for subsidized coverage under CalPrime. We assumed that no employers would do so, because the mandate is likely to increase worker demand for tax-favored employer coverage, plus the in-lieu tax would deter employers from dropping coverage. We also assumed that all workers who have declined employer coverage (about 20 percent of all uninsured workers) would accept it if they were subject to automatic enrollment and if their contribution was lower than their cost for public coverage. We also assumed that firms not meeting the health care tax threshold would pay the in-lieu tax instead of extending coverage to part-time or otherwise ineligible workers. In addition, start-up companies that would have offered coverage might choose not to do so, given the publicly funded alternative. We recommend monitoring trends in private coverage and if crowd-out is found to occur, taking steps to address it such as increasing the in-lieu tax, increasing the waiting period, or permitting employer contributions to be used for CalPrime coverage.

Costs for new Medicaid and SCHIP enrollees were estimated using current program costs for similarly situated people. Loss experience in the high-risk pool was assumed to be the same as for current enrollees.

Estimated Plan Costs And Financing Sources

Exhibit 2 shows estimated total subsidies required for applying alternative reimbursement rates (Medicare, Medicare plus 20 percent, or commercial) to the four options (Plan A, $2,000 front-end benefit only; Plan B, $2,000 front-end benefit and $10,000 deductible; Plan C, $2,000 front-end benefit and $2,000 deductible; and Plan D, full coverage with no deductible), plus the expected monthly premium cost for each option. Subsidies include $570 million in each scenario to cover additional enrollment in MRMIP and increased state funding for new Medicaid and SCHIP enrollees. Savings to safety-net programs are not incorporated. No projected reductions in hospital bad debt, emergency or inpatient services, or catastrophic care have been used to offset program costs.

■ **Financing sources.** Funding for new and expanded programs envisioned in this proposal would come from a combination of new tax revenues, safety-net savings, new federal funds, and enrollee premiums. We intend CalCAT to be entirely self-sustaining, based on direct enrollee premium payment through the income tax collection process, with no subsidy required from the state. Assuming provider payment at Medicare rates, the actuarially estimated tax amount needed to support CalCAT fully in 2006 is about $1,200 per adult and $600 per child.

The Lewin Group estimated the federal government's annual share of California's new Medicaid and SCHIP enrollment at $600 million for the first year. Lewin also estimated that $300–$900 million in safety-net savings (depending on the benefit plan and reimbursement rate chosen) would be realized by the state and

EXHIBIT 2
Estimated Premiums And Subsidies For CalPrime Options, Four Proposed Plans

Provider reimbursement rates	Monthly premium ($)	Subsidies ($ billion)
Plan A ($2,000 annual primary care benefit)		
Medicare	70	3.2
Medicare plus 20%	75	3.3
Commercial	80	3.5
Plan B (primary care + $10,000 deductible + catastrophic coverage)		
Medicare	145	5.8
Medicare plus 20%	180	7.0
Commercial	215	8.1
Plan C (primary care + $2,000 deductible + catastrophic coverage)		
Medicare	190	7.4
Medicare plus 20%	225	8.4
Commercial	275	9.7
Plan D (full coverage, no deductible, some copayments)		
Medicare	220	8.3
Medicare plus 20%	265	9.4
Commercial	310	10.6

SOURCE: Lewin Group and Kaiser Foundation Health Care Plan estimates.

counties through CalPrime's primary and preventive care incentives.

■ **Health care sales tax and in-lieu payroll tax.** We considered several sources to fund the state's remaining costs for covering the low-income uninsured through CalPrime, the newly enrolled Medicaid and SCHIP recipients, and the "uninsurable" portion of the population in MRMIP. Potential financing sources included increases in existing income, sales, and payroll taxes. Instead, we recommend two new dedicated revenue sources, selected to ensure a dependable funding stream dedicated to covering the uninsured: (1) a partial extension of the current statewide California sales tax to include health care services; and (2) an in-lieu payroll tax paid by employers who do not offer coverage for their employees.[7]

Taxation is always a volatile political issue, but funding is needed to subsidize care for low-income uninsured Californians. We proposed creating these taxes because they keep health care–related dollars within the health care system. They can be projected and protected as dedicated sources of future program revenue. The use of these tax sources also emphasizes that universal coverage can be affordable.

Any financing source for coverage subsidies should be broad-based, affordable, definable, and stable. An income tax increase would be the broadest-based tax but is not likely to be feasible in the near term—and even if it were, it is unlikely to be dedicated solely to subsidizing health care for low-income people. The taxes proposed here would be dedicated to health coverage and would guarantee the future availability of needed funds. We rejected an extension of the gross premiums tax because it would apply only to regulated carriers and would hasten the fast-growing movement to self-funded arrangements. In 2006, 31 percent of Californians with employer-based coverage were in self-funded plans. Thus, a gross premiums tax would result in an unstable revenue source that is not broad based and would primarily affect individual and small-group purchasers. Other states considering this financing mechanism would need to examine their own fiscal environments to determine if this approach or some other dedicated funding source would be more appropriate.

The health care sales tax would function like any other sales tax, collected directly by providers and individuals for the noninsured portion of their care and from health plans or insurance companies for insured care. Carriers would add the value of tax paid to the cost of doing business, costs ultimately paid by the employers and individuals through premiums. The imposition of the tax would represent a one-time rebasing of the cost of premiums, at a level well below the annual premium increases for most years in the past decade.

For most payers, future savings from a sizable reduction in cost shifting from uninsured patients to other payers should offset a portion of the tax expense. For example, several recent studies estimated employer-sponsored premium savings of 3–9 percent in California, if the currently uninsured are covered.[8] CalPrime coverage for low-income part-time employees who generally are not eligible for em-

ployer-sponsored coverage would benefit employers who cover only their full-time workers through these premium savings.

Employers that offer coverage would pay the health care sales tax through coverage costs; employers that do not sponsor employee health coverage would not. We address this inequity with an in-lieu payroll tax for employers that do not offer coverage or whose coverage generates health care sales taxes below a threshold amount. We set the in-lieu tax at a level appropriately higher than the health care sales tax for an insuring employer.

The in-lieu tax is not an employer mandate to purchase coverage. Employers would be encouraged to offer coverage by this provision and by helping their employees meet the state obligation to be individually insured. The in-lieu tax likely would not violate the preemption clause of the federal Employee Retirement Income Security Act (ERISA) because it is an option to pay a tax of general applicability to all employers. Just as a state can authorize an employer to deduct the cost of providing employee coverage from its corporate income tax, the state can provide different options for how the employer pays a generally applicable sales tax.

Employers offering group health coverage would not have to pay the in-lieu tax if their benefit plan meets a simple threshold. If the health care sales tax on services funded by the employer's group benefit plan exceeded 0.2 percent of the employer's payroll, during the same period, the in-lieu payroll tax would be waived. Policymakers might consider adjusting the obligations of the in-lieu tax for small employers with a largely low-income workforce.

Concerns may arise that some employers would drop coverage in favor of paying the in-lieu tax. We believe that this is unlikely, on balance, for several reasons: (1) CalPrime coverage will only be available to lower-income employees; (2) waiting periods will be imposed before CalPrime coverage would be available; (3) the marketplace will begin to offer competitive products that will likely be more attractive for individual employers than paying a payroll tax; (4) employers that now offer coverage have already determined that it is a reasonable benefit and thus have created expectations among their employees; and (5) imposing an individual obligation on every working Californian makes the employer the preferred choice of coverage. That factor will encourage employers to fulfill that role to attract and retain employees.

Exhibit 3 illustrates the alternative average tax rates for financing subsidies under the various benefit plan and reimbursement options. The revenue sources for subsidies include federal matching funds, savings to safety-net programs, and revenues from the health care sales tax and the in-lieu payroll tax.

The Challenge Of Enacting A Proposal In California

Any proposal for universal coverage will face major challenges because key stakeholders strongly favor approaches to reform that are often in conflict. The Massachusetts experience demonstrates that those divisions can be bridged.[9]

EXHIBIT 3
Estimated Health Care Sales And Payroll Tax Amounts To Finance CalPrime, Four Proposed Plans

Provider reimbursement rates	Health care sales tax (%)	Payroll tax (%)
Plan A ($2,000 annual primary care benefit)		
Medicare	1.2	2.2
Medicare plus 20%	1.3	2.3
Commercial	1.4	2.4
Plan B (primary care + $10,000 deductible + catastrophic coverage)		
Medicare	2.9	3.9
Medicare plus 20%	3.8	4.9
Commercial	5.0	6.0
Plan C (primary care + $2,000 deductible + catastrophic coverage)		
Medicare	4.0	5.0
Medicare plus 20%	5.1	6.2
Commercial	7.6	8.5
Plan D (full coverage, no deductible, some copayments)		
Medicare	4.9	5.9
Medicare plus 20%	7.1	8.1
Commercial	9.1	10.1

SOURCE: Lewin Group estimates.

However, as we also noted, both the magnitude of the uninsurance problem and the size of financial subsidies required to address the problem are much greater in California than in Massachusetts. There also are unique procedural challenges in California, such as the two-thirds vote of each house required to pass any legislation appropriating state funds or raising taxes.[10] Also, Proposition 98, passed by voters in 1988, amended the California Constitution to effectively prohibit any new revenue source for health coverage for the uninsured without a new amendment to the state constitution.[11] This proposal, therefore, can only be accomplished through an initiative placed on the ballot by the legislature or through public signatures. We believe that a major proposal for universal coverage will require a vote of the public, best accomplished through the support of key consumer, labor, business, provider, and health care safety-net groups and with bipartisan political support.

UP TO 98 PERCENT OF CALIFORNIANS could have health coverage if this proposal is enacted into law and implemented.[12] All tax filers would be covered, regardless of citizenship. Low-income legal residents who do not file taxes would also be covered if they voluntarily enrolled. It would not cover undocumented noncitizens who do not file state taxes. Studies show, however, that the undocumented population of California seeks most of their primary care from community clinics and most hospital care from county hospitals and emergency

rooms. As these sites of care are strengthened by this proposal, more capacity and resources should be available to the remaining 2 percent of the uninsured population; the proposal should offer at least an indirect benefit to most of the remaining uninsured population of California.

In the end, the state with the highest number of uninsured people can be a model for the nation, and the lives of millions of Californians can be greatly improved. We believe that our proposal offers a practical approach for providing near-universal coverage for Californians—a goal worth achieving.

NOTES

1. E. Neuschler and R. Curtis, "Massachusetts-Style Coverage Expansion: What Would It Cost in California?" Issue Brief, April 2006, http://www.chcf.org/documents/insurance/MAStyleCovExpansionIB.pdf (accessed 29 June 2006).
2. The Lewin Group estimates a monthly average of 5.3 million uninsured people using the California-adjusted HBSM model.
3. A key determinant in the passage of the Massachusetts legislation was that the state would lose $385 million in federal funds unless uncompensated care funds were shifted to provide subsidies for coverage of the uninsured.
4. The Lewin Group analyzed the cost and enrollment impacts of the proposal, while the Kaiser Foundation Health Plan developed the various benefit plan cost estimates through its actuarial department.
5. Because the mandate is enforced through the tax system, we assumed that anyone with income tax withheld during the year would file state taxes and thus be covered under Medicaid, SCHIP, or CalPrime if eligible. Of those with incomes at or above 300 percent of poverty who have not purchased coverage (individually or through an employer), we assumed that uninsurable people would enroll in the high-risk pool (MRMIP) and the remainder in the default plan (CalCAT). Most CalPrime enrollees would be identified through the tax system. Enrollment for income-eligible legal residents who do not file taxes was simulated based on the reduction in the premium they would pay for coverage using a multivariate model of how changes in premiums affect the likelihood of taking up coverage. The model is consistent with an average price elasticity of −0.34, varying with income, age, and other characteristics.
6. For more information about the HBSM and its specific application to this proposal, see Appendix 1, available online at http://content.healthaffairs.org/cgi/content/full/hlthaff.26.1.w80/DC2.
7. For more information about the health care sales and the in-lieu payroll taxes, see Appendix 2; ibid.
8. Neuschler and Curtis, "Massachusetts-Style Coverage Expansion"; and Families USA, *Paying a Premium: The Added Cost of Care for the Uninsured*, Pub. no. 05-101 (Washington: Families USA, 2005). Premium savings also depend on the scope of the benefit package.
9. For background on the Massachusetts reform and its political trade-offs, see a group of *Health Affairs* Web-Exclusive papers published 14 September 2006, available online at http://content.healthaffairs.org/cgi/content/full/hlthaff.25.w420/DC2.
10. Article XIII, Section 2, California Constitution.
11. Article XVI, California Constitution.
12. The Lewin Group estimates that 85 percent of the uninsured (4.7 million of an average monthly 5.3 million) would be covered under this proposal. They also estimate all sources of coverage with a total monthly average population of 36.3 million. If 640,000 remain uninsured once the proposal is fully implemented, approximately 98 percent of all Californians would be covered.