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CALIFORNIA HEALTH CARE DEFORMINATOR MODEL ABX1 1

by john r. graham

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MODEL ABX1 1

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California Health Care Deforminator Model ABX1 1

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< THE HEALTHY CALIFORNIA SERIES >

This is a briefing paper in the Pacific Research Institute's *Healthy California* series. *Healthy California* is a line of health policy research that addresses issues of immediate concern to Californians. These occasional papers look at the effects of government intervention in Californians' health care, and propose reforms based on individual choice and competitive markets.

Threat Assessment >> Health System Death Spiral

Californians entered 2007 hopeful that Governor Arnold Schwarzenegger and legislative leaders would collaborate to find real solutions to overcome the “root causes” of rapidly increasing health costs, the growing number of uninsured, and the rise in small businesses increasingly unable to provide health benefits. Instead, they got a proposed tax increase.

The year closed with Governor Schwarzenegger and Assembly Speaker Fabian Nuñez conspiring to increase taxation and government spending by more than \$14 billion. Their legislation, ABX1 1, proposes increasing government health-care spending by 7 percent over current levels and drastically expanding government control over our health choices, while reducing competition and choice in health care. Individual Californians and small businesses will suffer the most from this “reform.” Among the flaws in ABX1 1 are:

- > It almost certainly violates federal law, specifically the Employee Retirement Income Security Act (ERISA). Federal courts have invalidated similar statutes in Maryland and San Francisco, although the latter is under appeal. California might somehow find a loophole through ERISA, but only after having frittered away taxpayers’ dollars on legal fees.
- > ABX1 1 is based on a gross misunderstanding of the role of the uninsured in driving health costs. The notion that the uninsured are flooding emergency rooms and causing hospitals to jack up charges for insured patients is incorrect; the “hidden tax” that the uninsured levy on the insured, which the governor now claims to be \$15 billion, is actually no more than about \$2.5 billion. Furthermore, the uninsured, as a group, pay extra income taxes that are at least three times as great as this “hidden tax.”
- > ABX1 1 levies new, *real* taxes from various sources: the federal government, tobacco, workers’ incomes, and perhaps the lottery, none of which are as secure sources of funding as ABX1 1’s proponents insist.
- > The increased taxes will kill between 50,000 and 100,000 jobs in California for each year ABX1 1 is in force.
- > Proponents grossly *underestimate* the future taxes and government-driven health costs that ABX1 1’s “reforms” will cause. If enacted, ABX1 1 will likely cost about \$36 billion in 2010 2.5 times as much as budgeted.
- > ABX1 1 will *not* significantly reduce the number of uninsured Californians any more than similar “reforms” in Hawaii and Massachusetts have done.
- > Besides seeking to levy new taxes, ABX1 1’s proponents ignore other harmful taxes that already exist some “hiding in plain sight,” that reduce Californians’ access to affordable health care:

- >> Government programs that grossly underpay hospitals, by a factor about ten times as great as the governor's "hidden tax," and which ABX1 1 will make worse by expanding Medi-Cal and Healthy Families;
 - >> The hidden tax of *over-regulation* of private health insurance-government interference that increases premiums by up to 30 percent;
 - >> The hidden tax of *over-insurance*, caused by government policies that deliver too many of our health-care dollars to third-party payers, resulting in 20 to 30 percent of health spending being wasted;
 - >> The hidden tax of California's harmfully high minimum wage, which prevents low-income earners from taking health benefits in lieu of cash wages; and
 - >> The state's "sick tax"—a tax on Californians' contributions to Health Savings Accounts (HSAs). HSAs return control over health spending to individuals, and for which the federal government has allowed pre-tax contributions since 2004.
- > ABX1 1 imposes a new, arbitrary regulation on health plans, a minimum medical loss ratio (the percentage of premium dollars that must be spent on medical care, as opposed to administrative costs) of 85 percent. This is an arbitrary accounting convention, with no relevance whatsoever to how Californians choose their health plans. Currently two of California's top ten health plans do not comply with this ratio, and three more are close to the brink. Enforcing this arbitrary accounting convention threatens to reduce competition in health insurance by *one-half*.
 - > ABX1 1 imposes the harmful regulations of *guaranteed issue* and *community rating* on the individual market. These regulations were imposed in the small-group market in 1993, resulting in higher premiums and reduced coverage for small businesses, and destroying association health plans. Individually purchased health insurance has been the safety net for Californians driven out of the small-group market by these harmful regulations. ABX1 1 tears away that net.

This paper proposes six alternatives, *real* reforms to private health insurance that will make health care more affordable and accessible to ordinary Californians.

- > First, impose no new taxes on Californians: it's time for our politicians to stop destroying our ability to take control of our own health spending.
- > Second, repeal the sick tax. California is one of the last states that continue to tax residents' HSA contributions. To increase awareness of this issue, the Pacific Research Institute has launched a California Sick Tax Clock on its Web site.
- > Third, allow low-income workers and their employers to credit health-plan premiums toward the state minimum wage.

- > Fourth, make health insurers compete according to customers' preferences, not government preferences. *At least*, the state should allow us the freedom to opt out of certain state mandates if we choose to.
- > Fifth, roll back guaranteed issue and community rating. If not for the small-group market overall, at least eliminate them for associations, so that Californians who affiliate through professional or other fraternal organizations can take advantage of group purchasing in a competitive market. For small businesses, *at least* allow insurers to risk-rate for smoking.
- > Finally, allow employers and employees the freedom to direct pre-tax premiums to the purchase of individual insurance, as a new Missouri law does. This will be especially valuable to small businesses that, increasingly, cannot afford small-group policies, but employ young workers who could buy low-cost individual policies.

Current Reform Status >> Fatal Error

Californians enter 2008 after a year of false starts and dead ends on the health-policy front. Governor Schwarzenegger declared 2007 to be the year of health reform but things did not go according to plan. In December, he finally endorsed a deeply flawed bill, ABX1 1, which was passed by the Democratic majority in the Assembly, but not by the Senate.

Last January, a colleague and I proposed five precise steps to help achieve the goal of increasing Californians' access to affordable, high-quality health care.¹

1. **Repeal the California "Sick Tax."** California is one of the last states that continue to tax residents on their out-of-pocket health spending. Since January 2004, the federal government has allowed every working-age American to deposit pre-tax dollars into a Health Savings Account (HSA) so to speak, a 401(k) for your health. This money is never taxed as long as you spend it on health care the key word being *you*. Patients, not government bureaucrats or health-plan employees, decide how it's spent. Californians need the same tax break from our state government.
2. **Health Opportunity Accounts (HOAs) for Medi-Cal.** California has a good number of Medicaid waivers from the federal government, but the state is not taking advantage of HOAs which are basically HSAs for Medicaid. The federal government has authorized these as pilot projects for ten states that want to empower Medicaid beneficiaries to make good health decisions. California has not applied to be one of them.
3. **Freeing Low-Cost Medical Clinics to Compete.** In many states, entrepreneurs are opening hundreds of convenient storefront medical clinics where straightforward, transparent pricing makes health care more accessible and affordable. In California, over-regulation of the profession of nurse practitioner hinders these innovators from competing. Although some operators are finding ways to overcome these obstacles, such regulatory restrictions deny important choices to California patients.²
4. **Making Health Insurers More Competitive.** California's over-regulation of health insurance increases prices by up to 30 percent, contributing greatly to the growing number of uninsured in our state, especially among the middle class, who could and likely would buy health insurance if it were more price-competitive. Fortunately, California has dodged two very expensive mandates in the individual market, guaranteed issue and community rating, but ABX1 1 threatens to impose them.
5. **Design a "California Connector" to Increase Choice in Health Insurance.** The federal tax code connects health insurance to employment, something that Americans would likely not tolerate for any other area of their private lives.

Massachusetts has instituted the “Commonwealth Connector,” through which employers’ contributions can be credited to a worker’s choice of individual health insurance. The Massachusetts plan has many drawbacks. It includes a significant tax increase (also called a “pay-or-play mandate”), and it forces beneficiaries to choose only from plans approved by the Connector’s board. Unfortunately, the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) proposed in ABX1 1 suffers the same drawbacks. Even so, a narrowly defined health-insurance exchange that would allow employed Californians to use pre-tax dollars to pay premiums for individual health insurance has significant merit. Previously, we were concerned about some of the regulatory implications of such an exchange, even without a pay-or-play mandate, but this new paper describes an innovation from Missouri (HB 818) that mitigates those concerns somewhat.

One year later none of these five goals have been achieved. Certainly, there were some legislative proposals in the right direction. However, these steps were taken by Republican senators and assemblymen, who are in the minority, and they did not get to the governor’s desk for signature. For example, Assemblymen Alan Nakanishi, Cameron Smyth, and Chuck DeVore and Senators Abel Maldonado and George Runner introduced bills to repeal the “sick tax” by harmonizing the state’s income-tax treatment of HSAs with the Internal Revenue Code. Assemblyman Ted Gaines introduced a bill to create a California health insurance exchange, and Assemblywoman Audra Strickland introduced legislation to implement HOAs as pilots in Medi-Cal. Many of these positive proposals were bundled into an omnibus health reform bill that was dashed against the rocks of the Assembly health committee during the special legislative session in November.

The governor’s proposal, launched last January and developed throughout 2007, was not bereft of good ideas. Indeed, he vetoed the Democrats’ initial health-reform bill (AB 8) which would have levied a significant tax increase to fund “universal” health care because it was too expensive (but he caved into their demands a few weeks later). He called for tax harmonization of HSAs and deregulation of the health professions, specifically asking that nurse practitioners be given more freedom to operate in “convenient clinics.” The Democratic leadership was able to buy into the latter reform, and even agreed to a task force to examine restrictions on the scopes of practice of health professionals.

Unfortunately, the governor headlined his original proposal with a massive tax hike, which eventually grew into a \$14-billion-a-year “solution” to a problem that even he (originally) believed cost only \$9.5 billion. Furthermore, he persistently refuses to admit that he has proposed a tax hike. Although the governor’s tax hike was less than the Democrats’, they both were motivated by the misguided goal of achieving “universal” coverage through government power instead of individual choice. As we prepared to close the door on 2007, Governor Schwarzenegger endorsed the tax-hiking ABX1 1, which the Assembly passed on December 17. However, the Senate declined to take it up until this year.

Nevertheless, observers expect the governor and the Democratic legislative leadership to continue to stumble toward compromise on the size and shape of the tax hike while agreeing on a statewide “system” that will bring about “universal” health care. Indeed, the goal of the failed special legislative session called in September was to forge such a compromise, legislating the design of the system and leaving the funding thereof to the people via a proposition in 2008.

As ABX1 1 stumbles around the political landscape, Californians are faced with the specter of any number of confusing health-reform initiatives on the November 2008 ballot although time is quickly running out for even that option.

As 2007 began, it appeared to be a year of hope for health reform. Where did it go wrong? Governor Schwarzenegger would have us believe that all is well: we are in the final steps of the march toward “universal” coverage that former President Teddy Roosevelt proposed in 1912. (Of course, Roosevelt lost that election.) Why is this goal still so difficult to achieve today? The first stop on our tour of the crash site is the erroneous, and remarkable, assumption that clouds both Governor Schwarzenegger’s and the Democratic leadership’s thinking on health reform: *that we are not spending enough money on health care*. The “solution,” of course, is to increase spending, by about 6 percent immediately, according to the governor’s initial plan.³ As the year went on, and more special-interest groups jumped on the bandwagon of “reform,” the projected cost increased from \$12 billion to over \$14 billion. Because Californians will not spend more on health care voluntarily, the governor and his allies in the Democratic Party, the unions, and business believe that the state must help us spend more via increased taxation.

Warning >> Unhealthy Tax Outbreak

Table 1 // ABX1 1, Health Care Security and Cost Reduction Act, Spending and Funding Sources for 2010, Proposed First Year of Operation

SPENDING			FUNDING		
Recipient	Amount (Billions)	Share of Spending	Source	Amount (Billions)	Share of Funding
Cal-CHIP Subsidies	(\$6.4)	44%	Federal Matching Funds	\$4.6	32%
Provider Payment Increases	(\$4.0)	28%	Employer Payroll Tax	\$2.6	18%
Medi-Cal/Healthy Families Expansion	(\$2.4)	17%	Hospital Tax	\$2.3	16%
Other (Unspecified)	\$0.03	0%	Tobacco Tax	\$1.5	10%
Administration	(\$0.9)	6%	Employees' Premiums	\$2.1	15%
Section 125 Deductions/Tax Credits	(\$0.73)	5%	County Clawback	\$1.0	7%
Total	(\$14.4)	100%	Other (Unspecified)	(\$0.2)	-1%
			Medi-Cal/Healthy Families Savings	\$0.5	3%
			Total	\$14.4	100%

SOURCE: ASSEMBLY ANALYSIS, AUTHOR'S ESTIMATES.⁴

Table 1 shows how the \$14.4 billion would be raised and how it would be spent. The biggest source of tax funding is the federal government: one-third of the take.

What would cause this waterfall of federal money? Surprisingly, although common sense would indicate that taxing *providers* of health care would be an ineffective way to increase the *supply* of health care, a trick of federalism can make this appear so. Although the California Medical Association declined to support a 2-percent revenue tax on physicians (resulting in the governor's dropping it), the California Hospital Association did come around to accepting the governor's proposed 4-percent fee on hospitals' net incomes—although with significant reservations.⁵ As shown in Table 1, this is estimated to raise \$2.3 billion in the first year, 16 percent of the entire take.

The tax can generate federal money if the U.S. secretary of health and human services (HHS) grants a waiver for the proposed reform. In that case, money that California levies churns through the Beltway in Washington, D.C., and picks up federal matching dollars. So, the hospitals figure that, while they would sow the wind of a provider tax, they would reap the whirlwind of federal dollars. Indeed, the hospital tax is swamped by \$4 billion in increased payments to providers who serve government plans like Medi-Cal and Healthy Families. Also, those programs enjoy expanded enrollment, throwing another \$2.4 billion into the pot.⁶ So, it is not surprising that California's hospitals are enthusiastic backers of "reform."

However, getting this federal money is less likely than previously thought. HHS Secretary Michael Leavitt stated last March that his initial assessment of the governor's original proposal would likely result in \$3.45 to \$3.7 billion of federal funding.⁷ However, the Bush administration has subsequently become a lot tougher on states' never-ending desire to raid the federal Treasury. President Bush launched his campaign for responsible federal health spending in August, with a letter to state Medicaid directors that, among other requirements, insisted that states enroll 95 percent of children *below* 200 percent of the Federal Poverty Line (FPL) in their State Children's Health Insurance Program (SCHIP) *before* signing up higher-income kids.⁸ Governor Schwarzenegger admitted at the time that it was impossible for California to achieve this standard.⁹

Indeed, between 58 and 67 percent of California's uninsured children are *currently* eligible for government-run health plans but are not enrolled.¹⁰ Despite this, ABX1 1 increases eligibility for one welfare program, Healthy Families, to 300 percent of the FPL and eligibility for the larger Medi-Cal (Medicaid) program to 250 percent of the FPL for parents and young adults. These proposed limits are 50 to 100 percentage points higher than current eligibility.

Since the president's initial directive to prevent the abuse of federal matching funds, he has been engaged in an epic struggle with the Democratic majority in Congress to prevent the inappropriate government takeover of our children's health care. So far, he is winning: Congress has not overridden his veto of the Democrats' bill to expand SCHIP.

So, Governor Schwarzenegger continues his somewhat unholy alliance with New York Governor Eliot Spitzer to do an end-run around the president's veto: both governors hunger for rich plates of federal dollars to achieve their visions of health reform.¹¹ Happily for taxpayers, it looks increasingly unlikely that President Bush will hand over anywhere near the quantities of our money they seek, despite Governor Schwarzenegger's continuing confidence that federal funds will ride to the rescue of the state's budget deficit.¹² California is already struggling with its current level of taxing, borrowing, and spending. Estimates of the deficit continue to grow, the latest being \$14.5 billion, so the likelihood that increasingly limited federal money can solve this problem is fading.¹³

The business community, which is supposed to pitch in \$2.6 billion, 18 percent of the total haul, is generally less enthusiastic than the hospitals. Not all employers will suffer this burden, but only those who do not provide at least an arbitrary, government-dictated level of health benefits to their employees— between 1 percent and 6.5 percent of payroll, depending on the size of the firm. Now, the "reform" embraces a polite fiction: that there is no literal tax hike on businesses—the politically riskiest part of the proposal. Initially, the governor carefully labeled it an "in-lieu fee" levied on payrolls of employers who do not offer health benefits in accord with his proposed mandate.¹⁴ Colloquially, we refer to this as a "pay-or-play" mandate.

Of course, if they had thought that the "fee" would stand so defined, it would have made compromise between the governor and Democratic leaders much easier, because they could have passed the reform without having to get the people's approval via a ballot initiative. However, if the "fee" is (properly) labeled a tax, California requires that it be passed by two-thirds of both legislative chambers. This is impossible to achieve without Republican legislative support, and all signals from the Republican caucuses to date are that their members are unified in opposition to this measure.

However, as both the governor and Democratic leaders have searched far and wide to identify possible sources of revenue to throw at their “reform,” the fiction that the “in-lieu fee” is not a tax has largely fallen away. The proponents have realized that whatever they call the tax hike, it will have to go before the people as a ballot initiative.¹⁵ Truth in advertising has unexpectedly come to the campaign. Having spent 2007 trying to build as large a coalition as possible for his plan, the governor finally succeeded in getting a few local chambers of commerce to sign on: San Diego, Los Angeles, and San José/Silicon Valley. At a Sacramento press conference with the governor on September 17, L.A. Chamber President Gary Toebben, obviously carefully coached, referred to the proposed payroll “fee,” which was then just 4 percent. Less well briefed, Chamber Chair David Fleming called it a “tax,” and the governor looked for a second as if he were going to terminate him—but he let it go.¹⁶

Certainly, as the year progressed, it began to appear that the governor might bring enough of the business community into his tent. Some of the natural opponents of a tax hike began to waver. The California Restaurant Association, the California Small Business Association, and the California Retailers Association test-ballooned the idea of a 1-percent sales tax to fund “universal” health care.¹⁷

However, various scholars also published estimates of the true costs of these proposed taxes. Even the class warriors at the UC Berkeley Center for Labor Research and Education understood that this tax hike would be a burden, although they sought to emphasize that neither businesses nor jobs would suffer too much.¹⁸ Labor Center Chair Ken Jacobs and colleagues figured that the short-term increase in business operating costs due to increased payroll taxes would be less than 1 percent, and even less than that in the medium term. This is because “*firms will largely shift health spending onto workers in the form of lower wages over time*” (emphasis added.)

Thus, amazingly, California’s largest pro-union research center promotes *wage cuts* as a major selling point of these tax hikes. Jacobs and his co-authors point out correctly that many American workers value comprehensive health benefits over wage increases. However, not all do, and this choice is an important freedom.

Take two widget-making companies in Oakland: one pays \$50,000 without health benefits and the other \$40,000 plus tax-free health benefits (which are worth \$10,000). Why do both exist? After all, employees of the former are paying about \$2,000 in extra income taxes. They are free to ask for benefits in return for a cut in wages of \$10,000, but they value \$8,000 in their pockets more than \$10,000 of health benefits. (We discuss this extra, voluntary income tax below.)

So, if a payroll tax to fund “universal” health care passes, many workers will see their wages cut against their will and will have to either move out of California or reduce their quality of life. Especially if they are young, we can expect them to choose to move to another state. Sure, we can expect older, sicker workers to come to California to replace them, but driving people across state lines is an expensive way to give them the choice between money wages and health benefits. Indeed, it would not result in a net increase in social welfare, either in California or in the states that export or import residents as a consequence of the policy, because of the significant friction costs of moving.

Not only would these proposed payroll taxes undoubtedly reduce workers’ wages, but scholarly analyses conclude that mandatory health costs would also result in job losses. Professors Katherine Baicker of Harvard

University and Helen Levy of the University of Michigan estimate that a nationwide pay-or-play mandate that imposed a tax of \$3 per hour would immediately cost 225,000 jobs among low earners, assuming that a 10-percent increase in labor costs reduces employment by 1 percent.¹⁹ Professors Richard Burkhauser and Kosali Simon of Cornell University use a similar dataset but a more detailed analysis, and conclude that job losses would total 325,000, even if firms employing fewer than 25 workers were exempt. If jobs are even more sensitive to artificially high labor costs than these researchers believe, then the numbers quickly become worse. If a 10-percent increase in labor costs reduces employment by 2 percent, 750,178 jobs disappear nationwide; and over a million jobs disappear if a 10-percent increase reduces employment by 3 percent.²⁰ For California alone, a back-of-the-envelope calculation results in estimates about one-tenth of these: between 75,000 and 100,000 jobs lost.

Looking beyond the generic labor force to examine the effects of a health tax on different sectors, the National Federation of Independent Business (NFIB) estimates that AB 8, the initial Democratic progenitor of ABX1 1, which included a 7.5-percent payroll tax, would have affected four out of five California businesses and killed 249,000 California jobs over five years, concentrated in the retail and construction industries. Employers' costs would be \$8.3 billion, of which about \$3 billion would be administrative costs of compliance—deadweight losses.²¹ Again, a rough back-of-the-envelope calculation of the effect of the currently proposed 6.5-percent payroll tax would shrink these figures by only about 13 percent: 216,000 jobs lost and increased employers' costs of \$7.2 billion, of which \$2.6 billion would be "administrivia." (Actually, as the payroll tax was reduced, these paper-shuffling costs would probably not shrink so much, because they would be more or less fixed. Indeed, they might be fixed *whatever* the level of the payroll tax.)

These three studies broadly agree with each other: a pay-or-play mandate hurts workers. Above and beyond their detailed conclusions, of course, is the fact that having a job with no health insurance is undoubtedly better than having *no* job and no health insurance.

Nevertheless, even if the proponents of "universal" care decide that they can lay no more pain on California's businesses and workers than a 6.5-percent payroll tax, they still need a couple of billion more dollars to complete their vision. Two recently introduced possible sources of cash are unlikely to make up the difference in a healthy way. The governor's proposal anticipated revenue from royalties earned by leasing out the state lottery to a private operator. The current alternative is similar, but substituted an increase in the tobacco tax of \$1.75 per package for lottery-leasing royalties.

In fact, both lottery and tobacco revenues are less certain than their proponents expect. Although he has apparently abandoned this plan for now, the governor initially anticipated earning \$2 billion from the lottery in the first year to fund part of his \$14-billion spending increase.²² However, because *any* of the previously suggested tax targets might come back on the menu as the proponents of "universal" health care struggle to decide how to put their tax hike on the ballot, it is worth examining lottery funding.

The California State Lottery was established in 1984 through Proposition 37, which increases funding to public education. At least 34 percent of lottery revenue must go to education, making up to 2 percent of California's school budget; but this was not enough. In 2000, Proposition 20, the Cardenas Textbook Act, increased the percentage of lottery revenues going to education and devoted 50 percent of the increase to schools and community colleges for instructional materials.²³

Even so, according to William Evans of the University of Maryland and Ping Zhang of the Public Policy Institute of California, earmarked lottery profits “can never become the major source of finance for public education.”²⁴ If the lottery weakens, state projects funded with lottery money wither along with it. The North Carolina state lottery earned 25 percent less than anticipated after its first full year. A recent exposé in the *New York Times* noted that in such situations states offer larger winnings to attract players, meaning less money for public spending and more money for gambling advertisements.²⁵

Other critics of lottery funding focus on the moral implications of expanding lotteries, especially their indirect “taxation” of low-income residents. “The lottery is a voluntary tax on the poor, the desperate, the gullible and those who are easily entertained,” according to Steve Wiegand of the *Sacramento Bee*.²⁶ Any deal that generated leasing royalties for the state would entail the same problems as a state-run lottery.

Funding health care through tobacco taxes, upon which Governor Schwarzenegger and Speaker Nuñez have agreed for now, is also becoming less appealing. California voters showed this by defeating Proposition 86 in November 2006. A paper published by PRI in anticipation of that vote explained why the proposed tobacco tax was more likely to harm than help health care in California, and those arguments are still relevant today.²⁷ While the new tobacco-tax hike is marketed as a method to fund “universal” health care and help more smokers quit, it would actually reduce patient focus and competition among California’s health providers and harm Californians who continue to smoke.

Other key reasons for giving higher tobacco taxes a thumbs-down include:

- > Much of the windfall usually goes to ill-defined tobacco education efforts. The effectiveness of such programs is highly questionable. Americans began their journey toward smoking cessation years before the government got involved, and the rate of decline of smoking has not changed significantly as government power over smokers has expanded. Indeed, the prevalence of smoking among young adults increased by 21 percent between 1994 and 2005, despite massive government anti-smoking programs.
- > Non-smokers do not subsidize smokers. In fact, it is the other way around. By increasing the excise tax on remaining smokers, the Democrats’ proposal would confiscate resources that smokers would otherwise have to help them quit smoking and make healthier choices of their own accord.
- > By levying such a punitive excise tax, ABX1 1 would greatly increase the incentives to smuggle cigarettes into the state, a black market that would attract mobsters and terrorists. A violent society is not a healthy society. Indeed, after Canada imposed a similarly punitive excise tax, it was forced to backtrack because smuggling had grown to threaten the rule of law.
- > Remarkably, ABX1 1 also *outlaws* health insurers’ consideration of smoking risks when assessing individual health insurance and increasing premiums accordingly.

Scanning Alert >> Uncovering Hidden Taxes

Although actual tax hikes are harmful to California's welfare, the governor is seduced by the notion that we already suffer another, "hidden" tax. Indeed, the fundamental engine behind the governor's ambition to achieve "universal" coverage is this intuitively appealing, but actually quite unimportant, "hidden tax." This "hidden tax" is supposed to make premiums for private health insurance about 10 percent higher than they would be if everyone were insured. The storyline goes: Because uninsured Californians turn up at emergency rooms where they are treated but do not pay the bill, hospitals shift these costs to health plans, which pass them on to their customers.

As a marketing tool, the "hidden tax" is useful for the governor, who has tried to convince the great majority of Californians who have health insurance that their own self-interest should cause them to support his "reform." However, as a driver of health spending, the "hidden tax" is insignificant.

While the "hidden tax" does exist in an *extremely* narrow sense, there are five reasons why eliminating it should not be a goal of health reform. First, being insured does not improve a person's care as simply or cleanly as the governor believes. Second, the hospitals are not suffering the financial crisis that proponents claim. Third, the "hidden tax" is much smaller than the governor claims. Fourth, the uninsured, as a group, pay *extra* income taxes that more than cover the costs of uncompensated emergency-room care. Finally, there are other "taxes," some hiding in plain sight, whose reduction should take precedence in health-care reform.

The governor believes that forcing everyone to buy health insurance "controls rising medical costs by expanding coverage, improving access to preventive care, and reducing costly, unnecessary emergency room visits."²⁸ Certainly, the uninsured do use less primary care than the insured, but not that much less. According to UCLA's Center for Health Policy Research—an institution that is as obsessed with "covering the uninsured" as the governor and his allies—more than *three times* as many insured Californians delayed or avoided preventive care such as screening tests and visits to specialists, as well as urgent care, as uninsured Californians in 2003. Furthermore, the difference in likelihood between uninsured and insured Californians' delaying or not getting non-primary, "other medical care" was only *7 percent* in 2003.²⁹ In 2005, 7.6 million Californians accessed regular care through "safety net" providers: community health centers, public hospitals, and clinics. However, only one million of these patients were *uninsured all year*, whereas almost three million were *insured all year*.³⁰ The gap in access between the insured and uninsured is not really in primary care, for which there is a *general* shortage of practitioners.³¹

Even scholarly advocates for reducing the number of uninsured conclude that being insured does not necessarily elevate you to a higher level of primary care. In a 2006 survey of Californians *with* health insurance, purchased either privately or through government programs, 46 percent of those who presented at emergency rooms self-reported that the problem could have been handled by a primary-care practitioner. Unfortunately, primary care was not available when they needed it. Many of these insured patients did not have a primary-care physician, and others needed medical care after hours or on the weekend. Furthermore, 44 percent of these patients suffered from chronic illness, versus 32 percent of the overall California population. Being insured did not immunize them from the consequences of their chronic illness, and they were forced to present at the ER.³²

Table 2 // U.S. Health Spending for People Under 65, 2000

	Share of Population with Any Medical Expense	Median Expense per Person with Expenses	Total Expenses (Billions)	Share of Population with Any Emergency-Room Expense
Uninsured Privately	57%	\$305	\$28	7%
Insured	86%	\$638	\$320	10%
Taxpayer Insured	83%	\$465	\$76	18%

Source: Agency for Health Research and Quality.³³

Table 2 reports national health spending for 2000. Not only do the uninsured incur less than 7 percent of all medical-care expenses, significantly fewer of them are likely to present at an emergency room than either the privately insured or those dependent on government-run programs, such as Medicaid. We have precise data on California children. In 2003, 1.8 million *insured* kids visited California ERs, versus only 80,000 *uninsured* kids.³⁴ The claim that 4 percent of the kids who present at ERs are somehow driving hospitals to the financial brink is implausible on its face. Nonetheless, Governor Schwarzenegger claims that “In Los Angeles County, one fifth of emergency rooms have closed since 1995, leaving only 75 ERs open to the county’s 10 million residents.”³⁵

In fact, analysis from 1990 through 2001 shows ER capacity *increasing* in California, and even contributing to hospitals’ profitability. While a number of ERs closed (usually because of hospital closure), the number of beds per ER increased. Net, the number of ER beds per 100,000 Californians *rose* from 14.6 in 1990 to 15.1 in 2001. Nor was there a significant difference in the distance the average Californian had to travel to get to the nearest ER. Why did hospitals persist in keeping ERs open, given the constant gnashing of teeth about the “crisis”? One in seven ER visits resulted in an inpatient admission, and such admissions accounted for 40 percent of all admissions.³⁶ The conclusion: ERs are a *profit* center for hospitals.

Overall, the health of California’s hospitals is better than it was in the 1990s, according to a detailed report from last year, which also compared our hospitals with those in other states. It found that California hospitals are *more* efficient and have *less* ER use than those in many other states. Furthermore, California’s relatively healthier and younger population implies that the Golden State needs fewer beds than other states. Importantly, California experienced only 252 ER visits per thousand residents, versus a national average of 375.³⁷ Generally speaking, California hospitals are now profitable, and this has led to a hospital construction boom.³⁸

All right, maybe there is no “crisis,” but there are certainly *some* uninsured Californians who show up at emergency rooms and don’t pay their way. So *somebody* has to pay their bills, right? Unfortunately, the governor has accepted, and even inflated, a very flawed estimate of this “hidden tax.” According to an inaccurate and incomplete analysis prepared by staff of the New America Foundation, the uninsured impose a “hidden tax” of \$1,186 per insured family and \$455 per insured individual per year, for an estimated total of \$9.5 billion.³⁹ Although this figure has been debunked, as we shall see below, the governor not only continues to beat his drum with it, but has somehow inflated it to \$15 billion annually, without benefit of further public analy-

sis.⁴⁰ My guess is that because his proposed “solution” is a spending increase of \$14.4 billion, he had to have a “problem” that cost at least as much.

The true “hidden tax” is much less than estimated in the governor’s analysis. Professor John Cogan and colleagues point out that the New America Foundation’s analysis multiplied the number of people uninsured *at any point in the year* by the cost of care received by people uninsured *for an entire year*, and ignored the fact that we are *already* subsidizing much of the uninsured’s health costs through *actual*, not “hidden,” taxes.

The average uninsured Californian is without insurance for 9.1 months of the year. So, by inaccurately considering the number uninsured at any given time to be uninsured for a full year, the New America scholars overstate the “hidden tax” by about one-third (12/9.1). Remarkably, the governor appears to understand the difference better than the New America scholars do. His reform proposal noted that: “6.5 million Californians are uninsured for all or *part of* a year; 4.8 million Californians are uninsured at any given time” (emphasis added).⁴¹ Clearly, even the governor should understand that if you want to look at costs imposed by the uninsured over a twelve-month period, 4.8 million is the correct number to use.

Although government payments to health-care providers to cover this uncompensated care are difficult to estimate perfectly, Cogan and colleagues note a credible estimate of \$3.6 billion for California in 2005.⁴² Re-examining the “hidden tax” in the light of these factors, they estimated a *maximum* net “hidden tax” of 2.8 percent of premiums, versus 10 percent from the New America Foundation. As the authors point out, this upper bound is significantly larger than a very well estimated national figure of about 1 percent.⁴³ Still, their analysis ratchets the “hidden tax” down to \$127 per individually insured Californian and \$332 per family. Not zero, but—at less than a buck a day—hardly something for which to upset the whole applecart.

So, the “hidden tax” that California’s uninsured levy on the insured is not \$15 billion annually, nor even \$9.5 billion. Rather, it is impossible to reasonably conclude that it is more than \$2.5 billion, which is pretty insignificant for a state whose annual health spending is running just under \$200 billion annually.⁴⁴

Furthermore, there is little doubt that the uninsured, *as a class*, already pay enough voluntary extra taxes to cover the uncompensated care that they receive. Recall the example above, of a firm in Oakland that pays its employees an average salary of \$50,000 without health benefits, versus a competitor who pays \$40,000 in salary plus health benefits. Employees of the former pay extra income taxes, likely about \$2,000 per person. Many uninsured fit this profile. One-fifth earn more than three times the FPL—about \$50,000 for a family of three. Indeed, 15 percent earn more than \$75,000 annually. Even if we shrink the Census Bureau’s estimate by half, I estimate that the uninsured, nationally, likely pay at least \$60 billion *extra* in federal income taxes alone, by forgoing the tax savings associated with private health insurance—and the figure could easily be much higher.⁴⁵ If we pro-rate this for California, we get an estimate of at least \$6 billion. If we then add their state income taxes, the number rises yet more. Even the governor *himself* estimates these extra taxes at \$8.4 billion, a number very close to what I would figure.⁴⁶

It is important to understand that this does *not* mean that the average low-income uninsured person who presents at the emergency room is paying his way. This is certainly not the case. Rather this refers to a subsidy that middle- and high-income uninsured indirectly pay to hospitals. Indeed, better-off (but uninsured) Americans do not regularly burden ERs with their uncompensated and unwelcome presence. In Massachusetts, only

6 percent of uncompensated health care went to families with reported incomes greater than 200 percent of the FPL in 2005, whereas 42 percent of such care went to individuals reporting no income.⁴⁷

We cannot calculate an exact dollar figure for this extra, voluntary tax that the uninsured pay. However, this inability is an artifact of the tax system, which exempts health benefits entirely from tax calculations. If the federal government reformed the tax code along the lines recommended by Rudy Giuliani, whereby American families with private health insurance would add the value of the benefit to their income, and then take a \$15,000 deduction, the IRS could report this figure annually. The government could then take this amount and credit it to the insured, also via their tax returns, or use it to explicitly fund uncompensated care. This would easily solve the mystery of the “hidden tax.”

Nevertheless, we can confidently conclude that the uninsured already pay *at least three times more* explicit, extra, voluntary taxes than they cost via the so-called “hidden tax.” We should *thank* many of these people for remaining uninsured, not punish them.

A far more serious “hidden tax” on privately insured patients is underpayment by government payers. The cost shift that hospitals execute from government programs to private insurers *is* significant. Table 3 shows payment-to-cost ratios for in-patient care by payer. Private insurers pay \$129 for every \$100 of hospital costs. On the other hand, traditional Medi-Cal (Medicaid) pays only \$56, and other government payers also fail to cover the cost of treatment. Obviously, hospitals could not deliver the care they do if they relied fully on government payers. The failure of these government programs to pay providers adequately is especially galling given the ever-increasing *actual* tax burden that weighs on us to support these programs. For example, *every* American already pays \$944 of taxes annually to fund Medicaid and SCHIP.⁴⁸

Table 3 // Net Revenue as Percentage of Average Cost per Adjusted Patient Day, 2005

Private	Medicare Managed Care	Medicare Traditional	Medi-Cal Managed Care	Medi-Cal Traditional	County/ Other Indigent
129%	99%	74%	65%	56%	42%

Source: California HealthCare Foundation.⁴⁹

An analysis by Professor Daniel Kessler of Stanford University compared the hospitals’ cost shift from the uninsured to the insured (the governor’s “hidden tax”) to the cost shift from government payers to the insured. If the uninsured paid their full costs in hospitals, Kessler’s analysis implies, then private insurance premiums would go down by about 1.4 percentage points. However, if Medicare and Medi-Cal were to pay the full costs of their patients’ hospital care, premiums for private payers would go down by 11 percentage points.⁵⁰

Another tax that is “hiding in plain sight” is seldom discussed by politicians: it is the factor of *over-insurance*. Insured Californians use 2.5 times more health services than the uninsured.⁵¹ Much of this is wasted: Milton Friedman reckoned that if the U.S. government had not encouraged over-insurance, health spending would be about half of what it actually was in 1997.⁵² A recently published book reviews the literature on overuse and misuse of health care in the United States and concludes that the level of waste is between 20 and 30 percent.⁵³ By simply

ordering Californians to buy health insurance, without reforming incentives for the prudent use of medical care, proponents of “universal” health care would cause the heretofore uninsured to use resources as inappropriately as the currently insured do today. Indeed, the concentration of health expenses is almost identical in insured and uninsured populations: about half the people have little or no health expenses, and 5 percent of the people incur half of the group’s health expenses.⁵⁴ So, we should not expect compulsory private health insurance to magically transform the health-care incentives of the uninsured; instead, it would simply move them onto a higher spending baseline.

According to the analysis upon which the governor relies, the uninsured accounted for 8 percent of California’s health spending in 2004.⁵⁵ This implies \$20.2 billion of spending on health care for the uninsured in 2010, ABX1 1’s launch year.⁵⁶ If the uninsured all become insured in 2010, their spending would increase to \$50.5 billion. However, proponents of ABX1 1 have lowered their sights, anticipating that it will only “succeed” in compelling 72 percent of the uninsured to become insured.⁵⁷ In this case, their health spending will increase to \$36.3 billion—*more than double the amount budgeted*.

On the other hand, if ABX1 1 fails, the uninsured will continue to pay the insured a *hidden subsidy* of \$30.3 billion, the difference between \$50.5 and \$20.2 billion, owing to the health services they do *not* use. However, as long as California fails to institute real health reform, which consists of bringing about individual choice and competition in health care, the more significant hidden tax of over-insurance will continue to burden us. Let’s say that the insured waste one-quarter of the health resources they use: this implies a hidden tax of \$58 billion in 2010—which the *insured* levy on the *insured*! Politicians don’t talk about this hidden tax, because the majority of voters are insured, and asking them to take responsibility for the situation is a likely path to electoral defeat.

However, there is also a disadvantaged minority that does pay a hidden tax, which the governor and his Democratic allies ignore. As discussed above, Americans are generally free to either accept or decline private health insurance. However, low-income earners are not really free to make this choice because the state forbids them to take employment below the minimum wage. Some of these people would undoubtedly prefer to take health benefits as some fraction of their remuneration, as many higher earners do. In 2006, the California minimum wage was \$6.75 per hour and the median health-insurance premium for a single person in the small-group market worked out to \$2.02 an hour: almost one-third of the minimum wage.⁵⁸ In a very real sense, some of these uninsured low-income earners who are forbidden to trade some money wages for health benefits are already suffering from an unofficial pay-*don’t*-play mandate.

Currently in California, low-earning, childless adults are generally ineligible for Medi-Cal benefits, so they must rely on private health insurance if third-party paid health benefits are important to them. Let’s assume that such a person pays no income tax, so he is not penalized by the tax code for receiving money wages instead of health benefits. If an employer could have paid him \$4.73 per hour plus \$2.02 worth of health benefits, instead of the equivalent minimum wage of \$6.75, he might have considered himself better off. Unfortunately, this is illegal.

Workers earning more than the minimum wage are subject to the same trap. In an area where only the median health plan is available, a worker earning up to \$8.77 per hour will be unable to trade money

wages for health benefits, because choosing health benefits would result in his wage falling below the minimum.⁵⁹ There is some indication that this pay-don't-play tax is unnecessarily reducing the number of insured Californians. In 2007, only Connecticut, Oregon, and Vermont had minimum wages higher than California's.⁶⁰ Although we cannot draw a straight line between minimum-wage laws and annual incomes relative to the FPL (because annual incomes are affected by number of hours worked as well as wages per hour), low earners are marginally over-represented among the uninsured in California versus other states, a likely indicator that the high minimum wage is artificially inflating the number of uninsured.

Table 4 shows the percentage of uninsured in California and the rest of the United States, averaged over 2005 and 2006 and distributed by household income according to the Current Population Survey (CPS). Two words of caution are in order here: the actual number of long-term uninsured is likely *half* the figure the CPS reports; and the high number of illegal immigrants in California also skews the numbers, as discussed in a previous paper.⁶¹ Nevertheless, the CPS is the most current survey available that reports the uninsured state by state, and the difference between California and the rest of the United States is important to note. According to the CPS, 3.2 percentage points more of the California population is reckoned as uninsured versus the rest of the United States. However, three-quarters of this discrepancy (2.4 percentage points) is accounted for by people earning less than 200 percent of the FPL. Furthermore, the pay-don't-play tax increases every year with the minimum wage: now \$8 per hour in most of California and \$9.36 in San Francisco, but only \$5.85 federally. This means that minimum-wage workers in California are forced to take \$2.15 more in cash per hour than workers in states that accept the federal minimum wage. If they were exempted from this requirement, some of them would become insured.

Table 4 // Uninsured in California and Rest of United States, 2005-2006 Average

Income as % of Federal Poverty Line (FPL)	Uninsured as Share of Population			Distribution of Uninsured by Income	
	California	Rest of United States	Difference	California	Rest of United States
Under 200%	12.3%	9.9%	2.4%	67%	65%
200% Plus	6.2%	5.4%	0.8%	33%	35%
Total	18.5%	15.3%	3.2%	100%	100%

Source: Author's calculations from Kaiser Family Foundation's statehealthfacts.org.⁶²

The final tax is, of course, the “sick tax”—California’s continuing failure to harmonize its state income-tax code with the Internal Revenue Code’s provisions allowing tax deductibility of Health Savings Accounts. (Although ABX1 1 would cause the state to give \$730 million back to the people in its first year of operation via Section 125 “cafeteria” plans and tax credits for low-income Californians, these tax breaks are consequences of its proposed mandate that would force many of us to buy health insurance from a new government agency, Cal-CHIPP. The tax breaks are not due to abolishing the sick tax on HSAs.)

My PRI colleague Diana Ernst has reviewed the recent evidence on the benefits of HSAs and consumer-directed health plans, in which patients control more of their health-care spending than they do in traditional

plans.⁶³ A nationwide study of 470 employers by Aon Consulting and the International Society of Certified Employee Benefit Specialists found the number of employers offering HSA-eligible plans is on the rise, with 37 percent offering them in 2007, up from 28 percent in 2006 and 22 percent in 2005.⁶⁴

The 2007 United Benefits Advisors (UBA) health-plan survey, the largest survey of health plans in the country, recently reviewed more than 16,000 health plans sponsored by almost 12,000 employers nationwide. UBA found that consumer plans with a health reimbursement account (HRA) or HSA now account for almost 9 percent of all employer plans, versus 6 percent last year.⁶⁵ The survey shows that premiums for consumer-directed plans grew less than 3 percent in 2006, compared to 7 percent for all other plans.⁶⁶

CIGNA HealthCare also conducted a two-year study of 430,000 of its members with consumer-directed and HMO/PPO (health maintenance organization/preferred provider organization) plans. For the first year of the study, medical costs for members with consumer plans were more than 12 percent lower than those for HMO and PPO members. Members with HSA-eligible plans also increased their preventive care and use of maintenance medications for chronic conditions, and their expenses still decreased.⁶⁷

Interestingly, in its annual survey of U.S. insurance plans that offer HSAs and corresponding high deductibles, America's Health Insurance Plans (AHIP) found that 84 percent of such plans purchased in group and individual markets provide first-dollar coverage for preventive care.⁶⁸

Among consumer-directed policies that offer first-dollar coverage for preventive care outside deductibles, "100 percent cover adult and child immunizations; well-baby and well-child care; mammography; Pap tests; and annual physical exams. Nearly 90 percent of policies purchased provide first-dollar coverage for prostate cancer screenings and more than 80 percent offered this coverage for colonoscopies."⁶⁹

Clearly, it is becoming increasingly unconscionable for California to levy a "sick tax" on its residents who choose consumer-directed health care. And the sick tax is becoming increasingly significant, as more Americans enroll in consumer-directed health plans and open HSAs. In 2004, 18 percent of California employers offered a high-deductible health plan, versus 10 percent nationally. Unfortunately, in 2007 this participation decreased to 16 percent in California while it more than doubled nationally, to 21 percent. However, 19 percent of California employers are likely to offer a high-deductible plan with an HSA this year.⁷⁰

In order to raise awareness of this sick tax, PRI has launched the California Sick Tax Clock at our Web site. Table 5 shows the assumptions and estimates for the clock. In 2004, the first year HSAs were available, 7,500 California individual tax returns reported a total of \$20 million in HSA contributions, which Californians had to add back to their adjusted gross income for the purpose of calculating state income tax. The Franchise Tax Board reported this and used an estimated average state marginal tax rate of 7 percent to calculate state tax revenue of \$1.4 million levied on HSA contributions.⁷¹ The state has not reported figures for subsequent years, so Table 5 estimates the number of HSAs in California from 2005 through 2008 from national data and trends. By the end of 2008, Californians with HSAs will have paid almost \$100 million extra to the state in sick tax. If California harmonized its tax code with the Internal Revenue Code, this money would have been given back to Californians to spend on health care that we choose, instead of the government.

Table 5 // Health Savings Accounts in California and Cumulative Sick Tax Paid by HSA Owners

Year	Number of Accounts	Cumulative Contributions Sick Tax	Cumulative California
2004	7,500	\$20,000,000	\$1,400,000
2005	66,000	\$58,212,000	\$4,074,840
2006	216,000	\$304,992,000	\$21,349,440
2007	480,000	\$733,920,000	\$51,374,400
2008	795,496	\$1,317,099,049	\$92,196,933

Source: Author's estimates extrapolated from Information Strategies, Inc.⁷²

Although having this money returned to them would make a big difference for California's HSA owners, it is trivial to the state in the face of the \$14.4 *billion* annual cost of ABX1 1's "reform." Governor Schwarzenegger's initial proposal did anticipate abolishing the sick tax through harmonizing the tax code, but that would be anathema to the state's Democratic legislators, who would prefer to control our health dollars themselves. The fact that the governor endorsed ABX1 1 with the sick tax intact indicates that his "negotiations" with the Democrats on health reform achieved very little.

Deadly Virus >>

Health Insurance Over-Regulation

The best way to increase the number of people who buy any good or service is to lower the price of it. Unfortunately, ABX1 1 would do nothing to reduce bureaucratic burdens that drive up premiums for private health plans. In fact, it would impose new regulations that would *increase* premiums significantly.

First, ABX1 1 neither reduces the number of mandatory benefits that the state imposes, nor provides any way to opt out of them. Neither you nor your employer is free to negotiate benefits that are affordable. Rather, you are stuck with the package that the state dictates. In California, a health policy is regulated by one of two agencies: the California Department of Insurance (CDI), which regulates indemnity plans, and the Department of Managed Health Care (DMHC), which regulates “health service plans” (also called HMOs, managed care, or Knox-Keene plans). In 2005, commercial managed-care plans earned \$41.7 billion of premium revenue, whereas health insurers regulated by the California Department of Insurance earned only \$5.3 billion.⁷³

However, in the last few years, there has been some trend away from DMHC-regulated plans toward plans regulated by the CDI, because insurance carriers believe that the burden of over-regulation is lighter.⁷⁴ Unfortunately, this does not do much for the beneficiary who wants to customize his policy, because the Insurance Code and the Health and Safety Code contain the same mandatory benefits.

Since the early 1990s, a growing number of state-imposed mandates have been driving up premiums across the United States.⁷⁵ Studies of benefit mandates have concluded that a typical portfolio of mandates adds anywhere from 3 to 15 percent of premiums, with little evidence of value.⁷⁶ The Council for Affordable Health Insurance, a trade association, counts 49 benefit mandates in California. Altogether, these mandates increase premiums by as much as 30 percent.⁷⁷ The California Health and Safety Code takes 100 pages to describe these mandates and their accompanying rules and regulations.

Taken individually, each benefit mandate may not cost much, but when they are added up, it's hard to ignore the obstacles they create for those who would like to buy a lower-cost health policy that might exclude coverage that not every beneficiary values. Some of these mandatory benefits are: contraception, psychotherapy, marriage and family counseling, and the services of a licensed clinical social worker. In some cases, the state regulates prices. For example, the co-payment for inpatient maternity services cannot be greater than the most common co-payment for ambulatory care. Nor are these mandatory benefits closed-ended: experimental or investigational therapies must be covered when determined by an independent review.

Furthermore, benefit mandates are not the only type of over-regulation. From 1990 to 2004, California added more than 180 distinct managed-care regulations, an average of 12 per year.⁷⁸ While California health plans lie under a greater burden of over-regulation than those in most other states, virtually all U.S. health plans are open ended. That is, they must cover all “medically necessary” services, a term that resists standard definition and guarantees uncontrolled cost spiral.⁷⁹ The California Health and Safety Code requires that plans' decisions to provide or deny services be based on “sound clinical principles and processes”—not on how much they cost. Morally, this

sounds fine, but as long as health insurance looks like this, we will never get costs under control, and there will be many people who cannot afford insurance.

Compare this to car insurance, for example. If your policy indemnifies you for your car's replacement value, the insurer buys you a current model of the same car if you crash your old one. There is no quibbling about the appropriate "treatment," and everybody knows how much a new car costs (or can easily find out). For health care, however, providers determine how much goods and services cost. Unsurprisingly, medical costs are estimated to have grown by 8.4 percent last year, much more than the overall rate of inflation, though less than in previous years.⁸⁰

Health insurance will likely never be as simple as car insurance: they can't just replace your body! Nevertheless, ABX1 1 would command Californians to buy health insurance that does not serve everybody's needs, while forbidding us from negotiating benefits packages that many of us would prefer.

Second, ABX1 1 would impose a new regulation on health plans that would cause some plans to leave the state, resulting in less choice and higher premiums for Californians. The medical loss ratio (MLR) is the percentage of premium dollars that must be spent on medical care, as opposed to administrative costs. Currently, this is an accounting measure that California health plans report to the state, but which has no regulatory implications. ABX1 1 would mandate an MLR of at least 85 percent. While this sounds patient-friendly, it is not. The MLR is an accounting measure, not a measure of quality or efficiency. For some plans, the MLR is quite impossible to interpret, especially those that serve government programs. For example, Molina Healthcare of California is a Medicaid managed-care plan that reported an MLR of 167.26 for 2006.⁸¹ Obviously, there is no *real* way for a health plan to spend two-thirds *more* on medical costs than it earns. According to Professor James C. Robinson of the University of California, Berkeley, "the Medical Loss Ratio is an accounting monstrosity that enthralles the unsophisticated observer and distorts the health policy discourse."⁸²

There are a number of reasons for this "monstrosity," according to Professor Robinson. Many health insurers compete in markets across the country, allocating overheads across state lines, which makes accounting conventions even more arbitrary. (For example, Blue Cross of California is now owned by WellPoint, Inc., headquartered in Indianapolis. Blue Cross of California does *not* uniformly implement a single loss ratio or profit margin for all of its lines of business.⁸³) Narrow networks obviously have fewer administrative costs than broader networks, but patients appear to value broader networks nevertheless. Health plans with rich benefits or which operate in areas where providers are expensive will incur high MLRs. Also, integrated managed-care organizations, such as Kaiser Permanente, can have much higher MLRs because they move administrative costs to the provider side of their organizations. PPOs have higher administrative costs because they cannot do this.⁸⁴

This creates significant accounting advantage for HMOs. For all commercial plans in California, 1996 through 2000, administrative costs were 9.9 percent of premiums. Provider administrative costs were much greater: For California medical group practices in 2000, administrative costs ranged from 20.1 to 26.7 percent of revenues, and for California hospitals in 1999, administrative costs were 20.9 percent of revenues.⁸⁵ If an HMO, such as Kaiser Permanente, "crams down" some of that 9.9 percent to its staff doctors and the hospitals it owns, it can report an artificially high MLR. Obviously, regulating the MLR tilts the playing field in favor of HMOs.

Regulating the MLR is also deadly for consumer-directed plans, which are becoming increasingly popular. These plans are especially taking hold in the individual market. In 2006, individually purchased health policies in California had, on average, higher deductibles than small-group policies: \$2,136 versus \$348. However, because individual premiums were so much lower, the *total costs* for individual policies were less than those for small-group policies. Also, of every dollar of medical spending from a small-group policy, patients controlled less than 17 cents. For individually purchased policies, patients themselves controlled just under half of their spending on medical care.⁸⁶

Let's assume a scenario where a consumer-directed health policy incurs exactly the same costs as a traditional policy. (In fact, this is unlikely, because total costs of consumer-directed plans are significantly lower than for traditional ones, as patients have better incentives to control costs.⁸⁷) The traditional policy costs \$4,000 and spends \$3,400 on patient care, for an MLR of 85.00. With the consumer-directed policy, the patient controls \$800 more of the medical spending than with the traditional policy (through a higher deductible), and his premium goes down by \$800. In this case the MLR goes down to 81.25 (\$2,600/\$3,200). There is no *real* difference, but the accounting looks worse.

In any case, MLRs are irrelevant to the insured and their employers, who actually choose health plans based on other criteria—likely invisible to politicians and state regulators. Table 6 shows the top ten health-service plans (i.e., those regulated by the Department of Managed Health Care, not the Department of Insurance), by enrollment, as well as their MLRs as reported for the period from December 2006 to December 2007. The average MLR for all plans is 89.6, but there is significant variance.⁸⁸

Table 6 // California's Top Ten Health-Service Plans by Enrollment, December 2007

Health Plan Name	Medical Loss Ratio, 2007	Share of Total Patients Covered	Medical Loss Ratio, 1994/5	Change, 1994/5 to 2007
Kaiser Foundation Health Plan, Inc.	94.8	32%	96.8	(2.0)
Blue Cross of California	81.5	21%	93.5	(12.0)
California Physicians' Service (Blue Shield of California)	85.7	12%		
Health Net of California, Inc.	85.7	10%		
PacifiCare of California	86.2	8%		
Orange County Health Authority	90.5	2%		
Inland Empire Health Plan	93.3	2%		
Aetna Health of California, Inc.	83.3	1%	77.4	5.9
Cigna HealthCare of California, Inc.	95.2	1%	83.2	12.0
Molina Healthcare of California	167.3	1%		

Source: California Department of Managed Health Care; Robinson.⁸⁹ Top ten plans account for 90 percent of all patients covered by California health-service plans.

Table 6 also shows MLRs for some plans in 1994/5, and changes in the MLR from 1994/5 to the present.⁹⁰ Kaiser's loss ratio is very stable over the period. On the other hand, Blue Cross of California experienced a significant deterioration of its MLR over the period, while Cigna experienced an improvement of the same magnitude. Nevertheless, Blue Cross of California sits in the second spot in the rankings, covering one-fifth of all California patients enrolled in health-service plans, while Cigna is in the ninth spot, with just 1 percent of patients. Clearly, people who choose health plans are looking at things other than the MLR when they make decisions. If ABX1 1 passed, Blue Cross of California and Aetna would have to either withdraw from the market or waste resources re-inventing their accounting in order to satisfy the regulation concerning MLR. Blue Shield, Health Net, and PacifiCare are also very close to slipping under the proposed MLR.

Currently, health insurance in California is competitive compared with other states. The American Medical Association measures the concentration of health insurers in each state through the Herfindahl-Hirschman Index (HHI), which sums the squares of the market shares of all the competitors in an industry.⁹¹ The lower the number, out of a maximum of 10,000, the more competitive is the industry. (If there were just one health insurer in the market, this monopoly would result in an HHI of 10,000—that is, 100 times 100.) The HHI for California health insurance is 1,526. Of the 44 states examined by the AMA, only Florida was less concentrated. This level of competition is advantageous for California patients, and the proposed MLR regulation threatens a significant reduction in Californians' choice of health plans.

The third way in which ABX1 1 threatens health insurance in California is by imposing *community rating* and *guaranteed issue* for individually purchased health insurance. Basically, this means that insurers cannot price premiums according to applicants' risk factors: a smoker and a non-smoker pay the same premiums. These rules were imposed in the small-group market in the early 1990s and, devastatingly, for association health plans, too. Forbidding insurers to consider pre-existing conditions supposedly protects potentially ill citizens from discrimination. In fact, it victimizes everyone by allowing healthy people to wait until they get sick to apply for coverage.

In California, this caused a death spiral whereby healthy people quit association health plans and bought individual health insurance instead, leaving only the sick to buy association health plans. Before these rules came in, Marsh Affinity Services, which brokers and markets association health plans, had 142 clients in California. By 2007, only three remained. Association health plans used to be so popular that professional associations used them as a recruiting tool. Now, less than a quarter of 1,020 associations that were surveyed last February still offer health plans. Even the few large associations that still offer them, such as the California Association of Realtors, are likely to bail out.⁹² Tragically, associations predicted this when the new rule was enacted in 1993, but they were ignored by politicians.⁹³

There is no doubt that imposing community rating and guaranteed issue in the individual-health-insurance market will similarly cause premiums to climb out of control in that market. In the early 1990s, eight states imposed these regulations in the individual market. All have experienced this death spiral. Fortunately, some have begun to deregulate individual health insurance. It's easy to see why:

- > In New Jersey, monthly premiums for the state's standard "Plan D" policy, offered by Aetna, rose 683 percent between 1994 and 2005, and New Jersey Blue Cross/Blue Shield's increase

was similar. These were the only two of 14 carriers operating in 1994 that continued to offer Plan D in 2005.

- > In Vermont, the regulations drove out most carriers, resulting in Blue Cross/Blue Shield controlling 56 percent of the market by 2004. Many individuals who lost coverage became dependent on government health care, which was Governor Dean's thinly disguised objective.
- > In New York, premiums for a 30-year-old single male rocketed up 170 percent just *one month* after the regulations came into effect.
- > In Kentucky, 45 insurers had pulled out of the individual insurance market two years after the regulations came into force.
- > In Washington, 40,000 individual policyholders dropped their policies in 1996 and 14,000 in 1997. By 1999, individually purchased health insurance was *unavailable* in 32 of the state's 39 counties.
- > In Massachusetts, 20 carriers withdrew from the individual market within two years of the regulations.
- > In New Hampshire, the number of carriers serving the individual market shrunk from 12 to five within two years.
- > In Maine, these regulations resulted in a virtual monopoly for one carrier, Anthem, which had 97.3 percent of the market by 2001.⁹⁴

Nor do guaranteed issue and community rating make health insurance more available to less healthy enrollees, as Governor Schwarzenegger and his Democratic allies think. Contrary to popular belief, the market for individual health insurance does exceedingly well at pooling risk. National data from 1999 to 2004 show that privately insured Americans (in either group *or* individual markets) did not have a significantly lower risk profile than uninsured Americans. Furthermore, while individual premiums increased with the patient's age, they varied very little because of chronic conditions—only between 11.5 percent and 15.5 percent of what the risks indicated they should. Regulations such as guaranteed issue and community rating in the small number of states that vigorously imposed these regulations over the period increased the likelihood of high-risk individuals being insured by only about 8 percent.⁹⁵

Other states are learning the tragic lesson of guaranteed issue and community rating. Perhaps the most dramatic rebound is in South Dakota. There, the *repeal* of guaranteed issue has brought the individual insurance market back to life, only four years after 20 health insurers abandoned the state. In 1990, 30 carriers wrote individual policies in South Dakota. The guaranteed-issue law passed in 1996, and the number of carriers collapsed to seven by 2003. Guaranteed issue was repealed that year, and the number of carriers writing policies has almost doubled since, to at least 12.⁹⁶ The American Medical Association, recognizing the threat of more government intervention in health care, has recently adopted the position that governments should not interfere in underwriting decisions. Instead, high-risk patients who cannot afford fully risk-rated health insurance should be directly subsidized.⁹⁷

Unfortunately, analysts who broadly support Governor Schwarzenegger's plan have ignored the dramatic and painful increase in health-insurance premiums that would result from this "reform." They simply assume that rates will not change. Professor Jonathan Gruber of the Massachusetts Institute of Technology concluded that the governor's original proposal would add a total of 3.4 million people to either public programs

(Medicaid and Healthy Families) or the new “pool” (now called Cal-CHIPP), for a total cost of about \$7.55 billion.⁹⁸ For the “pool,” Professor Gruber assumed monthly premiums of \$224 (derived from the Medicare reimbursement rate) for a \$500-deductible policy for an individual.

Actual premiums would undoubtedly be significantly higher. Today, the average individually purchased plan in California costs only \$139 per month for a 33-year-old man, likely with a deductible between \$1,000 and \$2,000.⁹⁹ However, once ABX1 1 imposes guaranteed issue and community rating, we can be confident that premiums will quickly spiral upward. The average monthly premium for employer-sponsored health insurance in California, which *is* subject to community rating and guaranteed issue, was about \$364 in 2007.¹⁰⁰ Therefore, this is a more likely figure for the average premium for the policies in the pool than \$224. This average premium would increase the cost for public programs plus the pool to just under \$16 billion, when scratched over Professor Gruber’s model on the back of an envelope.

This premium inflation *might* be avoided if the state succeeded in enrolling *everyone* in health insurance—the goal of “universal” health care. After all, guaranteed issue and community rating for individually purchased insurance policies failed in the states that tried them because residents were free to abandon their health insurance after the state had made it too expensive. If California removes that freedom, perhaps the death spiral can be halted. But it is extremely unlikely that ABX1 1 will succeed in enrolling everyone, for the same reasons that have caused similar efforts to fail in other states.

Massive Hallucination >> “Universal” Coverage

First, a pay-or-play mandate violates ERISA (the Employee Retirement Income Security Act), which governs employee benefits. ERISA, passed in 1974, “shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan,” per ERISA § 514(a) and 29 USC § 114(a). In two cases, federal judges have overturned pay-or-play mandates after opponents launched ERISA-based lawsuits.¹⁰¹

In January 2007, a court struck down Maryland’s so-called Wal-Mart health bill (which levied a pay-or-play payroll tax on very large employers, Wal-Mart being the only real target). In *Retail Industry Leaders Association v. Fiedler*, 475 F.3d 180, the attorney general of Maryland attempted the remarkable argument that the pay-or-play mandate is a *tax*, but *not* a health benefit, and therefore outside ERISA’s scope. His argument did not convince the court.¹⁰² Recall that Governor Schwarzenegger has vigorously denied that his proposal is a tax, and so he puts himself in an even worse position than Maryland, should ABX1 1 pass and business interests sue the state.

In December, a federal judge responded to a suit brought by the Golden Gate Restaurant Association by overturning the pay-or-play mandate in San Francisco’s Health Access Plan, on the same grounds. The mandate would have levied a payroll tax of \$1.17 per hour on businesses with 20 or more workers.¹⁰³ Early this month, the City won an emergency stay, pending appeal. Clearly, businesses have wised up to pay-or-play mandates and are ready, willing, and able to respond quickly with a proven legal strategy against state and local governments that try to impose them. Indeed, the California Chamber of Commerce expresses its position unequivocally: Any pay-or-play mandate violates ERISA.¹⁰⁴

Second, the two states that have legislated “universal” health care have failed to achieve their stated goal of covering all the uninsured. In 1974, Hawaii decided to solve its uninsured problem by mandating that employers provide health insurance and forcing them to pay half the cost of a plan directly. Hawaiian legislators’ logic in passing the Prepaid Health Care Act paralleled that of today’s California policy makers: Most of the uninsured were employed, at least intermittently. So, if the state could force all employers to provide health care, it would make significant inroads into the number of uninsured.

As in Maryland and San Francisco, businesses in Hawaii resisted the pay-or-play mandate imposed by the Prepaid Health Care Act. In 1981, an ERISA lawsuit was launched, which Congress resolved in 1983 by waiving ERISA standards for Hawaii. This was done to grandfather the Prepaid Health Care Act, which the state had passed shortly *before* Congress passed ERISA.

Nevertheless, the 1974 act did not succeed in “covering the uninsured,” so the state has continued to fiddle with its health care. The State Health Insurance Program of Hawaii “moved the state closer to universal coverage” in 1989. As late as 1993, Hawaii’s efforts at “universal” coverage were described by a scholarly observer as “lodged somewhere in midstream.”¹⁰⁵

On the other hand, also in 1993, managers in the state's health department managed to convince themselves that Hawaii had covered 95 percent of its population.¹⁰⁶ If it were only so easy! In 1974, one in 50 Hawaii residents was uninsured. Today, after more than three decades of mandatory insurance, that number stands at one in ten.¹⁰⁷ Of course, Hawaii is not immune to national trends, but scholars have concluded that the state's pay-or-play mandate might have reduced the ranks of the uninsured by 5 to 8 percent at best.¹⁰⁸ Furthermore, the market for individual health insurance is so small and uncompetitive in Hawaii that observers cannot even estimate an average premium for the state. Premiums in the group market are about the same as in California.¹⁰⁹

More recently, Massachusetts has attempted to achieve "universal" health care, at any cost. The Massachusetts "reform" imposes fines both on businesses that do not offer health insurance and on individuals who do not obtain it: a dual pay-or-play mandate. Because nobody has launched an ERISA lawsuit against the Commonwealth, it stumbles along, taxing its people, organizing and subsidizing their health insurance, and growing a busy bureaucracy.¹¹⁰ The challenges it faces are illustrative for those who want to impose compulsory health insurance in an otherwise free society.

Although individuals were supposed to enroll in the state's mandatory health-care plan by last November 15, only 200,000 of an estimated maximum eligible 600,000 had signed up. Many residents don't know about the requirement, despite the state's spending \$600,000 on "outreach" (including advertising during Boston Red Sox baseball games), and the loss of a personal income-tax exemption of \$219 for those who do not comply. Unsurprisingly, of the 200,000 who have signed up, 188,000 are eligible for free or subsidized care. Only 12,000 belong in the category of those who earn enough to pay the full premium.¹¹¹ Enrollment in the *subsidized* plan, meanwhile, is growing so quickly that the state now figures it will cost \$147 million more in the current fiscal year than had been budgeted: a *one-third* increase.¹¹²

Small-business owners, the target of this "reform," are too busy minding their shops to waste time dealing with the mandate—or even to learn about it. Private employers in Massachusetts are faced with either providing health benefits, or paying the government \$295 a year per employee. However, less than a quarter of small employers are aware of the Commonwealth Connector, the pool through which universal coverage is supposed to be perfected.¹¹³

So, while facing out-of-control spending, the Massachusetts plan is also taking in a lot less than budgeted from non-compliant businesses—only about \$5 million in the current fiscal year. That's a serious shortfall from the \$45 million anticipated when Governor Romney signed the legislation in April 2006. This \$5 million comes from only 518 companies. Of 62,000 required to report their health benefits to the state, 44,000 complied on time, but more than half of those were *too small* to be subject to the mandate. Observers do not believe there's much financial blood to be squeezed from the 18,000 remaining firms.

Needless to say, advocates of government-run health care are disappointed that the shakedown is not going as planned, and they blame—of all people—former Governor Romney, who thought that the tax on employers was too high and vetoed the line item. The legislature overrode his veto and re-imposed the tax, but "allowed the administration to determine how it would be applied." Now, Governor Patrick appears to be a little gunshy about raiding the corporate coffers, perhaps fearful that businesses are ready to flee the Bay State.¹¹⁴

We should not be surprised that these pay-or-play mandates achieve much less than advertised, despite punishment for noncompliance. All but three states require car insurance, but 14.6 percent of drivers remained uninsured in 2004. In fact, the uninsured rate for auto is higher than for health in 17 states. Nor are the penalties for uninsured driving trivial: In Kentucky an uninsured motorist can be fined \$1,000 and serve six months in jail; Wyoming has a six-month jail term and a \$750 fine; in Louisiana, the driver's car can be impounded for failure to insure. Notwithstanding these penalties, the rate of noncompliance is 12 percent in Kentucky, 11 percent in Wyoming, and 10 percent in Louisiana.¹¹⁵

Furthermore, despite the hullabaloo about the “crisis of the uninsured,” there is a body of evidence indicating that many working uninsured *prefer* cash wages to health coverage. Above, I discussed how California's artificially high minimum wage reduces the incidence of health insurance among low-income earners, and how over-regulation drives premiums higher than many can afford. Regardless, even in a completely free market for deregulated health insurance, some will choose not to buy it. An experiment in 2000 subsidized small businesses' purchase of health insurance in San Diego. It offered a policy that cost \$145 per month, but charged monthly premiums of only \$20 to \$80. Even at the \$20 rate, only 40 percent of businesses took up the policy, and firms found little enthusiasm among their workers.¹¹⁶ Even completely removing mandatory benefits, as discussed above, will not cause everybody to have health insurance, as premiums would likely have to be cut in half to induce half of the uninsured to buy insurance, and cut by three-quarters to get at least four-fifths of the uninsured to buy in.¹¹⁷

Finally, there is the fact that many people currently eligible for free insurance, fully subsidized by taxpayers, fail to take it up. These ranks include between 58 and 67 percent of California children who are counted as “uninsured” but are eligible for Medi-Cal (Medicaid) or Healthy Families (SCHIP) in 2006. Up to 10 percent of eligible adults are also not enrolled. Combining adults and kids, between 15 and 21 percent of the “uninsured” population that could enroll in these fully taxpayer-funded programs have not done so.¹¹⁸

While chasing the impossible vision of universal coverage, Governor Schwarzenegger and his Democratic allies blindly assume that the way to go about it is to lean heavily on employers. In fact, reforms from over a decade ago that were supposed to solve the problems caused by employer-sponsored health insurance have failed to do so, and today's proposals suffer the same drawbacks.

Terminate >> Connection Between Jobs and Health Insurance

Many Americans think it “natural” that we get our health insurance from either our workplace or the government. Nothing could be further from the truth. We get health insurance from our employers because of a malformation of the tax code. In World War II, employers labored under wage and price controls. Because it was difficult for them to give their workers raises, they gave them health benefits instead. The IRS determined that this was a non-taxable benefit, and America has never looked back.¹¹⁹ By the 1950s, nearly eight out of ten workers in the private sector enjoyed health benefits.¹²⁰ However, this tax treatment has a hidden cost, as discussed above: patients control very little of the money spent on their health care. In 2005, only 7 percent of California PPO members paid more than a \$30 co-payment per visit, and the average PPO deductible was \$771 for a family.¹²¹

On the surface, California does pretty well under employer-sponsored health care, relative to the United States as a whole. In 2006, 71 percent of California employers offered health benefits, versus 61 percent nationally.¹²² And yet, fewer workers are covered by employer-sponsored health insurance in California than in the United States as a whole: 55 percent versus 62 percent.¹²³ It looks as if California employers offer health benefits, but California workers are less likely to take them up. What can explain this?

First, large firms are more likely to offer benefits than are small firms, as shown in Table 7, and these firms are exempt from expensive state health insurance regulations, if they choose to self-insure their health benefits.

Table 7 // California Employers Offering Coverage by Firm Size, 2005

Number of Workers	3-9	10-49	50-199	200-999	1000+
Firms Offering Coverage	62%	80%	94%	97%	99%

SOURCE: CALIFORNIA HEALTHCARE FOUNDATION AND CENTER FOR STUDYING HEALTH SYSTEM CHANGE.¹²⁴

Second, while the majority of small firms still offer health benefits, they have been subject to state and federal laws that make the health insurance they offer less attractive to an increasing number of workers. These laws were supposed to solve an obvious negative consequence that every American fears: when you leave your job, you are likely to lose your health insurance. This creates a problem of “job lock,” where people balk at seeking better opportunities for fear of falling through a crack in their employer-sponsored health insurance.

Large employers have a big enough risk pool that they can self-insure. Under the provisions of ERISA, this exempts them from state insurance regulations and the harmful effects of those regulations, discussed above. Large employers value this freedom: almost half of U.S. employees in 2002 were covered by their employers’ ERISA-regulated self-insured plans. Unfortunately, only about one-quarter of California workers were.¹²⁵

In the 1990s, both the federal government and most state governments recognized that small-group health insurance was in crisis, and implemented laws to shore up employer-sponsored health care. By 1994, 31 states had implemented a combination of guaranteed renewal, guaranteed issue, and portability reforms,

and this had increased to 47 states by 1997.¹²⁶ These are the same laws for small groups that Governor Schwarzenegger and Speaker Nuñez want to impose on individuals. They did not work for small groups, as today's crisis of small-group health insurance demonstrates; and they won't work for individual health insurance either, as discussed above.

Passed in 1992, California's small-group reform, AB 1672, brought guaranteed issue and community rating to California firms employing from 2 to 50 workers. AB 1672 outlawed most underwriting in the small-group market, for fear that carriers were picking and choosing healthy groups, and shunning those with sicker employees. AB 1672 requires carriers to bundle small businesses into no more than nine regions (defined by ZIP code) and charge a standard rate for each region, which they can modify up or down by 10 percent based on claims experience. They can also modify premiums for the ages of people in the group, but nothing else—not even smoking. Each carrier must take all comers and must market all its policies “fairly.”

AB 1672 also had the very specific goal of addressing job lock.¹²⁷ If a new employee was previously covered, the insurer must count that coverage toward any exclusion clauses for pre-existing conditions. In some circumstances, if a person loses small-group coverage, the carrier must issue an individual policy without any new pre-existing-condition exclusions. California law also mandates Cal-COBRA, whereby an ex-employee can stay on his old employer's small-group plan for up to a year and a half, if he pays the premiums himself.¹²⁸

To put it bluntly: these reforms did not achieve their goal of unlocking jobs. Certainly, the scholarly literature does not indicate that the state-based reforms of the early and mid 1990s broke the lock.¹²⁹ Indeed, Governor Schwarzenegger himself recently emphasized job lock as a continuing challenge to health-insurance reform in California.¹³⁰ It is remarkable that, instead of disintermediating employers from health insurance and freeing individuals to buy their own insurance, he is supporting a proposal mandating that employers offer it.

This is especially shocking because the individual market has been taking up the slack for workers whose employers are no longer able to afford over-regulated group health insurance. In 1993, when AB 1672 took effect, 57 percent of Californians had employer-sponsored health insurance. Although this figure went up during the booming economy of the late 1990s, it had dropped to 55 percent by 2006. Individually purchased health insurance increased by the same 2 percentage points, from 7 percent to 9 percent, while the total share of uninsured plus those dependent on government programs remained about the same, at 36 percent.¹³¹

If anything, California should be rolling back the harmful reforms of AB 1672, not expanding them to the individual market. However, even if California did free up small-group health insurance, we would still be subject to harmful federal laws that took effect shortly after AB 1672 and that also disguise themselves as “consumer protection.”

These policies derive from the Combined Omnibus Budget Reconciliation Act (COBRA) and the Health Insurance Portability and Accountability Act (HIPAA). According to Dick Armey, who voted for the law as Republican House Majority Leader, HIPAA was a mistake, crafted in a legislative panic for which he admits much responsibility. “It turned out that HIPAA did little to make insurance more portable, but it did set a dangerous precedent for the federal regulation of health insurance.”¹³²

If you lose your job and take COBRA and Cal-COBRA continuation insurance until it is exhausted in 18 months, you then have 63 days to apply for and purchase a guaranteed-issue HIPAA-eligible policy with an insurance company or health plan, as long as you are not eligible under a group health plan, Medicare, or Medi-Cal, and/or do not have other health-insurance coverage. HIPAA-eligible policies are each carrier's most marketed individual plans, which carriers must offer you regardless of health status.

Confused yet? Instead of trying to fix the distortions of employer-sponsored health insurance, the state should be trying to eliminate them as best it can, while encouraging Congress to fix the tax code, with its bias against individually purchased insurance.

A year ago, a colleague and I tentatively recommended a “connector,” although we were concerned that it was not possible to avoid guaranteed issue and community rating through a connector. This is because HIPAA requires that any employer contribution to a health plan define the employee as in the small group, and therefore subject to HIPAA's provisions.¹³³ This was not relevant to Massachusetts's connector, because the Commonwealth had already destroyed its market for individual health insurance through these regulations.¹³⁴

Today, there is a simpler way to achieve the goal of eliminating job lock. IRS regulations issued last August have clarified that an employer can make pre-tax payroll deductions via a Section 125 “cafeteria” plan, and use those deductions to pay a premium for an employee's individual health policy.¹³⁵ Missouri is taking advantage of this new regulation to free employees to buy individual health insurance, thus reducing the bureaucratic burden on small businesses. Instead of creating a connector or insurance exchange, Missouri House Bill 818 contained the Small Employer Health Insurance Availability Act. This act empowers a Missourian who already has an individual health plan to carry that health plan to a new job, where his employer can use a Section 125 cafeteria plan to pay the premiums for the policy. The employer can also make a contribution to the employee's insurance premiums as long as he makes the same contribution for all employees.

Governor Blunt and the legislators believe that this avoids the burden of HIPAA. Importantly, the Missouri bill does not compel a death spiral of small-group health insurance. Employers and carriers who want to continue with the status quo are free to do so, and carriers can require employers who enter small-group contracts to deliver up to three-quarters of their employees to the small-group plan, a standard precaution to reduce selection bias. Missouri HB 818 does not fully solve the problem of employer-sponsored health care. Indeed, because the U.S. Department of Labor (DOL), which regulates HIPAA, has not commented on the IRS regulations, there is a risk that the DOL might look unfavorably upon HB 818. Nevertheless, a California version of HB 818 would be a far easier, simpler, and voluntary way to eliminate job lock where it is most needed—without spending \$14.4 billion on new government programs.

Rebooting Health Care Reform in 2008 >>

A tax hike is not health reform; and ABX1 1 will achieve none of its objectives, but will send taxes and government spending into an upward spiral. The analysis in this paper suggests alternative reforms that can restore private health insurance in California, while increasing individual choice, reducing costs, and cutting—not increasing—taxes. The five proposals we made in 2007 are equally valid today. Because ABX1 1's greatest threat is to the viability of private health insurance, we emphasize alternative recommendations here, and leave Medi-Cal and provider-side proposals for subsequent papers.

First, impose no new taxes on Californians. Neither lottery funding, nor tobacco taxes, nor payroll taxes, nor raiding the federal Treasury constitutes true health reform. Instead of continuing to increase their power over our health care—a role governments have undertaken with increasingly negative consequences for over four decades—it's time for our politicians to stop destroying our ability to take control of our own health spending.

Second, repeal the California Sick Tax. California is one of the last states that continue to tax residents on their out-of-pocket health spending. Since January 2004, the federal government has allowed every working-age American to deposit pre-tax dollars into a Health Savings Account—a 401(k) for your health. This money is never taxed as long as you spend it on health care—the key word being *you*. Patients, not government bureaucrats or health-plan employees, decide how the money is spent; and Californians need the same tax break from their state government. To increase awareness of this issue, the Pacific Research Institute has launched a California Sick Tax Clock on its Web site.

Third, allow low-income workers and their employers to credit health-plan premiums toward the minimum wage. California has more low-income uninsured than other states. By allowing employers and workers to credit health premiums toward California's harmfully high minimum wage, the state can increase health insurance among low-income Californians without the job-killing effects of ABX1 1.

Fourth, make health insurers compete according to customers' preferences, not government preferences. California's over-regulation of health insurance increases premiums up to 30 percent, contributing greatly to the increasing numbers of uninsured in our state, especially among the middle class, who could and likely would buy health insurance if it were more competitively priced. At least, the state should allow us the freedom to opt out of certain benefits if we choose to.

Fifth, roll back AB 1672's guaranteed issue and community rating. If Governor Schwarzenegger and Democratic legislators cannot bring themselves to repeal these regulations in the small-group market overall, they can at least eliminate them for associations, so that Californians who affiliate through professional or other fraternal organizations can take advantage of group purchasing in a competitive market, as they did prior to 1993. For small businesses, at least modify the status quo by allowing insurers to risk-rate for smoking, which would give Californians a more appropriate incentive to quit this habit than tobacco taxes.

Finally, allow employers and employees the freedom to direct pre-tax dollars to the purchase of individual insurance, as Missouri HB 818 does. This will be especially valuable to small businesses, which, increasingly, cannot afford small-group policies, but which employ young workers who would buy low-cost, individual policies.

A tax increase is not health reform. In 2008, let's resolve to give health-care power—and dollars—to the people, not to politicians and their favored interest groups.

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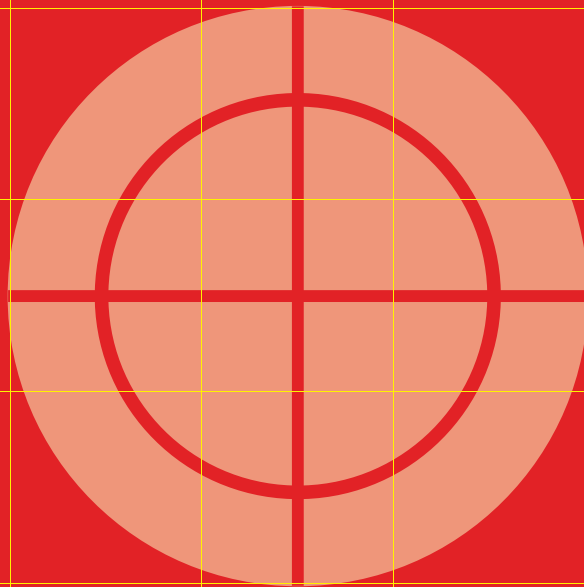
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