San Diego County Taxpayers Association

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***Assembly Bill 8* — Introduced by Senator Perata (D – Oakland) and Assemblyman Nunez (D-46th District)**

**Board Recommendation:** **OPPOSE for the following reasons:**

- **Creates significant risk of an under-funded state sponsored insurance pool**
- **Does not eliminate cost-shift**
- **Unfair burden on businesses**
- **Unaccountable, un-elected body is given authority to increase payroll tax with no cap**
- **Does not ensure fair payment to providers**
- **Creates unforeseen negative economic consequences**

## Proposal Summary

AB 8 is a combination of two previous health care proposals, AB 8 and SB 48, authored by Assemblyman Nunez and Senator Perata, respectively. The proposal seeks to provide health insurance to 3.4 million (69%) of California's 4.9 million uninsured individuals through the creation of a purchasing pool (Cal-CHIPP) funded by a 7.5% Social Security wage "pay or play" minimum requirement on all employers in the state. Under the conditions of the bill, MRMIB will administer a newly created insurance pool named Cal-CHIPP, and use market power to negotiate a system of three (3) plans employees can choose from. These plans offer varying levels of coverage and require the employee to contribute an amount proportional to their desired level of coverage.

**Key Points of Compromise between SB 48 and AB 8** (as of 6/25/07)

- The new form of the bill only requires employers to contribute to health coverage ("Pay or Play").
- The minimum contribution requirement of 7.5% of total wages placed on employers is subject to increase at any time without a cap. The determination of this percentage is left to the discretion of MRMIB and is not subject to legislative approval.
- No exceptions are given to small and/or start-up businesses.

## Rationale:

- **"Pay or Play" mandates create job loss in the labor market**

AB 8 creates the benefit of insuring an additional 3.4 million Californians, but carries with it unforeseen negative economic consequences. The newly created Cal-CHIPP purchasing pool is financed through employers, who will pass on the costs to employees whose wage is above the state minimum wage. In the case of low-wage employees, however, firms are unable to pass on the costs of health care provision. The anticipated labor market impact of this inability to pass on health coverage costs is increased unemployment estimated at 70,000 jobs.

- **An inflation adjusted 8% increase in private group coverage rates is likely to under-fund Cal-CHIPP**

The "trigger point" at which employers are expected to shift enough individuals to the newly created Cal-CHIPP pool is expected to occur if private group health insurance rates rise by only 8%[1]. Assuming that the cost of group private insurance is positively correlated with the cost of providing health care, the scenario where the pool becomes under-funded due to over-enrollment requires just a modest increase in health care costs.

- **Under-funding of Cal-CHIPP creates a cycle of "cost-shifting"**

In addition to the labor effect of AB 8 listed above, the financing of the Cal-CHIPP insurance pool raises some serious questions. In the event that Cal-CHIPP is under funded, the insurance market effects can be severe. As our analysis shows, in the event of under-funding, Cal-CHIPP is likely to underpay providers, causing a cost-shift to those insured in the private market. Ironically, such a cost-shift is what this legislation actually sets out to solve in the first place. As private insurance costs increase, employers will shift towards the less expensive Cal-CHIPP plan, raising its enrollment and administrative costs. This creates a cycle in which Cal-CHIPP continually grows into a gigantic insurance pool that chronically underpays providers of health care. The other option available to finance an under-funded pool is increasing the required 7.5% of payroll that employers are required to contribute towards employer health care.

- **Employer mandates yield negative economic impacts**

The imposition of employer health care mandates can carry additional negative economic consequences. Faced with higher costs of labor, firms are likely to reduce their overall levels of production, reduce employment, shut down, or relocate.

Small businesses are hit particularly hard by employer mandates because they increase the start-up costs of entrepreneurial activity. Therefore, the likelihood of new businesses starting is decreased, and those that do enter the marketplace face labor costs higher than the market dictates.

- **AB 8 faces legal challenges**

Given the legal barriers faced by a law similar to AB 8 (Maryland's "Fair Share Act"), there is at least a possibility that AB 8 does not fully comply with the guidelines set forth in The Employee Retirement Security Act (ERISA) of 1974. ERISA forbids states to mandate that employers pay for health benefits in many instances, and the extent to which AB 8 is lawful under ERISA is not certain.

While we support comprehensive health care reform legislation, acknowledge the benefits of AB 8, and applaud the effort to address the current health care status quo in the state, the above mentioned issues lead us to conclude that Nunez's and Perata's AB 8 insufficiently provides the means to correctly deal with health care reform in California.

[1] SDCTA has calculated the cost increase in real terms required to over-enroll the pool at 5%. The 8% figure is adjusted for a 3% inflation rate (2006-2007) provided by the Bureau of Labor Statistics: www.bls.gov

**Detailed Analysis:**

- **The labor market effects of the "Pay-or-Play" mandate**

Analysis of the labor market effects of the employer mandate in AB 8 yields some discouraging conclusions. Since a "pay-or-play" mandate applies to all employers without exception, firms are faced with a limited number of options with which to attempt to offset the cost of health care provision.

In some instances, firms may be able to transfer the entire cost of the mandated provision to their employees by including the entire cost as part of employee compensation. This could prove difficult at first because of firms' limited ability to lower nominal wages, but firms eventually will transfer this cost to employees by keeping wages constant and including health care benefit expenditures as part of compensation through the wage bargaining process. In other words, the nominal wages for jobs previously not including health care benefits will remain stagnant until the market wage rate rises high enough to cover the additional cost of the mandated health care contribution. Thus, provided that firms can transfer the cost of the mandated provision to employees, job loss will not occur.[2]

Unfortunately, firms will not always be able to transfer the full cost of health care provision to their employees. As a Public Policy Institute (PPI) study and conventional economic theory explains, when workers earn wages at or near the minimum wage and/or do not value health care benefits at or above their cost, firms can:

1) Accept lower profits
2) Charge higher prices for their products (This option is not viable if California firms produce in a competitive market where they face competition from out of state or international firms)
3) Relocate the firm out of state
4) Go out of business
5) Reduce employment, primarily of workers to whom they cannot shift the cost of health care provision[1]

The PPI generalized estimate modeled after the 1994 analysis of mandated benefits by Gruber[4] shows conclusively that firms will lower wages when possible to cover the cost of a mandate such as AB 8. In the event that employees do not value the mandated benefits at their cost, firms face a distinct challenge in the wage bargaining process because employees are unwilling to accept wages lowered enough to fully cover the cost of providing health coverage. Essentially, the employer is unable to shift the entire cost to the employee and gets stuck paying some portion of the cost of coverage. Intuitively, this scenario showcases an inherent inefficiency of an employer mandate because the cost of providing health care exceeds its value to the employee.

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[2] Yelowitz, Aaron S. "Pay-or-Play Health Insurance Mandates: Lessons from California." *California Economic Policy: Public Policy Institute of California*. 2006, Vol. 2, Num. 3. pg. 8.
"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."
[3] Gruber, Jonathan. "The Incidence of Mandated Maternity Benefits," *The American Economic Review,* June 1994, pp. 622-641.
[3a] Gruber's model examined the effect of mandated comprehensive childbirth benefits in health insurance policies. This study provided evidence that firms lowered wages *when possible* to pay for such mandates.

**Table 1** below provides a brief description of the effect of the proposed mandate on the California labor market using the assumption from Gruber's study that firms shift the entire cost of providing health care under AB 8 to employees when possible:

| Table 1: Labor Market Analysis of 7.5% CAL-CHIPP Mandate | |
|---|---|
| Per Person Employer Cost Estimate of AB 8 | $1,207.43 |
| California Minimum Wage (2008) | $8.00 |
| Effect of Mandate | Equivalent to $.58 additional min. wage increase |
| Job Loss Estimate | 70,000 |
| Economic Impact (Wages) | $1,249,220,000 |
| Estimated Newly Uninsured | 18,000 |

*Source:* CEP/PPI Estimates of "Pay or Play" Mandates in California[4]
Lines 1, 3, and 5 are SDCTA estimates calculated from the preliminary results given by the Gruber Microsimulation Model

The number of jobs expected to be lost as a direct result of the Cal-CHIPP employer mandate is conservatively estimated at approximately 70,000 for the state of California. This estimate is based on a previous minimum wage of $6.75, an employment elasticity of -.22 for low wage jobs, and a slightly higher per-person cost proposed in previous health care legislation. Although there are some differences in details, this estimate still offers a somewhat accurate account of the labor market's reaction to an employer mandate such as AB 8. This study found that most jobs lost were those that paid from less than $7.00 to $7.50 per hour. Given the new California minimum wage increase to $8.00 in January of 2008, the jobs defined as "at-risk" by Yelowitz in his study under AB 8 would be any that paid $8.58 and under (assuming full cost-shifting by employers when possible).

Operating under the above assumption that 70,000 jobs will be lost in the state of California from the AB 8 employer mandate, several additional effects occur. The first is that these newly unemployed individuals are not covered by the new Cal-CHIPP plan. While this is a small portion of the 3.4 million newly insured, an estimated 18,000 of these newly unemployed individuals will actually have had some form of employer benefits prior to the employer mandate.[5] Assuming an average salary of $17,846 for these 70,000 workers (an estimate that assumes an hourly wage of $8.58), the immediate economic impact on the state of California is a net decrease of $1,249,220,000 in wages. In reality, this underestimates the dollar value of lost wages, but displays that a significant economic impact results from the imposition of AB 8 that has been unaccounted for in any literature issued by its authors or proponents.

While the labor market costs above reveal a significant unforeseen drawback to AB 8's imposition, the bill does provide a significant economic benefit as well. The Gruber model estimates that 3.4 million (69%) of the currently 4.9 million uninsured Californians would be covered, with 3.23 million of them enrolling in the new Cal-CHIPP pool. For those in the pool, coverage would be relatively inexpensive because of the pool's use of market power to negotiate a tiered system of rates for its members.

In terms of insurance market benefits, insuring an additional 3.4 million individuals significantly reduces the portion of the cost-shift caused by the uninsured. On a national level in 2005, the cost of

[5]Yelowitz, Aaron S. "Pay-or-Play Health Insurance Mandates: Lessons from California." *California Economic Policy: Public Policy Institute of California*. 2006, Vol. 2, Num. 3, pg. 10.

medical care to uninsured individuals that is not paid for by these individuals was greater than $43 billion, $28 billion (approximately two-thirds) of which was shifted to the privately insured in the form of higher costs.[6] AB 8 provides a method by which 69% of the individuals belonging to this group in California become insured. In addition to the reduction of the cost-shift in the market for health insurance, other tangible benefits of the bill include the improvement of "health and productivity by increasing the use of preventative care and helping to ensure early treatment of acute illnesses as well as ongoing management of chronic conditions."[7] AB 8 does provide a method to reduce California's contribution to an estimated $260 billion of economic output lost due to health reasons in the United States.[6]

- **Funding and Financing of AB 8: California Insurance Market Analysis**

Analysis of the market effects of AB 8 from the Gruber Microsimulation Model gives the following explanation of what would happen under AB 8:

**Table 2:** The Allocation of Health Coverage Sources in California Before and After AB 8

| | Totals in Millions | | | |
|---|---|---|---|---|
| **Source of Insurance** | Before AB 8 | After AB 8 | Change | % Change |
| Medi-Cal/Healthy Families | 6.6 | 5.8 | -0.8 | -12% |
| Group Coverage (Private Market) | 18.8 | 20.3 | 1.5 | 8% |
| Individual Coverage (Private Market) | 2.1 | 1.5 | -0.6 | -29% |
| Cal-CHIPP | 0 | 3.2 | 3.2 | |
| Uninsured | 4.9 | 1.5 | -3.4 | -69% |

*Source*: Gruber Microsimulation Model Data provided by Assemblyman Fabian Nunez: http://democrats.assembly.ca.gov/members/a46/

As the table shows, the Gruber simulation model accounts for the new Cal-CHIPP pool, with an expected enrollment of 3.2 million. The model predicts that Medi-Cal enrollment will actually decrease despite an increase in its availability to workers and families with incomes below 300% of the FPL (Federal Poverty Level). On the private side of insurance, the model predicts an increase in Group Coverage and a sharp decrease in Individual Coverage.

The estimated amount of new employer spending predicted by the model is $3.9 billion. This is the amount that will be available to MRMIB to finance the Cal-CHIPP pool. Before accounting for any administrative or operating costs (which are not specified in the bill), this estimated spending yields a total of **$1,207.43** to be spent per individual in the Cal-CHIPP pool.

**The "Trigger Point" of Cal-CHIPP Under-funding**

Further analysis of the potential for under-funding of the Cal-CHIPP pool yields an ominous outlook for the pool, especially in the long run. A brief examination of the sources of revenue and expenditure for the pool provides the basis for determining a point of under-funding. The pool derives its funding from the 7.5% wage fee paid by employers that choose to pay, while its main expenditure is the negotiated cost of providing health insurance to the individuals enrolled in the

[6] Dobson, Allen et al. (2000). "The Cost-Shift "Hydraulic": Foundation, History, And Implications. Health Affairs", 25, no. 1: 22-33.
[7] Davis, Karen et al. (2005). "Health and Productivity Among U.S. Workers." The Commonwealth Fund: #856.

pool (approximately $1,207.43 as discussed in the previous section). A "Cost and Efficiency" analysis performed by Elliot Wicks estimates that the total revenue of Cal-CHIPP would exceed its costs by $3.8 million. This excess $3.8 million allows for an additional enrollment of 314,830 individuals above the anticipated number of enrollees.[8] Therefore, if the number of individuals in the pool were to *exceed* this amount, Cal-CHIPP would be under-funded.

The determination of enrollment in the pool is somewhat uncertain in that the size of the pool is ultimately completely dependent upon the decisions of firms. However, assuming the modeling estimates are reasonably accurate, further analysis requires examining a firms' decision to move its employees from private group coverage to the Cal-CHIPP pool. Assuming that the cost of health care and the price of private group health insurance are positively correlated, as health care costs rise, so does the price of private group coverage. As the price of health insurance rises for firms, some will switch their employees to the Cal-CHIPP pool. The rate in which firms are expected to behave in this fashion is represented by the Price Elasticity of Demand for group health coverage, which research shows is between -.31 to -.40.[9]

Using the conservative estimate of this elasticity (-.31), as the price of private group coverage increases, some firms will decide to switch their employees to the Cal-CHIPP pool. The "trigger-point" of under-funding is the point in which more individuals are enrolled in the pool than the pool has the funds to accommodate. In conclusion, once the cost of providing health care in the state increases by 5%[10] in real terms, (leading the cost of private group coverage to increase by 5%), firms are expected to switch enough individuals to over-enroll Cal-CHIPP to the point of under-funding.

| The Trigger Point of Cal-CHIPP Under-funding | |
|---|---|
| State Cost | $4.66 billion |
| Revenue from Wages | $5.04 billion |
| Surplus | $.38 billion |
| Number of excess individuals funded | 314830 |
| Percentage of 20.3 million in group coverage | 1.55% |
| Price Elasticity of Demand by Firms | 0.31 |
| Percentage increase in price that under-funds the pool | 5.00% |

*Source:* Jonathan Gruber & Michael Lettau, 2000.
How Elastic is the Firm's Demand for Health Insurance?
NBER Working Papers 8021, National Bureau of Economic Research, Inc.

### The Cal-CHIPP "Perpetual Motion" Insurance Machine

The possibility that this plan does not fully finance the Cal-CHIPP pool is an extremely significant point of contention with this proposal. In the event of any cost over-runs or greater than anticipated

[8] Wicks, Elliot, Ph.D. "Framework Assessment of Major Health Care Reform Proposals in California." Prepared for the California HealthCare Foundation. June, 2007.
[9] Jonathan Gruber & Michael Lettau, 2000. "How Elastic is the Firm's Demand for Health Insurance? NBER Working Papers 8021, National Bureau of Economic Research, Inc.
[10] SDCTA has calculated the cost increase in real terms required to over-enroll the pool at 5%. The 8% figure is adjusted for a 3% inflation rate (2006-2007) provided by the Bureau of Labor Statistics: www.bls.gov

enrollment in Cal-CHIPP (see the previous section regarding the "Trigger-Point"), a cycle of cost-shifting and underpayment ensues, resulting in a health-care scenario in California that is no better, and possibly worse than the current status quo. An important component to keep in mind while analyzing the market for health insurance given the imposition of AB 8 is that the decision of where the individual consumer of health coverage ends up is left to the firm, or employer. A step-by-step analysis is provided below:

**Phase 1**:

**Group Insurance (Private Market)**: This group of individuals initially grows according to the Gruber simulation. A larger number of individuals obtain their health coverage in groups on the private market in an effort to compete with the going rates negotiated by Cal-CHIPP. There is a significant incentive for employers to provide coverage in this fashion because they "receive credit" in the eyes of employees. From the perspective of the employee, they are receiving their health coverage from their employer, and this can be used by the employer more effectively in the wage bargaining process than a simple contribution to a pool such as Cal-CHIPP.

Alternatively, due to the fact that employers will be required to spend at least 7.5% of Social Security wages (payroll) towards health care for their employees, in order to maximize their ability to attract the most desirable workers for the lowest wage possible in the wage bargaining process, firms are increasingly likely to veer toward the Cal-CHIPP, or "pay," option of AB 8. This is caused by the lower cost, or most "bang for the buck" provided by Cal-CHIPP due to its pooled market power when negotiating rates with insurance providers.

Predicting which of these two lines of reasoning firms will use is subject to debate and depends on the discount achieved by Cal-CHIPP in rate negotiation, but the possibility that more firms than anticipated will opt for the Cal-CHIPP option exists, which would create an initial situation where Cal-CHIPP is under funded.

**Cal-CHIPP:** This new pool (estimated at 3.2 million people) will be financed by employers at a projected cost of $3.9 billion. A key point to remember is that the size of Cal-CHIPP is ultimately a result of the decisions of firms. If more firms enroll their employees in Cal-CHIPP than is expected (as discussed above), or the administrative costs (which are **not specified**) are higher than expected, Cal-CHIPP can face a funding shortage. In the event that insufficient funds exist to operate Cal-CHIPP and administer the provision of health insurance to its members, the pool faces two options:

1) It can increase the 7.5% of payroll that employers not privately providing health insurance are required to contribute. This can be done at any time without legislative approval, and represents a further increase in the cost of operating a business in the state of California.
2) It can underpay the health care providers its members obtain services from. In our view, this is the more likely scenario because increasing the 7.5% requirement may prove to be politically difficult, even without the requirement of legislative approval. Additionally, research shows that other similar public programs such as Medicare take the underpay option. By underpaying, these public programs currently force providers to charge higher

rates to those individuals and groups that do pay, combining with the uninsured population to create an estimated 17% cost shift to privately insured individuals.[11]

Assuming that the Cal-CHIPP program exercises the second option above, the process of cutting costs by underpaying is the source of the market cost-shift that AB 8 sets out to eliminate in the first place. By underpaying, the Cal-CHIPP program will presumably create higher rates for those in the privately insured Group Insurance category.

**The Uninsured:** The uninsured population in California decreases dramatically as a result of AB 8 (69%), although the bill's proponents do not account for the resulting labor market effect of additional unemployment that occurs because the newly unemployed will not be insured under AB 8. The number of individuals in this category is expected to grow, all else equal, if MRMIB increases the required 7.5% of payroll contribution by firms. Essentially, any increase in the 7.5% required contribution would increase the number of jobs lost, as well as create newly uninsured individuals.

**Phase 2:**

**Group Insurance (Private Market)**: Facing increasing costs as a result of Cal-CHIPP's underpayment to providers in Phase 1, an increasing number of people receiving insurance from this category would move to the less expensive Cal-CHIPP option.

**Cal-CHIPP:** Cal-CHIPP continues to grow as a result of private market group insurance rates increasing as a result of the cost-shift in Phase 1. Cal-CHIPP is still faced with the same two options, either underpaying or increasing the 7.5% requirement on firms.

**Phase 3:**

The cycle of Phases 1 and 2 continues and repeats, eventually all but removing the population of individuals that obtain health insurance through their provider on the private market at a group rate. Almost the entire employed population ends up in Cal-CHIPP, which faces skyrocketing administrative costs. At this point, either businesses are forced to pay an additional portion of their payrolls towards the financing of Cal-CHIPP, further exacerbating the costs of operating a business in California, or providers are continually underpaid on a much greater scale, cutting into already thin margins on the provider's end.

[11] Dobson, Allen et al. (2000). "The Cost-Shift "Hydraulic": Foundation, History, And Implications. Health Affairs", 25, no. 1: 22-33.

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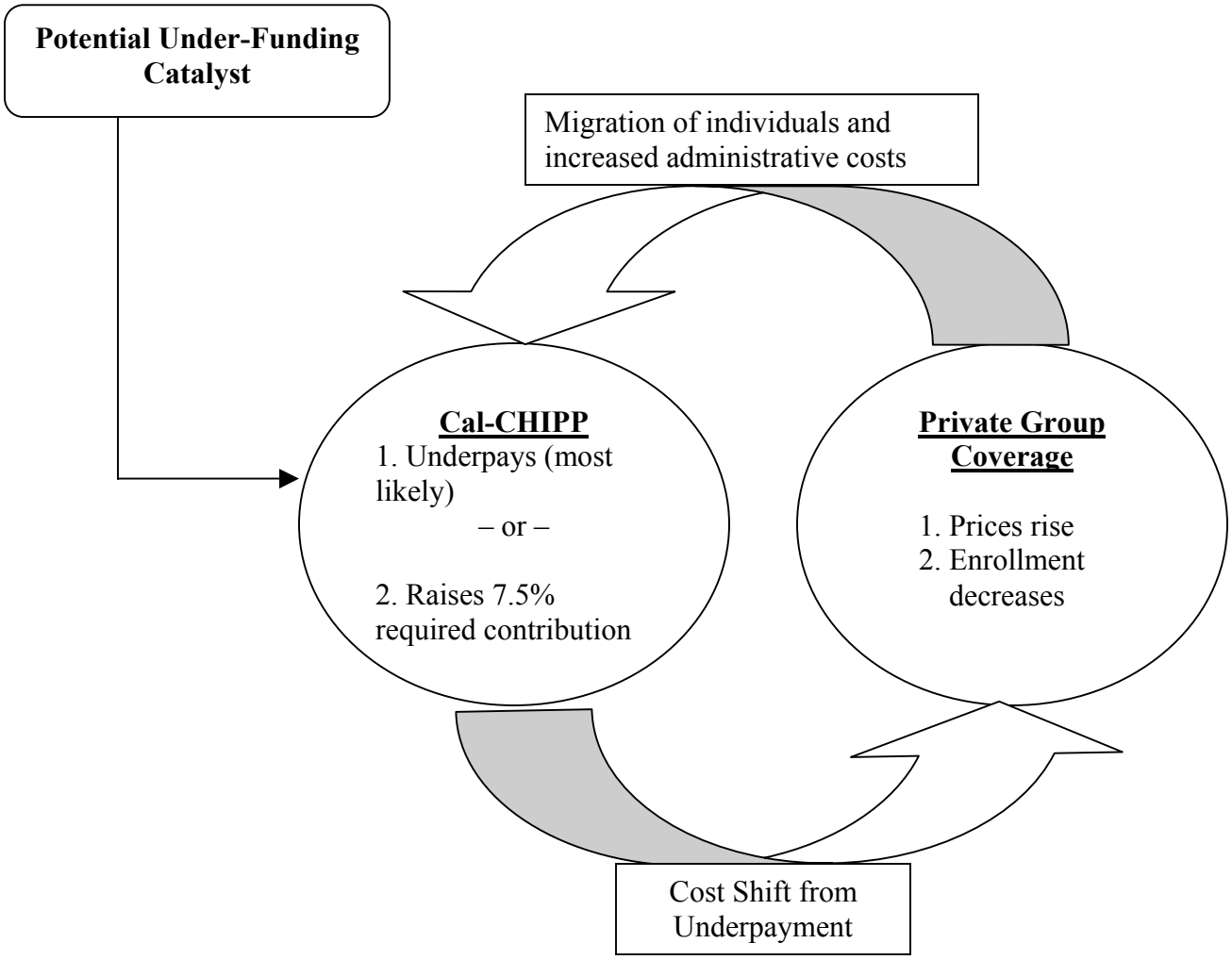
**Diagram 1: The Cal-CHIPP "Perpetual Motion" Insurance Machine:**



**AB 8 is Subject to ERISA and May be Ruled Illegal:**

The Employee Retirement Security Act (ERISA) of 1974 applies to benefits provided to employees in the private sector by their employer. This federal legislation has been a significant obstacle for states attempting to impose health care mandates because of a preemption clause. Provided below is an excerpt from The National Conference of State Legislatures discussion of the 2006 Maryland "Fair Share Act":

> "The preemption clause states that "[ERISA] shall supersede any and all State laws insofar as they relate to any employee benefit plan." These benefits include health care. Thus state reforms have often come into conflict with ERISA because they relate, directly or indirectly, to employee benefits and conflict with the federal law. States cannot mandate that employers pay for health insurance, directly tax benefit plans, or require reports on cost or use of the plans from employers. What states *can* do under ERISA is "regulate the business of insurance."[12]

As the passage above shows, any state health care mandate faces a legal challenge based on the language in ERISA. While much of the empirical research available concerns the Maryland "Fair Share Act" that was overturned in 2006, application of the ERISA guidelines to state "Pay or Play" mandates such as AB 8 leaves the legality of this bill in question. As a National Academy for State Health Policy study explains, "Pay or Play" mandates typically succeed in overcoming the ERISA legal challenge because they allow multi-state employers the option to provide health coverage through a nationwide plan or to pay into the pool at the individual state level.[13] However, an opposing legal hurdle for AB 8 is that under ERISA, workers should be eligible for Cal-CHIPP regardless of their employers' decision to provide health coverage or pay into the pool.[13] In the case of AB 8, there is no specific mention concerning the access to Cal-CHIPP of employees of firms that provide group insurance privately would not have access to Cal-CHIPP.

One of the arguments used to make a case for Constitutional Standing against the Maryland law was that an employer not previously providing a nationwide plan (Wal-Mart) was caused undue hardship based on the creation of the new act because they were forced to file reports concerning their payroll data and the amount contributed towards health benefits. As expressed in U.S. District Judge J. Frederick Motz's ruling:

> "Although the time and cost incurred in meeting this reporting requirement is somewhat trivial since ERISA imposes similar obligations, unquestionably it is both a concrete and particular burden to be required to file a report that need not be filed if the Act is unlawful."[14]

The decision of whether or not AB 8 complies with the language of ERISA is not within the realm of our expertise, but our research shows that at the very least, the issue is up for debate, and seemingly valid arguments exist on each side. In general, "pay or play" mandates are allowable under the guidelines set forth in ERISA, but evidence from the judicial opinion ruling on the Maryland

[12] "Maryland's Fair Share Health Care Fund Act Overturned in ERISA Challenge." National Conference of State Legislatures: Hhttp://www.ncsl.org/programs/health/fairsharenews.htm#ERISAH. Jan. 2007.
[13] Butler, Patricia A. "ERISA Implications for State Health Care Initiatives: Impact of the Maryland 'Fair Share Act' Court Decision." National Academy for State Health Policy, November, 2006.
[14] Motz, J. Frederick. Opinion: *Retail Industry Leaders Association v. James D. Fielder, Jr. Maryland Secretary of Labor, Licensing, and Regulation.* July 19, 2006.

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"Fair Share Act" and other policy research indicates that AB 8 could potentially face legal challenges if passed.

**AB 8 does not address the problem of "incentive alignment" inherent in any employer mandate:**

The inherent inefficiencies resulting from the imposition of employer mandates must be dealt with and minimized by any comprehensive health care reform legislation. Employer mandates suffer from a lack of "incentive alignment" in that employers make decisions about the consumption of a good they themselves do not consume. This phenomenon carries negative economic consequences such as unemployment, lower economic output, and possible firm relocation out of state, which further exacerbates job loss. Additionally, the "moral hazard" of over-consumption comes into play with newly insured individuals that do not bear any or a portion of the cost of their health care. This over-consumption drives up the cost of health care provision to those that do pay. (For a more detailed analysis of moral hazard, see the SDCTA health care reform policy document.)