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

Final Report

Prepared for:

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EXECUTIVE SUMMARY

In January and February of 2002, The California Health and Human Services (CHHS) Agency sponsored four symposia around the state to introduce nine proposals to expand health insurance coverage in California. As part of this effort, The Lewin Group was engaged to analyze the cost and coverage impacts of these proposals. In particular, we estimated the portion of the 6.6 million uninsured persons in California who would become insured under these proposals. To simplify the discussion, we have divided these plans into the following three groups:

- **Incremental Reforms** designed to expand coverage under existing public and private sources of coverage.
  - California PacAdvantage Premium Program (CPPP): Peter Harbage
  - Managed Care Expansion Plan (MCEP): Bob Brownstein
  - Cal-Health: Helen Schauffler
  - The Insure the Uninsured Project (ITUP) proposal: Lucian Wulsin
  - The Health California program – Stage I: E. Richard Brown & Richard Kronick

- **Employer Contribution** requirement using "Pay-or-Play" model.
  - The CHOICE program: Helen Schauffler
  - The Healthy California program – Stage II: E. Richard Brown & Richard Kronick

- **Single-Payer** proposals covering all Californians under a single program.
  - The Cal Care program: Judy Spelman
  - The California Single-Payer Plan: James Kahn M.D.
  - The California Health Service Plan (CHSP): Ellen Shaffer

We developed estimates of the cost and coverage impacts of these proposals using the Lewin Group Health Benefits Simulation Model that we adapted for use in California. Our estimates are summarized in the following sections.

Incremental Reforms

Of the five incremental reform plans, four would expand eligibility for the Medi-Cal and Healthy Families (HF) programs. These programs currently cover the aged and disabled, children living below 250 percent of the federal poverty level (FPL) and pregnant women and parents with custodial responsibilities for a child living below 200 percent of the FPL. Non-disabled adults without custodial responsibilities for a child, termed non-custodial adults, are not eligible for the program at any income level.

Three of these proposals would increase eligibility for custodial parents to 250 percent of the FPL to align the income eligibility levels for children and parents ***(Figure ES-1)***. In addition,

three of these proposals would extend coverage to at least come low-income non-custodial adults. The MCEP plan would increase eligibility to 400 percent of the FPL for all persons including non-custodial adults. Premium contributions typically would be required of newly enrolled persons at higher income levels (e.g., over 150 percent of the FPL).

Two of the incremental proposals are designed to increase the number of employers offering coverage. The California PacAdvantage Premium Program (CPPP) would provide premium subsidies for lower-wage workers in non-insuring small firms that decide to start offering coverage through the California PacAdvantage employer insurance pool. The premium subsidy would range between 25 and 55 percent depending upon the income of the worker. The ITUP plan would provide a 50 percent credit to small employers for coverage of lower-income workers. However, the ITUP plan differs from CPPP in that, small firms with low-wage workers (as defined in the plan) would be eligible for the credit even if they are already providing coverage.

The ITUP plan also provides a refundable tax credit to persons without access to employer coverage for the purchase of private non-group insurance. The credit would vary with age (e.g., $2,400 single/$3,200 family for persons age 40-54). The full credit would go to persons living below 200 percent of the FPL and would be phased-out on a sliding scale with income at $40,000 for a single individual or $70,000 for a family.

Among the incremental proposals, the ITUP plan would have the greatest impact on coverage, reflecting the fact that it includes both a Medi-Cal/HF expansion and other initiatives to expand private coverage. The ITUP plan would cover about 2.6 million (39 percent) of the 6.6 million Californians currently without health insurance ***(Figure ES-1)***. The net cost of the program to the state (i.e., program costs less offsets to other programs and federal matching funds) would be $3.2 billion in 2002, which is equal to about $1,231 per newly insured person.

Employer Contribution "Pay or Play" Model

Both CHOICE and Stage II of Healthy California would establish a pay-or-play plan where employers must either offer health insurance to employees or pay a payroll tax to cover their workers under a newly established public plan. This requirement would take the form of a payroll tax paid by all employers with employers receiving a credit equal to the full amount paid for each worker who has coverage.

Employers are expected to enroll in the public plan in cases where the payroll tax is less costly than insurance. We estimate that there would be about 22.4 million persons covered through the public plan under CHOICE and 17.2 million persons would be enrolled in the public plan under Healthy California ***(Figure ES-2)***. This reflects the fact that the payroll tax under Healthy California would be a bit higher than under CHOICE.

ES-1
Summary of Incremental Reform Proposals

	California PacAdvantage	Managed Care Expansion Plan(MCEP)	Cal-Health	Insure the Uninsured Project (ITUP) Proposal	Healthy California Stage I
Medi-Cal/Healthy Families Expansion	– –	• Cover all persons through 400% of FPL; • Benefits similar to HF; • Premium contribution at higher income levels.	• Outreach for eligible non-participants; • Cover parents to 250% of FPL.	• Cover non-custodial adults through 150% of FPL.	• Cover parents through 250% of FPL; • Cover non-custodial adults through 150% of FPL.
Employer Coverage Subsidies	25% to 55% premium subsidy for: • Workers below 35% of FPL; • in firms with up to 50 workers; • not offering coverage in past 6 months.	– –	– –	50% employer premium tax credit for: • Workers earning under $12.50/hr; • in firms with 2-10 workers; • no waiting period.	– –
Individual Program Subsidy for Persons without Access to Employer Coverage	– –	– –	– –	• Tax credit varied by age: e.g., $2,400 single / $3,200 family for 40-54 age group; • Phase out between 200% of FPL and $40,000 single/$70,000 family.	– –
Number Enrolled (in millions)	0.2	2.5	0.4	4.5	1.5
Reduction in Uninsured	0.1	1.9	0.4	2.6	1.2
Net Cost to State (in billions)	$0.2	$3.6	($0.1)	$3.2	$2.0
Net State Cost per Enrollee	$1,155	$1,457	($105)	$711	$1,271
Net State Cost per Newly Insured Person	$1,928	$1,937	($110)	$1,231	$1,601

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

ES-2
"Pay or Play" Employer Contribution Requirement Proposals

	Choice	Healthy California Stage II
Payroll Tax	All employers pay payroll tax of 5.5% to 6.5% depending on firm size	All employers pay payroll tax of 2.0% to 10.0% depending on firm size/worker wage levels
Credit (refund)	Employer tax refunded for each covered worker	Employer tax refunded for each covered worker
Worker Premium	Workers pay premium as percent of earnings – 0.0% - 2.5% depending on income level	Workers pay premium as percent of earnings - 1.3% - 3.3% depending on income level
Non-covered Workers	Automatic coverage under public plan	Automatic coverage under public plan
Declining Coverage	Worker can decline coverage *with* worker premium refunded	Worker can decline coverage *without* worker premium refund
Federal Funds	No provision	Federal match sought under 1931(b) for all families covered under public plan
Persons in Public Plan (millions)	22.4	17.2
Reduction in Uninsured (millions)	4.6	5.7
Net New State Costs (billions) a/	$47.8	$22.4
State Costs Net of Payroll Tax/Premium Revenue (billions)	$5.1	$3.5
Employer Cost Per Worker		
Currently Insuring Firms	($481)	($332)
Currently Non-insuring Firms	$1,360	$842

a/ Program costs net of federal funds and offsets to other programs.
Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

Employees who become covered under the public plan would also pay a premium that varies with wage level. This effectively subsidizes the cost of coverage to low-income persons because the amount paid by the family declines as income falls. Under both proposals, employees in firms that decide to offer coverage are given the option of taking coverage through the public plan, where premiums for lower-wage workers are subsidized (our public plan enrollment estimates reflect this effect on enrollment).

Though similar in design, there are several important differences in the two plans. First, CHOICE permits workers to avoid paying the worker premium contribution by declining coverage while Healthy California does not. This results in a larger reduction in the number of uninsured under the Healthy California program because the worker pays the premium regardless of whether they take coverage. The reduction in the number of uninsured under Healthy California would be 5.7 million persons (86 percent) compared with only 4.6 million persons (70 percent) under CHOICE.

The Healthy California program also differs from CHOICE in that it assumes federal matching funds are available for all families covered under the public program regardless of income. The state would use a 1931(b) expansion under Medicaid to cover families to an unlimited income level as appears to be permitted under federal law. Since this would be a Medicaid

expansion, costs for families under the program would be eligible for federal matching funds. Thus, net new state spending (i.e., public plan costs less offsets to other programs and federal matching funds) under Healthy California would be about $22.4 billion compared with $47.8 billion under CHOICE.

Single-Payer Proposals

The three single payer proposals are similar in terms of coverage. All three would cover nearly all health spending in the state for all California residents including the undocumented. For example, the services covered under these programs include hospital care, physician care prescription drugs, mental health, substance abuse, dental care, vision services, chiropractic and acupuncture ***(Figure ES-3)***. These plans would also use health expenditure budgets that would prevent health spending from growing faster than the state's Gross Domestic Product (GDP).

However, there are significant differences in these plans. For example, under the CHSP proposal, all health facilities would be purchased and operated by the state, and all providers would become salaried employees of the program. In addition, the Cal Care program and the California Single-Payer Plan would cover long-term care services and eyeglasses while CHSP would not.

The plans also differ in terms of patient co-payment requirements. For example, CHSP would not require co-payments for services while the California Single-Payer Plan would require a $5.00 co-payment for each provider visit and $5.00 per prescription. The Cal Care plan would have no co-payments for primary care and specialist care provided on referral from the primary care provider. However, it would require a $25.00 co-payment for specialist services without a primary care referral. These cost-sharing provisions would have an affect on the utilization of health services and program costs.

These single-payer models would result in a net reduction in total health spending in the state ***(Figure ES-3)***. We estimate that health spending in California will be about $151.8 billion in 2002. This includes payments for all services to all Californians and the cost of administering insurance and public programs. Under Cal Care, utilization of health services would increase by about $14.4 billion as previously uninsured persons become covered and the underinsured become covered for additional services.

However, theses increase in costs would be more than offset by $18.1 billion in savings from reduced administrative costs and bulk purchasing of prescription drugs and durable medical equipment. Net savings would be $3.7 billion under Cal Care. Net savings would be $7.6 billion under the California Single Payer Plan and $7.5 billion under CHSP, reflecting differences in covered services and cost sharing under these plans.

ES-3
Summary of Key Provisions of the Three Single-payer Proposals

	Cal-Care	California Single-Payer Plan	California Health Service Plan(CHSP)
Shared Features of Plans			
Coverage	All California residents including undocumented		
Covered Services	Hospital inpatient care; Hospital outpatient care; Emergency room care; Physician services;	Prescription drugs; Durable medical equipment; Mental health; Substance abuse;	Acupuncturists; Chiropractors; Dental care (except orthodontia); and Vision
Expenditure Budgets	Program spending is capped at current levels indexed by the rate of growth in state gross domestic product (GDP)		
Additional Coverage			
Nursing Home (except room and board)	✓	✓	– –
Home Health (people with 3+ ADEs only)	✓	✓	– –
Eye Glasses	✓	✓	– –
Other Alternative Care (herbalists etc)	✓	– –	– –
Co-payments for Services	• None for primary care • $25 co-pay for specialist care w/o referral	• $5.00 per visit • $5.00 per prescription	None
System-wide Impact on Health Spending (in millions)			
Current System-wide Spending	$151.8	$151.8	$151.8
New Utilization due to Coverage Expansion	$14.4	$9.6	$13.5
Savings in Administration and Bulk Purchasing	($18.1)	($17.2)	($21.0)
Net Change in System-wide Health Spending	($3.7)	($7.6)	($7.5)

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

Total program costs would vary between $129.0 billion under CHSP and $134.7 billion under Cal Care (some services would not be covered under these programs). These amounts would be partly offset by redirecting funds for existing government health benefits programs such as Medicare and Medicaid to the single-payer plan. This would leave between $65.1 and $69.0 billion in funds to be raised from other sources under these proposals ***(Figure ES-4)***.

Each of the three programs would have a payroll tax. The payroll tax rate is 8.0 percent under the California Single-Payer Plan with the employer paying the full amount. The payroll tax rate under Cal Care would be 9.7 percent, with the employer paying 6.1 percent and the employee paying the remainder. The Tax rate under CHSP would be 9.9 percent with the employer paying 7.4 percent. For employers who currently provide coverage, this payroll tax

payment is at least partly offset by the elimination of their expenditures for worker health insurance ***(Figure ES-4)***.

Each of the plans would include new dedicated taxes to fund the program such as taxes on tobacco, alcoholic beverages or an increase in the state's personal income tax. On average, families in California would see net savings of between $473 per family under Cal Care, $658 per family under the California Single-Payer Plan and $813 per family under CHSP, reflecting the reduction in health spending under these proposals.

Under all three proposals, families with annual incomes below $100,000 would generally see savings while higher income families would generally see a net increase in spending. This reflects the fact that higher-income families would typically find that the reduction in health spending for them under the program would be less than the new single-payer program taxes they would pay.

ES-4
Summary of Financing under the Single-payer Proposals in 2002

	Cal Care	California Single-Payer Plan	California Health Service Plan (CHSP)
Program Costs (in billions)			
Total Program Costs	$134.7	$129.6	$129.0
Offsets from Current Programs	$65.7a/	$63.9	$63.9
Net New State Spending	$69.0	$65.7	$65.1
Payroll Tax on Employers and Workers			
Payroll Tax	9.7 Percent: 6.5% employer; 3.6% worker	8.0 Percent employer only	9.9 Percent; 7.4% employer 2.5% worker
Change in Cost per Worker			
• **Currently Insuring Firms**	($642)	$362	($20)
• **Currently Not-insuring Firms**	$1,639	$2,203	$2,027
Other Dedicated Taxes			
Tobacco Tax	$1.00 per pack	$1.00 per pack	$1.00 per pack
Sales Tax Increase	¼ percent	– –	– –
Alcoholic Beverage Tax	800 percent increase	– –	– –
Income Tax Increase	– –	1.64 percent of taxable income	– –
Unearned Income Tax	2.8 percent	– –	– –
Cost/(Savings) Per Family			
All Families	($473)	($658)	($813)
Under $20,000	($1,096)	($873)	($963)
$20,000 - $49,999	($1,419)	($1,216)	($1,413)
$50,000 - $999,999	($811)	($999)	($1,300)
$100,000 or more	$2,952	$1,422	$1,440

a/ Includes a maintenance of effort requirement for counties equal to amount spent on indigent care.
Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

Caveats

Many of the proposals considered in this study have never been attempted on a broad scale in the United States. Consequently there are little data on the likely outcomes of such programs that can be used to estimate their impacts. In particular, programs that substantially restructure the health care financing system could fundamentally change consumer, employer and provider incentives, in ways that would have a significant impact on program costs. Moreover, there is little evidence to guide us in estimating the impact of the various tax subsidies and premium subsidy programs considered in this study. Consequently, there is a great deal of uncertainty surrounding these estimates.

To illustrate the potential sensitivity of our to estimates to the assumptions, we estimated the number of uninsured who would become covered and net public program costs under selected changes in the key assumptions for each of the eight proposals. We developed high-range and low-range estimates of enrollment by varying the participation rates for these programs by about 25 percent above and below our best estimate values. We also present our estimates of net program costs under these proposals at these high- and low-range enrollment levels assuming that per-capita costs differ from our projections by five percent above and below our best estimates. ***Figure ES-5*** presents the resulting range estimates for these proposals.

Figure ES-5
Sensitivity of Estimated Program Costs and Coverage Impacts Under Health Reform Options in 2002

	Reduction in Uninsured [a/] (millions)			Net Program Costs [b/] (billions)		
	Low-Range Estimate	Best Estimate	High-Range Estimate	Low-Range Estimate	Best Estimate	High-Range Estimate
Incremental Reforms						
California PacAdvantage Premium Program (CPPP): Peter Harbage	0.1	0.1	0.1	$0.1	$0.2	$0.2
Managed Care Expansion Plan: Bob Brownstein	1.5	1.9	2.3	$2.5	$3.6	$4.7
Cal-Health: Helen Schauffler	0.3	0.4	0.5	$0.0	$0.1	$0.1
The Insure the Uninsured Project (ITUP) Proposal: Lucian Wulsin	2.0	2.6	3.2	$2.3	$3.2	$4.2
The Healthy California Program Stage I: Brown & Kronick	0.9	1.2	1.5	$1.5	$2.1	$2.7
Employer Contribution						
The CHOICE Program: Helen Shauffler	4.4	4.6	4.8	$43.1	$47.8	$52.4
The Healthy California Program Stage II: Brown & Kronick	5.4	5.7	6.0	$20.2	$22.4	$24.5
Single Payer						
Cal Care: Judy Spelman	6.6	6.6	6.6	$62.0	$69.0	$76.6
California Single-Payer Plan: James Kahn M.D.	6.6	6.6	6.6	$59.0	$65.7	$72.9
California Health Services Plan (CHSP): Ellen Schaffer	6.6	6.6	6.6	$58.5	$65.1	$72.3

NOTE: Assumes that these programs are fully implemented in 2002.

a/ Assumes that program participation rates differ from our best estimate by an amount equal to one standard deviation of our estimated participation rate.

b/ Assumes that per-capita program costs differ from the predicted value by five percent (i.e., five percent lower in the low range estimate and five percent higher in the high range estimate).

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

I. INTRODUCTION

In January and February of 2002, The California Health and Human Services (CHHS) Agency sponsored four symposia around the state to introduce nine proposals to expand health insurance coverage in California. This was done as part of a grant from the U.S. Health Resources and Services Administration (HRSA) devoted to the development of proposals to expand health insurance coverage. As part of this effort, The Lewin Group was engaged to analyze the cost and coverage impacts of these proposals. This included estimating the portion of the 6.6 million uninsured persons in California who would become insured under each proposal.

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

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

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

A more detailed summary of these plans is presented below:

A. Incremental Reforms

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

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

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

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

B. Employer Contribution Requirements

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

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

- **Healthy California:** The Healthy California program would achieve near-universal coverage in two stages. The Healthy California program would first expand coverage for low-income adults. After a period of three years, the program would require employers to contribute to the cost of coverage for their employees by either offering insurance or paying a tax to cover their workers under a publicly sponsored plan. Persons not covered through employment would also be covered under the public plan.

C. Single-Payer Programs

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

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

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

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

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

II. DATA AND METHODS

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

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

HBSM was created to provide comparisons of the impact of alternative health reform models on coverage and expenditures for employers, governments and households. The key to its design is a "base case" scenario depicting the distribution of health services utilization and expenditures across a representative sample of households under current policy for a base year such as 2002. In this analysis, the base case scenario came from recent surveys of households and employers in California (listed above). We "aged" these data to be representative of the population in 2002 based upon recent economic, demographic and health expenditure trends. The resulting database provides a detailed accounting of the California health care system. These base case data serve as the reference point for our simulations of alternative health reform proposals.

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

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

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

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

The key steps in the simulation model are summarized below:

- **Establishing a Baseline:** In this analysis, HBSM was based upon a representative sample of households in the state, which includes information on the economic and demographic characteristics of these individuals as well as their utilization and expenditures for health care. These data were based upon the 1996 Medical Expenditures Panel Survey (MEPS) that we used together with the California sub-sample of the March 2001 Current Population Survey (CPS). We used the Kaiser/HRET survey of employers in California in 1999 for policy scenarios involving employers. We also adjusted these data to show the amount of health spending in the state by type of service and source of payment as estimated by the Office of the Actuary of the Center for Medicare and Medicaid Services and various state agencies. Using the MEPS data, we create a record of income, health coverage and health services utilization for each of 12 consecutive months.

- **Determining Eligibility:** The California MEPS/HRET database provides the detailed demographic and economic data required to identify those who would be eligible for programs designed to expand insurance coverage. The model simulates coverage for each "insurance unit" in the MEPS data (typically a family or single individual) one month at a time.[2] During each month, we identify those who meet the eligibility provisions for the coverage expansion proposals that we are modeling. Eligibility for Medicaid or other income-tested subsidy programs is determined on the basis of family income in each month.[3] The model also identifies persons who are potentially affected by programs designed to expand employer coverage such as tax credits and income-tested premium subsidy programs.

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

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

- **Modeling Program Participation by Individuals:** Most of the major health reform proposals developed in recent years would rely upon incentives for individuals to obtain coverage rather than mandating coverage. This has required the development of models that estimate the likely response of individuals to various forms of subsidized coverage. The Lewin Group has developed models of enrollment for the Medicaid/SCHIP program that we use to simulate enrollment among persons who become eligible under proposed expansions in these programs. We have also developed multivariate models of how changes in premiums affect the decision to take private insurance coverage.

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

- **Program Costs and Health Expenditures:** The model simulates the cost of health coverage expansion proposals based upon the coverage provisions of the proposal. For tax credit proposals and premium vouchers, program costs are equal to the amounts of the credits or vouchers for persons who participate in the program. Under proposals where benefits for eligible individuals are provided through a public program (e.g., Medicaid), costs are equal to the cost of the health services used by enrollees. These costs are estimated based upon the cost of covered services received by individuals in the household database who are simulated to enroll in the program. This includes expenditures reported in these data during the months in which the individual is simulated to participate in the program, plus an estimated increase in spending for newly insured individuals.

- **Utilization of Health Services:** The model simulates the change in health expenditures resulting from expansions in coverage. We assume that utilization for previously uninsured persons would adjust to the levels reported by insured persons with similar characteristics. This adjustment reflects the reductions in spending resulting from improved access to primary and preventive care and any increases in utilization of other elective services as these individuals become insured. HBSM also models the impact of provisions designed to expand the use of primary care and simulates the impact of patient cost sharing on utilization.

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

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

A. Medi-Cal/Healthy Families Expansions

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

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

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

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

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

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

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

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

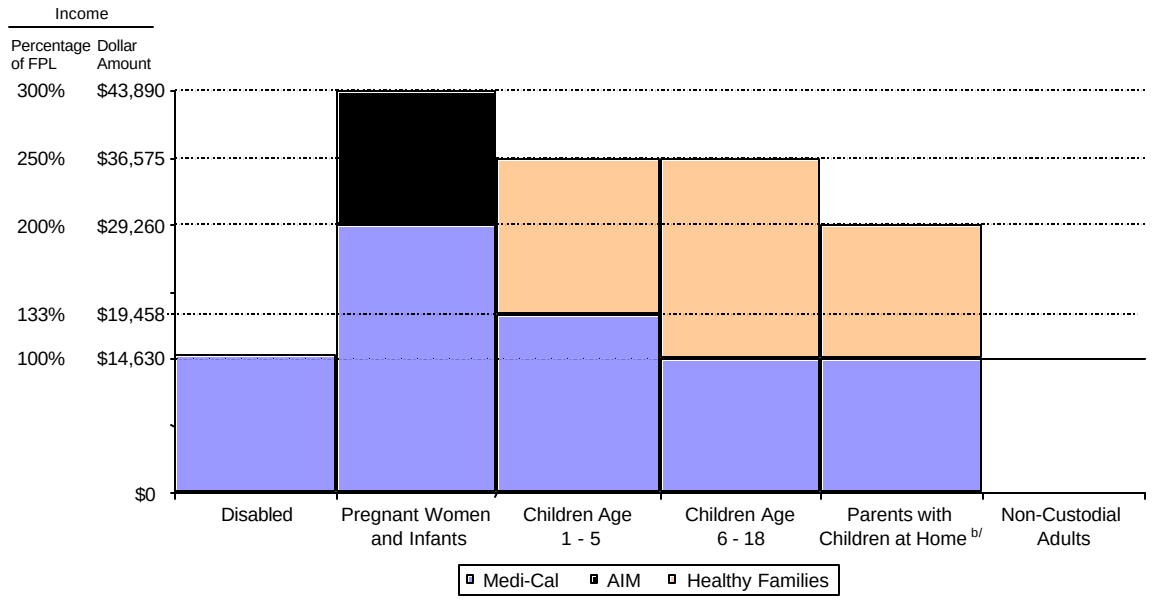
Medicaid regardless of income unless a state has obtained a federal waiver to cover these individuals (about four states have such waivers).[4]

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

C. Proposed Eligibility Expansions

Both the Cal-Health program and Stage I of the Healthy California proposal would increase eligibility for parents to 250 percent of the FPL. The Healthy California program would also cover non-custodial adults through 150 percent of the FPL ***(Figure 3)***. The MCEP plan would increase eligibility for all persons, including non-custodial adults through 400 percent of the FPL. The ITUP plan would cover non-custodial adults through 200 percent of the FPL but would not increase eligibility for parents (currently at 200 percent of the FPL) or children (currently eligible through 250 percent of the FPL).[5]

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



a/ Based on 2001 Poverty Level Guidelines for a family of three published in the *Federal Register* 2/16/01. For individuals living alone, the FPL equals $8,590.
b/ Assumes pending waiver is approved for parents.
Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

[4] Federal waivers must be budget neutral to the federal government. These four states obtained the waiver by reducing costs in some other parts of the state's Medicaid program by the amount necessary to meet the budget neutrality requirement.
[5] The Cal-Health program would cover non-custodial adults through 250 percent of the FPL if California obtains a waiver to the long-standing CMS requirement that Medicaid waivers be budget neutral to the Federal government.

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

	Cal-Health	MCEP Plan	Healthy California: Stage 1	Insure the Uninsured Project (ITUP)
Eligibility				
Families	200% FPL - 250% FPL	200% FPL - 400% FPL (15 year phase in)	200% FPL – 250% FPL	--
Non-Custodial Adults	None [a/]	Below 400% FPL (15 year phase in)	Below 150% FPL	Below 200% FPL
Non-Citizens	No Change	Below 400% FPL	No Change	Covers income eligible, documented and Emergency services only for undocumented (state-only program)
Premium Required	Same as HF for persons over 133% FPL	None below FPL; Phase in through 400% of FP:	None below 133% FPL; Same as for parents under SCHIP waiver	Same as HF for persons over 133% FPL
Benefits	HF for parents; Medi-Cal for non-custodial adults below 133% FPL; HF for non-custodial adults below 133% FPL	HF for all newly eligible	State standard benefits package (SSBP) (to be determined)	Medi-Cal below FPL; HF above FPL
Financing	Federal match for parents; Safety net savings; Savings from automating eligibility process for Medi-Cal and HF	Increased sales and income taxes [b/] (Medicaid matching funds not sought)	Federal match for parents; Medicaid waiver to reduce Medi-Cal/HF annual spending growth by two-percent per year; and Safety net savings	Federal match for parents; Medicaid waiver • Cover disabled under managed care • Reduce benefits for optional eligible groups; Safety net savings; Provider tax
Other	Outreach to eligible not enrolled	Employer permitted to pay family premium share for eligible persons	Point-of-service-like co-payments; waived for persons eligible under Stage 1	Medi-Cal/HF buy-in to employer coverage when available and cost-effective [c/]
Anti-crowd-out	6-month waiting period; Exceptions for involuntary coverage loss	6-month waiting period; Exceptions for involuntary coverage loss	No Provision	3-month waiting period; Exceptions for involuntary coverage loss
Delivery System	Choice of competing health plans	Choice of competing health plans	Choice of competing health plans	Choice of competing health plans
Number Eligible (thousands)	188	5,771	2,521	2,998

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

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

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

Source: Lewin Group analysis of plan proposals.

The MCEP plan would cover all income eligible persons including the undocumented. The ITUP plan would cover income eligible documented non-citizens regardless of a waiting period and would provide emergency services for income eligible undocumented persons. Under both proposals, the state would pay the full cost of covering these groups.

Cal-Health includes several measures to increase outreach through schools and would permit temporary enrollment through health care facilities and doctors' offices. This is likely to increase enrollment among currently eligible persons. Federal matching dollars would be automatically available for these currently eligible persons. The Cal-Health legislation would also implement an automated eligibility determination system for use throughout the Medi-Cal/HF program which would result in savings that would more than offset the increased cost of covering parents through 250 percent of the FPL.

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

D. Coverage, Costs and Financing

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

Our estimates of the number of newly eligible persons who would enroll in these expansions is based upon analysis of historical data on participation in the existing Medicaid program. This approach generally results in an estimated participation rate between 50 and 70 percent for newly eligible persons who are currently uninsured and about 40 percent among those who have access to employer-sponsored coverage. This shift from employer coverage to public coverage is known as "crowd-out". The larger the crowd-out, the more it would cost the state per newly insured person. To minimize crowd-out, Cal-Health and the MCEP Plan include a 6-month waiting period for persons moving to the program from private coverage unless there is an involuntary loss in coverage. Studies show that participation further declines by about one-third when premiums are required.

All of the proposals would reduce the overall number of uninsured in California. For example, Cal-Health would reduce the number of uninsured by 370,000 persons while the MCEP plan, which extends coverage to 400 percent of the FPL, would reduce the number of uninsured by about 1.9 million persons ***(Figure 4)***. Both the Healthy California program and the ITUP proposal would reduce the number of uninsured by about 1.2 million persons.

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

	Cal-Health [a/]	Managed Care Expansion Plan (MCEP) [b/]	Healthy California Stage I	Insure the Uninsured Project (ITUP)
Number of Persons Eligible (thousands)				
Number Eligible	188	5,771	2,521	2,998
Coverage Impacts (thousands)				
Number Enrolled	385 [c/]	2,464	1,548	1,535
Reduction in Uninsured	370	1,854	1,229	1,223
Decline in Private Coverage (Crowd Out)	15	610	319	312
Program Costs (millions)				
Total Program Cost	$530.7	$4,099	$2,828	$2,791
Program Offsets	$373.7 [d/]	$508	$766 [e/]	$693 [e/]
Net Program Cost	$157.0	$3,591	$2,062	$2,098
Federal Spending	$197.6	- - [f/]	$94	- -
State Spending	($40.6)	$3,591	$1,968	$2,098
Average State Cost				
State Cost Per Enrollee	($105)	$1,457	$1,271	$1,367
State Cost Per Newly Insured Person	($110)	$1,937	$1,601	$1,715

a/ The Cal-Health program would cover an additional 1.7 million non-custodial adults if the Federal government would agree to waive the CMS budget neutrality requirement so that federal matching funds can be obtained for this group. The net cost of Cal-Health to the State assuming that this waiver is granted would be about $856 million.

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

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

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

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

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

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

Net state costs would be about $2.0 billion under Stage I of the Healthy California program and $2.1 billion under the ITUP proposal.[6] Total net state spending would be about $3.6 billion under the MCEP Plan, reflecting the high-income eligibility levels under the program and the fact that the program would not seek federal matching funds. The state would actually save about $40.0

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

million under Cal-Health because the program includes the implementation of a cost saving automated eligibility system for use throughout Medi-Cal and HF.

E. Cover Medi-Cal/Healthy Families Enrollees Under Employer Plans

The ITUP proposal includes a provision to buy Medi-Cal/HF families into employer coverage when it is cost effective to do so. Under this approach, the state would screen applicants to identify families where a parent has access to employer-sponsored coverage. The state would pay the employee's share of the cost of family coverage in cases where it is cost effective to do so (i.e., premium is less than the cost of coverage under Medi-Cal or Health Families program).

We estimate that there are about 110,000 income eligible individuals with access to employer sponsored coverage who would enroll. Of these, about 38,800 would be persons who otherwise would have been uninsured. The program would save about $38.7 million in 2002.

III. EMPLOYER PREMIUM SUBSIDIES

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

Figure 5
Summary of Employer Subsidy Provisions Included in the Analysis

	California PAC Advantage Premium Program (CPPP): Premium Subsidy	Insure the Uninsured Project (ITUP) Proposal: Employer Tax Credit
Eligible firms	• Firms with 2 – 50 workers • Firms offering at least the CPPP minimum insurance standard	• Firms with 2 – 10 workers • Firms offering at least the Knox-Keene HMO benefits package • Firms with at least one-third of workers earning less than twice the minimum wage ($12.50/hour)
Waiting Period	• Firms not offering coverage for at least 6 months	• No waiting period requirement for firms
Eligible Workers	• Subsidy applies only to workers living below 350 percent of the federal poverty level (FPL) • Uninsured for previous six months • Only employees working 20 or more hours per week	• Credit applies only to workers earning less than twice the minimum wage ($12.50/hour) • No waiting period requirement for workers
Form of Benefit	Premium subsidy	Refundable tax credit
Benefit Amount	Subsidy varies between 55 percent of premium for persons below 200 percent of FPL and 25 percent for persons between 300 percent and 350 percent of FPL	50 percent of premium for eligible workers

Source: Lewin Group analysis of plan proposals.

A. Subsidy Provisions

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

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

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

Eligibility is limited to:

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

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

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

B. Coverage and Cost Impacts

About 1.5 million workers and/or their dependents would qualify for CPPP's proposed premium subsidies in 2002, compared to 1.1 million workers and/or dependents eligible through the ITUP proposal ***(Figure 6).*** Of those who qualify, less than 200,000 workers and/or dependents are estimated to enroll. For CPPP, enrollment in the ITUP program would be about 446,000 persons. The number of uninsured would drop by 112,000 under the CPPP proposal and 83,000 in the ITUP proposal.

The cost of the CPPP program would be $189 million, net of savings to safety-net programs.[8] Total costs, net of safety-net savings, under the ITUP plan would be $354 million. The net state expenditure per newly insured person would be $4,265 under the ITUP plan compared with

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

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

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

	California PACAdvantage Premium Program (CPPP)	Insure the Uninsured Project (ITUP) Proposal: Employer Tax Credit
Eligible Workers and Dependents in Eligible Firms (thousands)		
Number Eligible	1,478	1,132
Coverage Impacts for Workers and Dependents (thousands)		
Number Enrolling	187	446
Reduction in Uninsured	112	83
Currently Insured Who Enroll	75	363
Program Costs (millions)		
Total Program Cost	$216	$394
Program Offsets (safety net)	$27	$40
Net Program Cost	$189	$354
Average State Cost		
State Cost Per Enrollee	$1,012	$794
State Cost Per Newly Insured Person	$1,687	$4,265

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

IV. INDIVIDUAL PREMIUM SUBSIDIES

The ITUP proposal includes a state tax credit for the purchase of insurance by those who do not have access to employer-sponsored insurance (ESI). The tax credit amounts would vary by age as shown in ***Figure 7***. For example, the credit amount for someone age 40 to 54 would be $2,400 for single coverage and $3,200 for family coverage. There would be a full credit for individuals below 200 percent of the FPL with the amount phased-out at $40,000 for single individuals and $70,000 for families (i.e., Joint Filers and Head of Household returns). The tax credit would be refundable so that even those individuals who have no tax liability could qualify.

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

The Cal-Health program would also create a low-cost standard uniform benefits package (SUBP) that private insurers would offer throughout the state. The benefits package would limit covered days of hospitalization and the utilization of outpatient services. There would be no coverage for outpatient prescription drugs, alcohol or drug treatment, DME, supplies and supplements, vision care, hearing care, and skilled nursing facilities, with strict limits also placed on physical, occupational and speech therapy, multi-disciplinary rehabilitation, and home health care.

The cost of the packages would be fully covered by the premium charged to these persons. There would be no public subsidies for this coverage. However, the availability of such a product could induce some uninsured persons and firms to offer coverage. We estimate that such a program could reduce the number of uninsured by up to 59,000 persons.

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

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

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

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

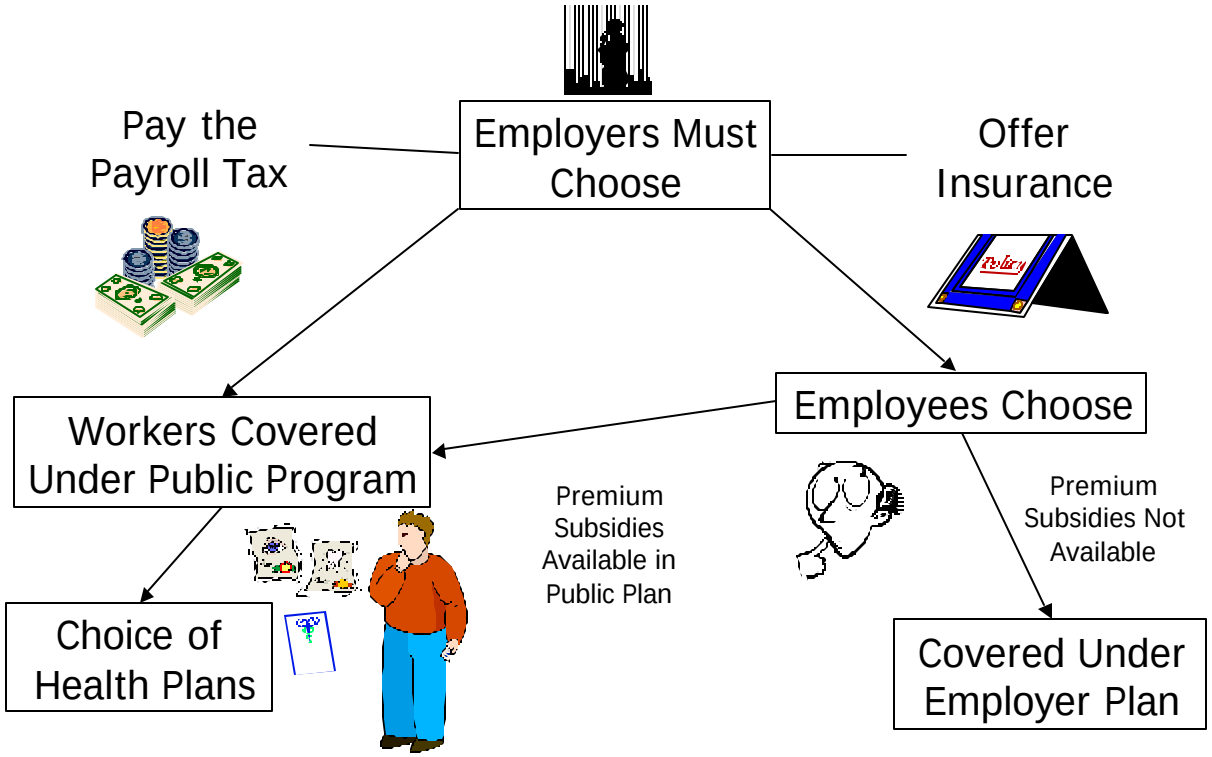
Eligibility and Enrollment (in thousands)	
Number Eligible	6,327
Number Receiving Credit	3,173
Reduction in Uninsured	1,858
Currently Insured Receiving Credit	1,315
Program Costs (in billions)	
Total Program Costs	$4.3
Program Offsets (safety net)	$0.9
Net Program Cost	$3.4
Per-Capita Cost	
Net State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

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

V. EMPLOYER CONTRIBUTION REQUIREMENT

Two of the plans studied would require employers to contribute to the cost of covering their workforce by either providing coverage or paying a tax to cover their workers under a public plan. This approach, known as "pay-or-play" is proposed under Stage II of the Healthy California Program and under the CHOICE Coverage Expansion Program. These programs could reduce the number of uninsured by 4.7 million persons under CHOICE and by 5.7 million persons under Healthy California. Total costs net of offsets and federal funds would be $47.8 billion under CHOICE and $22.4 billion under Healthy California.

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



A. Overview of Pay-or-Play Proposals

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

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

One of the main differences between the two programs is that choice permits workers to decline coverage and have their premium payment refunded to them. This differs from the Healthy California, proposal where the worker can decline the coverage, but the employee "premium" is not returned to the worker. Thus, there is no reason to decline coverage under the Healthy California plan. Another key difference is that there is no minimum employer benefits package under the CHOICE program while the Healthy California program requires that plans offer the benefits included in a benefits package created under the program called the state standard benefits package (SSBP). The key features of these plans are presented in ***Figure 9***.[9]

B. Changes in Coverage

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

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

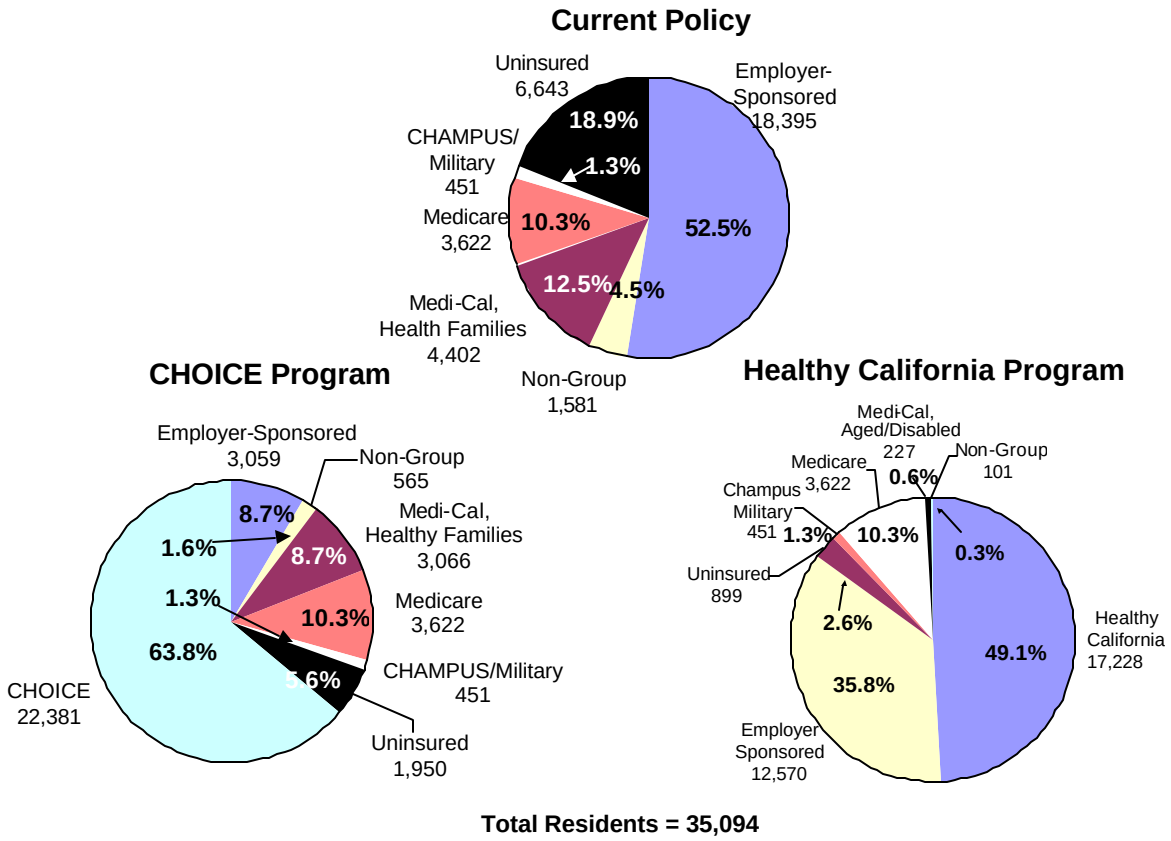
The CHOICE program would be open to all California residents including the undocumented, while the Health California program would exclude the undocumented. This could result in a loss of coverage among undocumented persons under Healthy California who currently have employer coverage through an employer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

[9] CHOICE proposes a CMS demonstration that would enable Medicare beneficiaries to enroll in CHOICE. The impact of this was not estimated in this analysis.

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

	CHOICE	Healthy California
Target Population	All non-elderly workers and non-working dependents	All non-elderly non-disabled persons
Employer Contribution Requirement	All employers pay a payroll tax varied by number of employees: 1st to 50th Worker 5.5% 50th Worker and Up 6.5%	All employers pay a payroll tax varied with wage levels: Small/Low-wage firms / other firms First $10,000 2.0% 4.0% Next $20,000 3.9% 5.9% Next $30,000 7.9% 7.9% Over $60,000 10.0% 10.0%
Employer Refund (tax credit)	Employers refunded payroll tax for workers covered by: • Employer Plan • Medicare • CHAMPUS	Employers refunded payroll tax for workers covered by: • Qualifying Employer Plan – Employer Offered – Dependent Coverage on Spouse's Plan • Medicare • CHAMPUS
"Qualifying Coverage" (i.e., minimum standard plan)	• All employer plans qualify; • No minimum employer contribution	"Qualifying Coverage" includes plans meeting state standard benefits package (SSBP); No minimum employer contribution
Public Plan Enrollment for Workers in Firms Not Sponsoring Coverage	• Automatic unless coverage is declined by worker • Employee "premium" returned if coverage declined	• Automatic • Can decline coverage but employee "premium" is not returned
Worker Premium in Public Plan	Tax on earnings up to Social Security maximum (about $80,000) Working Parent / Each Non-Working Dependent / Maximum Percentage <150% FPL 0.0% 0.0% 0.0% 150%-250% FPL 0.5% 0.5% 2.0% 250%-350% FPL 1.5% 0.5% 2.0% 350% FPL or more 2.0% 0.5% 2.5%	Worker premium computed as a percentage of wages Wage Level / Tax Rate First $10,000 1.3% Next $20,000 2.0% Next $30,000 2.6% Over $60,000 3.3%
Maximum Premium	Worker maximum of $166 per month per family	Sum of employer and employee premium maximum of $700 per month per worker
Self-employed	Pay payroll tax as if only worker in firm; also Pay worker premium if accept public plan coverage; refunded if has insurance	Pay payroll tax as if only worker in firm; Pay worker premium regardless of whether accepts public plan coverage; refunded if has insurance
End of Year Reconciliation	None	For persons without continuous coverage who are self-employed or have non-earning income (rental, investments, etc.)
Disposition of Medi-Cal and Healthy Families Programs	Retained for aged and disabled, long-term care, and wrap-around coverage for currently eligible	Retained for aged and disabled, low-income non-workers and wrap-around coverage for currently eligible
Premium Subsidies for Workers in Firms That Decide to Provide Coverage	None; Instead, workers in firms offering coverage can elect to enroll in public plan where premiums vary with income	None; Instead, workers in firms offering coverage can elect to enroll in public plan where premiums vary with income

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



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

C. Spending, Revenues and Offsets

Total expenditures for the two programs would be $74.0 billion under CHOICE and $56.2 billion under Healthy California. These figures include continued spending on Medi-Cal and Healthy Families for those not covered under the new plan. However, net new state spending (i.e., costs less program offsets and federal matching funds would be $47.8 billion under CHOICE and $22.4 billion under Healthy California.

The programs would be funded from a combination of employer payroll taxes, participant premiums, a tobacco tax increase and an increase in the State income tax. The programs are also funded by public program offsets including federal matching funds, and reductions in current state spending on Medi-Cal and Healthy Families ***(Figure 11).*** The CHOICE program would also be partly funded with a reduction in safety-net spending. There would be no reduction in safety-net spending under the Healthy California proposal.

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

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

a/ Includes Medi-Cal spending for acute care services for all non-working Medi-Cal beneficiaries.
b/ Includes Medi-Cal spending for the aged and disabled.
c/ Includes savings from using the Federal Supply Schedule for purchasing prescription drugs and durable medical equipment (30 percent less than Medicaid rates including rebate).
d/ Includes federal matching funds under continued portions of the program plus additional federal matching funds for newly eligible parents.
e/ Includes federal matching funds for the remaining portions of the Medi-Cal/HF program plus federal matching funds for all families covered under the public program.
f/ Includes changes in state income tax revenues due to wage effects and the net change in costs for state workers.
g/ Assumes that traffic fines in California are increased by 440 percent to raise additional revenues for the plan.
h/ Assumes that the state personal income tax is increased by the amount needed to fully fund these programs.
i/ Safety-net funding would not be reduced from current funding levels under the Healthy Families program.

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

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

In general, the taxes and premiums paid by employers and workers would not be sufficient to fund the program. This is because firms would typically cover their workers through the public program in cases where the tax is less costly than purchasing insurance. The CHOICE program would require an additional $5.1 billion in funding while the Healthy California program would require an additional $3.5 billion. The Healthy California program would raise these funds through a tobacco tax increase of $1.00 per pack and an increase in the state income tax. The Choice program would raise the required funds through the same tobacco tax increase plus an increase in the state sales tax of ¼ percent, a tax on soda of $0.10 per 12 ounces and an increase in the income tax.

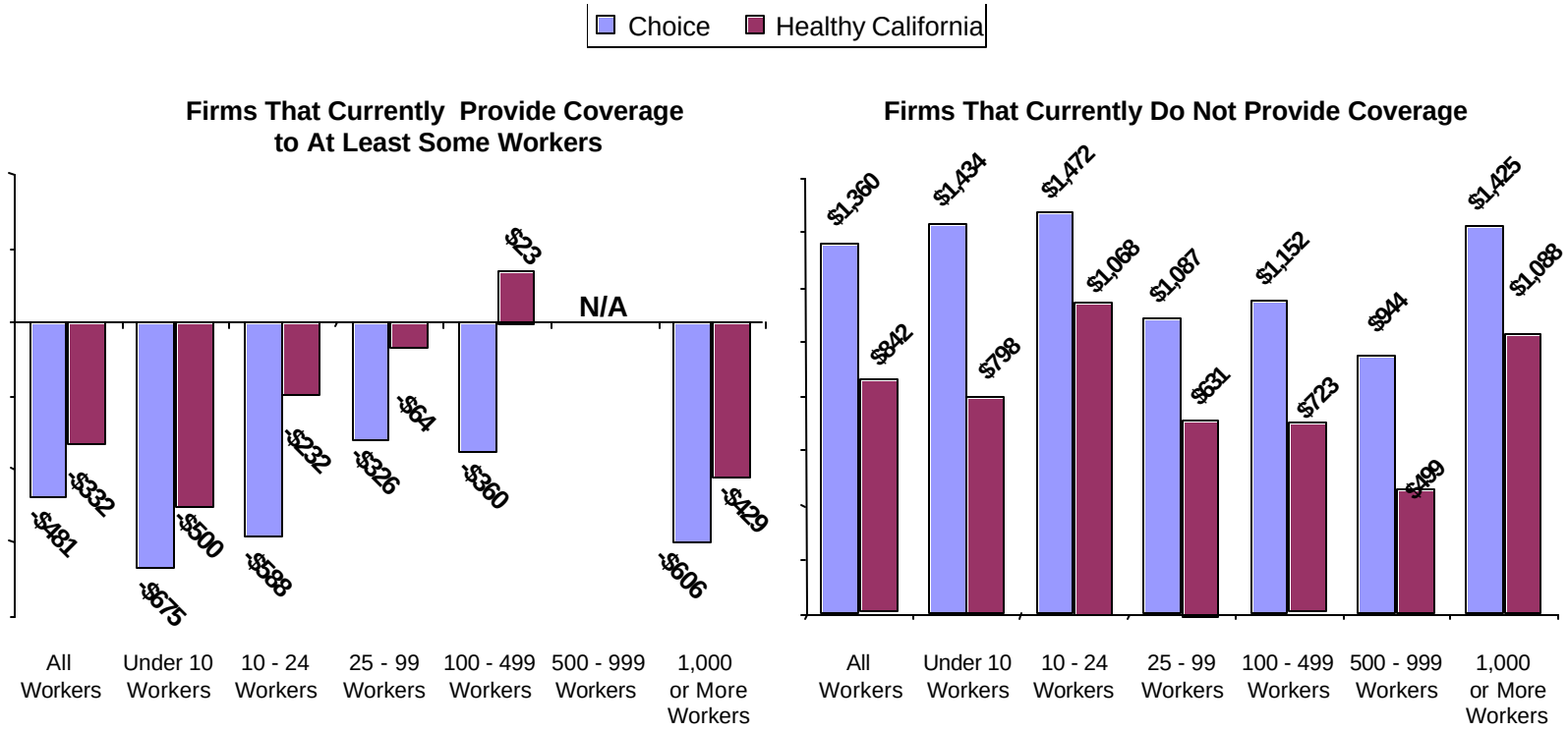
D. Changes in Health Spending for Employers and Families

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

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

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

Figure 12
Average Change in Employer Health Spending Per Worker by Firm Size Under "Choice" and "Healthy California" a/, b/



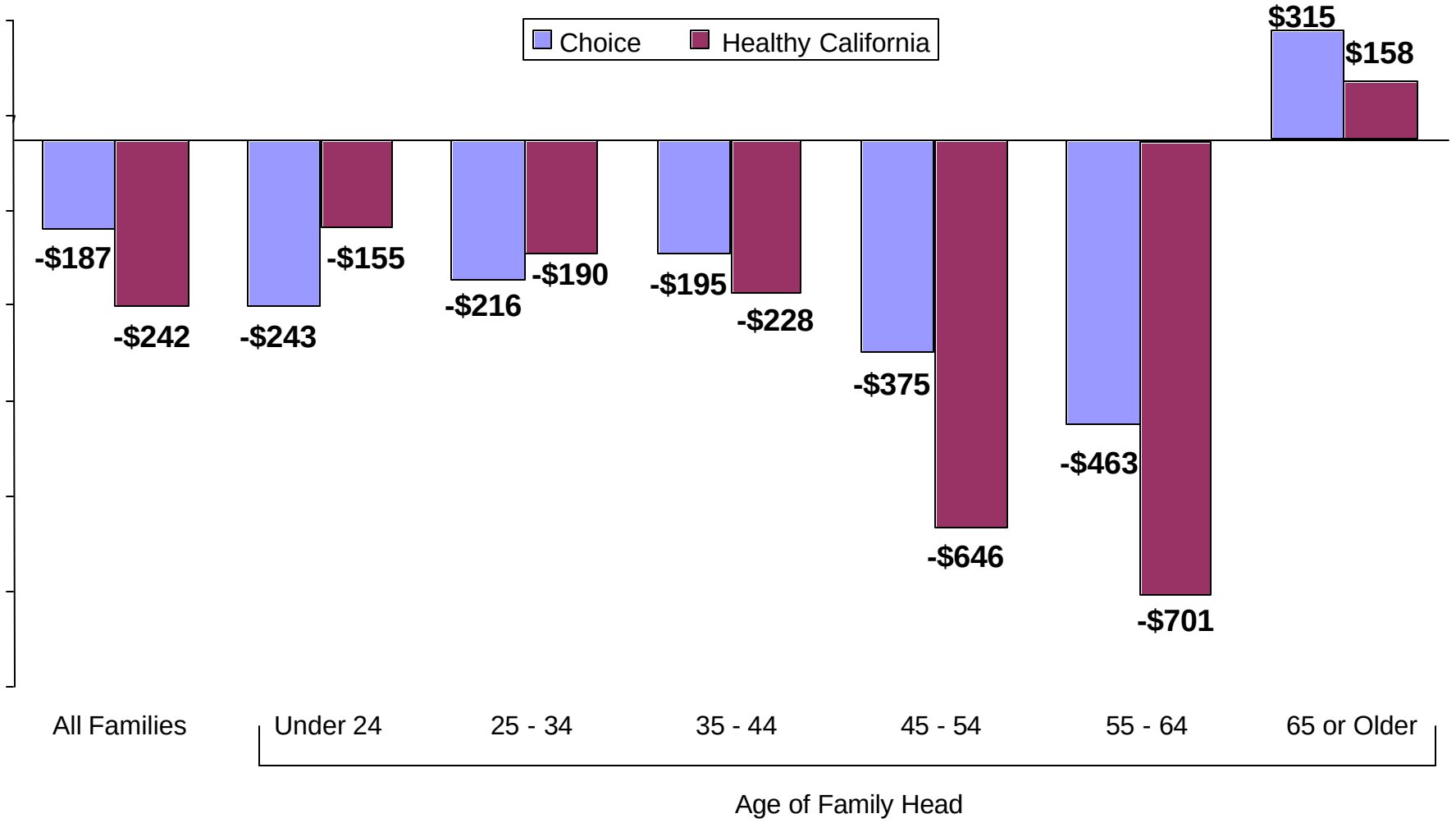
N/A – Insufficient sample size

a/ Assumes full implementation in 2002

b/ These changes in employer costs are assumed to be passed on to workers in the form of changes in wages.

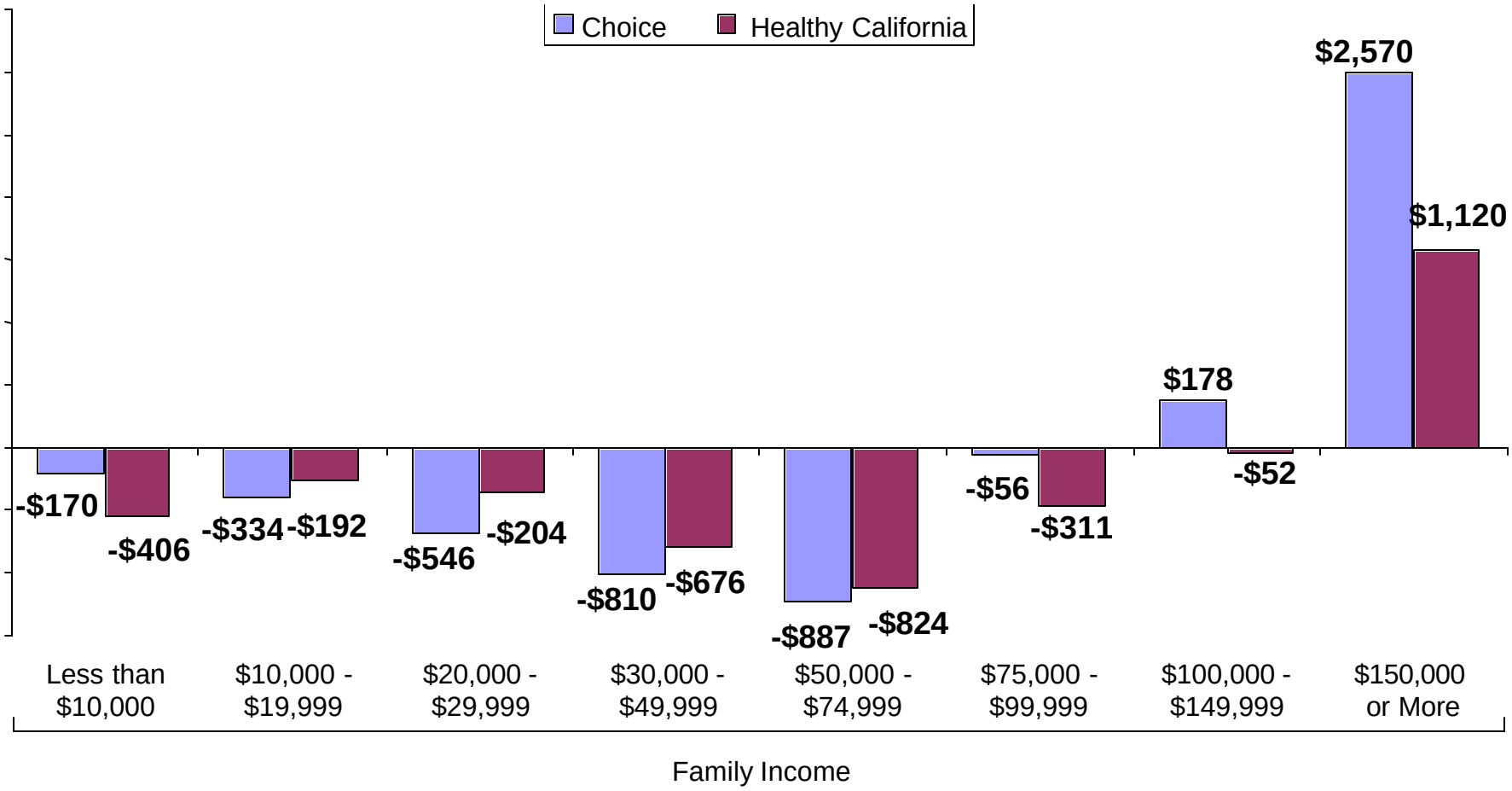
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 13
Change in Average Family Health Spending by Age of Family Head Under "Choice" and "Healthy California"



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

Figure 14
Change in Average Family Health Spending by Family Income Under "Choice" and "Healthy California" Compared [a/]



a/ Assumes full implementation in 2002.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

VI. SINGLE PAYER PROGRAMS

Three of the proposals included in this study are designated to achieve universal health insurance coverage through a single-payer model. These include the Cal Care proposal, the California Single-Payer Plan, and the Community Health Service Plan (CHSP). Under all three of these proposals, coverage would be provided to all state residents including both documented and undocumented persons. Total spending under these programs would range between $129 billion and $135 billion if fully implemented in 2002. These programs would be financed with funding for current government health benefits programs in California of roughly $65 billion, the rest of which would be financed with a payroll tax and other dedicated taxes.

A. Single Payer Program Design

Although covered services differ across the proposals, they all cover hospital care, physician visits, prescription drugs, and mental health care. The largest areas of difference in covered benefits are with long-term care (i.e., nursing home and home health). The plans also differ in terms of co-payment requirements. The Cal Care and CHSP plans would eliminate most or all cost sharing (i.e., co-payments) while the California Single-Payer Plan would require a $5.00 co-payment for all services and $5.00 co-payment for prescription drugs ***(Figure 15).***

The Cal Care and the California Single-Payer Plan would create a single-payer for all health services. Hospitals would be placed on annual operating budgets with separate budgets for capital expansion. Other providers would be paid under a uniform fee-for-service (FFS) payment schedule. The hospital budgets and provider payment levels would be calibrated so that total health spending in the state would grow no faster than the state gross domestic product (GDP). The CHSP plan would also use budgets to limit the growth in spending.

Under CHSP, all providers become state employees and all health facilities are purchased and operated by the state. We assume that the state would pay "fair market value" for these health facilities, which we estimate to be about $42.1 billion in 2002 (see ***Appendix A***). We assume that the state would purchase the system with a 30 year bond which we estimate would require annual payments of about $2.7 billion per year.[10]

All three single-payer models would be funded by reallocating revenues for current programs and by raising new revenue through various dedicated taxes ***(Figure 16)***. Current program revenues for Medicare, Medi-Cal/Healthy Families (Federal and State shares), CHAMPUS and Workers Compensation (medical component) are reallocated to the single-payer program under all three of the proposals.[11] These proposals would also reallocate savings in safety-net programs to fund the program. The Cal Care proposal differs from the other single-payer proposals in that it requires counties to forward to the state what they had been spending on indigent care programs prior to universal coverage.[12]

[10] Of this $2.7 billion, about $1.1 billion would simply replace current debt service costs for affected providers.
[11] This is sometimes referred to as "maintenance of effort requirement."
[12] Under the Cal Care proposal, counties would be required to forward funds to the state in an amount that they otherwise would have spent for health services and indigent care.

The proposals each specify additional sources of revenues for these programs. All three plans include a $1.00/pack increase in the state's tobacco tax (with proportional adjustment to taxes for other tobacco products). All three proposals include a payroll tax, although the amount of the tax and the proportion paid by employers vs. workers differs across plans. The Cal Care program would also have a tax on unearned income while the single-payer program for California would fund the balance of the program with an increase in the state's income tax. In addition, the Cal Care program includes an increase in the state sales tax and an increase in the state tax on alcoholic beverages.

Figure 15
Summary of Key Provisions for the Single-Payer Proposals

	Cal Care	California Single-Payer Plan	California Health Service Plan
Covered Persons			
Citizens	✓	✓	✓
Documented	✓	✓	✓
Undocumented	✓	✓	✓
Residency Requirement	Three Months	Three Months	Three Months
Ownership of Health System Assets	Current Private/Public	Current Private/Public	Government Owned
Covered Services			
Inpatient Care	✓	✓	✓
Hospital Outpatient	✓	✓	✓
Emergency Room	✓	✓	✓
Physician/Physician Assistant Visits	✓	✓	✓
Prescription Drugs	✓	✓	✓
Durable Medical Equipment (DME)	✓	✓	✓
Mental Health	✓	✓	✓
Home Health	Persons with 3+ ADLs Only	Persons with 3+ ADLs Only	- -
Nursing Home Care	Except Room and Board	Except Room and Board	- -
Dental Care	Covered except Orthodontia	Covered except Orthodontia	Covered except Orthodontia
Vision Care	Covered with Eyeglasses	Covered with Eyeglasses	Covered without Eyeglasses
Chiropractors	✓	✓	✓
Acupuncturists	✓	✓	✓
Other Alternative Care (herbalists, etc.)	✓	- -	- -
Co-payments for Services	None for primary care and specialty care on referral; $25 co-pay for physician specialists without referral	$5.00 co-pay per visit; $5.00 per prescription	None
Primary Care Measures	Patients choose a primary care physician; specialty care on referral	- -	Medical education funding shifted to primary care; geographic reallocation of physicians by need
Bulk Purchasing for Drugs and Durable Medical Equipment	Use federal supply schedule	Use federal supply schedule	Use federal supply schedule
Disposition of Medi-Cal	Retained for Medi-Cal covered services not covered under Cal Care (i.e., EPSDT, transportation, nursing home room and board, etc.)	Retained for Medi-Cal covered services not covered by Single Payer (i.e., EPSDT, transportation, nursing home room and board, etc.)	Retained for Medi-Cal covered services not covered by Single Payer (i.e., EPSDT, transportation, long-term care, etc.)
Expenditure Budgets	Capped at current spending indexed at GDP growth rate	Capped at current spending indexed at GDP growth rate	Capped at current spending indexed at GDP growth rate

Source: Lewin Group analysis of plan proposals.

Figure 16
Financing Measures for the Single-Payer Programs

	Cal Care	California Single-Payer Program	California Health Service Plan (CHSP)
Revenues for Current Programs			
Medicare	✓	✓	✓
Medi-Cal/Healthy Families			
State Share	✓	✓	✓
Federal Share	✓	✓	✓
CHAMPUS/Other Federal	✓	✓	✓
State Safety-Net Savings	✓	✓	✓
Maintenance of Effort for County Safety Net	✓	- -	- -
New Revenues			
Payroll Tax	9.7 percent; 6.1 percent for employers and 3.6 percent for workers	8.0 Percent on firms with annual gross earnings over $75,000	9.9 percent; 7.4 percent for employers 2.5 percent for workers
Tobacco Tax	$1.00 per pack	$1.00 per pack	$1.00 per pack
Sales Tax increase	¼ percent increase	--	--
Alcoholic Beverages	800 percent increase of current tax	--	--
Increase Income Tax	- -	Surtax of 0.3 percent on income over $250,000; Income tax rate increase sufficient to fund remainder of program (1.64 pct.)	- -
Tax on Unearned Income	Amount required to fund remainder of program; 2.8 percent in 2002	- -	- -

Source: Lewin Group analysis of plan proposals.

B. Impact on Health Spending

All three programs would result in an actual reduction in health spending despite the increased utilization of health services by newly insured persons. The savings would result from substantial reductions in administrative costs and savings from bulk purchasing of drugs and medical durable equipment.

Total health spending in California is projected to reach about $151.8 billion in 2002.[13] This includes total spending for all health services and the cost of administering insurance and public programs. Expenditures for health services would increase under the three proposals as coverage

[13] This includes spending for all health services and administrative functions in California for all sources of payment including Medicare, Medicaid, private insurance and out-of-pocket.

is extended to previously uninsured or underinsured persons. For example, spending for health services would increase by about $9.6 billion under the California Single-Payer Plan ***(Figure 17)***. There would be a larger increase in spending under Cal Care and CHSP ($14.4 billion and $13.5 billion respectively) because unlike the California Single-Payer Plan, these proposals would eliminate all patient co-payment requirements, which has been shown to result in higher utilization of health services.

Under all three proposals, these increases in spending would be more than offset by administrative savings and savings from bulk purchasing of prescription drugs and medical durable equipment (e.g., hearing aids etc.). Total savings would range between $17.2 billion and $21.0 billion which would more than offset the increase in utilization for the newly insured. We estimate that if fully implemented in 2002, total health spending in the state would be reduced by about $3.7 billion under Cal Care, $7.6 billion under the California Single-Payer Plan, and $7.5 billion under CHSP ***(Figure 17).***

Figure 17
Changes in Total Health Spending in California Under Single-Payer Proposals in 2002 (in billions)

	Cal Care	California Single-Payer Plan	California Health Service Plans (CHSP)
State Health Spending for 2002 Under Current Law			
Total Health Spending in 2002	$151.8	$151.8	$151.8
Change in Utilization With Expanded Access			
Increase in Acute Care Services	$11.8	$7.0	$13.5
Increase in Long-term Care Services	$2.6	$2.6	- -
Total Change in Utilization	**$14.4**	**$9.6**	**$13.5**
Spending Offsets			
Savings Due to Bulk Purchasing	($4.0)	($4.0)	($3.8)
Administrative Cost Savings	($14.1)	($13.2)	($17.2)
Total Offsets	**($18.1)**	**($17.2)**	**($21.0)**
Net Change in Health Spending			
Net Change	**($3.7)**	**($7.6)**	**($7.5)**

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

C. Program Spending

Most health expenditures would be covered under these single-payer programs. Total spending under the Cal Care program would be $134.7 billion, which includes $132.3 billion in provider payments for services and $2.4 billion in program administration ***(Figure 18).*** Thus, administrative costs would be equal to 1.8 percent of benefits.

Spending differs across the three plans due to differences in covered services and the use of patient cost sharing. For example, Cal Care, which would cost about $134.7 billion in 2002,

covers most health services including long-term care, dental care, and vision care, with no patient cost-sharing requirement.[14] The California Single-Payer Plan covers much the same services covered under Cal Care but includes patient co-payments that tend to reduce utilization of health services. Consequently, the California Single-Payer Plan would cost $129.6 billion. The CHSP program which does not require cost sharing but does not cover Long-term care as do in the other proposals, would cost $129.0 billion in 2002.

There are two unique aspects of the CHSP plan that affect spending levels. First, the CHSP plan would include a buy-out of the California health care system. We estimate that the states cost of purchasing all health facilities in the state would be about $45.0 billion (see ***Appendix A*****).** We also assume that the state would pay for capital acquisition with a 30 year bond issue that results in an annual payment by the state of about $2.7 billion. The Cal Care and the California Single-Payer Plan proposals would not have these costs because they would continue to purchase care through the current mix of public and private providers.

Second, administrative costs are reduced by the fact that CHSP completely eliminates claims processing costs by owning health care facilities and by putting health professionals on salary. This reduces administrative costs under CHSP to $1.5 billion, compared with about $2.4 billion under the other single-payer proposals.

All three of the single-payer proposals would be financed through some combination of redirecting funding for existing government health programs, a payroll tax, and some additional dedicated taxes. For example, the Cal Care program would be financed with $65.7 billion in current Federal, State, and County funding for health programs. This includes funding for Medicare, Medicaid, State spending for safety-net programs, and a maintenance of effort requirement for counties based upon what they would have spent for indigent care programs in the absence of the single-payer plan. As discussed above, the Cal Care plan would also include a 9.3 percent payroll tax on earnings, a $1.00 per pack increase in the tobacco tax, a ¼ percent increase in the sales tax, an eight-fold increase in taxes on alcoholic beverages and a 3.0 percent tax on unearned income.

[14] The Cal Care plan does include a $25 co-payment for specialist care provided without referral from a primary care provider.

Figure 18
Sources and Uses of Funds Under the Single-Payer Programs in 2002 (in billions)

	Cal Care	California Single-Payer Plan	California Health Service Plans
Uses of Funds			
Health Services Expenditures	$132.3	$127.2	$124.8
Capital Acquisition Payment	- -	- -	$2.7
Program Administration	$2.4	$2.4	$1.5
Total Uses of Funds	**$134.7**	**$129.6**	**$129.0**
Sources of Funds			
Funding from Current Government Programs	$65.7 a/	$63.9	$63.9
Payroll Tax	$61.4	$52.3	$64.1
Tobacco Tax ($1.00 per pack) b/	$1.0	$1.0	$1.0
Increase Sales Tax (1/4 percent)	$1.0	--	--
Increase Alcoholic Beverage Tax (800 percent)	$2.0	--	--
Increase Income Tax	- -	$12.4	- -
Tax on Unearned Income	$3.6	- -	- -
Total Sources of Funds	**$134.7**	**$129.6**	**$129.0**

a/ Includes maintenance of effort requirement for counties not required under the other single-payer programs.
b/ With a proportional increase in taxes on other tobacco products.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The CHSP and the California Single-Payer Plan proposals are also largely funded with spending on existing programs. However, unlike the Cal Care program, there is no maintenance of effort requirement for counties and a small amount of state funding would remain for those who would remain uncovered (e.g., out of state residents and undocumented persons who resist formally enrolling in the single-payer program). This reduces the funding available from existing programs to $63.9 billion. The California Single-Payer Plan would also be funded with an 8.0 percent employer payroll tax, and a $1.00 per pack increase in the tobacco tax, with the remainder of the funds needed ($12.3 billion) raised through an increase in the state's income tax. The CHSP plan would be fully funded with a tax on payroll of 9.6 percent and a $1.00 per pack increase in the tobacco tax.

D. Private Employer Impacts

We estimate that private employer health spending for workers, dependents, and retirees will reach $32.7 billion (includes employer share only) in 2002. The employer payroll taxes under each of the single-payer proposals would result in a net increase in private employer spending (i.e., employer payroll tax less current premium payments). The amounts differ in each proposal due to differences in the level of the employer share of the payroll tax (not shown in figure):

- Cal Care, by $0.2 billion;

- California Single-Payer, by $12.4 billion; and
- California Health Services Plan (CHSP), by $7.9 billion.

These estimates of increases in private employer spending are equal to total payroll tax payments less what employers were spending on employee health insurance under current policy. This includes changes in health spending both for firms that currently offer health coverage and for those that don't. The net increase in employer costs is lowest under the Cal Care plan because the employer share of the payroll tax is only 6.1 percent compared to 8.0 percent under the California Single-Payer Plan and 7.4 percent under CHSP (see ***Figure 16*** above).

The average increase in private employer health spending per worker varies by firm size and current insuring status ***(Figure 19).*** The Cal Care program would increase private employer spending by $1,625 per worker in 2002 for firms that do not now offer coverage and would decrease spending by $631 per worker for firms that are currently providing coverage. This reflects the fact that some of those firms that currently insure would find the payroll tax less costly than what they are now spending on benefits. Under the California Single-Payer Plan, private employer spending would increase by $2,203 per worker for currently non-insuring firms and would increase spending by about $362 per worker for employers that offer coverage. Private employer spending for non-insuring firms would increase by $2,027 per worker under the CHSP and would decrease spending by $20 per worker for firms that currently provide coverage.

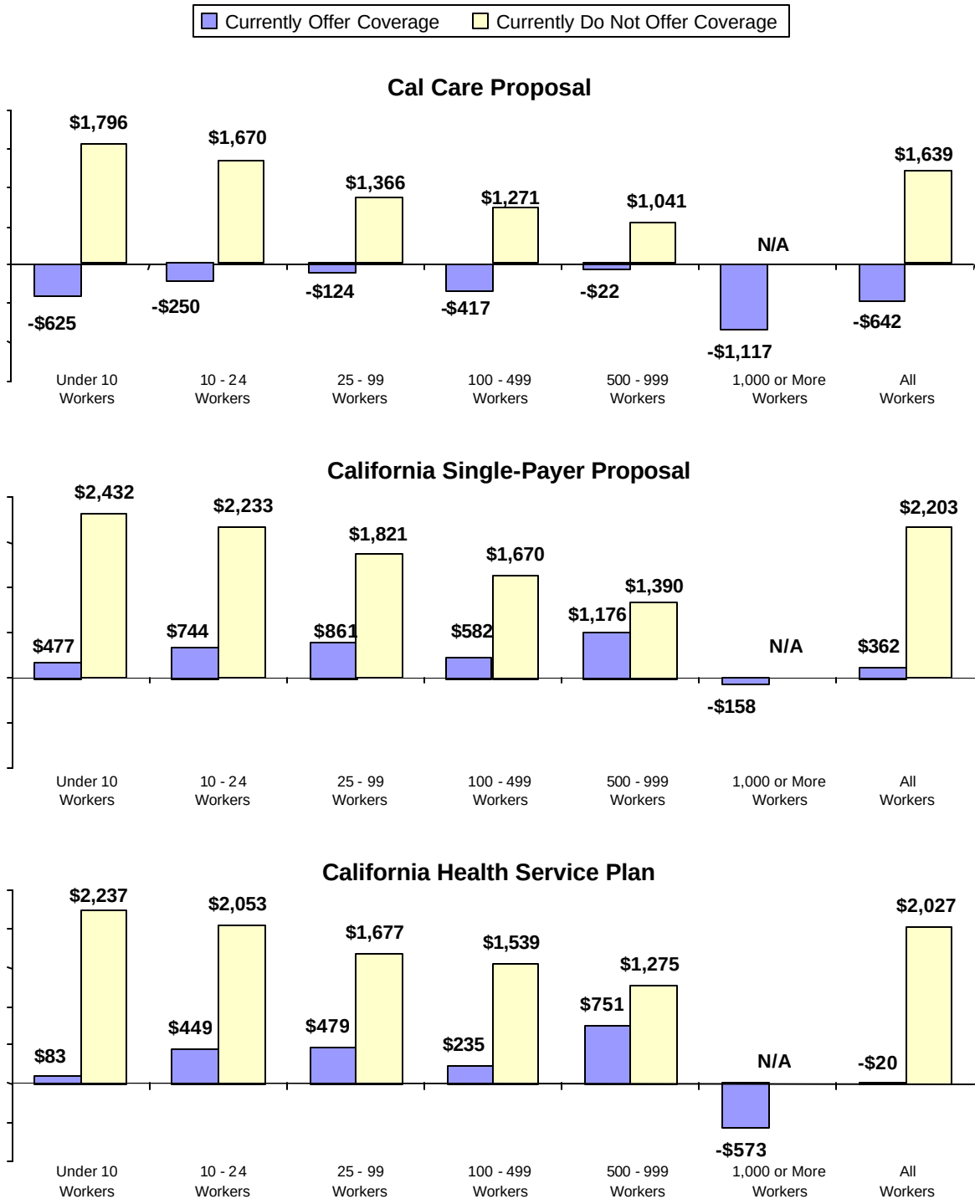
Research indicates that employers would pass-on much of the increase in health care costs to employers in the form of reduced wage growth or lost jobs. These wage effects are discussed below under family impacts.

E. Impact on Family Spending

All three single-payer proposals replace our current premium financed system with one, that is financed largely through dedicated taxes. This shift to a tax based financing system would have significant impacts on health spending for families. These proposals would eliminate family premium payments including the worker contributions for employer coverage and premiums paid for individually purchased non-group coverage. Family out-of-pocket health spending also would be reduced due to expansions in the scope of services covered under the single-payer plan and the reduction and/or elimination of patient co-payments under these plans.

Much of these savings would be offset by increased tax payments due to the various dedicated taxes created under these proposals. In addition, we expect employers to pass-on any increase in costs resulting from the single-payer plans (i.e., payroll tax) to workers in the form of reduced wage growth over time. The after-tax reduction in wages is treated as a cost of health care to families (wage loss would be partially cushioned by a corresponding reduction in income and payroll taxes). Similarly, wages are increased for workers in firms that find the payroll tax would be less than what they now pay for coverage.

Figure 19
Change in Private Employer Health Spending Per Worker by Firm Size and Current Insuring Status Under Single-Payer Proposals [a/]



N/A – Insufficient sample size

a/ Assumes full implementation in 2002

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

All three of these proposals would result in a reduction in average health expenditures per family. Savings would average $473 per family under Cal Care, $658 per family under the California Single Payer plan, and $813 per family under CHSP. This reflects differences in reductions in health spending under these proposals and reductions in federal tax payments for persons experiencing a reduction in wages.

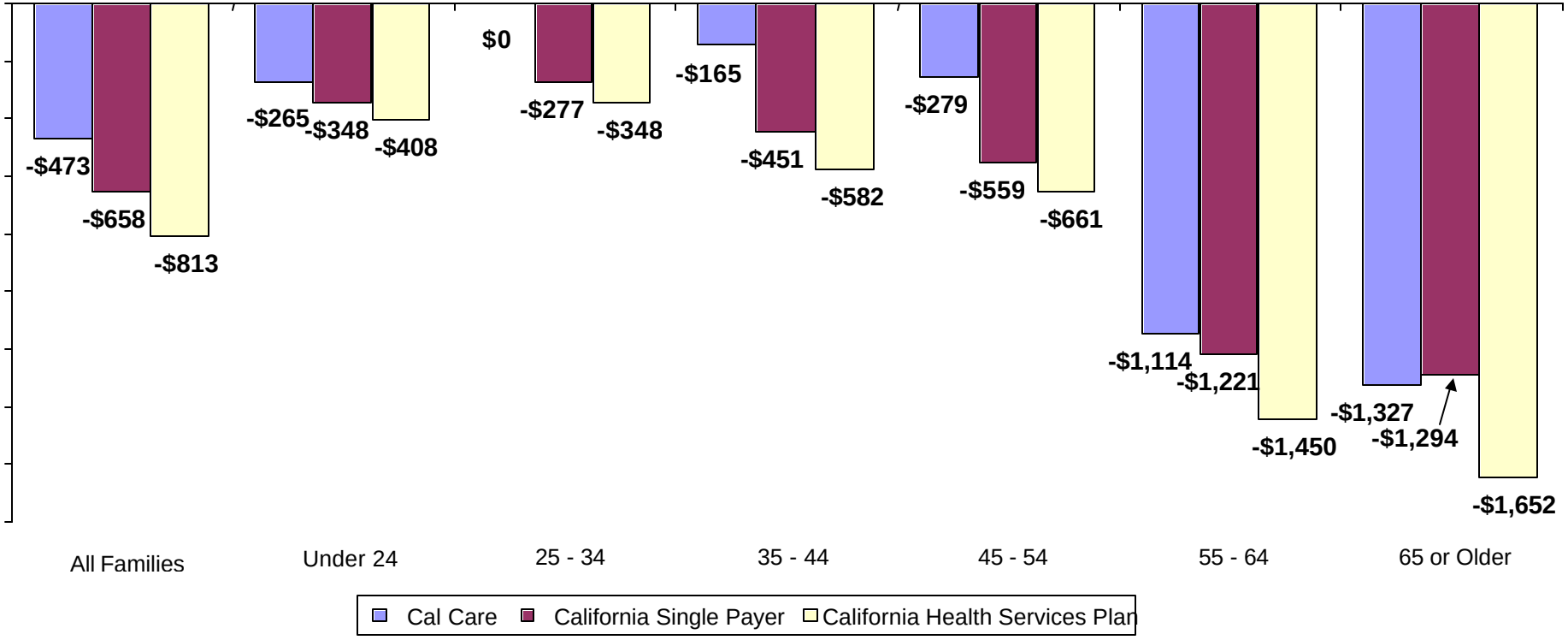
However, the impact of these proposals on health spending would vary by age of family head ***(Figure 20)***. For example, under CHSP, families headed by an individual age 65 or older would see average savings of about $1,652, while families with a family head under age 55 would see much lower savings (e.g., $398 for families headed by someone ages 25 through 34). A similar pattern is evident with the other two single-payer proposals as well.

The large savings for older families reflects the fact that the program would cover many of the services not covered by Medicare such as prescription drugs, and would eliminate and/or reduce the co-payments that they now face under Medicare. Also, persons who currently purchase supplemental "Medigap" coverage would no-longer need to purchase this insurance due to the extensive coverage provided under these plans. While the aged would receive substantial benefits under these single-payer plans they would pay only a small portion of the payroll taxes required to fund these programs because most of the aged are not working. Consequently, the use of a payroll tax to fund these programs implies a significant inter-generational transfer from the young to the old.

The distributional impact of these proposals also varies by family income ***(Figure 21).*** All three single-payer proposals would on average reduce family health spending for families with annual incomes below $100,000. However, under all three plans, health spending would increase among families with incomes of $100,000 or more. For example, average family health spending for families with incomes of $150,000 or more would increase by an average of $2,795 under the CHSP plan, $2,511 under the California Single-Payer Plan and $4,350 under Cal Care. The Cal Care plan has a larger impact on families in this income group because it includes a tax on unearned income, which is partly concentrated among higher income families.

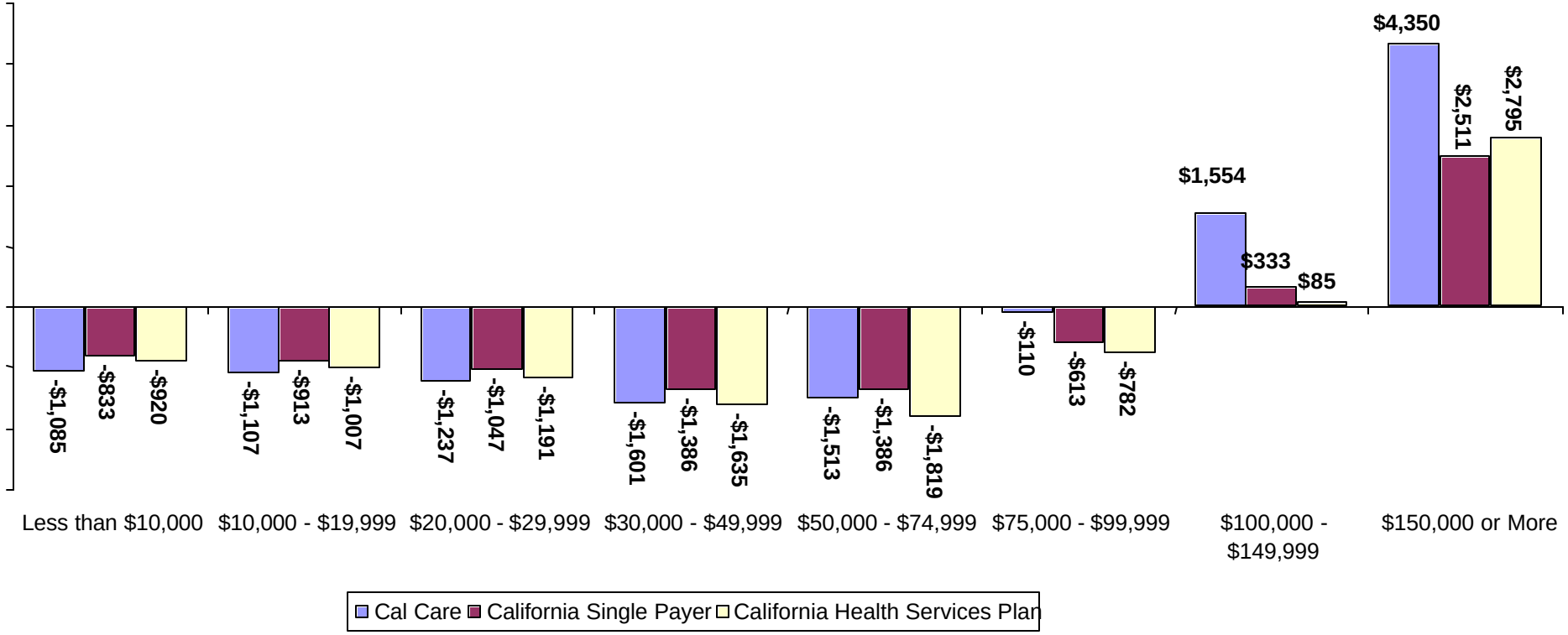
The shift from a premium financed system to a tax financed system explains much of the distributional impact of these proposals across income groups. Under today's premium financed system, the amount that a low-income worker contributes for employer coverage is typically the same as is contributed by the top executives of the firm (some plans now vary premiums with worker salary). Thus, within a firm, health spending for workers as a percentage of income declines as income rises. This differs from a payroll tax financed system where the amount paid by each worker is a fixed percentage of employee earnings. This results in higher payments by upper-income persons and reduced payments among lower-wage workers.

Figure 20
Change in Average Family Health Spending by Age of Family Head Under the Single-Payer Proposals



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

Figure 21
Change in Average Family Health Spending By Family Income Under the Single-Payer Proposals in 2002



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

F. Single-Payer and Benefits Design

Much of the difference in cost among the three single-payer plans is attributed to differences in covered services and patient co-payment requirements. All three of these plans provide comprehensive coverage for a "core" set of benefits including hospital care, physician services, mental health and prescription drugs. All three proposals also cover general dentistry. The differences in covered services are for eyeglasses and long-term care.

For example, all three plans would maintain at least the current level of coverage under Medi-Cal for nursing home and home health services. However, both the Cal Care and the California Single-Payer Plan proposals would also cover all nursing home expenses other than room and board. These plans would also provide home health services to all persons with three or more limitations in Activities of Daily Living (ADL). The cost of adding these services under CHSP would be $3.7 billion for nursing home care and $1.2 billion for home health care ***(Figure 22)***.

The California Single-Payer Plan is unique among the three proposals in that it requires patient co-payments for all services ($5.00 per visit, $5.00 per prescription). Studies have shown that eliminating patient cost sharing can increase utilization of physician services by up to 30 percent and increase the use of hospital care by 10 percent. Based upon these studies, we estimate that eliminating co-payments under the California Single-Payer Plan would increase costs by about $8.3 billion.

Benefits design can be used as a means of encouraging the use of primary care. For example, the Cal Care program would require all individuals to select a primary care provider. It would also impose a co-payment of $25 for physician specialist services received without a referral from their primary care physician. This is designed to reduce unnecessary use of costly specialist services and to improve quality by assuring that care is coordinated for patients receiving care from multiple providers. Including this provision reduces the cost of the Cal Care program from $138.5 billion without these primary care requirements to our current Cal Care estimate of $134.8 billion (***Figure 23***).

The CHSP also includes provisions to increase the share of physicians who specialize in primary care. These include reallocating California's providers across the state in proportion to need and increasing the emphasis placed on primary care in medical education in the state. However, it is likely to be 10 years or more before the full effect of these policies is reflected in program spending. Consequently, CHSP is not expected to have the immediate impact on utilization that we would see under the Cal Care cost-sharing incentives.

The plan could further reduce costs by requiring a co-payment for all services. As discussed above, the presence of a co-payment requirement can significantly reduce the use of health services. For example, with a co-payment requirement of $5.00 per visit and $5.00 per prescription, the total cost of the Cal Care program would be reduced to $127.7 billion. ***Figure 23*** shows how costs for all three single-payer proposals would change under these alternative benefits designs.

Figure 22
Cost of Selected Expansions in Covered Services Under Single-Payer Proposals

	Cal Care	California Single-Payer Plan [a/]	California Health Service Program (CHSP)
Costs Under Current Proposal	$134.8	$129.6	$129.0
Added Cost of Selected Benefits			
General Dental Care			
Dental Services	-- b/	-- b/	-- b/
Orthodontia	$2.1	$1.8	$2.1
Vision			
Vision Exams	-- b/	-- b/	-- b/
Eyeglasses	-- b/	-- b/	$1.1
Increased Long Term Care c/			
Nursing Home (except room and board)	-- b/	-- b/	$3.7
Home Health	-- b/	-- b/	$1.2
Eliminate Co-payments	-- d/	$8.3	-- d/

a/ Reflects presence of co-payments under the California Single-Payer Plan.
b/ Services already covered by plan.
c/ Includes only expansions in long-term care services in excess of the current Medi-Cal covered amounts, which would continue to be covered under all three proposals.
d/ These plans require no co-payments in most or all cases.
e/ General dental care added about $9.9 billion in spending to each plan.
Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

Figure 23
Total Program Costs (Net of Offsets) for the Single-Payer Proposals Under Alternative Co-payment and Benefits Designs a/

	Cal Care	California Single-Payer Plan	California Health Service Program (CHSP) c/
Costs Under Current Proposals	$134.8	$129.6	$129.0
Costs Under Alternative Benefits Designs			
No Co-payments for All Services	$138.5	$137.9	$129.0 b/
$25 Co-payment Only for Specialty Care Provided Without Primary Care Provider Referral	$134.8 b/	$135.1	$126.1
$5.00 Co-pay for All Services	$127.7	$129.6 b/	$120.7
$5.00 Co-pay for All Services with $25.00 Co-pay for Services Without Primary Care Provider Referral	$124.0	$126.1	$117.2

a/ Estimates assume that covered services for each plan are the same as under the current proposals. Cost changes reflect only the impact of varying co-payments and benefits design.
b/ Cost sharing and benefits design used under current proposals.
c/ The CHSP includes provisions that would promote increased use of primary care by reallocating physicians within the state by population and by increasing the emphasis on training for primary care in medical education. We expect the resulting savings from this approach to phase-in over a ten year period.
Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

VII. COMPARISON OF COMBINED EFFECTS

There are five proposals that would expand coverage incrementally through expansions in existing public and/or private coverage. These include the CPPP proposal, the MCEP proposal, Cal-Health, the ITUP plan, and Stage I of the Healthy California plan. The ITUP plan, which includes a combination of programs to expand both private and Medi-Cal/Healthy Families coverage, would reduce the number of uninsured by about 2.6 million persons (39.4 percent of the uninsured), at a total net cost to the state of about $3.2 billion (includes program expenditures less offsets to existing programs and federal matching funds.) The MCEP plan would reduce the number of uninsured by 1.9 million persons, while the CPPP employer subsidy program would reduce the number of uninsured by about 100,000 persons ***(Figure 24).***

The two pay-or-play proposals would cover a substantial portion of the uninsured. CHOICE would reduce the number of uninsured by about 4.6 million persons (70.0 percent). Stage II of the Healthy California program would cover about 5.7 million (86 percent) of the 6.6 million uninsured persons in the state. The Healthy California program would cover a larger percentage of the uninsured because the employee premium payment is non-refundable, even if the individual declines coverage. Thus, there is no reason to decline the coverage. This differs from CHOICE where the employee contribution would be returned if the worked declined coverage. The net cost of these programs to the state would be $47.8 billion under CHOICE and $22.4 billion under Healthy California. These include all expenditures under the public program less any offsets to existing State programs and any change in Federal matching funds under the program.

The single-payer programs are the only options considered in this analysis that would achieve universal coverage. They would also involve the largest net increases in public program health spending. The net increases in public program spending would be $69.0 billion under Cal Care, $65.7 billion under the California Single-Payer Plan and $65.1 billion under the CHSP program.

While public spending would increase under the single-payer models, total health spending in the state would actually decline. Total health spending includes all payments for all health services and the cost of insurer/program administration. We project that total health spending in California will be $151.8 billion in 2002. We estimate that total health spending would decline by between $3.7 billion and $7.6 billion under the proposals (i.e., between 2.4 percent and 5.0 percent). As discussed above, the single-payer models would result in substantial savings thorough administrative simplification and bulk purchasing that would exceed the cost of providing the additional health services that the uninsured and underinsured would use once they became covered. By comparison, total health spending would increase under the other proposals due to increased utilization, with little of administrative savings offsets.

Figure 24
Summary of Combined Program Costs and Coverage Impacts for Coverage Expansion Proposals in 2002

	Number Who Participate (millions)	Net Reduction in Uninsured (millions)	Net New Public Program Costs (billions) a/	Change in Federal Funds	Change in Employer Costs	Change in Total Health Spending In State
Incremental Reforms						
California PacAdvantage Premium Program (CPPP): Peter Harbage	0.2	0.1	$0.2	- - -	$0.1	$0.1
Managed Care Expansion Plan: Bob Brownstein	2.5	1.9	$3.6	- - -	- - -	$0.9
Cal-Health: Helen Schauffler	0.4	0.4	($0.1)	$0.2	- - -	$0.2
The Insure the Uninsured Project (ITUP): Lucian Wulsin	4.5	2.6	$3.2	- - -	($0.1)	$1.4
The Healthy California Program Stage I: Brown & Kronick	1.5	1.2	$2.1	0.1	- - -	$0.6
Employer Contribution						
The Choice Program: Helen Schauffler	21.2	4.6	$47.8	$0.6	$0.7	$2.8
The Healthy California Program Stage II: Brown & Kronick	21.6	5.7	$22.4	$9.7	$0.1	$3.0
Single-Payer						
Cal Care: Judy Spelman	35.1	6.6	$69.0	- - -	$0.2	($3.7)
Single Payer: James Kahn M.D.	35.1	6.6	$65.7	- - -	$12.4	($7.6)
California Health Service Plan: Ellen Shaffer	35.1	6.6	$65.1	- - -	$7.9	($7.5)

a/ Includes the cost of the program less offsets to other government programs and any change in federal funds.
Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

VIII. CAVEATS

Many of the proposals considered in this study have never been attempted on a broad scale in the United States. Consequently there are little data on the likely outcomes of such programs that can be used to estimate their impacts. In particular, programs that substantially restructure the health care financing system could fundamentally change consumer, employer and provider incentives, in ways that would have a significant impact on program costs.

It is difficult to predict enrollment in the Medi-Cal and Healthy Families programs for population groups who have never been covered under the programs. For example, it is difficult to predict enrollment behavior among newly eligible non-custodial adults, many of whom are in substantially different economic and family circumstances than the currently eligible population. In addition, there is wide disagreement over the extent to which newly eligible persons with employer-sponsored coverage would shift to public coverage.

Moreover, there is little evidence to guide us in estimating the impact of the various tax subsidies and premium subsidy programs considered in this study. We have attempted to estimate the number of eligible persons who would be induced to take coverage due to these programs based upon historical data on the relationship between the price of private insurance and the number of persons with coverage. However, the methods used to provide health insurance subsidies could have a significant impact on coverage levels. For example, a health insurance tax credit administered through the tax code may have a very different impact on coverage than a premium voucher program of equal amount that involves a separate application and income verification process.

Throughout this analysis, we have also assumed that the various subsidy schemes are administratively feasible, even though it is unclear how some of these programs would be implemented. For example, for a refundable tax credit program to be effective there must be ways for individuals to obtain the tax credit at the time they purchase coverage rather than waiting until the following spring for their tax refund. We assume that these administrative issues are resolved so that persons who are induced by the subsidy to take the coverage can do so.

To illustrate the potential sensitivity of our estimates to these assumptions, we estimated the number of uninsured who would become covered and net public program costs under each of the five incremental reform proposals and the pay-or-play proposals using alternative participation and cost assumptions. We developed high-range and low-range estimates of enrollment by varying our estimates of participation rates for these programs by about 25 percent above and below our best estimate values ***(Figure 25).***[15] We also present our estimates of net program costs under these proposals at these high- and low-range enrollment levels assuming that per-capita costs differ from our projections by five percent above and below our best estimates.[16]

[15] We varied the enrollment rates by the amount of the standard error of estimate for the program participation regression equations that form the basis of our enrollment estimates. This results in an approximate variation in coverage rates of 25 percent on either side of the predicted value.

[16] We assume that per-capita costs in the low range estimate are five percent lower than estimated and that per-capita costs in the high-range estimates are five percent higher than estimated.

Figure 25
Sensitivity of Estimated Program Costs and Coverage Impacts Under Health Reform Options in 2002

	Reduction in Uninsured [a/] (millions)			Net Program Costs [b/] (billions)		
	Low-Range Estimate	Best Estimate	High-Range Estimate	Low-Range Estimate	Best Estimate	High-Range Estimate
Incremental Reforms						
California PacAdvantage Premium Program (CPPP): Peter Harbage	0.1	0.1	0.1	$0.1	$0.2	$0.2
Managed Care Expansion Plan: Bob Brownstein	1.5	1.9	2.3	$2.5	$3.6	$4.7
Cal-Health: Helen Schauffler	0.3	0.4	0.5	$0.0	$0.1	$0.1
The Insure the Uninsured Project (ITUP) Proposal: Lucian Wulsin	2.0	2.6	3.2	$2.3	$3.2	$4.2
The Healthy California Program Stage I: Brown & Kronick	0.9	1.2	1.5	$1.5	$2.1	$2.7
Employer Contribution						
The CHOICE Program: Helen Shauffler	4.4	4.6	4.8	$43.1	$47.8	$52.4
The Healthy California Program Stage II: Brown & Kronick	5.4	5.7	6.0	$20.2	$22.4	$24.5
Single-Payer						
Cal Care: Judy Spelman	6.6	6.6	6.6	$62.0	$69.0	$76.6
California Single-Payer Plan: James Kahn M.D.	6.6	6.6	6.6	$59.0	$65.7	$72.9
California Health Services Plan (CHSP): Ellen Schaffer	6.6	6.6	6.6	$58.5	$65.1	$72.3

NOTE: Assumes that these programs are fully implemented in 2002.

a/ Assumes that program participation rates differ from our best estimate by an amount equal to one standard deviation of our estimated participation rate.

b/ Assumes that per-capita program costs differ from the predicted value by five percent (i.e., five percent lower in the low range estimate and five percent higher in the high range estimate).

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

We also estimated a range of possible outcomes for the three single-payer reform proposals under various key assumptions. We found that our estimates of net state costs for the single-payer models are very sensitive to variations in per-capita spending assumptions. For example, our analysis shows that a 5.0 percent increase in per-capita costs would increase the net increase in state spending (i.e., total costs in excess of spending under current programs) by about 9.0 percent.

Finally, all of the estimates presented above assume that these programs are fully implemented in 2002. In fact, our experience with SCHIP and prior Medicaid eligibility expansions suggests that it would take up to two years before these programs are fully implemented. This reflects the time it takes to establish and implement new programs and lags between the time that the program is introduced and the point at which the public has become generally aware of their potential eligibility. Consequently, for budgetary purposes, we provide in the appendices (***Appendices B*** through ***J***) ten-year estimates of the cost of these programs, which reflect these expected lags in enrollment, and the actual dates of implementation for these proposals.

Although we have tried to base our analyses upon the best data and research now available, these estimates should be considered illustrative of potential program impacts rather than point estimates of actual program outcomes. In fact, our analysis indicates that the ultimate impact of these proposals on government health spending and coverage is very sensitive to assumptions on employer and consumer behavioral responses under the new incentives created by these programs. Furthermore, the estimates are based on projections of health care costs, which are very sensitive to underling health care trends. Consequently, policy makers should recognize that any major health initiative is likely to require continued refinements in program design and financing over time.