Affording Shared Responsibility For Universal Coverage: Insights From California

To determine what level of costs for health coverage and out-of-pocket spending are “affordable,” and by whom, old partisan dogmas must be put aside.

by Rick Curtis and Ed Neuschler

ABSTRACT: This paper presents key insights from California’s recent experience in developing a plan for universal health coverage with “shared responsibility” among individuals, employers, and governments. A major challenge was finding an acceptable balance among the goals of affordability, equity, and cost to the state. Although reform did not pass, the state’s approach—particularly differences from Massachusetts regarding modest-income workers and related employer and public roles—provides important insights for federal reform. [Health Affairs 28, no. 3 (2009): w417–w430 (published online 24 March 2009; 10.1377/hlthaff.28.3.w417)]

Key proposals at the federal level (including those of Senators Max Baucus [D-MT], Edward M. Kennedy [D-MA], and President Barack Obama) to ensure that all Americans have health coverage involve “shared responsibility” among individuals, employers, and government. Interest in a shared-responsibility approach to achieving universal coverage has mounted ever since Massachusetts passed landmark legislation in 2006 to move toward universal coverage through a combination of reforms involving individual, government, and employer responsibilities.

However, no other state has Massachusetts’ combination of high incomes, low uninsurance rate, sizable existing federal waiver funds, and high health care and coverage costs. Relatively few Massachusetts workers with employer-sponsored coverage have incomes under its income threshold of 300 percent of the federal poverty level for subsidies (Exhibit 1), so Massachusetts had less need to balance employer and public responsibilities for modest-income workers.
California, on the other hand, has a large low-income population and high
uninsurance rate. Although reform was not enacted, California’s 2007 effort may
offer lessons that are more generally applicable. It also underscored the fiscal real-
ity that most states cannot afford universal coverage without federal policy
changes regarding employer and federal financing. Also, California’s ultimate fail-
ure to enact reforms underscores the need for responsive federal financing during
economic downturns.

**Why California’s compromise plan was not enacted.** The final compromise
bill, backed by Republican Gov. Arnold Schwarzenegger and Assembly Speaker
Fabian Núñez, passed the Assembly in December 2007. For a variety of fiscal and po-
litical reasons, it failed in the Senate Health Committee in January 2008, as Califor-
nia’s budget picture was rapidly deteriorating.

California’s legislature faced unique constraints: raising taxes in California re-
quires either a two-thirds majority in both legislative houses or a direct vote by
the people, and Republicans opposed to any new taxes held more than one-third of the seats in each house. This situation strongly influenced the legislative leadership's initial proposals and led to the separation of the necessary revenue provisions from the final bill, which instead referenced a separate ballot initiative.

Given uncertainty over out-year costs, there was concern that the (already filed) initiative left no flexibility for any adjustments in applicable revenues from employers or hospitals (which had insisted on such restrictive language). And it would face a legal challenge under the federal Employee Retirement Income Security Act (ERISA)—which preempts state regulation of employer benefit plans.1

Some labor groups opposed the package as placing too much responsibility on individuals and on the state general fund and not enough on employers. The State Council of the influential Service Employees International Union (SEIU) was opposed until its president was forced out in early December 2007. Also, some key Democrats wanted (only) a Canadian-style single-payer system, while Republicans uniformly opposed new taxes.

There was concern that the initiative was slated for the November 2008 ballot in the midst of turmoil over the state budget and would face well-financed opposition from the state Chamber of Commerce, which opposed employer-pay minimums; the tobacco industry, which opposed tobacco-tax financing; a major nurses union, which opposed anything other than a single-payer approach; and Blue Cross of California (WellPoint), which opposed the insurance market reforms. Although a broad coalition, including SEIU, Consumers Union, AARP, several major health plans, and local business groups, expressed support for the final package, it was too little, too late.

■ Purpose. Although California's compromise package was not enacted, elements of that package provide important insights for federal reforms. If “shared responsibility” is to be the common-ground approach that brings all Americans into coverage, difficult design issues must be addressed to arrive at a workable construct. Finding an acceptable balance among the goals of coverage affordability, equity, and cost to the state is a major challenge. We believe that California's design for shared responsibility was a workable approach, although some choices made were inherently subjective, and others were imperiled by federal constraints.

Our purpose here is to examine the design of key interrelated issues and provide insights into the substantive as well as subjective considerations involved, focusing on the working population above the federal poverty level. The insights we share derive from our role in providing technical assistance and analysis to senior state health officials in 2005 and 2006 during the development of the governor's plan, and to the legislative leadership's professional health staff from December 2006 through January 2008, as the State Assembly and Senate refined their own proposals and as the legislative and executive branches sought to identify a workable and mutually acceptable coverage package.
Elements Of California’s Shared-Responsibility Approach To Universal Coverage

The basic components of California’s shared-responsibility approach to coverage, agreed on by Governor Schwarzenegger, Speaker Núñez (D), and (during 2007) Senate President Pro Tem Don Perata (D), were the following: (1) individuals’ responsibility to obtain health coverage; (2) employers’ responsibility to make meaningful payments toward health coverage costs, either directly or by paying a payroll fee to the state, and to make tax sheltering available for workers’ premium payments; and (3) government’s responsibility to ensure affordable coverage by subsidizing low-income residents and by providing ready access to coverage through market reforms and via a state purchasing pool.2

Some important elements in the overall package are beyond the scope of this paper, including cost containment and quality improvement initiatives, increases in Medi-Cal (Medicaid) provider payments, and expanded public coverage for children and childless poor adults. Other revenue sources included a tobacco tax increase, federal matching funds, and hospital fees, representing hospitals’ “shared responsibility” to return some of the savings realized from reduced uncompensated care.

Counties were also to contribute to state coverage subsidies for low-income adults through a reallocation of county charity and indigent care funds. This requirement prompted concern regarding the viability of public hospitals and other safety-net providers whose newly insured patient base might shift to other providers. To address this concern, policymakers adopted an approach analogous to that in Massachusetts, which initially contracted only with existing Medicaid plans and specified public-provider plans to enroll subsidy recipients. In California, counties with public hospitals were allowed to establish “local coverage option” programs that for the first four years would be the exclusive coverage option for childless poor adults (newly covered under Medi-Cal expansions).3

Affordability Of Coverage For Individuals

If government is to require individuals to have health insurance, then it needs to ensure that coverage is available and affordable relative to income.

- **Individuals not eligible for employer coverage.** Subsidies for low-income people.

One major concern was the affordability of health coverage for low-income individuals without access to employer coverage. Governor Schwarzenegger’s January 2007 reform plan proposed providing subsidies for adult legal residents with incomes up to 250 percent of poverty. The state’s legislative leaders initially proposed providing subsidies up to 300 percent of poverty, as Massachusetts does.4 But 48.7 percent of nonelderly Californians had incomes below 300 percent of poverty in 2006, compared to only 35.9 percent in Massachusetts.5 This would have necessitated greater budget costs, with fewer taxpayers above the subsidy level. However, there was less
need to subsidize higher-income people because health insurance is less expensive in California than Massachusetts (average single-coverage premiums among private-sector employers in 2005 were $4,235 per year in Massachusetts and $3,823 in California).6

California policymakers compromised on the governor’s upper limit of 250 percent of poverty for broad government subsidies with free coverage for those earning less than 150 percent of poverty and the legislature’s limit of 5 percent of income for contributions.7 This is comparable to levels specified for Massachusetts by its Health Insurance Connector Authority: people earning 200–250 percent of poverty pay specified dollar amounts that range between 3.6 percent and 6.6 percent of income, depending on family size and income.8

Although an estimated 95 percent of residents, and 98 percent of documented adults and all children, were projected to have health coverage under California’s reforms, the treatment of undocumented immigrants was an important and sensitive issue in California—where noncitizens without green cards are estimated to represent 7.4 percent of all state residents under age sixty-five and 24.3 percent of the uninsured.9 California’s plan granted public coverage to low-income undocumented children but not to undocumented adults (who were expected to seek care from the county). The final compromise exempted from the mandate those with incomes below 250 percent of poverty whose premiums would exceed 5 percent of their income—essentially, undocumented people not eligible for subsidies.10

For others not receiving state-subsidized coverage, Governor Schwarzenegger’s proposal required people to purchase, at a minimum, insurance with a deductible (if any) not exceeding $5,000 per year. The rationale was that people should be responsible for having insurance for catastrophic costs that—if uninsured—could be “cost-shifted” to insured people and employer plans.

Credits for moderate-income people facing unaffordable premiums. A pressing concern California addressed quite differently than Massachusetts did was affordability of coverage for those with incomes above the low-income subsidy threshold. Some would face premiums that were unaffordable (relative to their incomes) because of their age or family size. Massachusetts established an affordability schedule and waives its individual mandate for state residents with incomes below a specified ceiling whose premium cost would exceed a designated amount. The ceiling ranges from 505 percent of poverty for a single person to 625 percent of poverty for a family of three. Many Massachusetts residents with incomes above 300 percent of poverty but below the ceiling, and without access to employer coverage, qualify for waivers from the individual mandate.

Some California groups advocated the adoption of Massachusetts-like “affordability waivers.” The governor resisted such proposals, believing that they would undermine his goal to create a “culture of coverage” and reach universal coverage. Instead, the governor proposed tax credits for those who would otherwise have to
pay more than the specified percentage of income for coverage.

The tax-credit concept was a critical breakthrough. By addressing real concerns about the affordability of coverage for moderate-income people, the tax credit made a broad individual mandate more acceptable. California’s consideration of the tax-credit concept involved several important issues.

First, what plan provides the basis for determining credit amounts? The governor proposed his $5,000 deductible minimum plan, but legislative constituencies were concerned about the affordability of out-of-pocket costs and argued against high-deductible insurance. Ultimately, he agreed to base tax-credit amounts on a “mid-range” plan with lower cost sharing. Maximum credit amounts in the final compromise were based on premiums for a $2,500 deductible plan with primary and preventive services covered outside the deductible.

Second, California policymakers had previously decided to allow age rating for nonsubsidized people, so that premiums for young adults would not increase greatly. Given lower premiums for younger people, the relatively low-cost plan basis, and assumed savings from Section 125 plan tax sheltering (which employers were required to offer to all workers), only older people and large families would face coverage costs high enough to get sizable tax credits. Consequently, state costs for tax credits would be relatively modest, and few employers would be induced to drop coverage or employer contributions for their employees. The estimated annual cost of tax credits under California’s final compromise ($415 million) was only about one-eighth the estimated cost of subsidies for low-income people in the purchasing pool ($3.2 billion)—a salient point for future efforts.

Third, to ensure that tax credits would work for those who needed them, the credits were to be both refundable (that is, payable even if no other taxes are owed) and payable in advance. Such tax credits are typically very expensive to administer (for example, the federal health coverage tax credit for displaced workers) and are often subject to abuse when applicable to myriad vendors. To avoid these problems, the tax credit would be available only through the state pool, whose core functions (enrollment, premium collection, and plan payment) could ensure efficient administration.

In their final form, California’s tax-credit provisions were structured so that those with incomes of 250–300 percent of poverty and without access to employment-based coverage could purchase a “mid-range” plan for a net cost not exceeding 5.5 percent of their income. From 300 percent of poverty to the 400 percent ceiling, the credit was reduced on a sliding scale to be worth half as much at 400 percent of the poverty level as at 300 percent. This structure in effect “phased in” age rating, which might be of interest to policymakers elsewhere. As incomes rise, the tax credit phased down, reducing the degree to which it reduced the net premium differential by age. The effects of California’s tax credit and Section 125 tax savings on age-rated coverage costs for a fifty-seven-year-old at 275 percent of poverty is shown in Exhibit 2.
The final bill also addressed affordability for higher-income older people (who faced the highest premiums), while retaining low rates for those under age thirty (who have lower incomes and high uninsurance rates). California regulatory agencies were directed to establish a maximum limit on the ratio between the standard premium rates for those ages 60–64 to standard rates for those ages 30–34. Other market reforms generally assured ready access, regardless of health status.16

Individuals with lower incomes who are eligible for employer coverage. A critical, and difficult, policy question is whether and how to subsidize coverage for lower-income workers and their dependents who are offered but cannot afford coverage from their employer. This question involves horizontal equity—treating people in similar financial circumstances similarly—and the state’s fiscal need to avoid “crowd-out”—substituting state financing for employer financing—which could result from a decline either in how many employers offer health coverage or in how many workers take up coverage. As discussed below, California dealt with these issues differently from Massachusetts.

Preventing public subsidies from crowding out employer coverage. The potential shift from employer to public financing is particularly important where subsidies are broadly available up to income levels at which many have employer coverage. (Even at 100–300 percent of poverty, twice as many nonelderly Americans have employer coverage as are uninsured, and others decline employer coverage available to them.)17

The risk of crowd-out was greater in California than in Massachusetts. The percentage of nonelderly Massachusetts residents with employer coverage who had incomes of 100–300 percent of poverty was only 17.6 percent—the lowest of

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**EXHIBIT 2**

**Premiums And Offsetting Tax Subsidies Under California Reforms For A Fifty-Seven-Year-Old Worker With Income At 275 Percent Of The Federal Poverty Level**

<table>
<thead>
<tr>
<th>Data element</th>
<th>Percent of income</th>
<th>Percent of premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual income (earnings)</td>
<td>$28,078</td>
<td>100.0%</td>
</tr>
<tr>
<td>Annual premium</td>
<td>5,400</td>
<td>19.2</td>
</tr>
<tr>
<td>Federal and state tax savings from use of Section 125 plan</td>
<td>1,472</td>
<td>5.2</td>
</tr>
<tr>
<td>Tax credit amount (per ABX1 1)</td>
<td>2,506</td>
<td>8.9</td>
</tr>
<tr>
<td>Net cost to purchaser, after tax savings</td>
<td>1,423</td>
<td>5.1</td>
</tr>
<tr>
<td>Total premium subsidy</td>
<td>3,977</td>
<td>14.1</td>
</tr>
</tbody>
</table>

**SOURCE:** Author’s illustration based on final compromise bill (ABX1 1) in California.

1Not applicable.
2Illustrative premiums are based on age-rated premiums for Blue Cross of California’s PPO Share 2500 Plan in Sacramento, California, as of September 2007. This plan has a $2,500 annual deductible, which does not apply to physician office visits or to specified preventive services.
3Taxpayer’s effective marginal tax rate, incorporating federal income tax, federal FICA (Social Security and Medicare) tax, California state income tax, and California state disability-income payroll tax.
any state (Exhibit 1). Thus, most Massachusetts employer plans have few workers who would be income-eligible for publicly subsidized coverage expansions. In California, this proportion was 26.3 percent—nearly 50 percent larger and close to the national average of 27.3 percent. Among legal-resident California adults at 100–300 percent of poverty (who could qualify for subsidized coverage or full tax credits), almost twice as many have employer coverage as are uninsured.18

Massachusetts gave priority to avoiding short-term crowd-out. Workers who are eligible for employer coverage are generally not eligible for Commonwealth Care, the new subsidized coverage program for residents under 300 percent of poverty. Many workers could qualify for affordability waivers from the state’s individual mandate, because average worker contributions for employer coverage in Massachusetts exceed the affordability schedule for single workers and married couples below 250 percent of poverty and for families below 300 of poverty.19

The “firewall” between employer- and state-subsidized health coverage in Massachusetts, together with significant contribution requirements for Commonwealth Care enrollees with incomes greater than 200 percent of poverty, apparently prevented crowd-out through the first year of implementation: workers’ take-up of employer coverage increased, while the percentage of workers offered employer coverage remained stable.20

Horizontal equity: combining subsidies and employer contributions. California policymakers faced severe constraints on their ability to raise new revenues and sought to avoid crowd-out of employer-group financing, but California’s governor and legislative leaders were also concerned about horizontal equity. They thought that it would be unfair to establish a Massachusetts-style firewall that would deny state assistance to lower-income working parents who were eligible for employer coverage but faced much higher out-of-pocket costs (plus reduced wages that offset employer contributions) than similar workers in the subsidized pool.21 They also thought that exclusion from public subsidies could create powerful longer-run incentives for low-income workers and their employers to arrange for jobs ineligible for employer coverage. Thus, a firewall policy intended to prevent shifts from employer to state financing could ultimately exacerbate those incentives.

For these reasons, California policymakers sought a workable way to combine employer contributions and public subsidies for low-income workers eligible for employer coverage. Governor Schwarzenegger proposed that such workers could enroll in the subsidized-pool coverage, with their employers transferring a contribution to the pool. However, ERISA precludes the state from requiring employers to do so. An alternative was to make workers’ access to subsidized-pool coverage contingent on an employer’s voluntary payment, but such voluntary contributions are generally not eligible for federal Medicaid matching funds.

Speaker Núñez’s bill instead included “premium assistance” to offset low-income workers’ contribution costs for employer coverage, making state subsidies contingent on enrolling in that coverage. The administration opposed this ap-
approach because it would be administratively cumbersome and expensive, so the parties sought an alternative approach that would be simpler and lower-cost for the state. Because of uncertainties regarding both ERISA and federal matching-fund rules, the final compromise bill directed state agencies to find some way to combine state subsidies and employer contributions, and it granted authority to establish pertinent requirements for health insurer roles.

**Shaping Employers’ Financial Responsibilities**

In addition to the common-ground appeal of “shared responsibility,” California had pragmatic reasons for requiring financial contributions from employers. First, California simply could not finance replacement of existing employer contributions for lower-income workers. Establishing minimum payment levels for all employers would reduce incentives to drop employer coverage and shift workers to state-subsidized coverage. Second, California, like most states other than Massachusetts, needed additional state revenue to provide coverage subsidies for low-income workers. (Massachusetts adopted only a de minimus employer contribution requirement.) Third, California public opinion polls indicate broad support for requiring employers to contribute toward health coverage.

Support for mandatory employer contributions came from, among others, labor groups that would otherwise oppose the plan and a Safeway-led coalition of employers that provide coverage to their workers. They wanted to preclude an unfair competitive advantage for employers that contribute little or nothing, send their workers to state-subsidized programs, or shift costs to other employers via spouses’ employer coverage.

Given a consensus for meaningful employer financial responsibility, California’s decisions regarding the nature and level of such requirements were influenced by ERISA considerations as well as economic and political concerns regarding the level(s) and application of the employer payroll fee.

**Issues related to ERISA.** Although ambiguities in the federal statute make almost any state approach uncertain, the employer “pay-or-play” construct in California’s plan was designed to defend against an inevitable court challenge under ERISA. It was therefore deemed important that the preponderant purpose and effect of any pay-or-play requirement be to produce revenues to finance subsidies for low-income people rather than to force changes in employer-sponsored plans.

California’s “pay-or-play” plan would require all California employers to pay the state sliding-scale percentages of the employer’s aggregate payroll. Amounts that a “play” employer spent on health services for its employees and dependents would be credited against the amount the employer owes the state.

Employers’ percentage-of-payroll minimum requirements were set high enough to produce meaningful revenue toward low-income subsidies but low enough that most employers currently offering coverage would not have to spend more on their health plans to comply with the required minimum. California’s
payroll fees and worker subsidies were also structured to avoid creating incentives for higher-wage employers to alter or drop their existing plans (which also avoids associated risk-selection problems). Such employers’ percentage-of-payroll amount would be high compared to subsidy benefits for their relatively few low-wage workers.

Conversely, the lower the firm’s average wage, the lower the percentage-of-payroll fee. A 6 percent fee on $15,000 (per worker) is only $900—far less than the actual cost of coverage. Where most of a business’s workers have incomes low enough to qualify for publicly subsidized coverage, the employer group would have a “pay” option to reduce the health cost component of total compensation.

California’s employer percentage-of-payroll fee compromise. Governor Schwarzenegger initially proposed that employers not offering health coverage pay a modest 4 percent of the employer’s aggregate Social Security payroll to the state.24 About 17 percent of California businesses offering coverage contribute less than 4 percent of Social Security payroll toward its cost.25 To avoid new costs for very small employers, he proposed to exempt businesses with fewer than ten workers from the payroll fee. California’s legislative leadership proposed a higher payroll fee (7.5 percent of Social Security payroll) and fewer exemptions. About 38 percent of California employers offering coverage now contribute less than 7.5 percent.26 The initial bills’ sole revenue source was employer fees, used exclusively to subsidize coverage of workers of fee-paying employers. This approach made the employer assessment a “fee” subject to a simple-majority-vote rule under California law, rather than a tax requiring a two-thirds “supermajority” to enact, but it meant that the plan covered fewer uninsured people than the governor’s plan did.

Legislative constituencies were also concerned that under the governor’s proposal, offering employers would find ways to make their low-income workers ineligible for employer coverage while still spending enough on health care for their higher-income workers to meet an aggregate percentage-of-payroll spending test. Low-income workers would be shifted to publicly subsidized coverage with no attendant employer fee. To address this and to obtain “fair share contributions” from all employers of part-time workers, early legislative bills included a second employer test for spending on part-time workers.27 Alternative approaches were subsequently explored, such as basing the second test on workers with low earnings rather than part-time status, or just monitoring to determine whether crowd-out was occurring.

The administration insisted that as long as an employer met an overall health spending test, it should not be subject to any other state requirements. This approach, they reasoned, was less vulnerable to an ERISA challenge and less likely to be opposed by employers already making substantial contributions that might be burdened by the second test. To reach agreement, the Assembly acquiesced.

The final compromise reflected the governor’s desire not to unduly burden very small businesses and labor’s insistence on higher payment minimums for large em-
ployers. It established the percentage-of-payroll standard as a sliding scale based on aggregate Social Security payroll (Exhibit 3). (Note that the concentration of workers in small firms with lower rates greatly reduced revenues.) Using aggregate payroll avoided both the administrative complexities associated with fluctuating employer sizes and unjust preferential treatment for small, high-wage firms over larger low-wage firms.

**Implications**

If federal policymakers are to adopt a “shared responsibility” construct to bring uninsured Americans into coverage, they will need to address the largely subjective question: What level of costs for health coverage and out-of-pocket spending is “affordable,” and by whom? California’s serious effort and ultimate failure underscore that workable answers to this question can be found if (but only if) old partisan dogmas are put aside.

Massachusetts found common-ground answers to this difficult question. But it did not adopt measures to make coverage affordable for modest-income working people; instead, it allows some of them to remain uninsured by granting “affordability waivers.” For example, those with incomes just above the eligibility threshold for subsidized comprehensive coverage can remain uninsured without penalty if they would have to pay more than the affordability schedule amounts for individual coverage. (Primarily older individuals, couples, and larger families with incomes somewhat above 300 percent of poverty could qualify.)

California’s plan offers ideas for federal policymakers who prefer to make coverage relatively affordable for such populations. California included affordability tax credits for those with incomes above the threshold for subsidized comprehensive coverage. State costs and employer crowd-out incentives were constrained by tying credit amounts to premiums for a health plan with a sizable deductible and

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**EXHIBIT 3**

**Estimated Payroll Fee Receipts From California Employers By Aggregate Payroll Brackets**

<table>
<thead>
<tr>
<th>Employer’s aggregate annual (Social Security) payroll</th>
<th>Applicable payroll assessment rate (%)</th>
<th>Estimated aggregate payroll of fee-paying employers ($ billions)</th>
<th>Estimated payroll fee revenue ($ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$250,000</td>
<td>1.0</td>
<td>33.6</td>
<td>336</td>
</tr>
<tr>
<td>$250,000–$1,000,000</td>
<td>4.0</td>
<td>13.4</td>
<td>535</td>
</tr>
<tr>
<td>$1,000,001–$15,000,000</td>
<td>6.0</td>
<td>10.9</td>
<td>656</td>
</tr>
<tr>
<td>&gt;$15,000,000</td>
<td>6.5</td>
<td>1.6</td>
<td>102</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>59.5</td>
<td>1,629</td>
</tr>
</tbody>
</table>

**SOURCES:** See below.

*Unpublished estimates by Jonathan Gruber.
by phasing out the credit as income rose.

State costs for the credit were also greatly reduced because they were based on premium costs after assumed (largely federal) tax savings made available through Section 125 plans (which employers were required to make available to all workers, including those ineligible for employer coverage and purchasing individual coverage). As in Massachusetts, this new and substantial tax savings was an important selling point to make the individual mandate palatable for people not eligible for other subsidies.

At the federal level, such broad extension of Section 125 plans would be a major new tax expenditure rather than a budget saver. On the other hand, by reconfiguring the existing regressive distribution of tax benefits for health insurance, Congress could greatly reduce or even obviate the need for a separate affordability credit. Further, if federal tax credits are used to make coverage affordable for modest-income populations, they need to be both refundable and payable in advance. To achieve timely, efficient, and accountable administration of such credits, policymakers should consider adopting California’s plan to extend credits exclusively through its pool—that is, through the “exchange(s)” in pending federal proposals.

To reduce short-run crowd-out of employer coverage, Massachusetts adopted a “firewall” denying subsidized coverage to lower-income workers eligible for employer coverage (although they are eligible for an “affordability waiver” if their contribution requirements are too high). California instead sought to assure affordable access and “horizontal equity” for such people, and it investigated alternative ways to harness rather than to crowd out employer contributions by combining them with state subsidies for low-income workers. The final plan deferred the selection of a specific course because traditional premium assistance acceptable under Medicaid and State Children’s Health Insurance Program (SCHIP) rules is administratively burdensome and costly, and because federal law constrains simpler approaches at the state level.

Simple, efficient and fair approaches might either (1) allow any low-income worker or dependent to enroll in subsidized coverage and, where they do so, require the employer to pay either a defined fee or its normal contribution; or (2) provide defined sliding-scale credits for lower-income workers choosing to enroll in employer coverage to offset their costs (whether in the form of premium contributions, other cost sharing, or wage concessions). At the state level, the former approach would be highly vulnerable to an ERISA challenge, while the latter would not qualify for federal matching funds unless a highly uncertain waiver were granted. A federal reform plan could include either or both approaches.

Federal policymakers considering meaningful employer requirements may find California’s approaches and levels, and the perspectives that drove them, instructive. However, the specific provisions were framed in an effort to avoid federal preemption under ERISA, and before the current wave of corporate bankruptcies.
As the California effort demonstrated, development of a shared-responsibility framework brings into painful relief how high health care costs have become relative to personal incomes. However, we are optimistic that Americans are more likely to make the difficult decisions necessary to constrain future health care spending if costs are more explicit under a framework of shared responsibility than if we continue supporting our failing labyrinth of cross-subsidies, hidden costs, and rising numbers of uninsured people.

California’s worsening fiscal plight underscores two facts: individual state economies are more volatile than the national economy, and states cannot incur deficits even when virtually all economists agree that government action is needed to stimulate a deteriorating economy. Even a high-income state like Massachusetts needed its large block of federal waiver funds. Whatever state roles are ultimately allowed or encouraged, a federal plan and financing are needed to achieve and sustain a shared-responsibility framework for coverage.

Preparation of this paper, and the multiyear technical-assistance project on which our insights are based, was supported by the California HealthCare Foundation. The authors led an interdisciplinary project team that included Massachusetts Institute of Technology economist Jonathan Gruber; who provided cost and population estimates with actuarial analysis from Jim Mays and Cathi Callahan (Actuarial Research Corporation); Susan Marquis (RAND, retired); and independent consultants John Grigurina, Cecil Bykerk, and Patricia Butler. They were fortunate to work with highly capable state professionals dedicated to understanding the probable implications of alternative measures and to developing workable and sustainable policies, including California legislative leadership health staff Sumi Sousa, Scott Bain, and David Panush, and executive branch officials Kim Belshé, Ana Matosantos, Sandra Shewry, Lesley Cummings, Ruth Liu, and John Ramey. Sumi Sousa, Bob DiPrete, Elliot Wicks, and Andrei Javier provided helpful review and comments.

NOTES
3. A summary of costs and revenues for the overall package is available in Supplemental Chart 1, and a summary of where the uninsured were estimated to obtain coverage is in Supplemental Chart 2. Both are available in the online appendix at http://content.healthaffairs.org/cgi/content/full/hlthaff.28.3.w417/DC2.
4. Subsidized coverage for children in families up to 300 percent of poverty, regardless of immigration status, was included in all proposals.
7. References to the “final compromise” are based on the text of Assembly Bill No. 1 in the 2007–08 First Extraordinary Session (ABX1 1) of the California Legislature, as amended in the Senate, 16 January 2008, http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_0001-0050/abx1_1_bill_20080116_amendedSen_v95.pdf
10. The only other waiver to the mandate was an individual exception for “undue hardship.”
12. This was the PPO Share 2500 Plan offered by Blue Cross of California as of September 2007.
13. Section 125 of the Internal Revenue Code allows workers to exclude from taxable income contributions to health insurance premiums.
17. In 2006, 44.4 million nonelderly Americans with incomes at 100–300 percent of poverty had employment-based insurance, while only 22.8 million in that income range were uninsured. Authors’ analysis using CPS Table Creator, 2007 (as in Note 5).
19. Inflating average worker contributions in Massachusetts (AHRQ, MEPS employer survey, 2005) at 7 percent per year yields $94 per month for single coverage, $192 for worker-plus-one coverage, and $310 for family coverage for 2008.
23. San Francisco’s “Health Care Security Ordinance,” currently in force while en banc review by the U.S. Court of Appeals (9th Circuit) is pending, takes a different tack. It requires a minimum-wage-like per hour employer payment to the city where an employer does not otherwise spend at least that amount on health care for its workers. The revenues are used to finance access to the city’s public provider network for such workers on a sliding-scale payment basis.
24. In 2008, the “Social Security wage base” is limited to $102,000. This limit avoids ERISA and health cost problems that would result from inducing high-wage employers to increase their already high ERISA-plan spending.