

COST AND COVERAGE: THE IMPACT OF IMPLEMENTING
VARIOUS STATE HEALTH CARE REFORM PROPOSALS NATIONALLY

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TABLE OF CONTENTS

Introduction	1
Methodology.....	1
Health Insurance Premium Subsidy Programs	2
Eligibility.....	2
Subsidies	3
Coverage	4
Financing	5
Growing Interest in Premium Subsidy Programs	6
Implementing a National Premium Subsidy Program	7
Mandatory Section 125 Plans.....	10
Group versus Non-group Coverage	10
A National Mandate for Section 125 Plans	12
Employer Mandates.....	14
ERISA Preemption	15
Existing Employer Mandates	16
A National Employer Mandate	17
Individual Mandate.....	22
The Role of a Mandate	23
A National Individual Mandate.....	23
A Model Combining Certain Features of the Massachusetts Plan	29
Features	30
Coverage Impact.....	31
Cost Impact	32
Conclusion	33

Introduction

With 45.7 million uninsured Americans in 2007, up from 38.4 million in 2000 (U.S. Census Bureau, 2008), health care reform is taking center stage as one of the top priorities for governors, state legislatures, and Congress. In the absence of a cohesive and actionable national health care reform agenda, many states are exploring opportunities to reform their health care systems in order to expand coverage. The Massachusetts health care reform effort is likely the most widely known, both because of the expansiveness and innovation involved, but many other states have considered and/or implemented less extensive and complex reforms as well. States are trying, and in some cases succeeding, to reduce the ranks of the uninsured among their residents. While health care reform may, indeed, occur one state at a time, transformation on a national scale should not be overlooked.

In this paper, we will present the findings of an analysis that explores the coverage and cost impacts of implementing various state health care reform proposals nationally. While there is no shortage of ideas for how to expand coverage, the analysis was limited to looking at five different reform options:

- A health insurance premium subsidy program,
- An employer mandate to implement Section 125 plans,
- An employer mandate to provide coverage,
- An individual mandate to have coverage, and
- A national implementation of certain combined features of the Massachusetts reform initiative.

For each of these options, we will discuss how a reform of this nature will affect both those who have coverage and those who do not, as well as the cost to Federal, state, and local stakeholders.

Methodology

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with The Lewin Group to model and analyze the cost and coverage impacts of implementing various state health care reform proposals nationally. The Lewin Group used their proprietary Health Benefits Simulation Model (HBSM) for the analysis. All modeling done for the various analyses were performed assuming full implementation of the reform(s) in the year 2010.

The HBSM model is a micro-simulation model of the U.S. health care system. The model is a fully integrated platform for simulating policies ranging from narrowly defined Medicaid and SCHIP coverage

expansions to broad-based reforms such as changes in the tax treatment of health benefits. HBSM was created to provide comparisons of the impact of alternative health reform models on coverage and expenditures for employers, governments and households. The model facilitates comparisons of alternative health reform initiatives by using uniform data and assumptions. For example, take-up rates for Medicaid, SCHIP and various subsidy proposals are simulated using uniform take-up equations and modules. Uniform methods are also used to simulate changes in health services utilization attributed to changes in coverage status and cost-sharing parameters. This uniform approach assures that it can develop estimates of program impacts for very different policies using consistent assumptions and reporting formats.

A more detailed description of the model is available in The Lewin Group's full report to ASPE, "The Cost and Coverage Impacts of Selected Health Reform Options Available to States." For a copy of the report, please contact Carrie Shelton or Thomas Musco, in ASPE's Office of Health Policy, at (202) 690-6870.

Health Insurance Premium Subsidy Programs

Premium subsidy programs provide financial support to individuals and families for the payment of health insurance premiums. Participation is usually limited to low-income individuals with earnings that are no more than two or three times the Federal Poverty Level (FPL), with the exact income limit varying from program to program. Subsidy amounts can vary based on a sliding scale, providing the most assistance to the lowest income participants and the least to those at the highest end of the income eligibility limit. Coverage is typically provided through the private insurance market, either through enrollment in an employer-sponsored insurance (ESI) plan or a state-contracted benefit plan.

Eligibility

Eligibility guidelines for premium subsidy program participation vary widely, but income is a key consideration across all programs. Premium subsidies are meant to provide increased access to coverage by improving health insurance affordability for populations for whom financial limitations make take-up less likely. By definition, this population therefore consists of low-income individuals and families. Low-income is typically defined as at or below 200% FPL, but many

programs limit eligibility to lower income levels and some go further up the income scale. For example, Utah provides subsidies for working adults with income up to 150 percent FPL and for children in families with income up to 200 percent FPL, while states such as Massachusetts and Vermont subsidize coverage for populations with income up to 300 percent FPL.

In determining what income groups to allow into a premium subsidy program, states consider factors such as how much funding is available for the program, the cost of the subsidy per participant, the number of uninsured by income levels, and what other programs exist that provide access to coverage for low-income populations in their state. In addition to the above, there are often other requirements for participation related to age, employment status, marital and/or parental status, residency, and duration of uninsurance.

Subsidies

The amount of the subsidy can vary based on a variety of factors. A subsidy may be a set dollar amount or it could be a percentage of a premium. In addition, if a subsidy is going towards a premium payment for ESI coverage, the employer contribution may impact the subsidy amount. Some states, particularly those that provide subsidies for individuals and families higher up the income scale, vary the subsidy based on income. Called a sliding fee scale, individuals at the lowest end of the income scale receive the full amount, with the subsidy decreasing incrementally as you move up the income scale.

For example, in Massachusetts the premium subsidies vary according to income with the subsidy reduced as a result of the required individual/family contribution as follows:

Income (As a percent of FPL)	Premium Contribution per Adult
<i>Less than 100% FPL</i>	None
<i>100% - 150% FPL</i>	None
<i>150% - 200% FPL</i>	\$35
<i>200% FPL – 250% FPL</i>	\$70
<i>250% - 300% FPL</i>	\$105

In Vermont the subsidies are reduced as a result of the individual/family contribution as follows:

Income (As a percent of FPL)	Monthly Premium (Depending on Family Size)
<i>150 - 175% FPL</i>	\$60
<i>175% - 200% FPL</i>	\$60 - \$65
<i>200% - 225% FPL</i>	\$60 - \$110
<i>225% - 250% FPL</i>	\$65 - \$135
<i>250% - 275% FPL</i>	\$110 - \$160
<i>275% - 300% FPL</i>	\$135 - \$185

While both Massachusetts and Vermont begin requiring premium payments at 150% FPL, Massachusetts increases the individual or family contribution based on 50% increments in FPL, while Vermont increases the individual or family contribution based on 25% increments in FPL.

Coverage

There is wide variation among programs for how coverage is achieved. Programs can be structured so that premium subsidies can be used for ESI only, for purchase of state-contracted benefit plans, or either depending on the participants' access to ESI. Some programs only enroll participants who have access to ESI (or whose employer agrees to offer ESI) in an effort to promote employment-based health insurance coverage. These programs will often require that the employer pay a portion of the premium, in addition to the subsidy and employee contribution, and are therefore referred to as "three share" programs (with the state share being the subsidized portion of the premium). Muskegon, Michigan has a three share program where the employee and employer each pay 30% of the premium, with the remainder subsidized with public dollars. According to a report by the Employee Benefit Research Institute, this program "is generally regarded as a successful community-based approach to expanding health care coverage to uninsured workers." The organization that runs the program has repeatedly been consulted for technical assistance by other communities throughout the country, suggesting it is perceived as a replicable model.

Other programs will enroll participants in a benefit plan (or one of several benefit plans available) that the state offers through a contract with a private insurer(s). Usually these participating plans are

required to provide a benefit package that adheres to certain minimum benefit requirements set by the state, based upon state-defined premium amounts. For example, the Pennsylvania *adultBasic* program is a state run premium subsidy program for low-income adults that enrolls participants in one of four plans offered through contracts with the state's Blue Cross and Blue Shield plans. The plans must adhere to certain minimum benefit requirements, and premiums are set by the state annually.

Another example is the Massachusetts Commonwealth Care plans. These plans must include:

- Outpatient medical care,
- Inpatient medical care (hospitalization),
- Mental health and substance abuse services,
- Prescription drugs,
- Rehabilitative services,
- Vision care,
- Emergency care, and
- Wellness care.

Regardless of the plan in which a participant chooses to enroll, they will all have these same covered benefits as required by Massachusetts law. There may, however, be some variation in the amount or scope of the benefits. All plans are required to be actuarially equivalent and to cover the minimum benefits, but they may offer slight differences in coverage.

Programs may also allow enrollment in either an ESI plan or a state-contracted plan. States can require eligible participants to enroll in ESI if they have access to it, while enrolling those without access into a state-contracted benefit plan. Because benefits can vary greatly from plan to plan, and states may not have control over the benefits offered or cost-sharing required for ESI, they may allow program participants the option of choosing between enrolling in ESI (if available) and the state-contracted plan.

Financing

Premium subsidy programs can be financed through state funds, federal funds, participant contributions and sometimes employer contributions. Many programs are financed through state-only funds, based on legislative authority and appropriations. Some state-only programs, such as the one in Pennsylvania, are funded in part with

tobacco settlement funds, while others use general fund dollars or other appropriations.

Some states have utilized Medicaid 1115 waivers to draw down federal funding as a portion of the subsidy. These states must receive CMS approval for their program after demonstrating how savings from their Medicaid program will be achieved to pay for the subsidy program and how the implementation of the program will be budget neutral to the federal government (i.e., federal spending will not exceed what it would have been in the absence of the waiver). These programs are financed the same way the state's Medicaid state plan is, using the annual Federal Medical Assistance Percentage (FMAP) to calculate the state share and federal share of expenditures. States pursue this option largely because it provides an additional funding stream that allows them to enroll more participants than would have been possible using state-only funds. States that already have a state-funded premium subsidy program have used the Medicaid 1115 waiver program to expand their program, particularly if they have a long wait list for their state-funded program.

As mentioned earlier, some programs utilize ESI, alone or as one option, as both a coverage and a financing mechanism. By requiring employer participation, states can make their dollars go further, and in some cases will also require an employee share to reduce the amount of the state subsidy. A premium subsidy program that is authorized under a Medicaid 1115 waiver could, therefore, have four funding sources overall: state, federal, employer, and employee. The more sources of payment, the further the money goes and the more individuals a program can cover.

Growing Interest in Premium Subsidy Programs

Many states already have premium subsidy programs, and more are considering them. In the spring of 2008 several states considered, either as part of state-based commission recommendations, or as gubernatorial or legislative proposals, implementing a premium subsidy program for low-income individuals, including such states as Virginia, Colorado, Connecticut, Kansas, and Missouri, and the District of Columbia. While none were successfully enacted, their discussion and consideration demonstrates the popularity of this reform option.

Implementing a National Premium Subsidy Program

Given the widespread interest in premium subsidy programs, ASPE worked with The Lewin Group to design and model a national premium subsidy program. The premium subsidies, including individual/family contribution requirements, reflect the Massachusetts program's premium subsidy schedule, and the benefits mimic those included in the Massachusetts Commonwealth Care plans (see descriptions above).

For this analysis, subsidies could only be used for the purchase of coverage on the individual market; they could not be used toward the purchase of ESI. We assume the subsidies are funded in full by the Federal government, in order to provide cost estimates for a nationalized premium subsidy program. In addition, we include two variations of the program – one including a “crowd-out” provision and one without; both presenting coverage and cost results. A crowd-out provision is a mechanism designed to keep people from dropping private coverage in order to enroll in subsidized public coverage. This crowd-out provision utilized a requirement that individuals must be uninsured for at least six months prior to enrolling in the program (referred to as a waiting period). This eligibility requirement is meant to be a deterrent from dropping coverage, as it would require individuals to “go bare” for six months. While most premium subsidy programs include some kind of crowd-out provision to ensure they are not substituting public coverage for private coverage, we have also included coverage and cost estimates of a subsidy program without any such provisions in order to see the impact of the crowd-out provision.

Coverage Impact

A national premium subsidy program that includes the crowd-out provision described above would reduce the number of uninsured by approximately 15.5 million (Figure 1). Of the 18.2 million who enroll, 15.5 would have been previously uninsured, 1.5 million would drop non-group coverage and endure 6 months “bare” before enrolling, and 1.2 would drop group (employer) coverage and endure 6 months “bare” before enrolling. While the crowd-out provision does not entirely eliminate the phenomenon of people dropping private coverage for subsidized public coverage, these individuals make up less than 15% of the participating population.

A national premium subsidy program that does not include the crowd-out provision would result in a net reduction in the number of uninsured of only 7.5 million. This is because employers would be more inclined to drop their insurance coverage since there is no waiting period of uninsurance required before enrolling. As a result, while 15.5 million people who were previously uninsured will enroll in the program, 8 million people will become newly uninsured and not be eligible to enroll in the subsidy program or other public insurance programs. Overall, it is estimated that 43 million people will participate in the program, over 22 million of whom previously had employer coverage. Without the crowd out provision, previously insured people make up almost 64% of the participating population.

Figure 1. Changes in Enrollment under a Voluntary Subsidy Program With and Without a Waiting Period Requirement (in millions)

	With Crowd-Out Rules	Without Crowd- Out Rules
Number of People who take the Subsidy (< 300% of FPL)	18.2	43.0
Previously uninsured	15.5	15.5
Previously non-group	1.5	5.2
Previously ESI coverage	1.2	22.3
Workers and dependents whose employer drops coverage^{a/}	--	39.0
Take non-group coverage	--	27.8
Enroll in Medicaid and SCHIP	--	3.2
Go uninsured	--	8.0
Take up ESI coverage^{b/}	--	--
Currently decline ESI who take it	--	--
Firms who start offering coverage	--	--
Net Reduction in uninsured	15.5	7.5
Newly covered from Medicaid or SCHIP ^{b/}	--	--
Newly covered people eligible for subsidy	15.5	15.5
Newly covered people ineligible for subsidy ^{b/}	--	--
Become uninsured from employer dropping coverage	--	(8.0)

a/ Impact of insurance market reforms on employer coverage.

b/ Not applicable for these particular policy options.

Source: Lewin Group estimates using the Health Benefits simulation model (HBSM).

Cost Impact

A national premium subsidy program that includes the crowd-out provision described above would have a net federal cost of \$91.8 billion dollars and a net state savings of \$10.1 billion, for a total program cost of \$81.7 billion (Figure 2). States achieve savings as a result of reduced costs for state programs for the uninsured due to the decrease in the number of uninsured. In addition, both the federal and state governments achieve savings in the form of increased tax revenue. This tax revenue gain is the result of increased wages for employees as employers experience increased savings due to employees shifting from ESI to public coverage. Previously uncompensated care costs, born by federal and state governments as well as providers, are also reduced, achieving an additional \$15.7 billion in savings. These savings are achieved as a result of the reduction in hospital uncompensated care for un- and underinsured individuals, as well as a reduction in free care provided by health care professionals.

A national premium subsidy program that does not include the crowd-out provision would have a net federal cost of \$152.6 billion and a net state savings of \$8.3 billion, for a total program cost of \$144.3 billion. The state savings is less than with the crowd-out provision because the corresponding loss of ESI due to the lack of a waiting period for enrollment causes many people to lose coverage and subsequently enroll in Medicaid or SCHIP. This increased enrollment in Medicaid and SCHIP results in higher state program costs, reducing the savings achieved from lower state program costs and tax revenue gains. Previously uncompensated care costs are reduced by \$11.4 billion, which is less than the estimate for the subsidy program with the crowd out provision. Again, because employers are expected to drop coverage if there is no waiting period, some individuals will lose coverage and become uninsured because they would not be eligible for the subsidy or other public insurance programs.

Figure 2. Summary of Public Program Costs under a Voluntary Subsidy Program With and Without a Waiting Period Requirement (in billions)

	With Waiting Period	Without Waiting Period
Total Program Costs	\$81.7	\$152.6
Spending by Program		
Federal Government Costs	\$91.8	\$160.9
Medicaid/SCHIP Programs	N/A	\$8.0
Premium Subsidies ^{a/}	\$94.8	\$188.8
Tax Revenue Loss/(Gain) Due to Wage Effects	(\$3.0)	(\$35.9)
State and Local Government Costs	(\$10.1)	(\$8.3)
Medicaid/SCHIP Program	N/A	\$6.1
Other State Programs	(\$9.8)	(\$10.7)
Tax Revenue Loss/(Gain) Due to Wage Effects	(\$0.3)	(\$3.7)
Uncompensated Care		
Net Reduction in Previously Uncompensated Care	(\$15.7)	(\$11.4)

a/ Includes \$171 annual cost per family for determining eligibility and administering premium subsidies.

Source: Lewin Group estimates using the Health Benefits simulation model (HBSM).

Mandatory Section 125 Plans

Section 125 plans (sometimes referred to as cafeteria plans), so named after Section 125 of the Internal Revenue Code enacted by Congress in 1978, are benefit plans offered by employers to their employees that allow employees to pay for certain benefits on a pre-tax basis. When employers offer health insurance through a Section 125 plan, employees can pay for their share of the premium with pre-tax dollars which reduces their taxable earnings. This affords a significant cost savings, making coverage more affordable and encouraging individuals to purchase health insurance.

Group versus Non-group Coverage

As of the writing of this analysis, it is unclear how extending mandatory Section 125 plans to employees for the purchase of health insurance coverage on the individual (non-group) market fits with existing state regulations of the insurance market (Lewin, 2008). Whether or not the employee is enrolling in group versus non-group coverage is an important distinction, because insurers offering group plans through employers are required to follow a more stringent set of regulations than for non-group plans; group plan regulations provide significantly more protections for enrollees than non-group plans. For example, group plans cannot deny coverage to employees, cannot

charge higher premiums based on health status, and are limited in applying pre-existing condition exclusion periods.

Recently states have expressed interest in either allowing or requiring employers to establish Section 125 plans, and also allowing contributions from employers toward their employees' health insurance premiums for policies obtained through the individual market. This sort of arrangement is perceived as promoting health insurance coverage for employed individuals by reducing their out-of-pocket cost as a result of an employer contribution. At the same time, while employers may be willing to provide a contribution to coverage for their workers, offering health insurance as a benefit may be prohibitively expensive. Therefore, allowing employers to establish Section 125 plans for the purchase of coverage on the individual market, and in some cases making a contribution that an employee can use towards purchasing coverage, is thought to be a potential model for expanding coverage to the uninsured by making the purchase of health insurance more affordable.

There is no inherent conflict with state laws that allow employees to enroll in non-group coverage when there is an employer Section 125 plan. However, if the employer would like to make a contribution to that coverage then the law becomes less clear. Because of federal laws and regulations governing what constitutes group coverage, it is unclear if this arrangement would be legally permissible. While the employer would not be offering coverage through a group plan, the law has been interpreted such that it is generally understood that if an individual is enrolled in health insurance coverage that is being paid for in part or in full through a contribution from an employer, then it is considered group coverage (Department of Health & Human Services Health Care Financing Administration, 2000). As a result, states are concerned that insurers will be reluctant to sell health insurance policies to individuals who are seeking coverage on the individual market using funds from an employer to pay for the premium. Insurers would be apprehensive about extending coverage to these individuals because they must abide by group market regulations that are more stringent than individual market regulations.

Federal and state laws and regulations would need to be enhanced or clarified in order for employer contributions made through this arrangement to be used toward employee insurance purchases on the individual market. In the meantime, one state, Massachusetts, has merged their individual and group markets as part of their health reform initiative. In addition, coverage obtained by individuals

through the Commonwealth Connector, an independent state agency that assists residents in identifying and enrolling in health insurance, is considered group coverage, allowing employers to make contributions to their employees' premiums without having to offer and administer a health insurance benefit themselves.

A National Mandate for Section 125 Plans

Due to the recent interest in expanding Section 125 plans, ASPE worked with The Lewin Group to design and model a national mandate to establish Section 125 plans. For the analysis, we assumed employees would be purchasing coverage in the non-group market through an employer Section 125 plan, with no contribution from the employer. We provide two variations of the mandate – a mandate for employers with 10 or more employees and a mandate for all employers regardless of firm size. Both scenarios assume no contribution toward premiums on the part of the employer.

Coverage Impact

A national mandate to establish Section 125 plans for employers with 10 or more workers would reduce the number of uninsured by 4.2 million (Figure 3). Of the 50.1 million people who would newly participate in a Section 125 plan, 4.2 million would have been previously uninsured, 5.1 million would have been previously covered by a non-group plan, and 40.8 million would have previously been covered by ESI.

A national mandate to establish Section 125 plans for all employers would reduce the number of uninsured by 5.6 million (Figure 3). Of the 58.1 million people who would newly participate in a Section 125 plan, 5.6 million would have been previously uninsured, 6.7 million would have been previously covered by a non-group plan, and 45.8 million would have previously been covered by ESI.

Figure 3. Number of Workers and Dependents Effected By Mandatory Section 125 Plans (in millions)

	Section 125 Plans Required for Firms With 10 or More Workers	Section 125 Plans Required for All Firms
Number of People Newly Using Pre-Tax Dollars For Insurance Under Section 125 Plans	50.1	58.1
Previously uninsured	4.2	5.6
Previously non-group	5.1	6.7
Previously ESI coverage	40.8	45.8
Net Reduction in uninsured Due to Section 125 Plans	4.2	5.6

Source: Lewin Group estimates using the Health Benefits simulation model (HBSM).

Cost Impact

A national mandate to establish Section 125 plans would result in a significant cost impact regardless of the impact on the uninsured, because roughly 30 percent of workers who now have ESI are in a firm that has not established a section 125 plan (The Lewin Group, 2008). The introduction of such a plan would result in decreased federal income and payroll taxes, as well as reduced state revenues in states that base their taxable income on federal adjusted gross income. The magnitude of the revenue loss would depend on the extent to which the creation of new Section 125 plans encouraged individuals to purchase coverage through employer withholdings.

A national mandate to establish Section 125 plans for employers with 10 or more workers would have a net federal cost of \$26.1 billion dollars and a net state cost of \$2 billion, for a total program cost of \$28.1 billion (Figure 4). These program costs are the result of lost revenue in the form of income and payroll taxes, due to an increase in workers paying for health coverage with pre-tax dollars.

Like the subsidy programs, there is a reduction in previously uncompensated care costs due to a decrease in the number of uninsured. The reduction in uncompensated care costs under this scenario is \$1.4 billion.

A national mandate to establish Section 125 plans for all employers would have a net federal cost of \$32.2 billion and a net state cost of \$2.5 billion dollars, for a total program cost of \$34.7 billion (Figure 4). Because even more individuals participate in the Section 125 plans when all employers are required to offer them (as opposed to only firms with 10 or more workers), the revenue losses are even greater under this scenario. However, because the number of uninsured is further decreased, the reduction in uncompensated care is greater, totaling \$2.3 billion.

Figure 4. Summary of Public Program Costs with Mandatory Section 125 Plans (in billions)

	Section 125 Plans Required for Firms With 10 or More Workers	Section 125 Plans Required for All Firms
Total Program Costs	\$28.1	\$34.7
Spending by Program		
Federal Government Costs	\$26.1	\$32.2
Tax Revenue Loss Due to Section 125 Plans	\$26.1	\$32.2
State and Local Government Costs	\$2.0	\$2.5
Other State Programs	(\$0.9)	(\$1.1)
Tax Revenue Loss Due to Section 125 Plans	\$2.9	\$3.6
Uncompensated Care		
Reduction in Previously Uncompensated Care	(\$1.4)	(\$2.3)

Source: Lewin Group estimates using the Health Benefits simulation model (HBSM).

Employer Mandates

An employer mandate to provide health insurance coverage for employees can be implemented strictly as a mandate requiring compliance without any alternative options, or it can be implemented as a mandate to either provide coverage or pay a “penalty” in the form of a tax or assessment. If significant enough, the penalty could be used to subsidize coverage of the firms’ uninsured workers through an alternative insurance program. This type of arrangement is often referred to as a “pay-or-play” mandate. While there are only a handful of employer mandates in force around the country, only one is strictly a mandate to provide coverage; the others are of the “pay-or-play” variety. In addition, states and local jurisdictions, as well as

presidential candidates, are considering the benefits of imposing pay-or-play mandates on employers.

Employer mandates are meant to build upon the strong base of employer-sponsored insurance in the United States, expanding coverage to working individuals and families and reducing the number of uninsured. Proponents of employer mandates argue that the majority of covered individuals in the U.S. get their health insurance through their employer, making this approach to expansion the most practical and efficient. But opponents fear that employer mandates will have a negative impact on employment for low-wage workers. The increased expenditures associated with requiring employers to offer a new benefit could result in reduced wages, which would have a significant impact for low-wage earners. Some could see wages reduced further, restricting already tight budgets, while others may actually become unemployed as firms lay off minimum wage workers because they cannot reduce their wages any further and they cannot afford to retain the positions with an added insurance benefit (NBER, 2007).

ERISA Preemption

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal statute that regulates employer benefit plans, including health insurance benefits. It does not require that employers provide a health insurance benefit, but for those that do it standardizes the treatment and administration of the benefit. ERISA preempts all state laws that "relate to" an employee benefit plan, including health insurance benefits. Thus, when a state mandates that an employer administer a health benefit plan, it is considered to be in violation of ERISA because it "relates to" an employee benefit plan. However, until the state law is legally challenged in a court of law and the preemption is upheld, employers are obligated to comply with the state mandate. For example, in 2006 Maryland passed the "Fair Share Health Care Fund Act" that required all non-governmental employers with 10,000 or more employees to allocate 8% of the company's payroll to health care benefits. If they did not spend the required 8%, the firms would be required to pay into a fund the difference between what they did spend for their health insurance benefit and 8% of employee wages (in Maryland). The law was challenged in federal court, and it was found to be in violation of ERISA. As a result, it is not enforceable.

Existing Employer Mandates

Two states and one locality have successfully legislated and implemented employer mandates.

Hawaii. The oldest employer mandate that is still in place is in the state of Hawaii. In 1972 the legislature passed the Prepaid Health Care Act that requires certain employers to purchase health insurance for all employees who work at least 20 hours per week. Exempt employers include government entities and small family businesses. The mandate is enforced through audits, employer reporting, and data matching, and the penalty for noncompliance is the greater of \$25 per day or \$1 per day per employee not in compliance (Glied, Hartz, & Giorgi, 2007).

Hawaii's employer mandate does not violate ERISA because it received a special exemption granted by Congress. Even with the mandate, however, Hawaii still has an uninsured rate of 8.6% (CPS, 2007). This is because the mandate does not reach all uninsured populations, but rather focuses on full-time workers, and therefore does not create universal coverage in the state.

Massachusetts. In 2006 Massachusetts passed a comprehensive health reform bill that included an employer mandate. While it is technically a pay-or-play mandate, because the penalty amount for not "playing" is so small and not tied to payroll taxes it is referred to instead as a "fair share contribution" or an assessment. Employers with 11 or more full-time employees are required to have 25% of their employees enrolled in the employer-sponsored health benefit plan and pay for at least 33% of premiums (Marathas, Rachal, & Montgomery, 2008). If they do not meet these requirements, employers are required to make an annual "fair share contribution" of \$295 per employee. While technically this requirement could be challenged as a violation of ERISA, no such challenge has yet to be made, possibly because of the relatively low amount of the fees leading the business community to not object.

Massachusetts also requires all employers that have 11 or more employees and do not pay the full cost of health care premiums for employees to establish Section 125 plans so that their employees can purchase health insurance with pre-tax dollars. In addition, employers face a "free-rider" surcharge if their employees use a significant amount of health care services provided through state-funded programs. The surcharge amount is determined based on the number

of employees, the number of visits per employee, the cost of services per employee, and the percentage of employees enrolled in the employer-sponsored plan.

San Francisco. Also in 2006, San Francisco became the first city to mandate that employers make health insurance payments. The city ordinance requires that for-profit firms with 20 or more employees and non-profit firms with 50 or more employees make health insurance payments on behalf of any employee who has worked for the firm for 90 days or longer, works a minimum of 10 hours per week, and is located within the boundaries of the city and county of San Francisco. The ordinance requires an expenditure rate per employee of \$1.17 per hour for firms with 20 and 99 employees and \$1.76 per hour for firms with 100 or more workers, beginning April 1, 2008. The ordinance further requires that as of January 2009 the rates increase to \$1.23 per hour for firms with 20 to 99 employees and \$1.85 for firms with 100 or more employees.

Failed attempts. Several states have enacted and then repealed employer mandates in the past 20 years. Massachusetts, Oregon, Washington State, and California all passed legislation mandating employers to provide or contribute to the purchase of health insurance coverage for employees that was repealed before being enacted. While Massachusetts recently passed another employer mandate that has thus far been successfully implemented, California attempted for a second time in 2007 to pass an employer mandate but the legislation failed to garner enough support.

A National Employer Mandate

ASPE worked with The Lewin Group to model the coverage and cost impact of a national employer mandate. The first analysis is modeled after the Massachusetts "fair share contribution" requirement, with a \$295 assessment per employee for firms with 11 or more employees. In order to avoid the assessment, firms must offer coverage to all employees. Employees of firms paying the assessment are not automatically enrolled into an alternative insurance program and they remain uninsured. In addition to the \$295 assessment, we include coverage and cost estimated for an assessment of a 4% payroll tax.

We also provide the coverage and cost analysis for more significant assessments, ranging from a 6% to a 10% payroll tax, which

generates enough revenue to automatically enroll employees of firms paying the tax into a public insurance program.

Modest Fair Share Assessments

With assessments this small, workers of firms who pay the assessment are not automatically enrolled in an alternative plan. Assessments of this level do not generate enough revenue to cover enrollment into alternative insurance programs. Therefore, the reduction in the uninsured is fairly low, and the cost of the program is really born by employers and revenue generating for the government.

Coverage impact. An employer mandate with an assessment of \$295 per employee for firms with 11 or more workers would result in a net reduction in the uninsured of 900,000 (Figure 5). An additional 300,000 individuals would drop non-group coverage in order to enroll in an employer plan, resulting in 1.2 million people newly covered by ESI. Approximately 200,000 employees would take up coverage newly offered by firms that did not previously offer but implement a health insurance benefit as a result of the mandate, while approximately 700,000 previously uninsured individuals gain coverage as a result of an employer expanding coverage to part-time workers.

An employer mandate with an assessment of a 4% payroll tax for firms with 11 or more workers would result in a net reduction of the uninsured of 1.1 million, only 200,000 more than the \$295 assessment. As mentioned, a mandate with a fairly small penalty such as this does not create a significant reduction in the uninsured.

Figure 5. Changes in Enrollment under an Employer Mandate with Various Employer Assessments (in millions)

	\$295 per Worker per Year	4% Payroll Tax
Number of People Newly Covered by Employer by Prior Insured Status	1.2	1.5
Previously Uninsured	0.9	1.1
Previously Non-Group	0.3	0.4
Number of People Newly Covered by Employer by Employers Insuring Status	1.2	1.5
Currently Insuring Firms Offer Coverage to Part-time Workers	1.0	1.0
Previously Non-Insuring That Now Offer Coverage	0.2	0.5
Net Reduction in Uninsured	0.9	1.1

Source: Lewin Group estimates using the Health Benefits simulation model (HBSM).

Cost impact. This type of health reform initiative costs money for employers instead of the Federal and state governments. An employer mandate with an assessment of \$295 per employee for firms with 11 or more workers would generate net Federal revenue of \$3.1 billion and achieve net state savings of \$100 million, generating total government revenue of \$3.2 billion (Figure 6). A mandate with a 4% payroll tax assessment for firms with 11 or more workers would generate net Federal revenue of \$7.4 billion while costing states \$300 million, generating total government revenue of \$7.1 billion. With a 4% payroll tax, a significant number of employers elect to offer coverage instead of paying the tax, resulting in reduced wages. The effect of the reduced wages is substantial enough that states experience reduced income taxes, resulting in the mandate costing them more than they save in other state programs.

Employers, on the other hand, would see increased costs with a mandate and this level of penalty in place. Under an assessment of \$295 per worker, employers would spend an additional \$6 billion a year, while under a 4% payroll tax they would spend an additional \$14.6 billion.

Previously uncompensated care costs would decrease by \$400 million under a modest employer assessment.

Figure 6. Summary of Public Program and Employer Costs under Various Employer Assessment Amounts (in billions)

	\$295 per Worker per Year	4% Payroll Tax
Net Public Costs	(\$3.2)	(\$7.1)
Spending by Program		
Federal Government Costs	(\$3.1)	(\$7.4)
Employer Assessments	(\$3.2)	(\$11.7)
Tax Revenue Loss/(Gain) Due to Wage Effects	\$0.1	\$4.3
State and Local Government Costs	(\$0.1)	\$0.3
Other State and Local Programs	(\$0.1)	(\$0.2)
Tax Revenue Loss/(Gain) Due to Wage Effects	\$0.0	\$0.5
Change in Spending for Employers^{a/}		
Change in Spending for Employers	\$6.0	\$14.6
Currently Insuring Firms	\$2.5	\$2.6
Previously Non-Insuring Firms	\$3.5	\$12.0
Uncompensated Care		
Net Reduction in Uncompensated Care	(\$0.4)	(\$0.4)

a/ Includes public and private employers.

Source: Lewin Group estimates using the Health Benefits simulation model (HBSM).

Payroll Tax with Automatic Public Program Coverage

In order to have a significant impact on the uninsured, the penalty needs to be high enough to generate a significant amount of revenue that can be used to subsidize alternative coverage for employees of firms paying the tax. These employees could be enrolled in alternative programs such as a publicly administered insurance program or a state benefit plan. Typically, employer mandate penalties of this magnitude are implemented in the form of payroll taxes.

For this analysis, three different payroll taxes are applied: 6%, 8%, and 10%. Employers with 11 or more workers would be required to offer coverage and pay at least 75% of the premium, or else pay the payroll tax. Coverage must be offered to employees working 100 or more hours per month. Workers would be required to take the employer offer unless they have creditable coverage from another source, and workers of firms who pay the tax are automatically enrolled into a new publicly administered health insurance program. No subsidies are provided to employees for their share of the premium.

Coverage impact. With a payroll tax penalty between 6 and 10%, an employer mandate would result in a net reduction of the uninsured of 20.2 million (Figure 7). The reduction in the uninsured does not vary despite the range of the tax because the model assumes that all employees of firms with 11 or more workers are required to take coverage if offered and workers in firms that pay the penalty are automatically enrolled in the publicly administered program. This holds the number of newly covered individuals constant, but as the payroll tax increases the number of people gaining coverage through the publicly administered program decreases and the number gaining coverage with ESI increases. This is because it is assumed that the lower the payroll tax, the more likely firms would be to pay the tax instead of offering private coverage, while the higher the tax the more likely they would be to offer private coverage.

As indicated in Figure 7, with a 6% payroll tax, 66.4 million people would be covered in the publicly administered program, including 14.3 million previously uninsured, while 115.9 million workers would have ESI coverage, including 5.9 million previously uninsured. With an 8% payroll tax, 37.1 million people would be covered in the publicly administered program, including 10.6 million previously uninsured, while 145.2 million people would have ESI coverage, including 9.6 million previously uninsured. Finally, with a 10% payroll tax only 21.7

million people would be covered in the publicly administered program, including 8.1 million previously uninsured, while 160.6 million would have ESI coverage, including 12.1 million previously uninsured.

Figure 7. Changes in Enrollment under an Employer Mandate with Various Payroll Tax Assessments (in millions)

	6% Payroll Tax	8% Payroll Tax	10% Payroll Tax
Number of People Covered Under Public Program	66.4	37.1	21.7
Previously Uninsured	14.3	10.6	8.1
Previously Non-Group	2.3	1.5	1.1
Previously ESI Coverage	49.8	25.0	12.5
Number of People Covered by Employer	115.9	145.2	160.6
Previously Uninsured	5.9	9.6	12.1
Previously Non-Group	1.8	2.6	3.1
Previously ESI Coverage	108.2	133.0	145.4
Number of People Affected by Employer Decision			
Insuring Firms - Continue to Offer	115.2	143.1	157.4
Insuring Firms - Pay Tax	56.9	29.0	14.7
Previously Non-Insuring - Offer Coverage	0.7	2.1	3.2
Previously Non-Insuring - Pay Tax	9.5	8.1	7.0
Net Reduction in Uninsured	20.2	20.2	20.2

Source: Lewin Group estimates using the Health Benefits simulation model (HBSM).

Cost impact. Overall, the net public cost of the program decreases as the payroll tax penalty for the mandate increases. With a 6% payroll tax, the net public program cost totals \$165.1 billion, while the net public cost with a 10% payroll tax is only \$57.2 billion (Figure 8). Net Federal costs for administering the public insurance program are reduced by employer and employee premiums, and range from \$176.2 billion with a 6% payroll tax to \$63.4 billion with a 10% payroll tax. State and local governments achieve savings as the result of increase tax revenues as employers pass on some of their savings to employees in the form of higher wages.

Overall, employers would see a reduction in spending with a 6% or 8% payroll tax. Firms that currently offer would see a reduction in health spending by electing to pay the payroll tax instead of administering a health insurance benefit that far outweigh the cost of the payroll tax; these savings would offset the costs incurred by newly offering firms, resulting in overall savings for employers. The lower the payroll tax, the higher the savings achieved for employers. With a 6% payroll tax, employer spending overall would decrease by \$98.6 billion; it would decrease by \$20.5 billion with an 8% payroll tax. However, with a

10% payroll tax, employers would be spending an additional \$10.2 billion overall because savings achieved by currently insuring firms would not offset spending by newly insuring firms.

Previously uncompensated care costs would decrease by between \$9.9 and \$13.1 billion.

Figure 8. Summary of Public Program and Employer Costs under an Employer Mandate with Various Payroll Tax Assessments (in billions)

	6% Payroll Tax	8% Payroll Tax	10% Payroll Tax
Net Public Costs	\$165.1	\$88.4	\$57.2
Spending by Program			
Federal Government Costs	\$176.2	\$96.3	\$63.4
Public Program Benefits & Admin.	\$332.9	\$191.8	\$122.0
Employer & Employee Premiums	(\$124.6)	(\$86.4)	(\$58.3)
Tax Revenue Loss/(Gain) Due to Wage Effects	(\$32.1)	(\$9.1)	(\$0.3)
State and Local Government Costs	(\$11.1)	(\$7.9)	(\$6.2)
Other State and Local Programs	(\$7.6)	(\$6.8)	(\$6.0)
Tax Revenue Loss/(Gain) Due to Wage Effects	(\$3.5)	(\$1.1)	(\$0.2)
Change in Spending for Employers^{a/}			
Change in Spending for Employers	(\$98.6)	(\$20.5)	\$10.2
Currently Insuring Firms	(\$114.2)	(\$40.8)	(\$12.6)
Previously Non-Insuring Firms	\$15.6	\$20.3	\$22.8
Uncompensated Care			
Net Reduction in Uncompensated Care	(\$13.1)	(\$10.6)	(\$9.9)

a/ Includes public and private employers.

Source: Lewin Group estimates using the Health Benefits simulation model (HBSM).

Individual Mandate

Under an individual mandate to purchase health insurance, individuals would be required by law to obtain health insurance coverage. A mandate of this kind would be precedent setting (Tanner, 2006). As noted by CBO in 1994, "the government has never required people to buy any good or service as a condition of lawful residence in the United States" (Hartman & van de Water, 1994). Thus far, only one state, Massachusetts, has legislated an individual mandate for health insurance coverage. As one component of their comprehensive health care reform program, Massachusetts has implemented an individual mandate that requires all residents in the state to have health insurance or pay a financial penalty. Tax filings are used to verify coverage, and exemptions are made when the cost of coverage does not meet the affordability standards defined by the state.

The Role of a Mandate

An individual mandate is meant to address the phenomenon of “free-riders,” or individuals without coverage who nonetheless access care but do not have the financial resources to pay for it. The cost of this “uncompensated care” is paid for through increased provider rates, higher insurance premiums, and Federal and state subsidy programs for health care institutions that are funded with taxpayer dollars. It is believed that if all individuals are insured, uncompensated care costs will be reduced or eliminated, thus decreasing provider rates and health insurance premiums and abolishing the need for Federal and state uncompensated care subsidy programs.

In addition, because many of the uninsured are young and healthy individuals who forgo coverage due to a perceived lack of health care needs, the covered population tends to be disproportionately sicker. By requiring the young and healthy to enroll, their participation in health insurance pools will spread the risk and reduce adverse selection. Their good health will improve the overall health rating of the pool, reducing overall premium costs.

However, a mandate for coverage does not guarantee access to health care for everyone. Many individuals have coverage, whether public or private, and still have limited or no access to certain providers and specialists because their insurer’s provider network does not have contracts with an adequate number of these types of doctors or practices. As well, purchasing health insurance does not necessarily relieve the purchaser of some out-of-pocket costs associated with the services they receive. Many policies have deductibles and almost all have co-payments, which for some may make accessing care unaffordable. So while individuals would be fulfilling their legal obligation to be covered by purchasing a policy, they would not necessarily have improved their circumstances for accessing medical care.

A National Individual Mandate

ASPE worked with The Lewin Group to design and model a national individual mandate for the purchase of health insurance. The key design elements of the model include:

- Premium subsidies – full premium subsidies are available to those below 150% FPL, while availability of premium subsidies for those with incomes between 150% and 300% FPL is on a

sliding scale basis with the subsidy decreasing as income increases (same as outlined for the Health Insurance Premium Subsidy Programs section);

- Mandate exemption – Individuals and families with incomes above 300% FPL would be exempt from the mandate if their premiums would exceed a certain percent of their income, as outlined in the following table:

Income as Percent of FPL	Premium as Percent of Income
300% - 350%	5.5%
350% - 400%	6.5%
400% - 500%	7.5%
500% - 600%	8.6%
Above 600%	No exemption

- Insurance market reforms – guaranteed issue is required for all insurers, and premiums cannot vary by health status; and
- Crowd out – to prevent the substitution of private coverage for public coverage, individuals must be without insurance for 6 months or longer to be eligible for the subsidy program.

Several design specifications were varied to produce a series of coverage and cost estimates. Consistently using the above four design elements, The Lewin Group modeled the individual mandate with the following five variations on enforcement mechanisms:

- Penalty – mimicking the Massachusetts program, individuals who do not obtain coverage are subject to a penalty equal to one half the cost of insurance under the minimum standard plan (same as the minimum benefit requirements outlined in the Health Insurance Premium Subsidy Programs section), except as exemptions apply (see above);
- Automatic enrollment through the tax system – based on tax filings, individuals would be enrolled in an insurance program;
- Automatic enrollment through other income tested programs – individuals would be identified and enrolled in an insurance program based on participation in various publicly funded programs such as food stamps and other social services programs;
- Automatic enrollment through the school system – all school-aged children and their parents would be enrolled if the parents or responsible adults could not show proof of insurance coverage; and

- Combined approach – automatic enrollment would occur through all three mechanisms described above.

Cost and Coverage Impacts

As indicated, the cost and coverage estimates vary based on the type of enforcement mechanism modeled. The results are presented below for each variation.

Individual mandate with a penalty. Establishing an individual mandate enforced by a penalty equal to one-half the cost of insurance would result in a net reduction in the uninsured of 22.3 million people (Figure 9). Under the mandate 16 million previously uninsured individuals would gain coverage in the premium subsidy program. Of the remaining 3.4 million people who would enroll in the subsidy program, 1.9 million would have previously had ESI coverage and 1.5 million would have previously had non-group coverage. In addition, 2.1 million people would be newly covered by Medicaid and SCHIP and 4.6 million people would gain coverage despite not being eligible for the subsidy program.

Approximately 300,000 individuals who previously would have been covered by ESI would become uninsured, and 100,000 who previously would have been covered by non-group coverage would become uninsured, resulting in 400,000 newly uninsured individuals. These are primarily individuals who would not be eligible for the subsidy and for whom the cost of coverage exceeds the cost of the penalty.

Figure 9. Changes in Enrollment under an Individual Mandate with Various Mandate Enforcement Mechanisms (Includes Premium Subsidy Program) (in millions)

	Penalty for Being Uninsured	Automatic enrollment through the tax system	Automatic enrollment through other income tested programs	Automatic enrollment at school	Combined Approach
Number of People who take the Subsidy (< 300% of FPL)	19.4	25.0	19.0	19.3	25.2
Previously uninsured	16.0	21.6	15.7	16.0	21.8
Previously non-group	1.5	1.5	1.5	1.5	1.5
Previously ESI coverage	1.9	1.9	1.8	1.8	1.9
Workers and dependents whose employer drops coverage ^{a/}	3.5	3.5	3.5	3.5	3.5
Take non-group coverage	3.0	3.2	2.8	2.7	3.2
Enroll in Medicaid or SCHIP	0.2	0.2	0.3	0.3	0.2
Go uninsured	0.3	0.1	0.4	0.5	0.1
Take up ESI coverage	2.6	4.3	1.7	2.4	4.4
Currently decline ESI who take it	2.0	3.7	1.1	1.8	3.8
Firms who start offering coverage ^{a/}	0.6	0.6	0.6	0.6	0.6
Net Reduction in uninsured	22.3	36.9	22.1	24.6	38.0
Newly covered under Medicaid or SCHIP	2.1	6.6	5.2	5.7	7.4
Newly covered people eligible for the subsidy	16.0	21.6	15.7	16.0	21.8
Newly covered people ineligible for subsidy	4.6	8.8	2.7	4.2	8.9
Uninsured from employer dropping coverage	(0.3)	(0.1)	(0.5)	(0.5)	(0.1)
Uninsured from dropping non-group coverage	(0.1)	(0.0)	(1.0)	(0.8)	(0.0)

a/ Impact of insurance market reforms on employer coverage.

Source: Lewin Group estimates using the Health Benefits simulation model (HBSM).

An individual mandate enforced by a penalty equal to one-half the cost of insurance would have a net Federal cost of \$70.8 billion and a net state savings of \$8.9 billion, for a total program cost of \$61.9 billion (Figure 10). As with the previously discussed premium subsidy program, states achieve savings as a result of reduced costs for state programs for the uninsured due to the decrease in the number of uninsured, and both the federal and state governments achieve savings in the form of increased tax revenue as a result of higher wages. The Federal government also achieves savings of \$22.1 billion resulting from penalty payments. Uncompensated care costs are reduced by \$18 billion.

Figure 10. Summary of Public Program Costs under an Individual Mandate with Various Mandate Enforcement Mechanisms (Includes Premium Subsidy Program) (in billions)

	Penalty for Being Uninsured	Automatic enrollment through the tax system	Automatic enrollment through other income tested programs	Automatic enrollment at school	Combined Approach
Total Program Costs	\$61.9	\$108.3	\$89.5	\$90.1	\$111.8
Spending by Program					
Federal Government Costs	\$70.8	\$116.1	\$96.2	\$97.9	\$118.5
Medicaid and SCHIP Programs	\$3.5	\$10.0	\$8.5	\$7.5	\$11.9
Premium Subsidies ^{a/}	\$91.3	\$107.4	\$90.4	\$93.1	\$108.1
Penalty for Remaining Uninsured ^{b/}	(\$22.1)	--	--	--	\$0.0
Tax Revenue Loss/(Gain) Due to Wage Effects	(\$1.9)	(\$1.3)	(\$2.7)	(\$2.7)	(\$1.5)
State and Local Government Costs	(\$8.9)	(\$7.8)	(\$6.7)	(\$7.8)	(\$6.7)
Medicaid and SCHIP Programs	\$2.6	\$7.7	\$6.4	\$5.6	\$9.0
Other State Programs	(\$11.3)	(\$15.3)	(\$12.8)	(\$13.1)	(\$15.5)
Tax Revenue Loss/(Gain) Due to Wage Effects	(\$0.2)	(\$0.2)	(\$0.3)	(\$0.3)	(\$0.2)
Uncompensated Care					
Reduction in Previously Uncompensated Care	(\$18.0)	(\$25.1)	(\$18.9)	(\$19.0)	(\$25.6)

a/ Includes \$171 annual cost per family for determining eligibility and administering premium subsidies.

b/ Assumes that 90 percent of the penalties owed are collected.

Source: Lewin Group estimates using the Health Benefits simulation model (HBSM).

Individual mandate with automatic enrollment through the tax system. An individual mandate enforced with automatic enrollment through the tax system would result in a net reduction of the uninsured of 36.9 million people (Figure 9). Over twenty-one and a half million previously uninsured people would participate in the subsidy program, 6.6 million would gain coverage through Medicaid and SCHIP, and 8.8 million would gain private coverage despite not being eligible for the subsidy program. Approximately 100,000 people who previously would have had ESI coverage would become uninsured.

While this enforcement mechanism achieves the greatest reduction in the uninsured of the four individual mandate enforcement mechanism variations modeled, it does not cover everyone because non-tax filers and non-residents would not be captured in the system.

An individual mandate enforced with automatic enrollment through the tax system would have a net Federal cost of \$116.1 billion and a net state savings of \$7.8 billion, for a total program cost of \$108.3 billion (Figure 10). States would experience an increase in Medicaid and SCHIP expenditures totaling \$7.7 billion, while achieving over \$15 billion in savings in other state programs. Previously uncompensated care costs would be reduced by over \$25 billion.

Individual mandate with automatic enrollment through other income tested programs. An individual mandate enforced with automatic enrollment through other income tested programs would result in a net reduction in the uninsured of 22.1 million people (Figure 9). Over fifteen and a half million previously uninsured people would participate in the subsidy program, 5.2 million would gain coverage through Medicaid and SCHIP, and 2.7 million would gain private coverage despite not being eligible for the subsidy program. Approximately 1.5 million people who previously would have had ESI or non-group coverage would become uninsured.

The program would have a net Federal cost of \$96.2 billion and a net state savings of \$6.7 billion, for a total program cost of \$89.5 billion (Figure 10). States would experience an increase in Medicaid and SCHIP expenditures totaling \$6.4 billion, while achieving almost \$13 billion in savings in other state programs. Previously uncompensated care costs would be reduced by almost \$19 billion.

Individual mandate with automatic enrollment through schools. An individual mandate enforced with automatic enrollment through schools would result in a net reduction in the uninsured of 24.6 million

people (Figure 9). Sixteen million previously uninsured people would participate in the subsidy program, 5.7 million would gain coverage through Medicaid and SCHIP, and 4.2 million would gain private coverage despite not being eligible for the subsidy program. Approximately 1.3 million people who previously would have had ESI or non-group coverage would become uninsured.

The program would have a net Federal cost of \$97.9 billion and a net state savings of \$7.8 billion, for a total program cost of \$90.1 billion (Figure 10). States would experience an increase in Medicaid and SCHIP expenditures totaling \$5.6 billion, while achieving over \$13 billion in savings in other state programs. Previously uncompensated care costs would be reduced by \$19 billion.

Combined approach. An individual mandate enforced using a combined approach of all three automatic enrollment mechanisms would achieve the greatest coverage, with a net reduction in the uninsured of 38 million people (Figure 9). Almost 22 million previously uninsured people would participate in the subsidy program, 7.4 million would gain coverage through Medicaid and SCHIP, and 8.9 million would gain private coverage despite not being eligible for the subsidy program. Approximately 100,000 people who previously would have had ESI coverage would become uninsured.

The program would have the largest price tag, as well, with a net Federal cost of \$118.5 billion and a net state savings of \$6.7 billion, for a total program cost of \$111.8 billion (Figure 10). States would experience an increase in Medicaid and SCHIP expenditures totaling \$9 billion, while achieving \$15.5 billion in savings in other state programs. Previously uncompensated care costs would be reduced by \$25.6 billion.

A Model Combining Certain Features of the Massachusetts Plan

The Commonwealth of Massachusetts is being watched closely after the recent implementation of their health care reform initiative. In April 2006 the Commonwealth enacted legislation that is aimed at providing nearly universal coverage for their residents. There are many different components to the plan, many of which we have discussed and modeled in previous sections of this paper. Due to the extraordinary interest in the impact of this reform effort, ASPE worked with The Lewin Group to model a national health reform initiative with many, but not all, of the elements in the Massachusetts plan.

Features

The features included in the combined model include: an individual mandate, insurance market reforms, premium subsidies for low-income populations, mandatory Section 125 plans, an employer mandate, and a creditable coverage requirement.

Individual mandate. All individuals would be required to obtain health insurance coverage or pay a penalty equal to one half the cost of coverage (less any subsidy they could have received). The mandate would be enforced through automatic enrollment facilitated through the tax system, other income tested programs, and schools. Individuals in families with incomes between 300% and 600% FPL would be exempt from the mandate, and could elect to remain uninsured, if the cost of coverage exceeded a certain percentage of income, ranging from 5.5% for the lowest income families to 8.6% for higher income families.

Insurance market reforms. The insurance market would be modified to assure that all individuals can obtain coverage. The reform would require guaranteed issue, so that no one could be turned down for coverage for any reason. Also, premiums could not be varied based on health status. These protections would ensure individuals could obtain the necessary coverage to meet the individual mandate requirements.

Premium subsidies. Premium subsidies would be provided for individuals in families earning up to 300% FPL. Those with income below 150% FPL would receive fully subsidized premiums, while those with incomes between 150% and 300% FPL would receive a partial subsidy that decreases as income increases. The amount of the individual contribution to the premium would be equal to between 2 and 5 percent of income, with the remainder being covered by the subsidy.

Mandatory Section 125 plans. Employers with 10 or more workers would be required to create Section 125 plans so that their employees could purchase health insurance coverage using pre-tax dollars.

Employer mandate. Like the Massachusetts program, employers would be assessed a \$295 fair share contribution for each employee who does not have health insurance coverage. Firms are not assessed the fee if they offer coverage to all employees and pay at least 33% of the premium. Uninsured workers of firms who pay the assessment are

not automatically enrolled into an alternate coverage program. The assessments would be used to fund, in part, the premium subsidies for low-income families (see above).

Creditable coverage. The mandate for coverage includes a defined benefits package, which must be met to meet the coverage obligation and to receive the premium subsidy (for those eligible). The benefit package required to be eligible for the subsidy is modeled after the Massachusetts Commonwealth care plans, described in the Health Insurance Premium Subsidy Programs section. For those not eligible for the subsidy, creditable coverage would be a benefit package that is actuarially equivalent to the Federal employees' BlueCross Blue Shield standard plan. This is estimated to have an actuarial value at approximately the 60th percentile of employer health plans (Lewin, 2008).

Excluded features. The features of the Massachusetts plan that were not included in our combined model consist of an expansion of the State Children's Health Insurance Program (SCHIP), improved Medicaid and SCHIP provider payment rates, and the creation of a health insurance "connector" program.

Coverage Impact

A national combined health care reform initiative modeled after the Massachusetts plan would reduce the number of uninsured by 39.4 million (Figure 11). Over twenty million previously uninsured individuals would be newly covered with the premium subsidy, 7.4 million would gain coverage from Medicaid and SCHIP, and 11.7 million would gain private coverage despite not being eligible for subsidized or public coverage. Approximately 100,000 individuals would become newly uninsured as a result of their employer dropping coverage.

Figure 11. Changes in Enrollment under a Combined Reform Approach (in millions)

	Change in Coverage
Number of People who take the Subsidy (< 300% of FPL)	23.3
Previously uninsured	20.4
Previously non-group	1.4
Previously ESI coverage	1.5
Workers and dependents whose employer drops coverage ^{a/}	2.2
Take non-group coverage	2.0
Enroll in Medicaid/SCHIP	0.1
Go uninsured	0.1
Take up ESI coverage	8.3
Currently decline ESI who take it	5.2
Previously ineligible workers now offered coverage	1.4
Firms who start offering coverage	1.7
Net Reduction in uninsured	39.4
Newly covered under Medicaid/SCHIP	7.4
Newly covered people eligible for the subsidy	20.4
Newly covered people ineligible for subsidy	11.7
Uninsured from employer dropping coverage	(0.1)
Uninsured from dropping non-group coverage	(0.0)

a/ Impact of insurance market reforms on employer coverage.

Source: Lewin Group estimates using the Health Benefits simulation model (HBSM).

Cost Impact

A national combined health care reform initiative of this magnitude would have a net federal cost of \$155.8 billion dollars and a net state savings of \$2.4 billion, for a total program cost of \$153.4 billion (Figure 12). States would achieve a savings of \$15.6 billion as a result of reduced spending on other state and local programs, but would incur expenditures totaling \$9 billion for the increased enrollment in Medicaid and SCHIP. Previously uncompensated care would be reduced by almost \$26 billion.

Figure 12. Summary of Public Program Costs under a Combined Reform Approach (in billions)

	Change in Health Spending
Net Public Costs	\$153.4
Change in Spending by Program	
Federal Government Costs	\$155.8
Medicaid and SCHIP Programs	\$11.9
Premium Subsidies	\$103.0
Penalty for Remaining Uninsured	\$0.0
Employer Assessments for not Offering Coverage	(\$2.9)
Tax Revenue Loss from Mandatory Section 125 Plans	\$41.9
Tax Revenue Loss/(Gain) Due to Wage Effects	\$1.9
State and Local Government Costs	(\$2.4)
Medicaid and SCHIP Programs	\$9.0
Other State and Local Programs	(\$15.6)
Tax Revenue Loss from Mandatory Section 125 Plans	\$4.1
Tax Revenue Loss/(Gain) Due to Wage Effects	\$0.1
Uncompensated Care	
Net Reduction in Uncompensated Care	(\$25.9)

Source: Lewin Group estimates using the Health Benefits simulation model (HBSM).

Conclusion

This analysis included a range of health care reform options with widely varying cost and coverage impacts. Figure 13 summarizes some of the key data from each, including the net reduction in the uninsured, as well as the cost to the Federal and state governments. As expected, the most comprehensive reforms, particularly when combined, often result in the greatest reduction in the uninsured and have the highest price tag. In addition, the details of the reform can have a significant impact on the outcome. For example, a voluntary subsidy program that includes a provision to reduce the likelihood of crowd-out results in a reduction in the uninsured of 15.5 million at a cost of \$81.7 billion; without this provision the same reform only reduces the uninsured by 7.5 million but costs \$144.3 billion. It is evident that the specific design elements greatly influence the return on investment in terms of maximizing coverage based on spending.

In addition to those analyzed here, there are a variety of other health care reform proposals that we did not discuss. Indeed, the list of issues to be considered in order to embark on national health care reform is significant. While states will continue to consider proposals and some may successfully legislate reforms, it remains to be seen if

there is enough political will to launch a comprehensive transformation nationally, particularly given the potential cost.

Figure 13. Summary of Selected Data Elements

	Net Reduction in Uninsured (millions)	Federal Cost (billions)	State & Local Cost (billions)
Health Insurance Premium Subsidy Programs			
With Crowd-Out Rules (Waiting Period)	15.5	\$91.8	(\$10.1)
Without Crowd-Out Rules (Waiting Period)	7.5	\$160.9	(\$8.3)
Mandatory Section 125 Plans			
Firms With 10 or More Workers	4.2	\$26.1	\$2.0
All Firms	5.6	\$32.2	\$2.5
Employer Mandates			
Enforced with Assessment of \$295 Per Worker Per Year	.9	(\$3.1)	(\$0.1)
Enforced with Assessment of 4% of Payroll Tax	1.1	(\$7.4)	\$0.3
Enforced with Assessment of 6% of Payroll Tax	20.2	\$176.2	(\$11.1)
Enforced with Assessment of 8% of Payroll Tax	20.2	\$96.3	(\$7.9)
Enforced with Assessment of 10% of Payroll Tax	20.2	\$63.4	(\$6.2)
Individual Mandate			
Enforced with a Penalty for Being Uninsured	22.3	\$70.8	(\$8.9)
Enforced with Automatic Enrollment Through the Tax System	36.9	\$116.1	(\$7.8)
Enforced with Automatic Enrollment Through Other Income Tested Programs	22.1	\$96.2	(\$6.7)
Enforced with Automatic Enrollment at School	24.6	\$97.9	(\$7.8)
Enforced with a Combined Approach	38.0	\$118.5	(\$6.7)
Model Combining Certain Feature of the Massachusetts Plan			
Individual Mandate, Insurance Market Reform, Premium Subsidies, Section 125 Plans, Employer Mandates, & Creditable Coverage	39.4	\$155.8	(\$2.4)

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