Cost and Coverage Analysis of Nine Proposals to expand Health Insurance Coverage in California

Final Report

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By:

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Executive Summary

Forthcoming

I. INTRODUCTION

In February and March of 2002, The California Health and Human Services (CHHS) Agency sponsored four symposia around the state to introduce nine proposals to expand health insurance coverage in California. This was done as part of a grant from the U.S. Health Resources and Services Administration (HRSA) devoted to the development to proposals to expand health insurance coverage. As part of this effort, The Lewin Group was engaged to analyze the cost and coverage impacts of these proposals.

Each of the proposals is detailed and complex. To simplify the discussion, we have divided these plans into three groups. Five of the proposals would attempt to expand voluntary coverage incrementally through existing public and private sources of coverage ***(Figure 1).*** Another two of the plans would establish an obligation for employers to contribute to the cost of covering their workers and their dependents. We also analyzed three plans that would achieve universal coverage by creating a single-payer public program to administer health insurance coverage for all Californians.

Figure 1
Summary of Key Features of the Nine Health Reform Proposals

	Single Payer	Medi-Cal/Healthy Families Expansions	Subsidies for Employers	Subsidies for Workers and Dependents	"Pay or Play" Model
Incremental Reform					
California PacAdvantage Premium Program (CPPP): Peter Harbage			✓		
Managed Care Expansion Plan: Bob Brownstein		✓			
Cal-Health: Helen Schauffler		✓			
The Insure the Uninsured Project (ITUP): Lucian Wulsin: Stage II		✓	✓	✓	
The Healthy California Program: Brown & Kronick: Stage I		✓			
Employer Contribution					
The Choice Program: Helen Schauffler		✓		✓	✓
The Healthy California Program: Brown & Kronick				✓	✓
Single Payer					
Cal Care: Judy Spellman	✓				
Single Payer: James Kahn	✓				
California Health Service Plan: Ellen Shaffer	✓				

A more detailed summary of these plans is presented below:

Incremental Reforms

- **The California PacAdvantage Premium Program (CPPP):** The CPPP proposal would provide small employers with subsidies to purchase coverage for lower-wage workers. Subsidies would be provided for workers living below 350 percent of the Federal Poverty Level (FPL) in firms with 2 to 50 employees who have not offered insurance in six months. To qualify for the premium subsidy, the employer must provide a benefits package that is at least actuarially equivalent to certain benchmark benefits packages specified in the proposal.

- **The Managed Care Expansion Plan (MCEP):** MCEP would gradually expand eligibility under Medi-Cal and Healthy Families to 400 percent of the federal poverty level (FPL) for all persons. This includes children, parents and non-custodial adults - who currently are not eligible under these programs at any income level. These expansions in eligibility would be phased-in over a period of 15 years.

- **The ITUP proposal:** The Insure the Uninsured Project (ITUP) proposal would expand coverage through a combination of initiatives designed to expand public and private insurance coverage. These include: a coverage expansion under Medi-Cal and Healthy Families; an employer tax credit to encourage small employers to start offering coverage; and a tax credit for individuals purchasing non-group coverage.

- **Cal-Health:** The Cal Health proposal consists of an expansion in eligibility under Medi-Cal and Healthy Families (HF) to 250 percent of the Federal Poverty Level (FPL) for parents. The proposal also includes an outreach initiative to increase enrollment among persons who are already eligible for, but not enrolled in, these programs. In addition, the plan creates low-cost standard uniform benefits packages (SUBP) designed to increase coverage among those over 250 percent of the FPL.[1]

Employer Contribution Requirements

- **CHOICE:** The CHOICE program would expand access to health insurance coverage through a requirement that employers contribute to the cost of covering workers and their dependents. Employers would face a "pay-or-play" requirement where employers must either provide coverage or pay a tax to cover their workers under a newly created public plan. The CHOICE program also includes an outreach initiative to increase enrollment of adults and children who are eligible for Medi-Cal and Healthy Families (HF), but are not enrolled in these programs.

- **Healthy California:** The Healthy California program that would achieve near-universal coverage in two stages. The Healthy California program would first expand coverage for

[1] In addition, the plan would apply for a waiver of the federal budget neutrality rule to cover non-custodial adults with incomes below 250 percent of the FPL. To be consistent with assumptions used to evaluate the other eight reform proposals considered in this project, we assume that the federal budget neutrality requirement is not waived for California.

low-income adults. After a period of three years, the program would require employers to contribute to the cost of coverage for their employees by either offering insurance or paying a tax to cover their workers under a publicly sponsored plan. Persons not covered through employment would also be covered under the public plan.

Single-Payer Programs

- **Cal Care:** The Cal Care proposal would establish a single payer for all health services provided in California. Hospitals and clinics would be placed on annual budgets for operations, thus eliminating claims processing for these services. Other providers would be reimbursed on a fee-for-service (FFS) basis according to a uniform billing system. A Group model HMO option would be available.

- **The California Single-Payer Proposal:** This proposal would create a single payer program covering nearly all health services provided in California. Hospitals would be placed on annual budgets for operations and capital expenditures, thus eliminating the need for billing for hospital services. Other providers would be reimbursed on a fee-for-service basis according to a uniform billing system.

- **The California Health Service Plan (CHSP):** Under CHSP, all providers would be employed by the state to provide health services to all California residents. The state would purchase all health facilities used by covered persons in California and all providers would become salaried employees of the state (excluding nursing homes). Health services would then be provided to all California residents through this health care system with an increased emphasis on primary care. A Group model HMO option would be available.

In this report we present estimates of the number of persons who would become covered under these programs and the reduction in the number of uninsured. We also present estimates of the cost of these coverage expansion proposals to the state government, employers, and households. In addition, we present a detailed analysis of each proposal in the appendices together with a documentation of the uniform methods and assumptions used in the analysis. Our analysis is presented in the following sections:

- Data and Methods;
- Medi-Cal/Healthy Families Expansions;
- Employer Premium Subsidies;
- Individual Premium Subsidies;
- Employer Contribution Requirement;
- Single-Payer Programs;
- Comparison of Combined Effects; and
- Caveats.

II. Data and Methods

We estimated the cost and coverage impacts of these proposals using the California version of the Health Benefits Simulation Model (HBSM), developed by the Lewin Group. HBSM is a micro-simulation model of the health care system that we have used to simulate a broad range of health insurance reform proposals for over 15 years. We adapted it for use in California by basing the model on health spending data for the state and by adjusting national samples to reflect the economic and demographic characteristics of California. The data bases used include: economic and including:

- The California sub-sample of the March 2001 Current Population Survey (CPS) data;
- The 1996 National Medical Expenditure Panel Survey (MEPS) data;
- A survey of California employers in 1999 conducted by the Kaiser Family Foundation and the Health Research and Education Trust (HRET);
- State Health spending data from the Centers for Medicare and Medicaid Services (CMS);
- Medi-Cal and Health Families program data;
- Data from the Office of State-wide Planning and Development; and
- Studies of the safety-net programs in the state.

HBSM was created to provide comparisons of the impact of alternative health reform models on coverage and expenditures for employers, governments and households. The key to its design is a "base case" scenario depicting the distribution of health services utilization and expenditures across a representative sample of households under current policy for a base year such as 2001. In this analysis, the base case scenario was based upon recent surveys of households and employers in California (listed above). We will also "aged" these data to be representative of the population in 2001 based upon recent economic, demographic and health expenditure trends. The resulting database provides a detailed accounting of the California health care system. These base case data serve as the reference point for our simulations of alternative health reform proposals.

We estimate the impact of health reform initiatives using a series of methodologies that apply uniformly in all policy simulations. The model first simulates how these policies would affect sources of coverage, health services utilization and health expenditures by source of payment. Mandatory coverage programs such as employer mandates or single-payer models can be simulated based upon the detailed employment and coverage data recorded in the database. The model also simulates enrollment in voluntary programs such as tax credits for employers and employees, based upon multivariate models of how coverage for these groups varies with the cost of coverage (i.e., modeled as the premium minus the tax credit). In addition, the model simulates enrollment in Medicaid or SCHIP expansions based upon a multivariate analysis of take-up rates under these programs, including a simulation of coverage substitution (i.e., "crowd out").

HBSM is designed to facilitate comparisons of alternative health reform initiatives using uniform data and assumptions. For example, uniform methods are used to simulate changes in health services utilization attributed to changes in coverage status and cost-sharing parameters. Employer behavior under each of the policy options was simulated with a single model of the

impact of the price of insurance on the number of employers offering coverage. A uniform model of consumer responses to reductions in the price of insurance is used to model the impact of premium subsidies for individuals. This uniform approach assures that we can develop estimates of program impacts for very different policies using consistent assumptions and reporting formats. The model is also designed to simulate any "adverse selection" resulting from the design of these policy options (adverse selection is the disproportionate accumulation of higher cost cases in a given insurance pool).

Once changes in sources of coverage are modeled, HBSM simulates the amount of covered health spending for each affected individual, given the covered services and cost sharing provisions of the health plan provided under the proposal. This includes simulating the increase in utilization among newly insured persons and changes in utilization resulting from the cost sharing provisions of the plan. In general, we assume that utilization among newly insured persons will increase to the level reported by insured persons with similar characteristics.

The key steps in the simulation model are summarized below:

- **Establishing a Baseline:** In this analysis, HBSM was based upon a representative sample of households in the state, which includes information on the economic and demographic characteristics of these individuals as well as their utilization and expenditures for health care. These data were based upon the 1996 Medical Expenditures Panel Survey (MEPS) that we used together with the California sub-sample of the March 2000 Current Population Survey (CPS). We used the Kaiser/HRET survey of employers in California in 1999 for policy scenarios involving employers. We also adjusted these data to show the amount of health spending in the state by type of service and source of payment as estimated by the Office of the Actuary of the Center for Medicare and Medicaid Services and various state agencies.
- **Determining Eligibility:** The California MEPS/HRET database provides the detailed demographic and economic data required to identify those who would be eligible for programs designed to expand insurance coverage. The model simulates coverage for each "insurance unit" in the MEPS data one month at a time.[2] During each month, we identify those who meet the eligibility provisions for the coverage expansion proposals that we are modeling. Eligibility for Medicaid or other income-tested subsidy programs is determined on the basis of family income in each month.[3] The model also identifies persons who are potentially affected by programs designed to expand employer coverage such as tax credits and income-tested premium subsidy programs.
- **Modeling Program Participation by Individuals:** Most of the major health reform proposals that have been developed in recent years would rely upon incentives for individuals to obtain coverage rather than mandated coverage. This has required the development of models that estimate the likely response of individuals to various forms of subsidized coverage. The Lewin Group has developed models of enrollment for the

[2] Monthly incomes are estimated from these data by dividing earnings and self-employment income over period of employment. Unemployment insurance income is distributed over periods of employment and investment and retirement income is evenly distributed across months.

[3] Once persons are simulated to enroll in the program, they are "certified" to be covered under the program for a period of 6 to 12 months depending upon the program.

Medicaid/SCHIP program that we use to simulate enrollment among persons who become eligible under proposed expansions in these programs. We have also developed multivariate models of how changes in premiums affect the decision to take private insurance coverage.

- **Modeling Responses of Employers:** The model simulates the impact of policies that affect the employer's decision to offer insurance and the resulting impact on employee coverage. This includes employer tax credit proposals designed to encourage employers to offer coverage and tax reform proposals that change the relative tax advantages of providing insurance through employers. In these simulations, the model first simulates changes in employer decisions to offer coverage at the firm level using the California HRET data and then simulates the corresponding impact on workers who have been assigned to each of the firms in the California MEPS/HRET database. As discussed above, this often involves compiling data on the workers assigned to each firm such as the average marginal tax rate for workers or the number of employees who are eligible for a particular coverage expansion program.

- **Program Costs and Health Expenditures:** The model simulates the cost of health coverage expansion proposals based upon the coverage provisions of the proposal. For tax credit proposals and premium vouchers, program costs are equal to the amounts of the credits or vouchers for persons who participate in the program. Under proposals where benefits for eligible individuals are provided through a public program (e.g., Medicaid), costs are equal to the cost of the health services used by enrollees. These costs are estimated based upon the cost of covered services received by individuals in the household database who are simulated to enroll in the program. This includes expenditures reported in these data during the months in which the individual is simulated to participate in the program, plus an estimated increase in spending for newly insured individuals.
- **Utilization of Health Services:** The model simulates the change in health expenditures resulting from expansions in coverage. We assume that utilization for previously uninsured persons would adjust to the levels reported by insured persons with similar characteristics. This adjustment reflects the reductions in spending resulting from improved access to primary and preventive care and any increases in utilization of other elective services as these individuals become insured. HBSM also models the impact of provisions designed to expand the use of primary care and simulates the impact of patient cost sharing on utilization.

- **Administrative Costs:** The model simulates the impact of alternative health care financing models on the cost of administering insurance and government programs. It also simulates changes in hospital and physician administrative costs under these systems.

A detailed documentation of the data and methods used in HBSM is presented in ***Appendix A***. A discussion of how the model was adapted to simulate the unique elements of each of these proposals is presented in our detailed analysis of each plan in ***Appendices B*** through ***J***.

III. MEDI-CAL /HEALTHY FAMILIES EXPANSIONS

Four of the nine plans included in this study would expand eligibility for coverage under public programs. These include:

- Cal-Health;
- The Managed Care Expansion Plan (MCEP);
- Stage I of The Healthy California Program; and
- The Insure the Uninsured Project (ITUP) Proposal.

With the exception of the MCEP proposal, these plans would expand coverage under the existing Medi-Cal and Healthy Families program. The MCEP proposal would create a new state-run program to cover persons who become newly eligible under the proposal.

We estimate that these proposed coverage expansions would reduce the number of uninsured by between 370,000 and 1.9 million persons, depending upon the income level to which eligibility is expanded. Net cost to the State varies from actual savings by about $40 million under Cal-Health to net state costs of about $3.6 billion under MCEP.

A. Current Medi-Cal/Healthy Families/AIM Eligibility

Eligibility under the current Medi-Cal, Health Families and Aid to Infants and Mothers (AIM) programs is complex. Medi-Cal is the California Medicaid program and Healthy Families is the California State Children's Health Insurance Program (SCHIP). These programs generally cover the aged and disabled, low income pregnant women and infants, children, and low income parents. Medi-Cal and Healthy Families qualify for federal matching dollars while AIM is funded solely by the state.

Aged and disabled persons living below the Federal Poverty Level (FPL) are covered under the Medi-Cal program ***(Figure 2).*** Pregnant women and infants are covered by Medi-Cal up to 200 percent of the FPL and then by the AIM program up to 300 percent of the FPL. As required by federal law, Medi-Cal covers children in families with incomes below 133 percent of the FPL for children age 1 to 5 and 100 percent of the FPL for children age 6 to 18.

Healthy Families covers children in families that are not covered by Medi-Cal up to 250 percent of the FPL. Parents with children at home are covered by Medi-Cal up to 100 percent of the FPL, and California has received a waiver to cover parents up to 200 percent of the FPL under Healthy Families. Certain groups, primarily adults without custodial responsibilities for children,

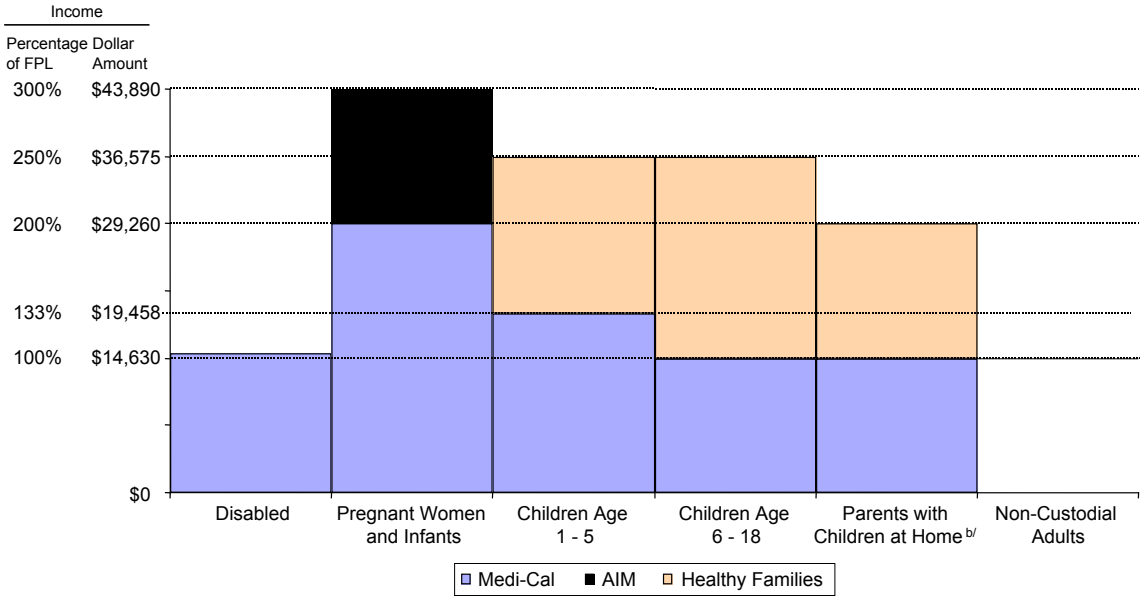
are not eligible for Medicaid regardless of income unless a state has obtained a federal waiver to cover these individuals (about four states have such waivers).[4]

Federal matching funds for non-US citizens are limited. Undocumented persons legally residing in the U.S. who arrived after 1996 must wait five years before becoming eligible for Medi-Cal, and they are eligible only for emergency services. However, California currently covers many of these individuals with the total cost paid by the State.

B. Proposed Eligibility Expansions

Both the Cal-Health program and Stage I of the Healthy California proposal would increase eligibility for parents to 250 percent of the FPL ***(Figure 3)***. The MCEP plan would increase eligibility for families through 400 percent of the FPL, which includes children living under 400 percent of the FPL, who are not eligible for Healthy Families, and their parents. Three of these plans would extend coverage to non-custodial adults living below 150 percent of the FPL. The ITUP plan would cover non-custodial adults through 200 percent of the FPL while MCEP would cover these individuals through 400 percent of the FPL.[5]

Figure 2
Current Eligibility for State Health Coverage: Family of Three [a/]



a/ Based on 2001 Poverty Level Guidelines for a family of three published in the *Federal Register* 2/16/01. For individuals living alone, the FPL equals $8,590.

b/ Assumes pending waiver is approved for parents.

Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

[4] Federal waivers must be budget neutral to the federal government. These four states obtained the waiver by reducing costs in some other parts of the state's Medicaid program by the amount necessary to meet the budget neutrality requirement.

[5] The Cal-Health program would cover non-custodial adults through 250 percent of the FPL if California obtains a waiver to the long-standing CMS requirement that Medicaid waivers be budget neutral to the Federal government.

Of the four plans, only ITUP would offer coverage for non-citizens. The proposed plan would cover documented immigrants meeting income requirements regardless of a waiting period and would provide emergency services for income eligible undocumented persons. The full cost of covering these groups would be paid by the state. Cal-Health includes several measures to increase outreach through schools and would permit temporary enrollment through health care facilities and doctors' offices using automated eligibility determination systems.

The proposals would generally offer enrollees the Medi-Cal or the Healthy Families benefits package or something similar**.** Under all four proposals, at least some of the newly eligible people would be required to make a premium contribution. Also, all plans would deliver services through a choice of managed care plans to the extent possible. The MCEP Plan would also offer fee-for-service reimbursement for providers at Medicare levels to increase provider participation in areas where managed care plans are not now operating.

C. Coverage, Costs and Financing

Not all of those who are eligible for coverage under the proposed expansions would enroll. Nationally, we estimate that only about two-thirds of children (excluding those receiving cash assistance) who are eligible for Medicaid (called Medi-Cal in California. Similarly, many of those who would become eligible under these proposed eligibility expansions would not enroll. However, due to increased outreach for new programs, some currently eligible, non-enrolled persons would come into the program.

Our estimates of the number of newly eligible persons who would enroll in these expansions is based upon analysis of historical data on participation in the existing Medicaid program. This approach generally results in an estimated participation rate between 50 and 70 percent for newly eligible persons who are currently uninsured and about 35 percent among those who have access to employer-sponsored coverage. This shift from employer coverage to public coverage is known as "crowd-out". The larger the crowd-out, the more it would cost the state per newly insured person. To minimize crowd-out, Cal-Health and the MCEP Plan include a 6-month waiting period in moving from private coverage unless there is an involuntary loss in coverage. Studies show that participation further declines by about one-third when premiums are required.

All of the proposals would reduce the overall number of uninsured in California. Cal-Health would reduce the number of uninsured by 370,000 persons ***(Figure 4).*** Under the MCEP plan, which extends coverage to 400 percent of the FPL, the number of uninsured would be reduced by about 1.9 million persons. Estimated total net costs to the state in 2002 range from a savings of 40 million for Cal-Health to about $2.1 million under Healthy California program and ITUP proposals.[6] Total net state spending would be about $3.6 billion under the MCEP Plan, reflecting the fact that the proposal would not seek federal matching funds for the program.

[6] The savings under the Cal-Health derive from the fact that it includes a provision to implement an automated eligibility system throughout the Medi-Cal and Healthy Families programs that would reduce program administrative costs.

Figure 3
Summary of Proposed Expansions in Coverage Under Medi-Cal/Healthy Families

	Cal-Health	MCEP Plan	Healthy California: Stage 1	Insure the Uninsured Project (ITUP)
Eligibility				
Families	200% FPL - 250% FPL	200% FPL - 400% FPL (15 year phase in)	200% FPL – 250% FPL	--
Non-Custodial Adults	None [a/]	Below 400% FPL (15 year phase in)	Below 150% FPL	Below 200% FPL
Non-Citizens	No Change	No Change	No Change	Covers income eligible, documented and Emergency services only for undocumented (state-only program)
Premium Required	Same as HF for persons over 150% FPL	None below FPL; Phase in through 400% of FP:	None below 150% FPL; Same as for parents under SCHIP waiver	Same as HF for persons over 150% FPL
Benefits	HF for parents; Medi-Cal for non-custodial adults below 133% FPL; HF for non-custodial adults below 133% FPL	HF for all newly eligible	State standard benefits package (SSBP) (to be determined)	Medi-Cal below FPL; HF above FPL
Financing	Federal match for parents; Safety net savings; Savings from automating eligibility process for Medi-Cal and HF	Increased sales and income taxes [b/] (Medicaid matching funds not sought)	Federal match for parents; Medicaid waiver • Cover disabled under managed care • Reduce Medi-Cal/HF annual spending growth by two-percent per year Safety net savings	Federal match for parents; Medicaid waiver • Cover disabled under managed care • Reduce benefits for optional eligible groups; Safety net savings; Provider tax
Other	Outreach to eligible not enrolled	Employer permitted to pay family premium share for eligible persons	Point-of-service-like co-payments; waived for persons eligible under Stage 1	Medi-Cal/HF buy-in to employer coverage when available and cost-effective [c/]
Anti-crowd-out	6-month waiting period; Exceptions for involuntary coverage loss	6-month waiting period; Exceptions for involuntary coverage loss	No Provision	No Provision
Delivery System	Choice of competing health plans	Choice of competing health plans	Choice of competing health plans	Choice of competing health plans
Number Eligible (thousands)	188	5,771	2,521	2,998

a/ The Cal-Health program would cover non-custodial adults through 250 percent of the FPL if California obtains a waiver to the CMS requirement that Medicaid waivers be budget-neutral to the Federal government. As with all other plans analyzed in this study, we assume that waivers would be budget-neutral.

b/ The MCEP plan calls for funding gradual increases in eligibility over the next 15 years, which would be funded by expected growth in budget surpluses over time. We assume that any increase in budget surplus would be earmarked for other uses resulting in no new funding for health programs.

c/ Estimated to affect 110,000 persons with a reduction in the number of uninsured of 38,800. Estimated net savings of $38.7 million in 2002.

Source: Lewin Group analysis of plan proposals.

Figure 4
Coverage and Cost Impacts of Proposals to Expand the Medi-Cal/Healthy Families Programs in 2002

	Cal-Health [a/]	Managed Care Expansion Plan (MCEP) [b/]	Healthy California Stage I	Insure the Uninsured Project (ITUP)
Number of Persons Eligible (thousands)				
Number Eligible	188	5,771	2,521	2,998
Coverage Impacts (thousands)				
Number Enrolled	385 [c/]	2,464	1,548	1,535
Reduction in Uninsured	370	1,854	1,229	1,223
Decline in Private Coverage (Crowd Out)	15	610	319	312
Program Costs (millions)				
Total Program Cost	$530.7	$4,099	$2,828	$2,791
Program Offsets	$373.7 [d/]	$508	$616 [e/]	$693 [e/]
Net Program Cost	$157.0	$3,591	$2,212	$2,098
Federal Spending	$197.6	- - [f/]	$86	- -
State Spending	($40.6)	$3,591	$2,126	$2,098
Average State Cost				
State Cost Per Enrollee	($105)	$1,457	$1,373	$1,367
State Cost Per Newly Insured Person	($110)	$1,937	$1,730	$1,715

a/ The Cal-Health program would cover an additional 1,676 non-custodial adults if the Federal government would agree to waive the CMS budget neutrality requirement so that federal matching funds can be obtained for this group. The net cost of Cal-Health to the State assuming that this waiver is granted would be about $856 million.

b/ For illustrative purposes, assumes a full expansion in eligibility to 400 percent of the FPL in 2002. The program for newly eligible persons under the MCEP plan would be separate from the Medi-Cal and Healthy Families programs.

c/ Includes 268,000 currently eligible non-enrolled persons who would enroll due to outreach.

d/ Includes administrative savings from the implementation of a new automated eligibility determination process throughout Medi-Cal and Healthy Families. Also includes safety-net savings.

e/ Includes savings in the safety net and Medicaid waiver savings.

f/ The MCEP plan would not seek federal matching funds.

Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

IV. EMPLOYER PREMIUM SUBSIDIES

Two of the proposals in this analysis include provisions designed to substantially expand private coverage in California. These proposals include employer premium subsidies under the California PacAdvantage Premium Program (CPPP) and an employer tax credit under the Insure the Uninsured Project (ITUP) proposal. Both proposals would provide employers with subsidies to help pay for coverage provided to workers below specified income levels. Under both proposals, employer subsidies are available only for low-income employees of the firm. The key features of these plans are provided in ***Figure 5.***

Figure 5
Summary of Employer Subsidy Provisions Included in the Analysis

	California PAC Advantage Premium Program (CPPP): Premium Subsidy	Insure the Uninsured Project (ITUP) Proposal: Employer Tax Credit
Eligible firms	• Firms with 2 – 50 workers • Firms offering at least the CPPP minimum insurance standard	• Firms with 2 – 200 workers • Firms offering at least the Knox-Keene HMO benefits package • Firms with at least one-third of workers earning less than twice the minimum wage ($12.50/hour)
Waiting Period	• Firms not offering coverage for at least 6 months	• No waiting period requirement for firms
Eligible Workers	• Subsidy applies only to workers living below 350 percent of the federal poverty level (FPL) • Uninsured for previous six months • Only employees working 20 or more hours per week	• Credit applies only to workers earning less than twice the minimum wage ($12.50/hour) • No waiting period requirement for workers
Form of Benefit	Premium subsidy	Refundable tax credit
Benefit Amount	Subsidy varies between 55 percent of premium for persons below 200 percent of FPL and 25 percent for persons between 300 percent and 350 percent of FPL	50 percent of premium for eligible workers

Source: Lewin Group analysis of plan proposals.

A. Subsidy Provisions

The California PacAdvantage Premium Program (CPPP) would provide qualified small employers with subsidies to purchase health care coverage for their eligible workers. Premium subsidies under the program would be targeted to workers living below 350 percent of the FPL in firms with 2 to 50 employees that have not offered insurance in six months.[7] To qualify for the

[7] As the FPL for a family of three is $14,630 in 2001, 350 percent FPL would typically include workers with family incomes less than $51,205.

premium subsidy, the employer must provide a benefits package that is at least actuarially equivalent to certain benchmark benefits packages specified in the CPPP proposal. Firms that are currently purchasing coverage through PacAdvantage also would be eligible for subsidies under the program if they have income eligible workers. Under the CPPP, the subsidy amount varies with the income of each employee covered by the employer plan, ranging from 25 percent for employees with incomes between 300-349 percent of FPL to 55 percent for workers below 200 percent FPL.

Eligibility is limited to:

- Firms with 2 to 50 employees at time of determination. Firms would continue to be eligible for the program until they grow to over 50 employees;
- Firms purchaseing insurance that is at least actuarially equivalent to the CPPP minimum insurance standard (described below); and
- Firms that have not offered insurance (other than CPPP) in the previous 6 months.

The Insure the Uninsured Project's (ITUP) proposal would expand coverage under ESI by providing tax credits to employers who cover lower-income workers. The tax credits would be limited to workers in eligible firms earning less than twice the state's minimum wage (i.e., $12.50 per hour). To qualify for the ITUP tax credit, the firm must have between 2 and 200 employees and at least one-third of the workers in the firm must earn less than twice the state's minimum wage. The firm must also provide benefits at least as comprehensive as the Knox-Kenne HMO benefit package, plus prescription drugs with a $10 co-payment.

Under the ITUP proposal, the credit would be available to all firms meeting the above criteria regardless of whether they already provide coverage. Unlike the PacAdvantage proposal, no waiting period would be required before a firm is eligible for the credit. The tax credit proposed by ITUP applies only to workers earning less than twice the minimum wage ($12.50/hour), whereas the CPPP provides subsidies for workers through 350 percent of the FPL.

B. Coverage and Cost Impacts

About 1.5 million workers and/or their dependents would qualify for CPPP's proposed premium subsidies in 2002, compared to 3.3 million workers and/or dependents eligible through the ITUP proposal ***(Figure 6).*** Of those who qualify, less than 200,000 workers and/or dependents are estimated to enroll in the CPPP program. Enrollment in the ITUP program would be about 1.3 million persons, reflecting the fact that many currently insured persons would qualify and apply for the credit. The number of uninsured would drop by 112,000 under the CPPP proposal and 242,000 in the ITUP proposal.

The cost of the CPPP program would be $189 million, net of savings to safety-net programs.[8] Total costs, net of safety-net savings, under the ITUP plan would be $976 million. The net state

[8] In California there are a range of state and county programs providing care to the medically indigent which is called the safety-net. Costs for these programs are expected to decline as the number of uninsured is reduced.

expenditure per newly insured person would be $4,033 under the ITUP plan compared with $1,687 under the CPPP program. This reflects the fact that the ITUP plan would provide the subsidy to employers regardless of their current insuring status (i.e., no waiting period) while CPPP limits most payments to firms that have not been providing coverage.

Figure 6
Coverage and Cost Impacts of Employer Subsidy Programs in 2002

	California PACAdvantage Premium Program (CPPP)	Insure the Uninsured Project (ITUP) Proposal: Employer Tax Credit
Eligible Workers and Dependents in Eligible Firms (thousands)		
Number Eligible	1,478	3,316
Coverage Impacts for Workers and Dependents (thousands)		
Number Enrolling	187	1,306
Reduction in Uninsured	112	242
Currently Insured Who Enroll	75	1,064
Program Costs (millions)		
Total Program Cost	$216	$1,093
Program Offsets (safety net)	$27	$117
Net Program Cost	$189	$976
Average State Cost		
State Cost Per Enrollee	$1,012	$747
State Cost Per Newly Insured Person	$1,687	$4,033

Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

V. INDIVIDUAL PREMIUM SUBSIDIES

The ITUP proposal includes a state tax credit for the purchase of insurance by those who do not have access to employer-sponsored insurance (ESI). The tax credit amounts would typically be about $2,400 for single coverage and $3,200 for family coverage, with the credit amount varying with age ***(Figure 7).*** There would be a full credit for individuals below 200 percent of the FPL with the amount phased-out at $40,000 for single individuals and $70,000 for families (i.e., Joint Filers and Head of Household returns). The tax credit would be refundable so that even those individuals who have no tax liability could qualify.

Although an estimated 6.3 million individuals would be eligible for the tax credit, less than 3.2 million would receive it. We estimate that the ITUP individual tax credit would reduce the number of uninsured by over 1.8 million persons. Another 1.3 million currently insured persons would also receive the tax credit. Total program costs would be $4.3 billion in 2002. Net program cost drops to $3.4 billion after accounting for safety-net savings (i.e., savings to indigent care programs). The net state cost per enrollee would be $1,074, and the net state cost per newly insured person would be $1,834.

Figure 7
Coverage and Cost Impacts of the ITUP Tax Credit for Persons Without Access to Employer Coverage 2002

- Refundable tax credit for persons not eligible for employer plan
- Refundable tax credit amount

Age of Policy Holder	Single	Family
Under Age 40	$1,200	$2,200
Age 40 – 54	$2,400	$3,200
Age 55 – 64	$3,600	$4,500

- Credit phase out between 200 percent of FPL and $40,000 single/$70,000 family
- No waiting period requirement

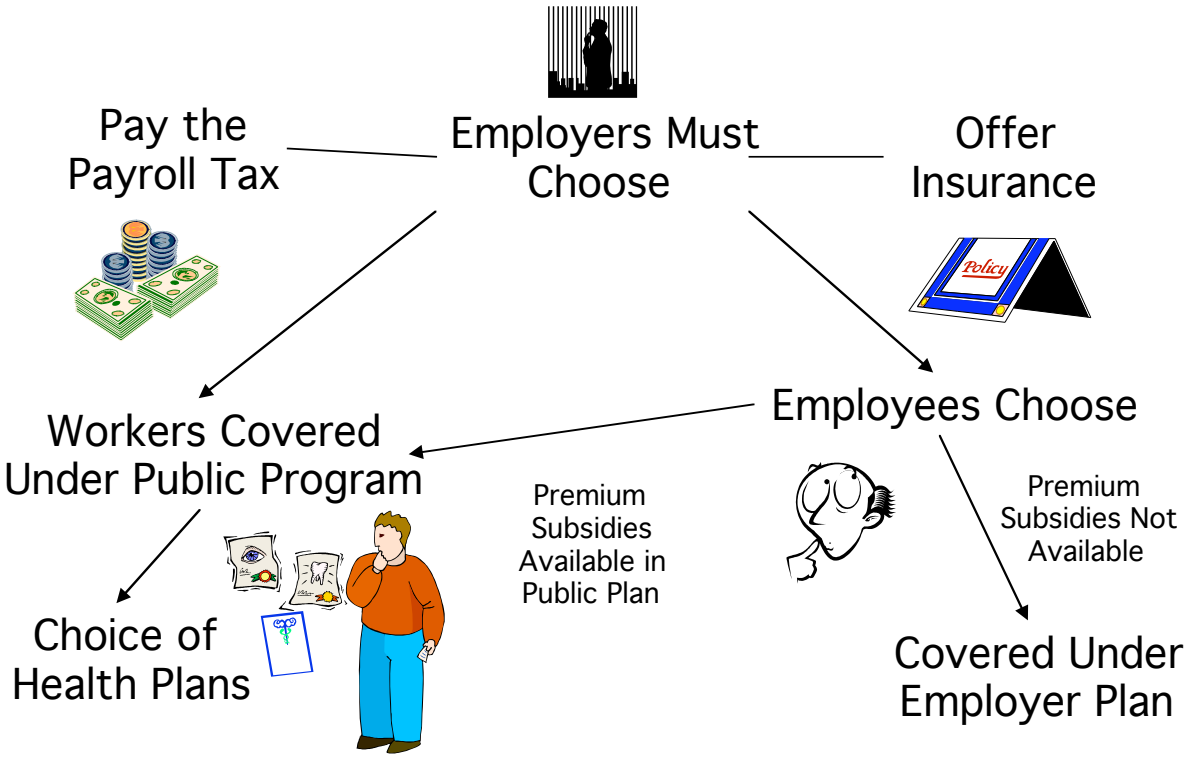
Eligibility and Enrollment	
Number Eligible (thousands)	6,327
Number Receiving Credit (thousands)	3,173
Reduction in Uninsured (thousands)	1,858
Currently Insured Receiving Credit (thousands)	1,315
Program Costs	
Total Program Costs (billions)	$4.3
Program Offsets (safety net) (billions)	$0.9
Net Program Cost (billions)	$3.4
Per-Capita Cost	
Net State Cost Per Enrollee	$1,074
Net State Cost Per Newly Insured Person	$1,834

Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

VI. EMPLOYER CONTRIBUTION REQUIREMENT

Two of the plans studied would require employers to contribute to the cost of covering their workforce by either providing coverage or paying a tax to cover their workers under a public plan. This approach, known as "pay-or-play" is proposed under Stage II of the Healthy California Program and under the CHOICE Coverage Expansion Program. These programs could reduce the number of uninsured by 4.7 million persons under CHOICE and by 5.7 million persons under Healthy California. Total program expenditures would be $74 billion under CHOICE and $56.2 billion under Healthy California.

Figure 8
The Pay-or-Play Model - "Healthy California" and "Choice" Proposals



A. Overview of Pay-or-Play Proposals

Both CHOICE and Stage II of Healthy California would establish a pay-or-play requirement for employers to either offer health insurance to employees or pay a payroll tax to cover their workers. This requirement would take the form of a payroll tax paid by all employers with employers receiving a credit the tax amount paid for each worker who has coverage. Both programs would offer coverage to workers and their non-working dependents, excluding the elderly and disabled. The plans would vary the employer payroll tax contribution by the number of employees or wage levels, and would be administered through an employer refund, or tax credit. Employees would also pay a premium that varies with wage level. In both plans,

employees have the option to participate in either the employer-sponsored insurance (if it is offered) or the public plan ***(Figure 8).***

The biggest difference between the two programs is that under Healthy California, enrollment in the public plan is automatic if the worker's firm is not sponsoring coverage (i.e., paying the tax). The worker can decline the coverage, but the employee "premium" is not returned to the worker. Under the CHOICE Program, the worker has the option to decline coverage without paying the employee "premium". Another key difference is that there is no minimum benefits package under the CHOICE program while the Healthy California program requires plans offer the benefits included in a benefits package created under the program called the state standard benefits package (SSBP). The key features of these plans are presented in ***Figure 9***.

B. Changes in Coverage

Both programs would substantially reduce the overall number of uninsured. Under current policy, the uninsured represent 18.9 percent (6.6 million) of total California residents ***(Figure 10).*** The number of uninsured persons in California would be reduced by 4.7 million under CHOICE, and 5.7 million under Stage II of Healthy California.

There also would be a large shift in coverage from employer sponsored insurance to the public plan. The percentage of persons with employer sponsored coverage would decline from 52.5 percent (18.4 million persons) under current policy to 8.7 percent (3.1 million) under CHOICE and 24.5 percent (12.6 million) under Healthy California. This shift to the public plan reflects the fact that the payroll tax under these proposals is often less than the cost of continuing to provide private coverage. Medi-Cal and Healthy Families coverage would also decline, reflecting the fact that low-income workers would obtain coverage under either the public plan or an employer program.

The CHOICE program would be open to all California residents including the undocumented, while the Health California program would not. This could result in a loss of coverage among undocumented persons who currently have employer coverage through an employer who decides to pay the tax. While citizens and documented employees in these circumstances would become covered under the public plan, the undocumented employees would not be permitted to enroll. We estimate that Healthy Families could affect about 400,000 people in this way.

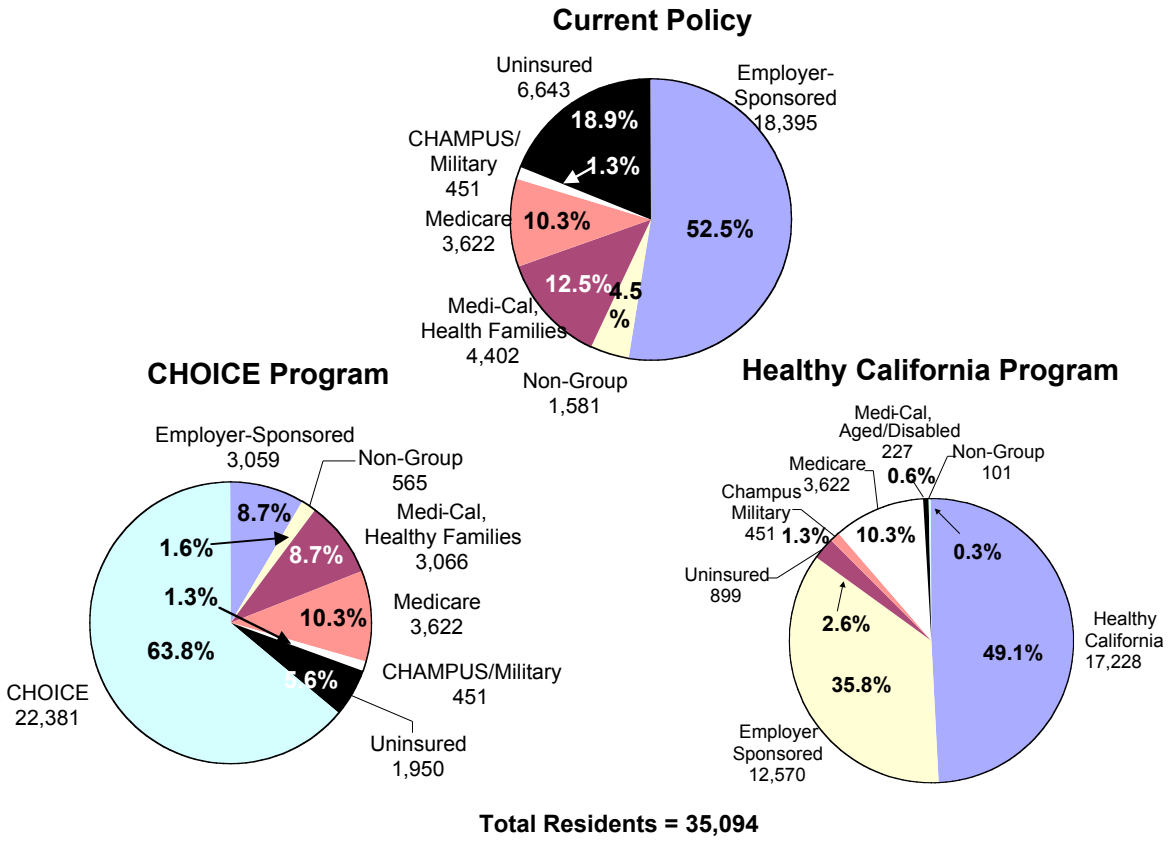
C. Spending, Revenues and Offsets

Total expenditures for the two programs would be $74.0 billion under CHOICE and $56.2 billion under Healthy California. These figures include continued spending on Medi-Cal and Healthy Families for those not covered under the new plan. The programs would be funded from a combination of employer payroll taxes, participant premiums, a tobacco tax increase and an increase in the State income tax. The programs are also funded by public program offsets including federal matching funds, reductions in current state spending on Medi-Cal and Healthy Families, and safety net savings ***(Figure 11).***

Figure 9
Summary of Pay-or-Play Employer Contribution Proposals

	CHOICE	Healthy California
Target Population	All non-elderly workers and non-working dependents	All non-elderly non-disabled persons
Employer Contribution Requirement	All employers pay a payroll tax varied by number of employees: 1st to 50th Worker 5.5% 50th Worker and Up 6.5%	All employers pay a payroll tax varied with wage levels: First $10,000 3.2% Next $20,000 5.1% Next $30,000 7.1% Over $60,000 9.2%
Employer Refund (tax credit)	Employers refunded payroll tax for workers covered by: • Employer Plan • Medicare • CHAMPUS	Employers refunded payroll tax for workers covered by: • Qualifying Employer Plan – Employer Offered – Dependent Coverage on Spouse's Plan • Medicare • CHAMPUS
"Qualifying Coverage" (i.e., minimum standard plan)	No requirement, (all employer plans qualify); No minimum employer contribution	"Qualifying Coverage" includes plans meeting state standard benefits package (SSBP); No minimum employer contribution
Public Plan Enrollment for Workers in Firms Not Sponsoring Coverage	• Automatic unless coverage is declined by worker • Employee "premium" returned if coverage declined	• Automatic • Can decline coverage but employee "premium" is not returned
Worker Premium in Public Plan	• Tax on earnings up to Social Security maximum (about $80,000) • Working Parent / Non-Working Dependent / Maximum Percentage <150% FPL 0.0% 0.0% 0.0% 150%-250% FPL 0.5% 0.5% 2.0% 250%-350% FPL 1.5% 0.5% 2.0% 350% FPL or more 2.0% 0.5% 2.5%	• Worker premium computed as a percentage of wages • Wage Level / Tax Rate First $10,000 1.0% Next $20,000 1.7% Next $30,000 2.4% Over $60,000 3.0%
Maximum Premium	• None	• Sum of employer and employee premium maximum of $700 per month per worker
Self-Employed	• Pay payroll tax as if only worker in firm; also Pay worker premium if accept public plan coverage; refunded if has insurance	• Pay payroll tax as if only worker in firm; Pay worker premium regardless of whether accepts public plan coverage; refunded if has insurance
End of Year Reconciliation	• None	• For persons without continuous coverage who are self-employed or have non-earning income (rental, investments, etc.)
Disposition of Medi-Cal and Healthy Families Programs	• Retained for aged and disabled, long-term care, and wrap-around coverage for currently eligible	• Retained for aged and disabled, low-income non-workers and wrap-around coverage for currently eligible
Premium Subsidies for Workers in Firms That Decide to Provide Coverage	• None; Instead, workers in firms offering coverage can elect to enroll in public plan where premiums vary with income	• None; Instead, workers in firms offering coverage can elect to enroll in public plan where premiums vary with income

Figure 10
Distribution of California Residents by Primary Source of Coverage Under Current Policy, CHOICE, and Healthy California: Stage II in 2002 (in thousands) a/



a/ Average monthly primary insurance status.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

One key difference in the two programs is that the Healthy California program assumes that federal matching funds are available for all families covered under the public program. The state would use a 1931(b) expansion under Medicaid to cover families to an unlimited income level as appears to be permitted under federal law; however, no other state has expanded to such high income levels. Since this would be a Medicaid expansion, the costs would be eligible for Federal match. The state would use the payroll tax as the state match for the program. As a result of this assumption, the level of employer payroll tax for Healthy California is substantially less than the tax under the CHOICE program.

In general, the taxes and premiums paid by employers and workers will not be sufficient to fund the program. This is because firms will typically cover their workers through the public program in cases where the tax is less costly than purchasing insurance. The CHOICE program would require an additional $5.1 billion while the Healthy California program would require an additional $3.5 billion. The Healthy California program would raise these funds through a tobacco tax increase of $1.00 per pack and an increase in the state income tax. The Choice program would raise the required funds through the same tobacco tax increase plus an increase in

the state sales tax of _ percent, a tax on soda of $0.10 per 12 ounces and an increase in the income tax.

Figure 11
Spending, Revenues and Offsets Under the New Public Plan and Remaining Medi-Cal/HF Under the "Pay-or-Play" Proposals

	CHOICE		Healthy California: Stage II	
Program Expenditures				
Total Expenditures		**$74,016**		**$56,216**
Public Plan Spending	$54,283		$41,025	
Continued Medi-Cal/HF	$20,907 [a/]		$15,191 [b/]	
Bulk Purchasing Savings [c/]	($1,174)		$0	
Program Revenues				
Total Revenues		**$41,559**		**$18,844**
Employer Payroll Tax	$31,727		$14,133	
Participant Premiums	$9,832		$4,711	
Public Program Offsets				
Total Program Offsets		**$27,369**		**$33,852**
Federal Matching Funds	$13,511 [d/]		$22,574 [e/]	
Current State Medi-Cal/HF Spending	$10,913		$10,913	
Safety Net Savings	$2,522		--	
Waiver Savings	$0		$474	
Other [f/]	$423		$(109)	
New Tax Revenues				
Total New Tax Revenues		**$5,088**		**$3,520**
Tobacco Tax Increase ($1.00 per pack)	$1,011		$1,011	
Increases Assessment on traffic Fines [g/]	$500		$0	
Increase state sales tax (1/4 percent)	$1,000		--	
Tax on Soda ($0.10 per 12 ounces)	$1,800		--	
Increase in State Income Tax [h/]	$777		$2,509	
Total Revenues and Offsets				
Total Revenues and Offsets		**$74,016**		**$70,401**
Net Surplus (Deficit)		**N/A**		**N/A**

a/ Includes Medi-Cal spending for acute care services for all non-working Medi-Cal beneficiaries.
b/ Includes Medi-Cal spending for the aged and disabled.
c/ Savings from using the Federal Supply Schedule for purchasing prescription drugs and durable medical equipment (30 percent less than Medicaid rates including rebate).
d/ Includes federal matching funds under continued portions of the program plus additional federal matching funds for newly eligible parents.
e/ Includes federal matching funds for the remaining portions of the Medi-Cal/HF program plus federal matching funds for all families covered under the public program
f/ Includes changes in state income tax revenues due to wage effects and the net change in costs for state workers.
g/ Assumes that criminal fines in California are increased by 440 percent to raise additional revenues for the plan.
h/ Assumes that the state personal income tax is increased by the amount needed to fully fund these programs.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

D. Changes in Health Spending for Employers and Families

Overall, firms that currently provide health coverage to at least some workers would save $481 annually per worker under CHOICE and $332 under Healthy California ***(Figure 12).*** These firms see savings because we estimate that on average it would be less expensive to pay the payroll tax than to provide coverage. Firms with less than 10 workers would save the most under the Choice program and firms with over 1,000 workers would save the most under the Healthy California program. Firms that currently do not provide health coverage would see new costs of $1,360 per worker under Choice and $842 under Healthy California.

Figure 13 shows average changes in family health spending by age for both programs. These estimates include reductions in family spending for premiums and out of pocket medical expenses offset by increased taxes and changes in wages as employers pass on the increased cost of the payroll tax (the wage effect). On average, families in all age groups would realize savings under both programs. The only exception to this is for persons age 65 where spending would increase by an average of $315 per family under CHOICE and $158 per family under Healthy California. This reflects the fact that these individuals would see increased income taxes, along with everyone else, even though coverage is generally unaffected for this group. In general, the Healthy California program would generate greater savings for families because the federal government would pay a substantial portion of the program costs for families. Thus, requiring a smaller increase in state income taxes.

Figure 14 shows average family spending by income. Both programs would generate savings for families at every income level except $150,000 or more. At this income level family health spending would increase by about $2,570 per family under Choice and $1,120 under Healthy California. At these higher income levels, the increased cost of income taxes outweighs the savings in premiums and out of pocket expenses.