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Pay-or-Play Health Insurance Mandates

Lessons from California

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SUMMARY

The growing number of Americans without health insurance and the rising cost of health care are perpetual sources of concern for policymakers. These concerns are particularly salient in California, where the percentage of uninsured is among the highest in the nation. In 2003, California's legislature enacted a so-called pay-or-play law—an employer health insurance mandate—which voters narrowly repealed less than a year later. The law would have required that California employers pay a fee to the state to provide health insurance to its employees (to "pay"), unless the employer provided health insurance coverage directly to its workers (or "play"). The law required minimum standards for who would be covered and for what services and how much employees would pay for premiums. Pay-or-play legislation is currently being considered in 21 states and has become law in Maryland and Massachusetts, although the Maryland law was overturned in federal court.

Because the employer pay-or-play concept has attracted such attention nationally, it is important when crafting such legislation to consider what works and what does not. This study uses California's 2003 experiment as a way to highlight which features need to be present in employer-mandate legislation to create the greatest reduction in the number of uninsured and what is likely to happen when those features are not included. It also considers the likely economic effects—intended or unintended—of employer mandates when policymakers add provisions that entail substantial redistribution of wealth from one group to another. It estimates the likely effect that California's pay-or-play mandate would have had on employer costs, on the uninsured, and on the labor market, and it offers suggestions for crafting future pay-or-play legislation.

Several lessons emerge from California's experience. The mandate was an expensive way to cover the uninsured, because its provisions affected workers who already had health insurance. The annual employer cost per newly covered uninsured individual would have been approximately $6,500 (without other employer responses), because two-thirds of the employer spending under California's legislation would have gone to individuals who were already insured. One simple way to lower these costs in the future would be to scale back the employer's premium obligation for family plans and to require a less-expensive baseline plan, such as one that provides high-deductible catastrophic coverage.

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The mandate would have provided coverage to nearly two million of California's uninsured. Even under the most expansive employer mandate, however, close to 40 percent of the uninsured are still unlikely to be covered, because they have only a weak attachment to the labor force. To provide more universal coverage, other legislative actions beyond employer mandates must be considered.

Finally, California's legislation would have affected the labor market. Over the long run, much of the mandate's cost to employers would have been shifted back to employees in the form of lower wages. For workers close to the minimum wage, where wage-shifting is not possible, approximately 70,000 workers would have lost their jobs as a result of the legislation.

Introduction

According to Census Bureau estimates, 45.8 million Americans in 2004 had no health insurance, about 15.7 percent of the total population.[1] Concurrently, the Henry J. Kaiser Family Foundation reports that the cost of health premiums has increased 73 percent since 2000 and that the average annual premium for family coverage reached $10,880 in 2005.[2] These trends are only magnified in California, where 18.7 percent of the state's residents—more than 6.7 million Californians—were uninsured in 2005.[3] Over the years, California has consistently had a higher percentage of uninsured residents than the rest of the nation.

The larger number of uninsured in California appears to stem from lack of private health insurance in the state. Many policy interventions could reduce the number of uninsured, including enacting universal health care coverage, expanding government insurance for those who are poor but ineligible for Medicaid, offering tax credits for privately purchased insurance, imposing a mandate on individuals to buy insurance, and regulating insurance prices, among others. Pay-or-play ideas—mandates on employers to provide private health coverage directly to their workers or pay a tax to the state to cover them—attracted attention in California perhaps because of the lack of employer-provided coverage and because such mandates do not require additional tax revenues.

California's Health Insurance Act (HIA) of 2003 would have been phased in starting in 2006. But in November 2004, the provisions of the law were invalidated through a referendum election, by a margin of about 80,000 of 10 million votes cast.[4] The law's supporters, mainly labor unions, spent about $15 million, and its opponents, mainly retailers and the restaurant industry, spent about $14 million.[5]

Historically, pay-or-play mandates have not been embraced widely. State-level employer mandates face a variety of potential legal problems—such as the 1974 Employee Retirement Income Security Act (ERISA), which exempts from state

regulation those employers who self-insure their health benefit plans—as well as political challenges.[6] Recently, however, the idea of pay-or-play employer health insurance mandates has grown in popularity and may be revisited in the future in California. In 2005, Maryland passed a largely symbolic piece of legislation, the Maryland Fair Share Health Care Fund Act, which focused attention mainly on Wal-Mart. Maryland's law was overturned in July 2006, when a federal judge found that the legislation violated the ERISA provisions for promoting uniform treatment of employers.[7] The AFL-CIO has targeted 32 states for passage of pay-or-play mandates in 2006 similar to that of Maryland; legislation is currently pending in 21 of those states.[8] Employer mandates are still a possibility in California; state Senator Carole Migden has introduced the Fair Share Health Care Act as Senate Bill 1414, which has provisions similar to Maryland's legislation.

The Health Insurance Problem in California

Figure 1 shows the percentage of Californians without health insurance, based on tabulations from the *Current Population Survey*.[9] Between 1995 and 2003, the percentage of uninsured Californians hovered around 20 percent. California has historically had 40 percent more uninsured residents than the rest of the country and 20 to 30 percent more than other western states; 6.5 million Californians were uninsured in 2003. This placed it 43rd out of 50 states and the District of Columbia, as shown in Table 1. Four of the poorest states in the country—Mississippi, Arkansas, West Virginia, and Utah—ranked higher than California.

Further understanding of Californians' health insurance status is revealed from an analysis of their coverage sources. An individual can be classified into one of four categories: uninsured, exclusively privately insured, mainly government insured, or a combination of private and government. It is important to note that the vast majority of private health insurance (roughly 88% nationally) comes through the employer.[10] The third category—mainly government insured—includes all individuals who were insured exclusively through a government source such as Medicare, Medicaid, the State Children's Health Insurance Program, and CHAMPUS/TRICARE (for military families)[11] as well as the elderly covered by Medicare and a private Medicare supplement plan.[12] The fourth group—a combination of private and government—includes individuals who likely moved between government and private plans during a calendar year.

Over the 1995 to 2003 period, roughly 55 percent of Californians had private health insurance, 22 percent had mainly government health insurance, 20 percent were uninsured, and a relatively insignificant 3 percent combined private and government insurance throughout the year.

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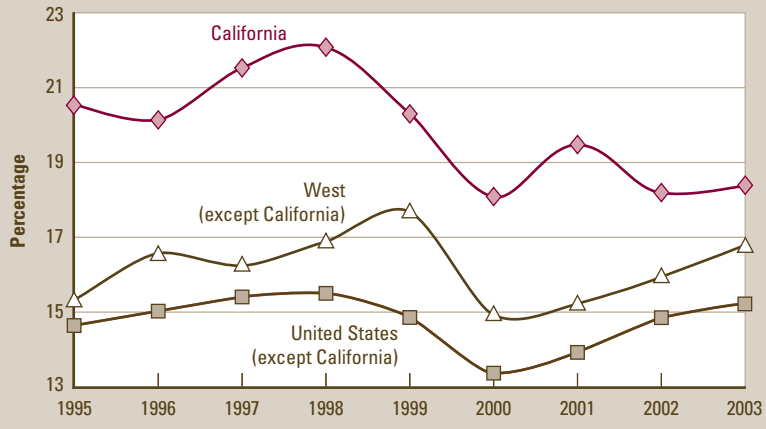
Figure 1. Percentage of Population That Is Uninsured, 1995–2003



Source: Author's tabulation of the March 1996–2004 CPS.

Table 1. California's Rank in Percentage of Uninsured, 2003

Rank	State	Percentage
1	Minnesota	8.7
2	Vermont	9.5
3	Hawaii	10.1
4	Rhode Island	10.2
5	New Hampshire	10.3
6	Connecticut, Maine	10.4
8	Massachusetts	10.7
9	Michigan, North Dakota, Wisconsin	10.9
12	Kansas, Missouri	11.0
14	Delaware	11.1
15	Iowa, Nebraska	11.3
17	Pennsylvania	11.4
18	Ohio	12.1
19	South Dakota	12.2
20	Utah	12.7
21	Virginia	13.0
22	Tennessee	13.2
23	Indiana, Maryland	13.9
25	Kentucky, New Jersey	14.0
27	Alabama	14.2
28	District of Columbia	14.3
29	Illinois, South Carolina	14.4
31	New York	15.1
32	Washington	15.5
33	Wyoming	15.9
34	Georgia	16.4
35	West Virginia	16.6
36	Arizona	17.0
37	Colorado, Oregon	17.2
39	North Carolina	17.3
40	Arkansas	17.4
41	Mississippi	17.9
42	Florida	18.2
43	California	18.4
44	Idaho	18.6
45	Alaska, Nevada	18.9
47	Montana	19.4
48	Oklahoma	20.4
49	Louisiana	20.6
50	New Mexico	22.1
51	Texas	24.6

Source: Census Bureau tabulations of the March 2004 CPS.
Note: Western states are shaded.

Figure 2 shows that over time, the percentage of uninsured Californians tends to be negatively correlated with the percentage who are privately insured. As one rises, the other falls, and vice versa. Because private coverage is such an important component of overall insurance rates, this negative correlation suggests that lack of private insurance coverage may have contributed to California's relatively higher rate of uninsured residents overall. This hypothesis is supported by the data in Figure 3, which shows insurance coverage by type over time for California, relative to that in the rest of the nation.

Figure 3 shows clearly that not only does California have a relatively higher percentage of uninsured residents than other states but that it also has a relatively low percentage of privately insured residents and virtually the same percentage who carry government insurance or combined government and private insurance. Changes in the percentages of uninsured and privately insured Californians are virtual mirror images, suggesting that differences in the private market (rather than in government provision) are largely responsible for California's lagging position.

These data allow some conclusions to be drawn. First, health insurance coverage and the sources of that coverage have remained fairly stable over the last decade in California. The problem of the uninsured has gotten neither substantially worse nor better when comparing California to other states (although there has been some improvement in the last few years relative to the rest of the country). Second, the modest fluctuations in private coverage over time are negatively correlated with the fluctuations in the number of uninsured. Third, the gaps in private coverage explain most of the gaps in insurance coverage between California and other states.

The Appeal of Employer Mandates

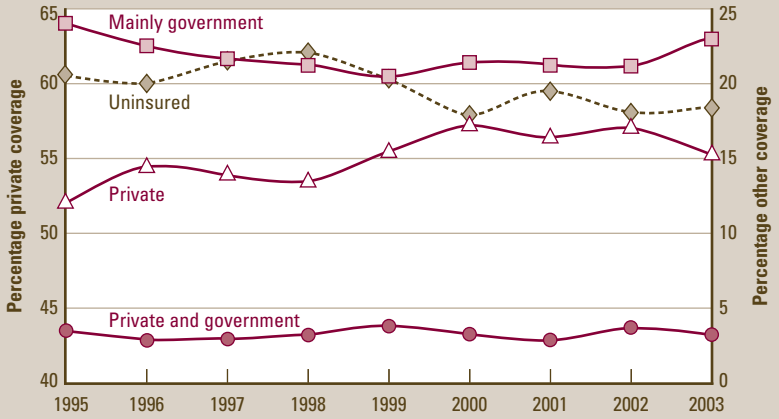
Employer mandates have strong, intuitive appeal. Private health insurance, and employer-provided health insurance more specifically, is overwhelmingly the most common source of coverage among the nonelderly popu-

lation. In 2004, 82 percent of individuals in the United States younger than age 65 had some form of health insurance, and nearly 77 percent of insured individuals had employer-provided coverage.[13] Extending health insurance through employers seems like a natural progression.

In addition, employer-provided health insurance offers multiple benefits. Employer contributions for premiums are not taxed at the federal or state levels, in effect giving a subsidy to employers who provide health insurance. In 2005 alone, this subsidy translated to $113 billion in lost tax revenue for the federal government.[14] Another benefit stems from risk-pooling. Individuals trying to buy health insurance on their own are much more likely to be excluded on health grounds than are employees purchasing health insurance in a larger risk pool. Finally, the per-person cost of administering a large group plan is much lower than for an individual or small group plan.

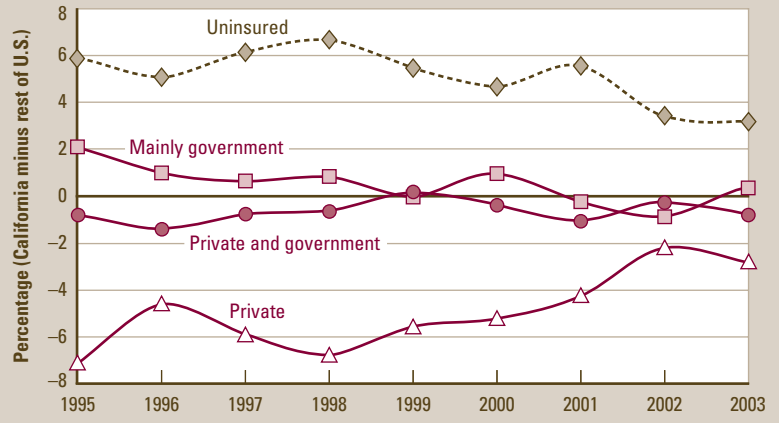
Politically, employer mandates are a popular middle-ground approach between no public action (which may appeal to conservatives) and direct government provision (which may appeal to liberals), as Summers (1989) convincingly argues. Another political attraction of employer health insurance mandates is that they expand coverage without the need for new tax revenue. Employer mandates may also appeal to the broader view that employers and workers, rather than the government and taxpayers, should be responsible for health insurance coverage.

Figure 2. Composition of Insurance Coverage in California, 1995–2003



Source: Author's tabulation of the March 1996–2004 CPS.

Figure 3. Sources of Coverage in California Relative to the Rest of U.S.



Source: Author's tabulation of the March 1996–2004 CPS.

California's Pay-or-Play Mandate

Although California's plan was repealed by voters in 2004, related proposals are likely to emerge in the future, both in California and elsewhere. A careful consideration of California's Health Insurance Act can provide valuable lessons about some of the pitfalls of such legislation and how it might be improved. California's HIA would have placed four separate requirements on employers and employees:

Employer offering mandate: Firms must offer health insurance to all eligible employees or pay a fee to the state.

Employee take-up mandate: Eligible employees must accept the health coverage they were offered from their employer.

Health insurance quality mandate: The health insurance that was offered had to contain a minimum set of benefits.

Premium-sharing mandate: Employers were responsible for at least 80 percent of premiums on the minimum quality plan.

Although the requirements appeared relatively simple, in reality they presented a host of implementation difficulties. The HIA had additional provisions that intentionally or unintentionally targeted certain workers or businesses. These targeting provisions included

Firm size: Large firms would have been required to offer family coverage, whereas medium and small-to-medium firms would have been required to offer individual coverage. Small firms were exempt under HIA.

Hours of work: Only full-time employees were eligible.

Nonemployer health coverage: Workers who were insured from a nonemployer source would have most of their costs paid by their employer.

Family income: Low-wage earners would have received greater premium assistance from employers.[15]

The goal of the targeting provisions was premium cost redistribution—it was thought that some workers or firms would have particular difficulty complying with the premium-sharing mandate and would need assistance. The motivation for targeting by firm size was to keep down employer costs; smaller firms may be significantly less profitable than larger firms and would therefore have greater difficulty operating under a more-expansive mandate.

The next four sections explore these requirements in more detail and explain where the targeting provisions fit in. They highlight the subtle details of the legislation and show some of the unintended consequences from those details.

Employer-Offering Mandate

The mandate would have required that employers with 200 or more employees offer coverage for both the worker and his or her dependents (including spouses and same-sex domestic partners). Employers with 50 to 199 employees would have been required to provide coverage for workers but not to dependents. Employers with 20 to 49 employees would have been exempt unless the state provided a tax credit equal to 20 percent of the employer's net cost of the fee. In such cases, employers would have faced the same requirements as those with 50 to 199 employees. Employers of fewer than 20 workers would have been entirely exempt.

Employee Take-Up Mandate

The HIA specified that employees would qualify for coverage if they worked 100 hours a month for three months, or roughly 23 hours per week. Those who met this work requirement and who were employed at firms of an appropriate size were required to pay, at most, 20 percent of the cost of coverage for the mandated minimum-quality health care plan. HIA allowed employers to deduct this payment directly from their employees' paychecks.

An important provision of the take-up requirement was that HIA did not permit employees who already had employer-provided insurance from another source to opt out of the mandate. For example, a wife who worked at a medium-sized firm would have been required to take up coverage

from her firm, even if her husband worked for a large firm that offered more generous family coverage. As noted below, this provision could have created serious problems.

Another feature related to targeting—or more accurately nontargeting—was that workers who already had government insurance or private insurance were not treated any differently from other workers. Under the California law, employees who qualified for full medical insurance through government programs and were working at least 100 hours per month would still have been classified as enrollees and mandated to pay for coverage under HIA. However, workers could have provided to a state agency the information necessary to determine their eligibility for Medi-Cal (California's Medicaid program) or the Healthy Families Program (a state-run program for children and teens ineligible for Medi-Cal). The enrollee contribution would have been refunded to eligible workers. The employer's contribution, however, would not. Instead, it would have been used to pay the state's contribution under the matching funds portion of Medi-Cal.

If the employee were receiving Medicare or CHAMPUS/TRICARE coverage, he or she would be provided redundant coverage either through the employer's private plan or through a contribution to the state fund. HIA did not permit firms to simply offer a wraparound plan—one that covers benefits beyond the core set of services provided by government insurance. Any wraparound plan to supplement the government insurance programs would have to be offered *in addition* to the mandated coverage under HIA.

Health Insurance Quality Mandate

Without a minimum-quality component, an employer could simply pay the modest premiums on a bare-bones plan with high out-of-pocket costs for the employee. The California law specified that if an employer chose to offer health insurance rather than paying a fee, its plan must offer minimum benefits: inpatient and outpatient care, physician services, preventive services, lab and radiology, home health, hospice, and emergency services. This coverage would also have included a prescription drug benefit plan.

The legislation would have given the state the sole power—through the California Managed Risk Medical Insurance Board—to determine the coverage standards against which private coverage would be measured. If employers provided inadequate health coverage, they would have been forced to find other coverage or have their workers covered by the state plan.

Premium-Sharing Mandate

HIA also introduced a premium-sharing mandate that would have affected many workers already covered, in addition to the uninsured. Employers would have been required to contribute at least 80 percent of premium costs for all workers eligible for the minimum-quality health care plan. Employers could have paid less than 80 percent and provided other benefit packages (with employees contributing higher premiums), as long as one of the packages complied with the requirements of the law. If the employer provided health insurance before the law went into effect, but paid less than 80 percent of the costs, then the legislation entailed redistribution of premium costs from the employee to the employer, which might not be a bad outcome, although it could still leave the worker uninsured.

The California law specified that if an employer chose to offer health insurance rather than paying a fee, its plan must offer minimum benefits: inpatient and outpatient care, physician services, preventive services, lab and radiology, home health, hospice, and emergency services.

For many low-wage workers, the cost to their employers of providing them with health care coverage could have been higher than 80 percent of premium costs. This could have occurred when a worker's income was under 200 percent of the federal poverty line; in such cases, the employee's pre-

mium obligation would have been no more than 5 percent of his or her earnings. This provision would have further raised the cost of hiring such workers, beyond the costs of other parts of the legislation. This in turn would have created incentives to avoid hiring such workers, or to pay workers above this threshold, rather than pay higher premiums.

Effects of Employer Health Insurance Mandates

Employer mandates can take on many forms and it is not enough just to discuss the general idea without considering specific effects, such as California's. First to be examined is the effect on wages and employment, drawing on earlier estimates to illustrate these effects (Yelowitz, 2004). Next, other avenues of adjustment—higher prices, lower profitability, and so forth—are explored; the literature is less developed on this aspect, so no estimates are provided. Finally, other effects of the offering, take-up, quality, and premium-sharing mandates are considered.

Wages and Employment

Employer mandates will affect the labor market in ways that include lower wages and, most likely, the loss of jobs. Summers (1989) presents a compelling analysis of mandated benefits; those such as HIA create a tax-benefit linkage, in his view. A simple supply-demand analysis of the labor market reveals that, to the extent that employees value employer-provided health insurance, they would be willing to accept lower wages. In the extreme, where workers value the health insurance at the full cost of providing it, employers will pass on the full economic costs of such a pay-or-play mandate in the form of lower wages, and there will be no job loss.

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If employees value the fringe benefit at its full cost, would the firm not simply provide it in the first place? When employers can observe employees' preferences and can easily calculate the costs of providing the benefit, this provision will likely occur. For example, the costs of running a company cafeteria are easy to calculate for an employer. Observing the costs of providing insurance benefits is more difficult, however. In many cases, one would not expect such mandated benefits—especially very specialized benefits—to emerge in the private market because of the adverse selection problem. Some benefits—such as covering in vitro fertilization—have huge appeal to a small segment of workers, and if only one firm offered such benefits, that firm would tend to attract expensive-to-insure workers. Because of this, no single firm would unilaterally provide such benefits, because its insurance costs would be much more expensive than its competitors'. If all firms follow this logic, a potentially valuable benefit is not offered.

There are instances when job loss is likely to occur, rather than wage-shifting. When employees value health insurance (or some other benefit) at less than its full cost, employers will not be able to fully offset the costs of health insurance with lower wages. In such a case, the mandated benefit works like a tax and results in job loss. Alternatively, low-wage workers may value the mandated benefit at its cost, but there may simply not be enough room for wage adjustment downward because of the minimum wage. In this case, the mandated benefit acts like a minimum wage, potentially resulting in job loss.

One careful, but specialized example of this effect is found in Gruber's 1994 study of mandated benefits. He studied several state and federal laws that mandated comprehensive childbirth benefits in health insurance policies and that, therefore, substantially raised the cost of insuring all women of childbearing age. He found that employers shifted the entire cost of the mandate to employees who would obtain value from this benefit. Thus, he provides strong evidence that firms will lower wages when possible to pay for the mandate. It is not clear, however, whether such results, from a study of a highly targeted benefit to a narrow demographic group, apply more generally. The possibil-

ity of this kind of wage-shifting, especially in the long run, significantly changes the interpretation of redistribution that would have occurred had HIA gone into effect. Although the costs to employers would have risen initially, those costs would have been passed on eventually to workers in the form of reduced wage growth or lower wages.

There are two impediments to full wage-shifting. The first is the employee's valuation of the benefit—some workers will certainly not value the employer coverage very much. For example, as shown below, more than a million recipients of government health care would have had such insurance replaced by employer-provided health insurance under HIA. For these enrollees, the additional value of employer health insurance over their current health plan is surely quite small, and it would be more difficult for employers to pass along the cost of the mandate in the form of lower wages. The same is also probably true for the uninsured who are eligible but not participating in Medi-Cal. Brown et al. (2002) estimated that 1.12 million adults and children were eligible for Medi-Cal or Healthy Families but were not participating. It is also likely that some of the uninsured—especially younger, healthier adults—do not put a very large valuation on health insurance relative to its cost. The fact that these groups are unlikely to value HIA anywhere close to its true cost calls into question the applicability of the Gruber (1994) findings.

The second issue is the minimum wage. Summers (1989) notes that if there is a binding minimum wage, then "wages cannot fall to offset employers' cost of providing a mandated benefit, so it is likely to create unemployment." As shown below, even with full valuation of employer health insurance from HIA, wage-shifting would have been constrained for approximately 1.4 million employees because of the California minimum wage of $6.75 per hour.

Estimating Labor Market Responses

Shifting a large health care obligation onto employers through a pay-or-play mandate makes labor market adjustments, such as wage-shifting and job loss, more likely. But such employer responses themselves create consequences that are likely unintended. Some low-skilled and less-experienced workers who would otherwise be able to find jobs will instead become unemployed, because pay-or-play would drive up the cost of their labor. Also, many currently insured workers would have experienced greater government regulation of premiums, cost-sharing, and benefits. To the extent that employers and employees already have agreed on an acceptable compensation package (as would be true in a competitive labor market but not a monopsonistic one), this sort of government intervention could make both parties worse off. Third, by reinforcing the link between employment and health insurance, pay-or-play could increase job lock, that is, the creation of disincentives to look for new employment.[16] To the extent that employers must offer health insurance to sicker employees who meet the statutory requirements of HIA, job lock could decrease as well.

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Only one state has successfully enacted such a sweeping pay-or-play health insurance mandate, so there is little direct evidence about its potential effect. Hawaii's 1974 employer health insurance mandate required that employers provide health care coverage for all employees who work at least 20 hours per week.[17] The state's Prepaid Health Care Act further mandates that workers pay no more than 1.5 percent of their wages for their share of the cost of coverage. Thurston (1997) finds that the percentage of Hawaiian workers employed fewer than 20 hours per week (and thus exempt from the law) is significantly higher than the national average. One could argue that Hawaii's uninsured rate is extremely low, which suggests that the labor market distortions are probably fairly moderate. However, Dick (1994) contends that Hawaii's law reduced the number of uninsured by no more than 10 percent.[18] His models suggest that after adjusting for demographics, Hawaii's uninsured rate

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would be almost identical to the national average.

To find the most conservative estimate of job loss, the following analysis assumes that employers shift as much of the cost of pay-or-play mandates onto the worker as possible in the form of lower wages (consistent with the Gruber, 1994, findings). Employment losses would ensue only to the extent that wages would have to be shifted below the California minimum wage of $6.75. For example, if the total mandated HIA cost for the employer was $2,080 for a worker, then this would translate into a $1.00 per hour shift in wages for a full-time, full-year worker. If the worker earned $7.50 an hour, only 75 cents of this mandate could be passed along in the form of a lower wage; the remaining 25 cents is analogous to a minimum wage increase (where the percentage change in wages is 25 cents divided by $6.75, or 3.7 percent).

Nearly 11 million workers would have been affected by HIA; of these, 1.4 million workers would not have experienced full wage-shifting because of the minimum wage. Assuming that for the remaining 9.6 million workers in the California labor market employers can pass on the cost of the mandate fully, no job loss ensues. For the 1.4 million low-wage workers, I draw upon Neumark and Wascher's (2000) convincing reevaluation of Card and Krueger's (1994) study of minimum wages in New Jersey. Using payroll data, they estimate an employment elasticity of –0.22, which is interpreted to mean that a 10 percent increase in the minimum wage will translate into a 2.2 percent decrease in employment.

Figures 4 and 5 summarize the findings. These figures, adapted from Yelowitz (2004), show modest job loss as a result of HIA. When full wage-shifting is possible until the minimum wage, approximately 70,000 workers become unemployed, or 5 percent of at-risk workers (where "at-risk" is the population of 1.4 million workers for whom full-wage pass-through is not possible).

Of those who would have become unemployed, Figure 4 shows that almost 18,000 already had employer-provided health insurance. The 33,000 workers who were initially uninsured are of particular interest because, although they continue without insurance, they also lose their jobs. This is a noteworthy unintended consequence of the legislation: Some of these workers might have eventually moved into jobs that offered health insurance. Another 15,000 workers with government insurance would have lost their jobs but would have kept this insurance even when unemployed. Figure 5 breaks out the employment loss by wage level. It shows that almost all of the job loss occurs in the $6.75–$8.00 per hour range. Finally, it is important to note that the full valuation, full wage pass-through assumption clearly makes the estimates of job loss too conservative.

Other Economic Adjustments

Although adjusting wages and employment is the most obvious economic response employers are likely to make, they do have other options: They can accept lower profits, charge higher prices, relocate the firm out of state, or go out of business. The latter three responses all imply job loss and if they were significant, would cast doubt on the notion that all of the adjustment would come from firms accepting lower profits.

The most discussed of these possibilities is charging higher prices, but the potential for doing so may be quite limited. HIA imposed relatively high costs on a small number of large firms, more moderate costs on medium-sized firms, and no costs on small firms. Data from the California Employment Development Department for 2003 show that less than 5 percent of all firms have more than 50 employees, yet these firms employ nearly 61 percent of workers in California. The overwhelming majority of firms would have been unaffected by HIA because of their small size, and this fact would constrain the ability of their larger competitors to raise product prices. The ability to pass along the

higher HIA costs in the form of higher prices varies by industry rather than by the entire labor market, however. This argument would not hold if large firms are concentrated in certain industries across which consumers do not substitute—for example, shoe repair versus air travel.

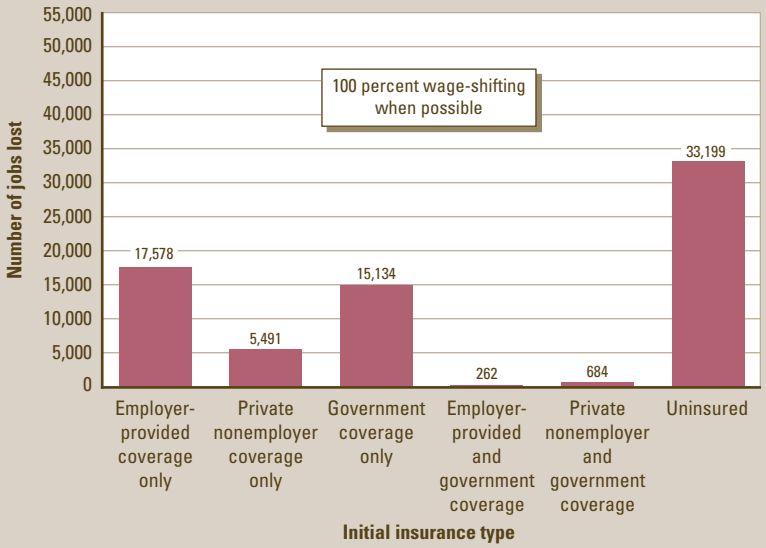
Effects of the Employer-Offering Mandate

A point worth noting about the repealed California legislation is that policymakers have many choices about how to structure a health insurance mandate. There are several intended and unintended consequences of differentiating the employer mandate by firm size, hours of work, family income, or health insurance status. The key problem is the efficiency-equity tradeoff. The mere act of creating preferred groups or exempt groups such as small firms or low-income workers, which was one result of the HIA targeting, could lead to unintended and adverse behaviors by profit-maximizing firms.

The intended effect of making the employer-offering mandate binding on larger firms is to adjust the mandate to a firm's presumed ability to pay. One consequence of this targeting is to reduce overall coverage, because employees at smaller firms remain uncovered. Thus, HIA did not provide anything close to universal coverage even among the employed.

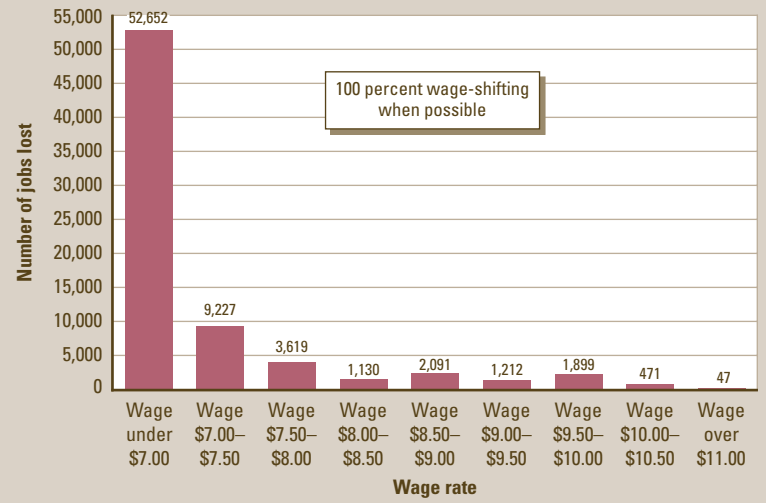
The employer-offering mandate also creates an incentive for firms to game the system. There is a strong possibility that firms whose employee populations are near the 20-, 50-, or 200-worker cutoff may decide to not expand employment. Firms slightly above those cutoffs may decide to reduce employment (or consolidate part-time jobs into full-time jobs) to get below the threshold. This could be thought of as an "employment-notch" tactic, because the marginal cost of hiring the 20th, 50th, or 200th employee is extremely high. Using health care premiums for 2003, for example, a firm that was previously offering single coverage could face a marginal cost to its health care bill of approximately $850,000 when it hired its 200th employee, because it would have to offer all of its workers family coverage (if they qualified). Similarly, hiring the 20th employee entails a marginal cost to its health care bill of nearly $40,000, and hiring the 50th employee entails a marginal cost of nearly $26,000, because of the loss of the tax credit.

Figure 4. Estimated Number of Jobs Lost Under HIA, by Current Insurance Type



Source: Author's calculations based on the March 2003 CPS.

Figure 5. Estimated Number of Jobs Lost by Initial Wage Rate



Source: Author's calculations based on the March 2003 CPS.

There was one exception, however, where HIA offered an incentive for firms to grow rather than shrink. For small firms close to the 20-employee cutoff that already offered HIA-compliant health insurance coverage (i.e., the firm pays at least 80% of the premiums), a tax credit would have effectively reduced the employer's contribution from 80 percent to 64 percent (with the state picking up the residual 16%). This could therefore have encouraged additional hiring up to the 20-employee limit for the firm to fall within HIA's jurisdiction. More generally, firms in the 20- to 49-employee range who already offered HIA-compliant coverage would have seen their costs fall, not rise, because of the tax credit. In all of these instances—both where the costs are substantially raised or lowered—the economic incentive to adjust firm size is unquestionable although the magnitude of the response to the incentive is open to debate.

Effects of the Employee Take-Up Mandate

The most important economic consequences of the take-up mandate stem from possible adjustments to an employee's work hours and to the comprehensiveness of family coverage and from the effect on workers with preexisting, nonemployer health insurance coverage.

The effective hourly cost of offering health insurance (which is a fixed cost per employee) is significantly more expensive for part-time workers. The hours-of-work provision of the California law would have created unintended hiring incentives, however. In the same way that the law increased the cost of hiring additional workers beyond a given firm size or employee population threshold, it also significantly drove up the costs of hiring additional employees who worked more than 99 hours per month; this could be thought of as an "hours notch." In Hawaii, where there was a similar hours-of-work provision (20 hours per week for eligibility), Thurston (1997) found that the percentage of Hawaiian workers employed fewer than 20 hours per week (and thus exempt from the law) was significantly higher than the national average.

In addition, HIA did not permit employees who already had employer-provided insurance elsewhere to opt out of the mandate. One unintended consequence was that insurance coverage within a family would have become more disjointed. For example, it would have been possible under HIA for a husband to have coverage under one private plan, a wife under a different plan, and a teenager (who worked more than 23 hours per week) under a third plan. If each person's insurance plan restricted choice of physician, it would have been possible that each family member would have to receive health care treatment at different facilities and possibly deal with three different insurance plans. In addition, if the health insurance plans were not a managed care arrangement, the family members would have been unable to combine medical expenses into one deductible and would have been forced to use three individual deductibles. For large families, the family deductible is typically less than deductibles in individual plans multiplied by the number of family members. For example, a plan might have a $1,000 deductible for an individual and $2,500 for a family. In this case, total payments for the family could rise with three different policies rather than one.

Finally, by making no distinction between workers with nonemployer health coverage and all other workers, HIA would have resulted (initially at least) in a substantial shifting of costs onto employers by crowding out other forms of health insurance. Some of these increased costs would likely be borne by workers in the form of lower wages. Many would argue that it is inappropriate for taxpayers to subsidize the employers of low-wage workers by providing Medicaid to their employees, especially when state budgets are so tight. Possibly, this provision is not really targeting but rather simply a disguised tax increase that shifts costs from the government to the firm.

Some of this cost-shifting—the crowding out of Medi-Cal or private plans—was probably intended. One could argue that because the degree of government responsibility for providing health care would have fallen, state and federal government expendi-

tures would have as well. This is likely to be true for Medi-Cal. But creating potentially redundant coverage for Medicare and CHAMPUS/TRICARE is probably inadvertent. It is less clear that Medicare or CHAMPUS/TRICARE recipients would have dropped their government coverage, so the government savings would be more modest.[19]

Effects of the Quality Mandate

The motivation for a quality mandate was to prevent employers from circumventing the intent of HIA with a bare-bones health plan. Although this quality mandate makes intuitive sense, it should be noted that some firms and workers might in fact want a bare-bones plan, especially if it resulted in higher wages or more generous other benefits. It could be easier for employers to attract and retain workers if they designed plans that take into account their workers' preferences toward wages, health insurance, and other benefits. If a minimum-quality plan is significantly more generous than what workers and employers want, such a quality mandate can work against the worker's best interests. For some workers, such as those covered by Medicare or CHAMPUS/TRICARE, HIA unquestionably provided coverage that could be considered too generous. For many workers, however, we can only speculate whether the quality mandate would have had a serious effect.

Effects of a Premium-Sharing Mandate

HIA also required that employers contribute at least 80 percent of the premium costs of all eligible workers. Such a provision would have minimized the financial effect of HIA on newly covered employees, many of whom may have had difficulty paying for their own health premiums. One estimate from 2002 revealed that 58 percent of employees who declined coverage (and did not have health insurance coverage elsewhere) could not afford their share of the premiums.[20] The requirement might also have increased the political appeal of the plan for millions of Californians who paid high premiums for private health insurance.

The mandate also reflected the goal of HIA's authors to level the playing field between employers who paid for a significant amount of health insurance premiums and those who did not. In practice, this would have meant raising the health care costs for firms that provided inadequate coverage. The assumption that the playing field was unbalanced is an open question, however. The 2003 California Establishment Survey, which surveyed business and nonprofit establishments with five or more employees, found that 90 percent of the employers that did not offer health benefits were in markets where most of their competitors did not provide such benefits either.[21] The argument that companies that do not provide affordable health care to their employees have a competitive advantage over companies that do does not hold up, because the so-called race to the bottom—not providing health benefits—has already occurred.

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During the heated campaign to repeal HIA, there was a great deal of confusion about how binding the premium-sharing mandate would have been. Even though California employers on average nearly met the premium-sharing part of the mandate requirement already, there was considerable discrepancy, with some employers paying more than 80 percent and others paying considerably less. In the 2002 California Employer Health Benefits Survey, 20 percent of small or medium-sized firms and 21 percent of large firms did not cover 80 percent of the premium costs of a single plan, and about half of large firms did not cover 80 percent of the premiums for a family plan.[22]

A final targeting provision reduced premiums for low earners and shifted the costs onto the employer. This provision would have driven up the cost of insuring low-wage workers, which would have had effects similar to raising the minimum wage. For example, a full-time, full-year worker

earning the $6.75 per hour minimum wage in California would be responsible for $702 in premiums, representing 8.4 percent of the total cost of the median family plan. An employer in this case would be responsible for nearly 92 percent of the premiums. Although the intent of HIA was surely to target individuals in poor households for premium assistance, the way the law was written, HIA counted only individual earnings, not family income, for this poverty determination. Without correcting this wording, some low-wage earners in high-income families would have received reduced health premiums. This potential mis-targeting of low-wage workers in nonpoor families could easily have been corrected by more precisely specifying family or household income rather than individual earnings.[23]

Assessing the Coverage Effects and Costs of California's Pay-or-Play Plan

An analysis of the HIA provides insight into issues that should be considered in future proposals to mandate health insurance—should policymakers choose to go that route—both in terms of how to increase coverage the most and in terms of costs. The previous section discussed the potential effects of the policy. This section first considers expansion of coverage and then costs.

Thirty-one percent of uninsured Californians would have become insured after implementation of HIA. Even though it was not universal, coverage of this magnitude would have dramatically improved California's relative position in terms of the percentage of its population who were uninsured.

Coverage

To compute the coverage and employer cost effects of HIA, the 2003 March *Current Population Survey* Annual Social and Economic Survey was used. The 2003 CPS surveyed 16,779 people in California who lived in 5,600 households. Although the CPS identified only 32 of the 58 counties in California (either individually or within a metropolitan statistical area), these 32 contain roughly 95 percent of California's population.

Adding the number of individuals in the brown bars in Figure 6 shows that nearly 11 million workers would have been covered by HIA provisions, and when all family members are included (Figure 7), nearly 18 million individuals would have been covered. Nearly 80 percent of workers who would have been eligible for HIA could have seen some sort of change in the coverage or generosity of their policy.

In 2002, the year covered by the data, more than 10.6 million Californians (6.5 million workers) received health coverage from employers but paid a portion of the premium, with more than 488,000 people (more than 316,000 eligible workers) paying the entire cost of coverage.[24] Many of the 6.5 million eligible workers would have required additional coverage to meet the minimum standards under HIA in terms of both cost and quality of coverage.

Under the most expansive interpretation of HIA, 1.98 million individuals who previously had no insurance would have received new coverage in 2002 (shown in Figure 7). Previously uninsured individuals make up a minority of those employees who would have been affected by this legislation. Thirty-one percent of uninsured Californians would have become insured after implementation of HIA. Even though it was not universal, coverage of this magnitude would have dramatically improved California's relative position in terms of the percentage of its population who were uninsured. California would have had 12.6 percent of its population uninsured rather than 18.2 percent (and would fall below the national average of 15.2% for that year) and would have ranked 21st rather than 46th in terms of the percentage of its insured population.

More than 1.5 million individuals (nearly 700,000 workers) who had nonemployer health insurance coverage would have received additional coverage as a result of the legislation. These included more than 360,000 Californians who purchased private coverage and more than one million

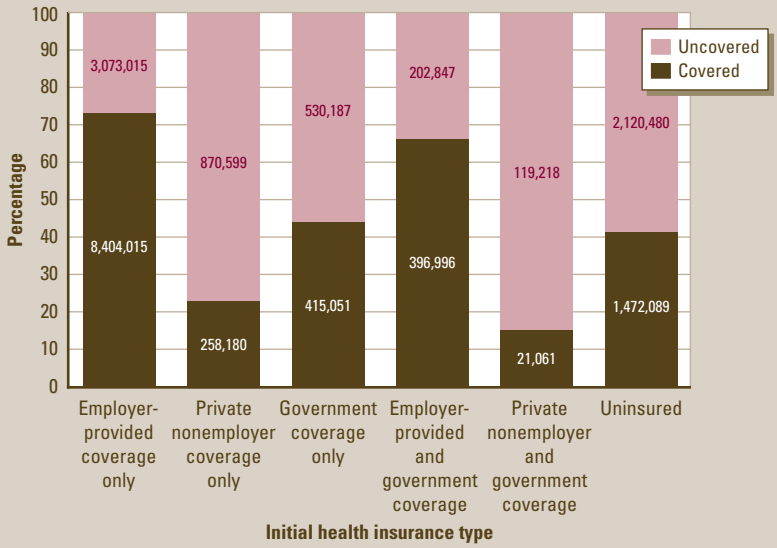
Californians (more than 415,000 workers) who received coverage through government programs.

In summary, enacting HIA alone would have significantly reduced the number of uninsured, but the actual requirements would have still left the majority of uninsured without coverage. The combination of weak labor force attachment, hours-of-work requirements, and narrower coverage requirements for smaller firms would have led to far-from-universal coverage. Clearly HIA would have been just one of the steps needed to provide universal coverage.

To what degree can employer mandates reduce the number of uninsured? Figure 8 helps explain this best case scenario, using health insurance units (HIUs) to assign dependent coverage, derived from the 2003 March CPS. A conventional HIU includes the head of household, spouse, minor children under age 18, unmarried children between ages 19 and 22 who are full-time students, and disabled children of any age. The HIU definition does not include the head's parents, grandchildren, foster children, or unrelated individuals, nor does it include same-sex domestic partners. For each of the 6.39 million uninsured Californians in 2003, the larger of the head's or spouse's annual work hours was assigned if the person was in the HIU; otherwise the individual's own work hours were assigned.

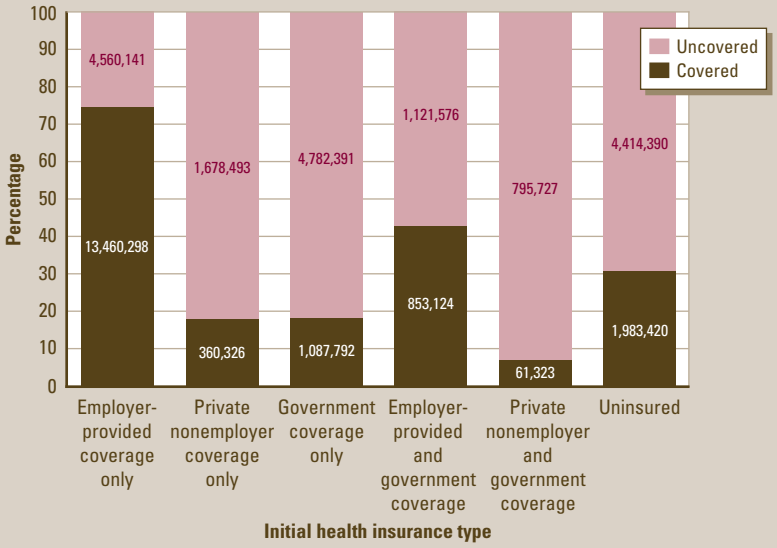
A more direct way for policymakers to reduce the number of uninsured is a very broad mandate for family coverage of workers, irrespective of firm size. Figure 8 illustrates the potential reduction in the number of uninsured. Slightly more than one-half of the uninsured either work full-time, full-year or are in an HIU where the head or spouse holds a full-time, full-year job. These individuals could be covered under a broad mandate. Another 10 percent of the uninsured have what might be called moderate attachment to the workforce—in this case they work 1,500 to 1,999 hours annually. Roughly 38 percent of the uninsured have very weak attachment to the labor force and would not qualify for employer health insurance under the conventional HIU definition. Although individuals in this final category may work full-time

Figure 6. Number and Percentage of Workers Covered Under Fully Phased-in HIA



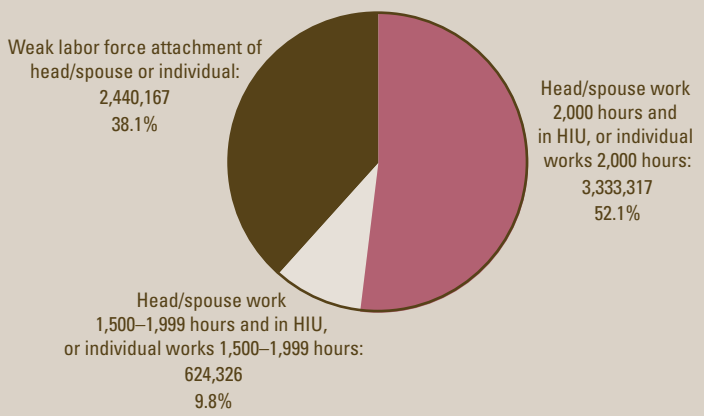
Source: Author's calculations based on the March 2003 CPS.

Figure 7. Number and Percentage of Workers and Family Members Covered Under Fully Phased-in HIA



Source: Author's calculations based on the March 2003 CPS.

Figure 8. Number and Percentage of Population That Is Uninsured by Workforce Attachment, 2002



Source: Author's calculations based on the March 2003 CPS.

but for only part of the year, an employer mandate would provide only partial-year insurance coverage for the months that they worked. In general, close to 40 percent of the uninsured are unlikely to be reached by even the most expansive employer mandate. Nevertheless, even though coverage would still not be universal, an expansive mandate would be sufficient to move California near the top of states in terms of insurance coverage. A broad mandate that covered households with strong labor force attachments would have lowered the uninsured share to 8.7 percent in 2002, propelling California to the second-highest ranking (behind Minnesota) for that year. A broad mandate covering households with both a strong and moderate attachment would have lowered it to 6.9 percent, and would have moved California to the highest spot.

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Employer Cost Estimates

The benefits of expanded coverage ultimately have to be weighed against costs and against who pays for those costs. In this section, it is first assumed that the employer pays costs as specified by HIA. Understanding the effect on employers, before any behavioral adjustments (such as wage-shifting, job loss, higher prices, and so forth), is a natural starting point.

Figure 9 presents estimated costs using 2003 numbers and assumes that HIA would have affected firms with 20 or more employees. Costs are shown for different groups of workers based on health insurance status at that time. It shows that a fully phased-in HIA would have cost employers roughly $13.2 billion statewide, using 2003 data on insurance premiums.

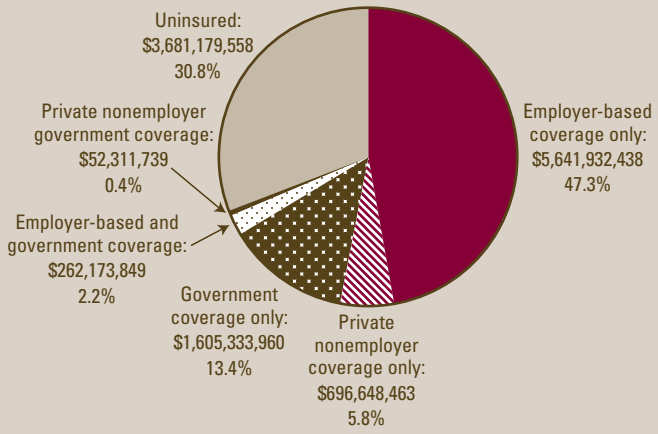
Given the coverage findings in Figure 7, the employer cost breaks down to nearly $6,500 per newly covered individual. This relatively high figure comes about because two-thirds of the employer costs would stem from providing insurance to individuals who already had coverage. For every employer dollar that would have been spent under HIA, only 30 to 35 cents benefited the previously uninsured.

The estimates presented here, adapted from Yelowitz (2004), are significantly higher than other publicly released estimates. The employer costs for the uninsured, approximately $4.4 billion statewide, represent about one-third of the total employer cost and are roughly in line with previous work. Neglected in most studies, however, is the cost from what is by far the largest single group—those who had employer-provided insurance. The premium-sharing and dependent requirements of HIA entailed employer costs of between $5.8 billion and $6.0 billion for employers. Those with employer-provided coverage only, and those with employer-provided and government coverage, represent roughly one-half of the cost of the mandate. Nearly 500,000 Californians who would have qualified for the HIA were covered by employer insurance for which the employee was paying the full premiums. From the employer's viewpoint, the additional cost of paying for these individuals is the same as paying for uninsured individuals under the mandate.

The cost shift from government health insurance to employer-provided health insurance is between $1.5 billion and $1.7 billion. Currently, more than 8.7 million Californians receive insurance through Medicare, Medi-Cal, and CHAMPUS/TRICARE. Of these, more than two million would have been affected by the HIA mandate because of their work hours, tenure, or the size of the firm.

Although the costs to employers would have risen dramatically as a result of HIA, the cost to the government and to employees would have fallen—making the net cost to society far lower than the gross cost to employers. This cost-shifting is a consequence of private insurance replacing Medi-Cal coverage. But one unintended effect would have been the potential loss of federal matching dollars for Medi-Cal to the state. Although businesses would have paid between $1.5 billion and $1.7 billion more for employer insurance for Medi-Cal recipients under the HIA, most of this dollar amount represents savings to the Medi-Cal program. Not all of the saving accrues to the state government, however, because the federal government matches California's Medi-Cal spending dollar-for-dollar. Thus, the savings to California is on the order of $750 million to $850 million (with a similar savings to the federal government). Another consequence stems from the fact that employer contributions to health insurance are not taxed, whereas wages are. In Yelowitz (2004), downward wage adjustments—to offset the higher cost of providing health insurance—were shown to reduce tax payments to the state of California by at least $800 million. This finding, along with the Medi-Cal savings to the state, suggests that HIA would not have improved the state's finances. A fair way of characterizing HIA is that without other adjustments on the part of employers, it would have involved substantial attempted cost-shifting to employers from employees and the government. There is a strong possibility that these employers would have tried to unravel this shifting through labor force adjustments, thereby passing the costs back onto workers in the form of lower wages.

Figure 9. Total Costs Under a Fully Phased-In HIA



Source: Author's calculations based on the March 2003 CPS, adapted from Yelowitz (2004).
Note: Percentages may not sum to 100 because of rounding.

Recent Activity and Policy Recommendations

The key benefit of pay-or-play is that its mandates have the potential to significantly reduce the number of uninsured; at the same time they do not come close to providing universal coverage because many uninsured have a weak attachment to the workforce. Employers' labor costs increase dramatically as they are shifted from employees and the government. Over the long run, however, it is likely that workers will bear at least some of the cost of the mandate in the form of lower wages and in decreased employment, although the overall magnitude of the latter is small.

The key benefit of pay-or-play is that its mandates have the potential to significantly reduce the number of uninsured; at the same time they do not come close to providing universal coverage because many uninsured have a weak attachment to the workforce.

Other states studying health insurance mandates have consolidated the various individual mandates that California's HIA proposed into one single health expenditure mandate. This critique of some features of California's plan also helps illu-

minate potential problems with versions of plans that other states are considering. One could do far worse than California, in terms of covering the uninsured, through some of the alternative health insurance mandates that have been proposed.

Maryland's Fair Share Health Care Fund Act—enacted when the legislature overrode the governor's veto but then overturned in court—required that all firms with more than 10,000 employees spend at least 8 percent of their payroll on health care expenses. It was thought that this requirement would affect only one company operating in Maryland—Wal-Mart. If a firm spent less than that amount, it would have had to pay a tax to the state equal to the difference between 8 percent of payroll and actual health expenditures.

In Washington's Health Care Responsibility Act (which has not been enacted), businesses with more than 50 employees pay a fee to the state based on the number of hours worked by their employees. Employers can then deduct health care expenditures from their mandated fee and would owe no additional tax if their health care expenditures were greater than the fee.

Although these two systems may effectively collapse the health insurance quality and premium-sharing mandates into a single requirement on spending, they do nothing to address the offering or take-up issues created by California's HIA. Some employers in Maryland or Washington, for example, may already meet the spending requirements (relative to the hourly fee in Washington or the payroll tax percentage in Maryland) yet not be offering coverage to all their employees. Other employers could be exceeding these expenditure requirements, offering health insurance to all employees, but have less-than-complete employee take-up of health insurance benefits.[25] Thus, the potential for significantly reducing the number of uninsured is diminished.

The reality is that those costs would largely have been passed on to workers in the form of lower wages (the economic incidence). By not framing the issue this way, one gains voter support, but it is an inaccurate way of representing who really pays.

How could California's pay-or-play mandate have been made more effective? What recommendations can be incorporated into pay-or-play proposals moving forward based on California's experience, such as the proposals currently pending in nearly half the states?

First, California's employer mandate was too expensive. Two-thirds of the total cost of the mandate would have been borne by individuals who were already insured. This is because the benefit to insured workers—primarily the 80 percent employer premium-sharing for family plans—was far more generous than what a typical firm provides. One obvious recommendation is therefore to cut back on the generosity of the mandate by restricting it to individual workers rather than to families. Another potentially valuable modification relates to one of the stated motivations for imposing an employer mandate—mitigating the fiscal externalities associated with emergency room care. This could be addressed by mandating a high-deductible, catastrophic health care plan rather than one that resembles the typical plan of a currently insured worker. Such a plan could currently be obtained for a healthy, nonsmoking, 35-year-old male in Los Angeles for as little as $62 per month.[26]

Second, employer mandates should better align statutory incidence with economic incidence. Under HIA, employers were nominally responsible for 80 percent of the premium costs (the statutory incidence). The reality is that those costs would largely have been passed on to workers in the form of lower wages (the economic incidence). By not framing the issue this way, one gains voter support, but it is an inaccurate way of representing who really pays. At the same time, there is a key economic motivation for aligning the statutory incidence with the likely economic incidence. Firms are unable to pass through the costs of the mandate for low-wage workers, because of the minimum wage. In this case, the likely response is job loss rather than wage-shifting.

Third, pay-or-play legislation at the state level should recognize the loss of federal dollars and should be designed to avoid them. Medicare and

CHAMPUS/TRICARE are fully federally financed, and in California, half of Medi-Cal's spending is federally financed. The structure of HIA in California may have led to employers crowding out Medi-Cal with private coverage, resulting in cash flows out of the state. Many current pay-or-play proposals aim to make large companies pay their fair share of health care expenses and are motivated by the fact that some employees have children who are covered by Medicaid.[27] Since federal matching rates for Medicaid range from one-to-one (in more affluent states such as California) all the way up to four-to-one (in poorer states such as Mississippi), policies that replace Medicaid with private coverage generate relatively little in terms of savings to the state.

Fourth, it is important for policymakers to include all four of the requirements necessary for a comprehensive pay-or-play system: an offering mandate, a take-up mandate, minimum quality, and premium-sharing. When any of these are omitted or combined, it is possible that the effect of the policy will be severely diminished.

Finally, pay-or-play mandates will not completely solve the problem of the uninsured alone, but they can make a serious dent. Other policies—such as Medicaid expansions or individual mandates for nonworkers—are probably necessary for near-universal coverage, because a significant number of uninsured have a very weak labor force attachment. By incorporating these insights, a scaled-back pay-or-play mandate could significantly reduce the number of uninsured, while having fewer detrimental effects on the labor market. The recent health care reform in Massachusetts seems to recognize the limitations of employer mandates. It combined a modest employer mandate (a $295 annual fee to "pay" rather than "play"), with sliding-scale premiums for low-income residents and an individual mandate to buy insurance. ❖

Notes

[1] See http://www.census.gov/prod/2005pubs/p60-229.pdf, p. 16.

[2] See Employer Health Benefits 2005 Annual Survey.

[3] See http://pubdb3.census.gov/macro/032005/health/h06_000.htm.

[4] See http://www.ss.ca.gov/elections/sov/2004_general/ssov/formatted_ballot_measures_detail.pdf.

[5] The California State Council of Service Employees, the California Teachers Association, the United Food and Commercial Workers International Union Local 120, the California Healthcare Association, the Service Employees International Union, the Californians for Quality Healthcare, the California Federation of Teachers, and the AFL-CIO all gave donations to the "Yes" side of at least $400,000. The California Restaurant Association, Wal-Mart, McDonald's, Yum! Brands, CKE Restaurants, Robinson-May, Macy's West, and Sears Roebuck all gave donations to the "No" side of at least $400,000. See http://cal-access.ss.ca.gov/Campaign/Measures/Detail.aspx?id=1260875&session=2003.

[6] ERISA prohibits a state from considering a self-insured employer plan to be an insurer. Thus, self-insured health coverage plans cannot be regulated by the state, whereas insured health coverage plans can be regulated. State pay-or-play laws are vulnerable to an ERISA preemption challenge if they interfere with the administration of private sector, employer-provided plans or impose substantial burdens on them. Hawaii is the only state that can regulate the health insurance plans of self-insured companies under a special ERISA exemption granted by Congress. See California HealthCare Foundation and also http://www.ncpa.org/w/w24.html.

[7] See http://www.mdd.uscourts.gov/Opinions152/Opinions/Walmartopinion.pdf.

[8] See http://www.retail-leaders.org/new/resources/Matrix.pdf and http://www.ncsl.org/programs/health/payorplay2006.htm.

[9] The 1996–2004 March *Current Population Survey* (CPS) Annual Social and Economic Surveys are used to construct the figures. The CPS asks detailed questions about health insurance and work behavior for the entire previous calendar year. Health insurance status is asked for all household members; the survey includes questions about employer-provided health insurance, private health insurance, and government insurance. The survey asks about coverage of specific types of insurance, and respondents who answer no to all of the categories are considered uninsured. Coverage is defined as any time during the preceding calendar year, so being uninsured reflects lack of health insurance for all 12 months.

[10] See http://www.census.gov/prod/2005pubs/p60-229.pdf, p. 17. In 2004, 59.8 percent of individuals were covered by a health insurance plan related to employment, and 8.3 percent had other private coverage.

[11] In the remainder of this paper, the government-insured category will be called Medicaid or Medi-Cal. CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and TRICARE are health insurance programs that cover both active-duty and retired military personnel, their dependents, and survivors.

[12] Thirty-seven percent of directly purchased private coverage is purchased by the elderly, which is assumed by many analysts to be Medicare supplemental insurance (Medigap). See ASPE Issue Brief in References, p. 22.

[13] See http://pubdb3.census.gov/macro/032005/health/h05_000.htm.

[14] Gruber, p. 510.

[15] California's law, as written, referred to individual rather than household income. It is hard to believe that the intent of HIA was to target low earners in wealthy households for premium assistance, however. The analysis in the text assumes that the legislators intended to target family income, rather than individual income.

[16] Job lock describes the situation of a person who is not free to leave for another job because the first job has medical benefits associated with it that the person needs and the second one does not.

[17] See http://www.ncpa.org/iss/hea/2002/pd012302d.html and http://www.ncpa.org/iss/hea/ for a more general discussion of state health insurance mandates.

[18] Hawaii's percentage of uninsured is quite low—around 10 percent—meaning that the mandate reduced the uninsured by around a percentage point.

[19] If an individual had dual coverage from government and private plans, it is not clear which plan would actually pay medical expenses. Many private plans currently carve out benefits around what the government plan covers, but HIA did not allow such a carve-out.

[20] See The Henry J. Kaiser Family Foundation and Health Research and Educational Trust (KFF/HRET) (2003), Chart 6.

[21] Dube and Reich (2003). The actual question leaves some room for ambiguity. The exact question asked of survey respondents was, "Do most of your business competitors offer health insurance to their employees?" The wording of the question apparently forced the survey respondents to decide who the competitors were and how to interpret the term "most."

[22] See KFF/HRET (2003), Charts 9–11.

[23] HIA (2003), p. 9: "For enrollees making a contribution for family coverage and whose wages are less than 200 percent of the federal poverty guidelines for a family of three, as specified annually by the United States Department of Health and Human Services, the applicable enrollee contribution shall not exceed 5 percent of wages. For enrollees making a contribution for individual coverage and whose wages are less than 200 percent of the federal poverty guidelines for an individual, the applicable enrollee contribution shall not exceed 5 percent of wages." If the goal was to target family income rather than individual earnings, the above sentence could substitute "family income" wherever "wages" are mentioned.

[24] The CPS asks whether the employer paid for all, part, or none of the premiums of the health insurance plan.

[25] Employer Health Benefits 2005 Annual Survey published by The Henry J. Kaiser Family Foundation and Health Research and Educational Trust reveals that within firms that offer health insurance, 80 percent of workers are eligible for coverage, and 83 percent of those who are eligible elect to enroll. See http://www.kff.org/insurance/7315/summary/ehbs05-summary-2.cfm.

[26] Author's calculation from www.ehealthinsurance.com.

[27] See http://www.ncsl.org/programs/health/payorplay2006.htm for the most recent legislative activity. Many of the bills—with firm size thresholds of 10,000 or more—are binding only on Wal-Mart.

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Pay-or-Play Health Insurance Mandates

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